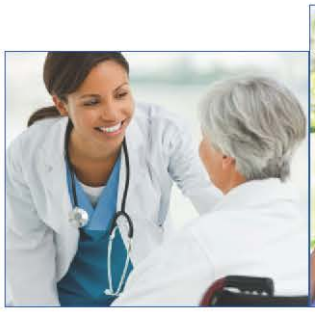
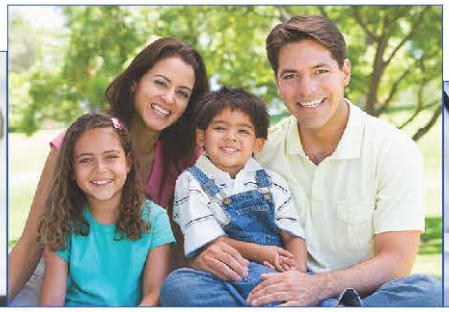
AGENCY FOR HEALTH CARE ADMINISTRATION

SFY 2020-2021

External Quality Review Technical Report

May 2022

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Glossary of Acronyms

42 CFR	Title 42 of the Code of Federal Regulations
AAAHC	Accreditation Association for Ambulatory Health Care
AAPD	American Academy of Pediatric Dentistry
ADHD	Attention-Deficit/Hyperactivity Disorder
ADT	Admission, Discharge, and Transfer
Agency	Florida Agency for Health Care Administration
AOD	Alcohol or Other Drug
BMI	Body Mass Index
C-section	Caesarean Section
CAP	Corrective Action Plan
CCM	Chronic Care Management
CHIP	Children's Health Insurance Program
CHW	Case Health Worker
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
CQS	Comprehensive Quality Strategy
CY	Calendar Year
DOH	Department of Health
DY	Demonstration Year
ED	Emergency Department
ENS	Encounter Notification Service
EQR	External Quality Review
EQRO	External Quality Review Organization
FAR	Final Audit Report
FFS	Fee-for-Service
FFY	Federal Fiscal Year
HbA1c	Hemoglobin A1c
HEDIS®,*	Healthcare Effectiveness Data and Information Set
HHS	United States Department of Health and Human Services
HIPPA	Health Insurance Portability and Accountability Act
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HPV	Human Papillomavirus

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

HSAG.....Health Services Advisory Group, Inc.
IS.....Information Systems
ITN.....Invitation to Negotiate
LO.....Licensed Organization
LTC.....Long-Term Care
LTSS.....Long-Term Services and Supports
MAT.....Medication-Assisted Treatment
MCO.....Managed Care Organization
MCP.....Managed Care Plan
MCRC.....Managed Care Rule Compliance
MLTSS.....Managed Long-Term Services and Supports
MMA.....Managed Medical Assistance
MRRV.....Medical Record Review Validation
MSR.....Member Service Representative
MY.....Measurement Year
NA.....Not Applicable
NABD.....Notice of Adverse Benefit Determination
NAS.....Neonatal Abstinence Syndrome
NCQA.....National Committee for Quality Assurance
NR.....Not Reported
OCR.....Office of Clinical Research
PAHP.....Prepaid Ambulatory Health Plan
PCCM.....Primary Care Case Management
PCP.....Primary Care Practitioner
PDP.....Primary Dental Practitioner
PDSA.....Plan-Do-Study-Act
PHE.....Public Health Emergency
PIHP.....Prepaid Inpatient Health Plan
PIP.....Performance Improvement Project
PMV.....Performance Measure Validation
PNOU.....Provider Network Oversight Unit
PPA.....Potentially Preventable Admission
PPE.....Potentially Preventable Event
PPR.....Potentially Preventable Readmission
PPV.....Potentially Preventable ED Visit
PRM.....Provider Relations Management

QI ..... Quality Improvement
RY ..... Reporting Year
SAPO ..... State-Authorized Portable Order
SFY ..... State Fiscal Year
SME ..... Subject Matter Expert
SMMC ..... Statewide Medicaid Managed Care
Tdap ..... Tetanus, Diphtheria, and Pertussis
TOC ..... Transition of Care
UM ..... Utilization Management

Executive Summary

1

Introduction to the Annual Technical Report

Overview and Purpose Statement

Title 42 of the Code of Federal Regulations (42 CFR) §438.364 requires that states use an external quality review organization (EQRO) to prepare an annual technical report that describes the manner in which data from activities conducted for Medicaid managed care organizations (MCOs), in accordance with the CFR, were aggregated and analyzed. Health Services Advisory Group, Inc. (HSAG) used the United States Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services' (CMS') December 2018 update of its External Quality Review (EQR) Toolkit for States when preparing this report.[1-1] To meet this requirement, the Florida Agency for Health Care Administration (Agency) contracted with HSAG as its EQRO to perform the assessment and produce this report for EQR activities conducted.

The purpose of this state fiscal year (SFY) 2020–2021 External Quality Review Technical Report is to draw conclusions about the quality, timeliness, and access to healthcare services provided by the contracted MCOs.

Overview of Florida's Managed Care Program

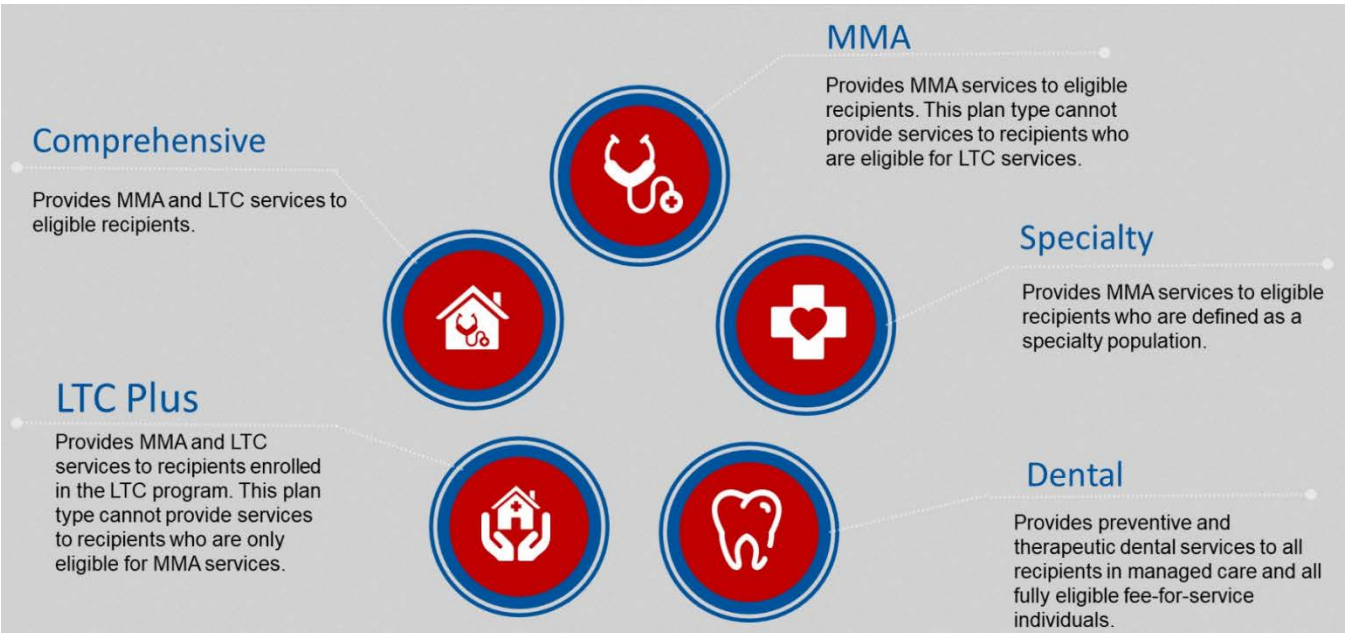
Statewide Medicaid Managed Care Program

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

[1-1] Centers for Medicare & Medicaid Services. CMS-R-305, External Quality Review (EQR) of Medicaid Managed Care, EQR Protocols, and Supporting Regulations. Available at: https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-R-305.html. Accessed on: Mar 9, 2022.

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

Figure 1-1—Florida Plan Types



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

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

Please see Appendix A for a list of the plans. Appendix B includes the Medicaid managed care enrollment for each plan.

Florida Medicaid Managed Care Demographics

The demographics of the Florida Medicaid population (excluding the fee-for-service [FFS] population) as of June 2021 were as follows.[1-2]

- Approximately 3.5 million were enrolled in a comprehensive or standard MMA plan.
- Approximately 170,000 were enrolled in an specialty plan.
- Approximately 121,000 were enrolled in the LTC program.
- Approximately 4 million were enrolled in a dental plan.

Quality Strategy

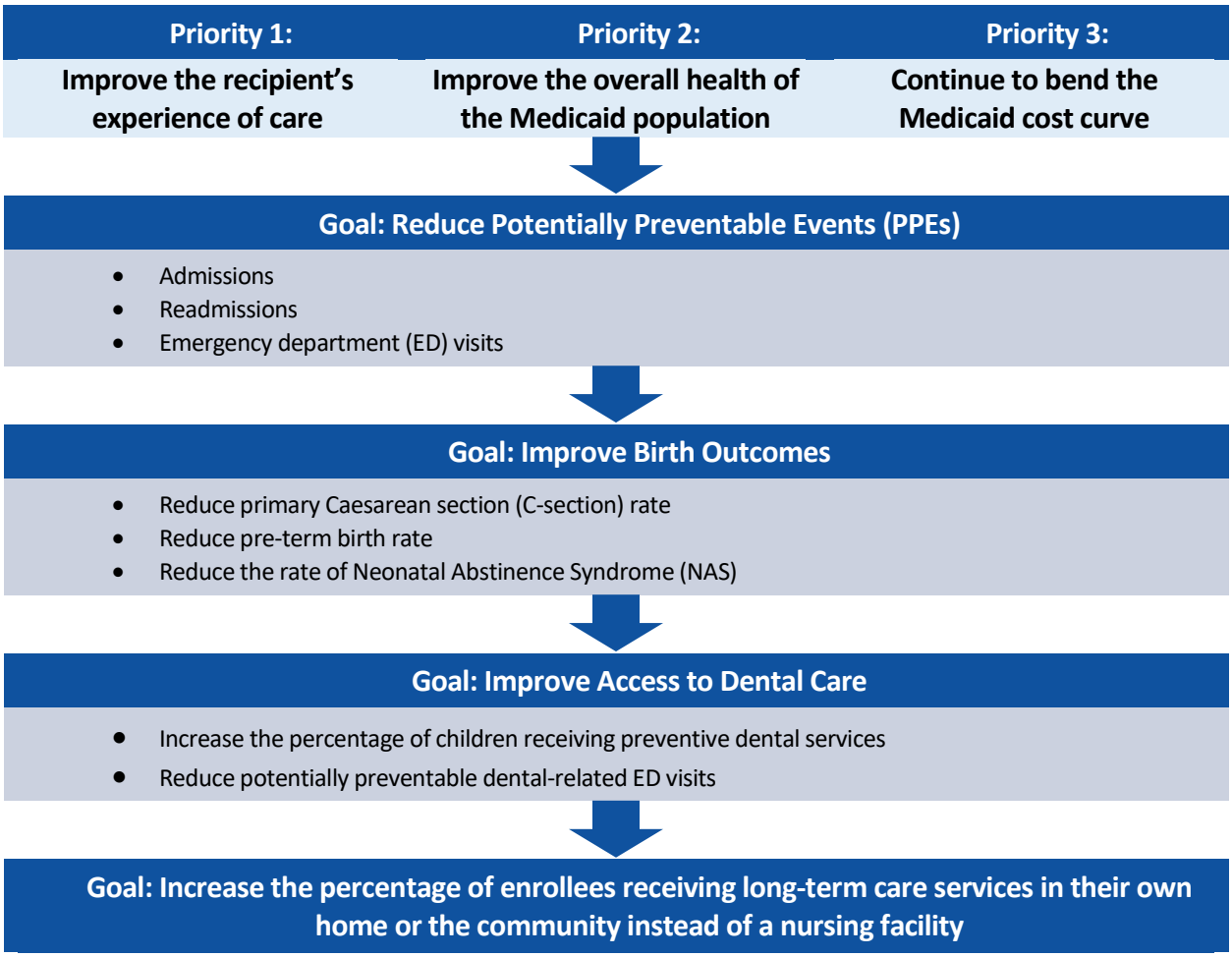
CMS Medicaid managed care regulations at 42 CFR §438.340 require Medicaid state agencies operating Medicaid managed care programs to develop and implement a written quality strategy for assessing and improving the quality of healthcare services offered to their enrollees and update it every three years.

The Comprehensive Quality Strategy (CQS) outlines Florida's strategy for assessing and improving the quality of healthcare and services furnished by the plans and other providers within the Florida Medicaid system.[1-3] The Agency began the process of updating the CQS during demonstration year (DY) 13 and completed this process during DY 14 (July 1, 2019, through June 30, 2020). The updated CQS addresses various strategies to assess progress toward meeting the Agency's goals. The Agency's established goals seek to build upon the success of the SMMC program and to ensure that quality improvement (QI) is a continual process.

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

[1-2] Agency for Health Care Administration. Florida Statewide Medicaid Monthly Enrollment Report. Available at: https://ahca.myflorida.com/medicaid/finance/data_analytics/enrollment_report/index.shtml. Accessed on: Mar 9, 2022.
[1-3] Agency for Health Care Administration. Comprehensive Quality Strategy. Available at: https://ahca.myflorida.com/medicaid/policy_and_quality/quality/docs/Comprehensive_Quality_Strategy_Report.pdf. Accessed on: Mar 9, 2022.

Figure 1-2—Three Priorities and Corresponding Goals[1-4]



Scope of External Quality Review Activities

To conduct this assessment, HSAG used the results of mandatory and optional EQR activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by CMS (CMS EQR protocols).[1-5] The purpose of these activities, in general, is to improve states' ability to oversee and manage plans they contract with for services, and help plans improve their performance with respect to quality, timeliness, and access to care. Effective implementation of the EQR-related activities will facilitate state efforts to purchase high-value care and to achieve higher-performing healthcare delivery systems for their Medicaid and Children's Health Insurance Program (CHIP) members. For the SFY 2020–2021 assessment, HSAG used findings

[1-4] Ibid

[1-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 9, 2022.

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

Table 1-1—EQR Activities

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

* Until the CMS network adequacy validation protocol is issued, there are only three mandatory EQR-related activities.
** HSAG received the documentation for compliance monitoring for this activity from the Agency.

Aggregating and Analyzing Statewide Data

For each comprehensive, standard, and specialty plan, HSAG analyzed the results obtained from each EQR activity. From these analyses, HSAG determined which results were applicable to the domains of quality, timeliness, and access to care and services. HSAG then analyzed the data to determine if common themes or patterns existed that would allow conclusions about the overall quality, timeliness, and access to care and services to be drawn for each plan independently and the overall program. Detailed information about each activity's methodology is provided in Appendix C of this report. For a detailed, comprehensive discussion of the strengths, weaknesses, conclusions, and recommendations for each plan, please refer to the results of each activity in sections 2 through 4 of this report, as well as in Appendix D for a plan-specific analysis.

Quality, Timeliness, Access

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

Quality

as it pertains to EQR, means the degree to which an MCO, prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics, the provision of services that are consistent with current professional, evidence-based knowledge, and interventions for performance improvement.[1]

Timeliness

as it pertains to EQR, is described by the National Committee for Quality Assurance (NCQA) to meet the following criteria: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care).

Access

as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by MCPs successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services). Under §438.206, availability of services means that each state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner.[1]

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

How Conclusions Were Drawn From EQRO Activities

To draw conclusions about the quality, timeliness, and access to care provided by the plans, HSAG assigned each of the EQR activities to one or more of three domains. Assignment to these domains is depicted in Table 1-2.

Table 1-2—EQR and Agency Activities and Domains

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

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

Florida Managed Care Program Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from SFY 2020–2021 to comprehensively assess the plans' performance in providing quality, timely, accessible healthcare services to Agency Medicaid and CHIP members. For each plan reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the plans' performance, which can be found in sections 2 through 4 and Appendix D of this report. The overall findings and conclusions for all plans were also compared and analyzed to develop overarching conclusions and recommendations for the Florida managed care program. Table 1-3 highlights substantive findings and actionable state-specific recommendations, when applicable, for the Agency to further promote its CQS goals and objectives.

Table 1-3—Florida Managed Care Program Substantive Findings

Strengths	Program Strengths
	Quality • **Overall:** The Agency provided evidence of strong follow-up on deficiencies identified during plan readiness reviews and through its regular and ongoing monitoring and oversight of plan performance. The Agency also provided evidence of ongoing compliance monitoring by Agency subject matter experts (SMEs), which enabled a more thorough review of the plans' operational elements related to the quality, timeliness, and access to care and services. • **Overall:** The Agency required MMA, LTC, and dental plans to be accredited by a private accreditation organization. As part of the accreditation process, all plans undergo a HEDIS Compliance Audit conducted by the plans' contracted NCQA licensed organization (LO). A review of the comprehensive, standard, and specialty MMA plans' HEDIS measurement year (MY) 2020 final audit reports (FARs) showed all plans were fully compliant with NCQA HEDIS Compliance Audit information systems (IS) standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0. • **MMA plans:** The statewide average met or exceeded the Agency's minimum performance targets (the 25th percentile) for 23 of 38 (60.5 percent) measure indicators (Figure 1-3). • **MMA plans:** In the Pediatric Care domain, the statewide average for the *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Continuation and Maintenance Phase* measure indicator met or exceeded the performance target. The results suggest that providers followed up with children after being diagnosed with ADHD through the continuation of their treatment to ensure their medication levels were managed appropriately. • **MMA plans:** In the Living With Illness domain, the statewide average for the *Asthma Medication Ratio—Total* measure indicator met or exceeded the Agency's performance target. The results suggest that members with persistent asthma are receiving recommended care and are better able to control their chronic condition.

Program Strengths	
Strengths	

- **LTC plans:** Of the seven measure indicators for which performance targets were established, five statewide rates in the LTC program met or exceeded the Agency's reporting year (RY) 2021 performance targets.
- **LTC plans:** Of the 15 performance measure indicators reported for the LTC program, eight of the statewide rates demonstrated an improvement of more than 3 percentage points from RY 2020 to RY 2021.
- **The LTC plans results indicate that**:
  - The plans had established documentation of in-person comprehensive assessments, comprehensive care plans, and shared care plans to promote the coordination of long-term services and supports (LTSS).
  - Plans were conducting timely assessments and creating care plans with their members.
  - Members were screened for history of falls and received a risk assessment to prevent future falls.

Timeliness

- **MMA plans:** Fourteen performance measure indicators that were comparable to established benchmarks and related to timeliness were evaluated as part of the Pediatric Care, Women's Care, and Behavioral Health domains.
  - The statewide average met or exceeded the Agency's minimum performance targets for seven of 14 (50.0 percent) measure indicators (Figure 1-4).
- **Overall:** Performance measure results suggest children received a dental treatment service. Additionally, children visited a dentist within seven days of their ED visit to ensure the wellbeing of oral health and to avoid further potential emergency care.

Access

- **Overall:** Access to care was demonstrated through the results of the *Administration of the Transportation Benefit* PIP. All three plans that progressed to reporting Remeasurement 1 rates (Prestige-M, United-C, and Staywell-C), demonstrated statistically significant improvement over the baseline.
- **MMA plans:** Seventeen performance measure indicators that were comparable to benchmarks and related to access were evaluated as part of the Pediatric Care, Women's Care, Behavioral Health, Access/Availability of Care, and Appropriate Treatment and Utilization domains. Eight of seventeen (47.1 percent) performance indicators related to access met or exceeded the Agency's minimum performance targets (Figure 1-4).

Program Weaknesses	
Weaknesses	Note: When referring to the performance target comparisons bulleted below, caution should be used between the comparisons due to the impact of the COVID-19 PHE.

Quality

- **Overall:** Although regular compliance monitoring, oversight, and reviews occurred, the Agency did not demonstrate compliance with the CMS Medicaid Managed Care Rule requirements for conducting a comprehensive compliance review every three years. However, the Agency has since then put into place a process to ensure compliance going forward.
- **Overall:** Plan PIP documentation identified opportunities for improvement. Plans did not consistently report cumulative annual data for PIP performance indicators, as required.
- **MMA plans:** One of three statewide average Women's Care rates related to women's preventive screenings fell below the minimum performance targets. Additionally, the statewide average rate of the *Cervical Cancer Screening* measure demonstrated a decline of more than 4 percentage points from RY 2020 to RY 2021.
- **MMA plans:** In the Women's Health domain, the statewide average rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator declined more than 8 percentage points and fell below the minimum performance target.
- **MMA plans:** In the Living With Illness domain, the statewide average rates for three of the four *Comprehensive Diabetes Care* measure indicators fell below the minimum performance targets and three measure indicator rates demonstrated a decline of more than 3 percentage points from RY 2020 to RY 2021.
- **MMA plans:** In the Living With Illness domain, the statewide average rates for two of the three *Medical Assistance With Smoking and Tobacco Use Cessation* measure indicators fell below the minimum performance targets and demonstrated a decline of more than 3 percentage points from RY 2020 to RY 2021.
- **LTC plans:** The statewide average for the *LTSS Minimizing Institutional Length of Stay* measure declined more than 21 percentage points, and the statewide average for the *LTSS Successful Transition After Long-Term Institutional Stay* measure declined more than 11 percentage points from RY 2020 to RY 2021.

Timeliness

- **MMA plans**: The statewide average for the *Follow-Up After ED Visit for Mental Illness* and the *Follow-Up After ED Visit for Alcohol or Other Drug (AOD) Abuse or Dependence* measures in the Behavioral Health domain fell below the minimum performance targets.
- **MMA plans**: In the Behavioral Health domain, the statewide average rates for the three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure indicators declined more than 5 percentage points from RY 2020 to RY 2021. Additionally, the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total* measure indicator rate fell below the minimum performance target.

Program Weaknesses

Weaknesses

Access

- For the *Preventive Dental Services for Children* PIP, there was a decline or no improvement in the PIP performance indicator rate, despite evidence of clinically significant or programmatically significant improvement in PIP outcomes.
- **MMA plans:** The statewide average declined for pediatric care measures pertaining to the immunizations of children and adolescents, and the rate for the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tetanus, Diphtheria, and Pertussis [Tdap])* measure indicator fell below the minimum performance target.
- **LTC plans:** The statewide average for the *Screening, Risk Assessment, and Plan of Care to Prevent Future Falls—Falls Part 2—Plan of Care for Falls* measure indicator declined more than 14 percentage points from RY 2020 to RY 2021.
- **Dental plans:** The statewide average for the following measure indicators declined more than 5 percentage points from RY 2020 to RY 2021:
  - *Annual Dental Visits—Total*
  - *Topical Fluoride for Children at Elevated Caries Risk—Total*
  - *Oral Evaluation—Total*
  - *Follow-Up After ED Visits for Dental Caries in Children—30 Day Follow-Up—Total*
  - *Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk—Total*
  - *Follow-Up After Dental-Related ED Visits*

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

This section describes how the state can target goals and objectives in the quality strategy, under 42 CFR §438.340, to better support improvement in the quality, timeliness, and access to healthcare services furnished to Medicaid enrollees.

Domain	Program Recommendations	Quality Strategy Priority, Goal, & Objective
Quality	• HSAG recommends that the Agency implement its planned process to conduct compliance reviews of all plans within the required three-year cycle. The Agency should utilize the tools provided by HSAG to ensure that all standards required in the CMS Medicaid Managed Care Rule are reviewed during the compliance reviews. Complete results of each plan's compliance reviews and follow-up on corrective actions should be submitted to HSAG annually to demonstrate compliance with conducting compliance reviews. • HSAG recommends that the MMA plans conduct a root cause analysis or focus study to determine why: – Female members are not receiving timely screenings. – Pregnant members are not obtaining prenatal care. – Members are not receiving timely recommended screenings for diabetes. – Members are not quitting tobacco use. • HSAG recommends that, upon identification of a root cause, plans implement appropriate interventions to improve utilization of women's screenings, prenatal care, and recommended diabetes care. • HSAG recommends that plans consider if there are disparities within their populations that contributed to lower performance in a particular race or ethnicity, age group, ZIP code, etc.	**Priorities:** • Improve the overall health of the Medicaid population • Continue to bend the Medicaid cost curve **Goals:** • Reduce PPEs • Improve birth outcomes • Improve access to dental care • Increase the percentage of enrollees receiving long-term care services in their own home or the community instead of a nursing facility
Timeliness	• HSAG recommends that the MMA plans enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs. • HSAG recommends that the plans conduct a root cause analysis to determine why:	**Priorities:** • Improve the recipient's experience of care • Improve the overall health of the Medicaid population • Continue to bend the Medicaid cost curve

Domain	Program Recommendations	Quality Strategy Priority, Goal, & Objective
	– Members who access the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, HSAG recommends the plans increase the use of telehealth services. – Members are not receiving regular metabolic testing. Upon identification of a root cause, HSAG recommends that the health plans implement appropriate interventions to improve the performance related to metabolic testing. • HSAG recommends that plans consider if there are disparities within their populations that contributed to lower performance in a particular race or ethnicity, age group, ZIP Code, etc.	**Goals:** • Reduce PPEs • Improve birth outcomes • Improve access to dental care • Increase the percentage of enrollees receiving long-term care services in their own home or the community instead of a nursing facility
Access	• HSAG recommends that the MMA plans conduct a root cause analysis or focus study to determine why child and adolescent members are not receiving all recommended vaccines. HSAG recommends that, upon identification of a root cause, plans implement appropriate interventions to improve the quality, timeliness, and access to care and services. • HSAG recommends that the LTC plans continue to monitor their rates over time to identify coronavirus disease 2019 (COVID-19) public health emergency (PHE) rate impact, ensuring lower quality of and access to care are not driven by a non-PHE cause. • HSAG recommends the dental plans continue to monitor their rates over time to identify PHE rate impact, ensuring lower access to dental care is not driven by a non-PHE cause, and adopt QI strategies to improve rates. If access to care is the reason for lower rates, the plans should also evaluate their networks to ensure enough providers are available to ensure access to services for members. • HSAG recommends that plans consider if there are disparities within their populations that contributed to lower performance in a particular race or ethnicity, age group, ZIP Code, etc.	**Priorities:** • Improve the overall health of the Medicaid population • Continue to bend the Medicaid cost curve **Goals:** • Reduce PPEs • Improve birth outcomes • Improve access to dental care • Increase the percentage of enrollees receiving long-term care services in their own home or the community instead of a nursing facility

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

Review of Compliance

The compliance review evaluates plan compliance with federal and state requirements and includes all required CMS standards and related Florida-specific plan contract requirements. The Agency conducts compliance monitoring activities for each plan at least once during each three-year EQR cycle. The compliance review standards are derived from the requirements as set forth in the *Department of Human Services, Division of Health Care Financing and Policy Request for Proposal No. 3260 for Managed Care*, and all attachments and amendments in effect during the review period. During 2021, the Agency monitored the plans' implementation of federal and state-specific requirements.

In addition, federal regulations allow the Agency to exempt an MCO, PIHP, or PAHP from a review of certain administrative functions when the plan's Medicaid contract has been in effect for at least two consecutive years before the effective date of the exemption, and during those two years the plan has been subject to EQR and found to be performing acceptably for the quality, timeliness, and access to healthcare services it provides to Medicaid beneficiaries.

Performance Improvement Projects

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

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

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

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

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

The Agency also contractually required the health plans to focus on mental/behavioral health or the integration of mental healthcare with primary care as a plan-selected third PIP topic. In SFY 2020−2021, the Agency amended the requirement for a plan-selected third PIP topic to that of a mandated requirement of initiating a new behavioral health PIP, *Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and ED Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence.* This amendment was initiated by the Agency after considering historical and calendar year (CY) 2019 HEDIS data for the targeted measures and the effects of the COVID-19 PHE.

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

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

Table 1-4 displays the PIP topics and the type of review conducted by HSAG for the health plans.

Table 1-4—SFY 2020–2021 PIP Topics and Review Type for Health Plans

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

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

^ This PIP topic was discontinued by Florida Community Care-L because the PIP topic was not applicable to the LTC Plus population served by the health plan. Additionally, Florida Community Care-L did not submit the *Reducing PPEs* PIP. Florida Community Care-L indicated that it is in discussion with the Agency regarding the appropriateness of the PIP data for the population served by the health plan.

The dental plans submitted three state-mandated PIPs. Table 1-5 displays the PIP topics and the type of review conducted by HSAG for the dental plans. SFY 2020–2021 was the third year for the validation and review of all three topics.

Table 1-5—SFY 2020–2021 PIP Topics and Review Type for Dental Plans

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

Performance Measure Validation

HSAG conducted PMV activities for the measures calculated and reported by the comprehensive plans, standard MMA plans, specialty plans, dental plans, and one LTC Plus plan for SFY 2020–2021. All plan measure indicator data were audited by an NCQA LO in line with the NCQA HEDIS Compliance Audit policies and procedures. HSAG's role in the validation of performance measures was to ensure that audit activities conducted by the LO were consistent with the CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019 (CMS Protocol 2).[1-7] This included validating the audit process to ensure key audit activities were performed and verifying that performance measure indicator rates were collected, reported, and calculated according to the specifications required by the state.

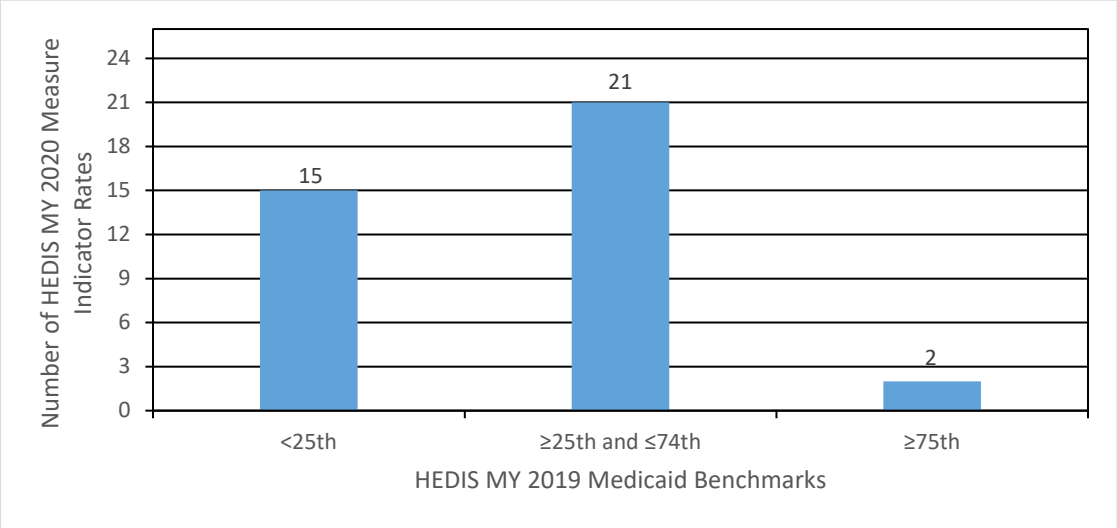
MMA Program

Plans were required to report 76 performance measure indicators. The Agency established performance targets for 40 of the measure indicators based on the HEDIS MY 2019 Quality Compass national Medicaid All Lines of Business 75th percentile. Minimum performance targets were also established based on the 25th percentile. When referring to the performance target comparisons, caution should be used between the comparisons due to the impact of the COVID-19 PHE. Factors that may have contributed could include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The measure indicators were grouped into six domains (Pediatric Care, Women's Care, Living With Illness, Behavioral Health, Access/Availability of Care, and Appropriate Treatment and Utilization). In addition to the 76 measure indicators, comprehensive MMA plans were required to report on the 15 LTC measure indicators. Out of the 76 measure indicators, eight measure indicators were to be reported by the specialty plans only. HSAG received FARs that contained IS capability findings from all comprehensive, standard, and specialty plans. For the current MY, all plans were fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.

[1-7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: March 8, 2022.

Thirty-eight performance measure indicators comparable to benchmarks and related to **quality** were evaluated as part of the Pediatric Care, Women's Care, Living With Illness, Behavioral Health, and Access/Availability of Care domains. Of the 38 measure indicators related to quality, two (5.3 percent) met or exceeded the Agency-established performance targets (the 75th percentile). The statewide average met or exceeded the Agency's minimum performance targets (the 25th percentile) for 23 of 38 (60.5 percent) measure indicators.

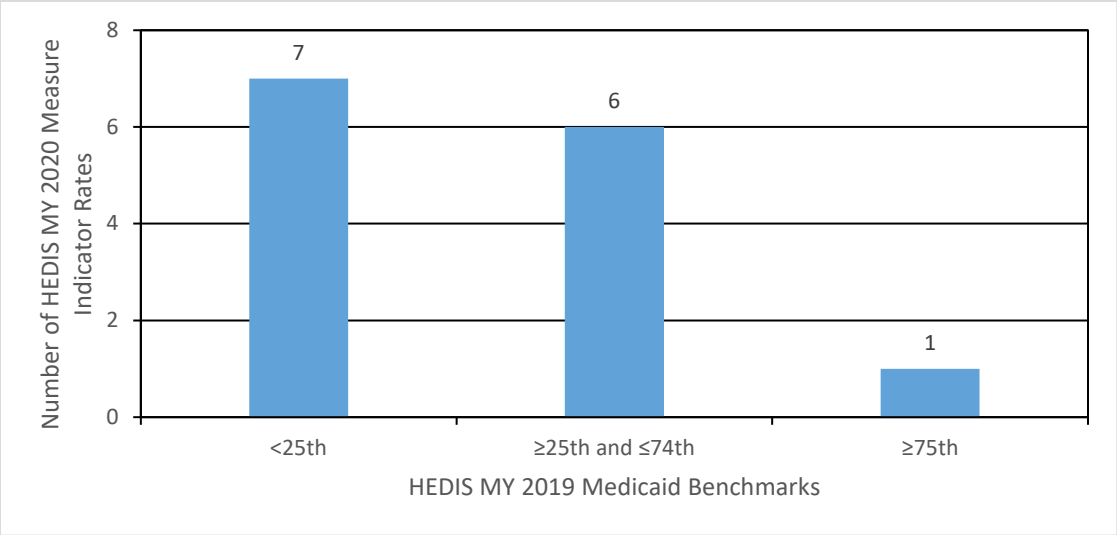
Figure 1-3—Performance Indicator Results Related to Quality



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

Fourteen performance measure indicators comparable to benchmarks and related to **timeliness** were evaluated as part of the Pediatric Care, Women's Care, and Behavioral Health domains. One of the 14 (7.1 percent) measure indicators in this area met or exceeded the Agency-established performance targets. The statewide average met or exceeded the Agency's minimum performance targets for seven of 14 (50.0 percent) measure indicators.

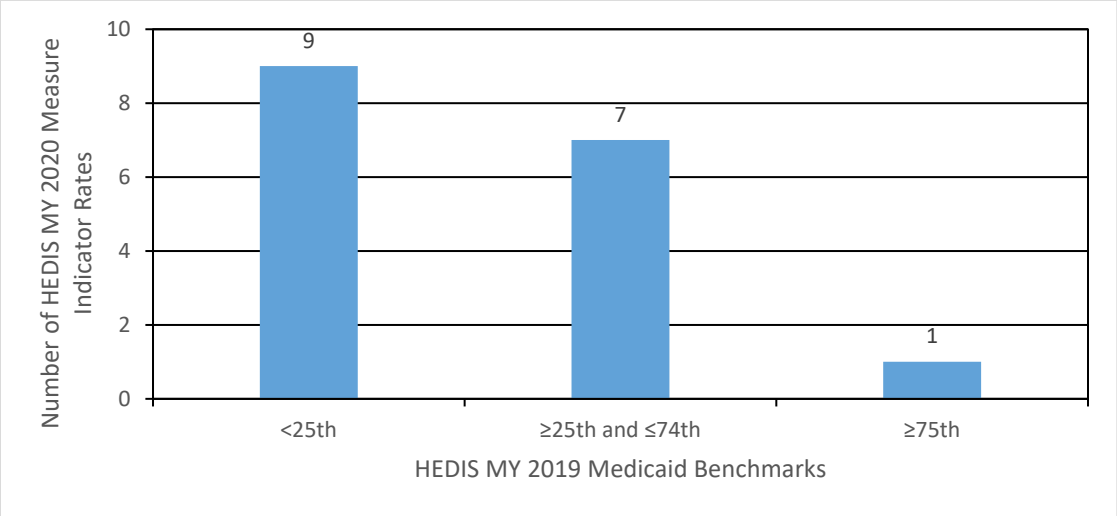
Figure 1-4—Performance Indicator Results Related to Timeliness



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

Seventeen performance measure indicators comparable to benchmarks and related to **access** were evaluated as part of the Pediatric Care, Women's Care, Behavioral Health, Access/Availability of Care, and Appropriate Treatment and Utilization domains. One of the 17 measure indicators in this area met or exceeded the Agency-established performance targets. The statewide average met or exceeded the Agency's minimum performance targets for eight of 17 (47.1 percent) measure indicators.

Figure 1-5—Performance Indicator Results Related to Access



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

Long-Term Care Program

For RY 2021, the comprehensive MMA plans and the one LTC Plus plan were required to report 15 Agency-required measure indicators. The Agency established performance targets for seven of those measure indicators. HSAG had no concerns with the data systems and processes used by the plans for LTC measure calculations based on the information presented in the FARs and/or final audit statements. The plans reporting LTC measures continued to have adequate validation processes in place to ensure data completeness and accuracy. Five of seven (71.4 percent) measure indicators for which performance targets were established met or exceeded the performance targets for reported LTC Managed Long-Term Services and Supports (MLTSS)/HEDIS measures (85 percent for each measure indicator). HSAG received FARs that contained IS capability findings from all MMA and LTC plans. For the current MY, all plans were fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.

Dental Plans

For RY 2021, the dental plans were required to report 12 dental measure indicators. HSAG had no concerns with the data systems and processes used by the plans for dental measure calculations based on the information presented in the FARs and/or final audit statements. HSAG received FARs that contained IS capability findings from all three dental plans. For the current MY, all plans were fully compliant with the requirement that all three plans be audited by an LO.

Performance Snapshot

Table 1-6 shows the statewide average performance as compared to the Agency-identified performance targets and minimum performance targets, which were established based on NCQA's Quality Compass national Medicaid All Lines of Business 75th and 25th percentiles, respectively, for HEDIS MY 2019, and statewide rate increases or decreases from RY 2020 to RY 2021. When referring to the performance target comparisons, caution should be used between the comparisons due to the impact of the COVID-19 PHE. Factors that may have contributed could include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. Performance results for the comprehensive, standard, and specialty plans are grouped into the following domains of care:

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

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

Table 1-6—Performance Snapshot SFY 2021◊

Domain of Care	# of Rates	Met or exceeded the performance target (75th percentile)	Ranked below the minimum performance target (25th percentile)	↑ Improved from prior year*	↓ Declined from prior year**
Pediatric Care	**8**	▪ *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*	▪ *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*	▪ *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*	▪ *Childhood Immunization Status—Combination 2* and *Combination 3* ▪ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Body—Mass Index (BMI) Percentile Documentation—Total*
Women's Care	**5**	▪ *None*	▪ *Cervical Cancer Screening* ▪ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*	▪ *None*	▪ *Breast Cancer Screening* ▪ *Cervical Cancer Screening* ▪ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
Living With Illness	**8**	▪ *Asthma Medication Ratio—Total*	▪ *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, HbA1c Poor Control (>9.0%)*, and *Eye Exam (Retinal) Performed* ▪ *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications—Total* and *Discussing Cessation Strategies—Total*	▪ *None*	▪ *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed* ▪ *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications—Total* and *Discussing Cessation Strategies—Total*
Behavioral Health	**16**	▪ *None*	▪ *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total* ▪ *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* ▪ *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*	▪ *None*	▪ *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total, Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total*

Domain of Care	# of Rates	Met or exceeded the performance target (75th percentile)	Ranked below the minimum performance target (25th percentile)	↑ Improved from prior year*	↓ Declined from prior year**
			▪ *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total* ▪ *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*		
Access/ Availability of Care	**1**	▪ *None*	▪ *Adults' Access to Preventive/Ambulatory Health Services—Total*	▪ *None*	▪ *Adults' Access to Preventive/Ambulatory Health Services—Total*
Appropriate Treatment and Utilization	**2**	▪ *None*	▪ *Use of Opioids at High Dosage*	▪ *None*	▪ *None*
Long-Term Care^	**15**	▪ *LTSS Comprehensive Assessment and Update—Assessment of Core Elements* and *Assessment of Supplemental Elements* ▪ *LTSS Comprehensive Care Plan and Update—Care Plan With Core Elements* and *Care Plan With Supplemental Elements* ▪ *LTSS Shared Care Plan With Primary Care Practitioner (PCP)* ▪	▪ *None*	▪ *LTSS Comprehensive Assessment and Update—Assessment of Core Elements* and *Assessment of Supplemental Elements* ▪ *LTSS Comprehensive Care Plan and Update—Care Plan With Core Elements* and *Care Plan With Supplemental Elements* ▪ *LTSS Shared Care Plan With PCP* ▪ *LTSS Reassessment/Care Plan Update After Inpatient Discharge—Reassessment After Inpatient Discharge* and *Reassessment and Care Plan Update After Inpatient Discharge* ▪ *Screening, Risk Assessment, and Plan of Care to Prevent Future Falls—Falls Part 1—Screening*	▪ *Screening, Risk Assessment, and Plan of Care to Prevent Future Falls—Falls Part 2—Plan of Care for Falls* ▪ *LTSS Minimizing Institutional Length of Stay* ▪ *LTSS Successful Transition After Long-Term Institutional Stay*

Domain of Care	# of Rates	Met or exceeded the performance target (75th percentile)	Ranked below the minimum performance target (25th percentile)	↑ Improved from prior year*	↓ Declined from prior year**
Dental Care#	12	▪ *None*	▪ *None*	▪ *None*	▪ *Annual Dental Visits—Total* ▪ *Topical Fluoride for Children at Elevated Caries Risk—Total* ▪ *Oral Evaluation—Total* ▪ *Follow-Up After ED Visits for Dental Caries in Children—30 Day Follow-Up—Total* ▪ *Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk—Total* ▪ *Follow-Up After Dental-Related ED Visits*

◊ Indicates using caution when comparing performance targets between RY 2020 and RY 2021 due to the impact of the COVID-19 PHE.
* Statewide rate demonstrated an increase of more than 3 percentage points from RY 2020 to RY 2021.
** Statewide rate demonstrated a decline of more than 3 percentage points from RY 2020 to RY 2021.
# A plan-specific target was identified by the Agency for one dental measure.
^ The Agency established performance targets for four reported LTC MLTSS/HEDIS measures (85 percent for each measure indicator).

Review of Compliance

2

Background

This section presents line-of-business-specific results and conclusions of the Agency's monitoring, oversight, and review of plan compliance with Medicaid and CHIP managed care regulations. The Agency's Managed Care Rule Compliance (MCRC) internal team meets regularly to develop and implement plans for the federal compliance review process. As a result of the COVID-19 PHE, the Agency conducted a comprehensive desk review that included the use of tools designed to include all federal compliance review requirements during its monitoring and oversight processes. The Agency's process was designed to evaluate each plan's compliance with federal and state requirements. The Agency's process included a review of plan documentation submitted as evidence of each plan's compliance with the CMS Medicaid Managed Care Rule and state-specific contract requirements.

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

Table 2-1—Florida Compliance Reviews for All Plans

Standard #	Standard	SFY 2021	Quality	Timeliness	Access
Provider Network Management					
I	Availability of Services	✓	✓	✓	✓
II.	Assurance of Adequate Capacity and Services	✓	✓	✓	✓
V.	Provider Selection	✓	✓	✓	✓
VIII.	Subcontractual Relationships and Delegation	✓	✓	✓	✓
Member Services and Experiences					
III.	Coordination and Continuity of Care	✓	✓	✓	✓
IV.	Coverage and Authorization of Services	✓	✓	✓	✓
VI.	Confidentiality	✓	✓		
VII.	Grievance and Appeal System	✓	✓	✓	✓
XIII.	Enrollee Rights	✓	✓		
XIV.	Emergency and Poststabilization Services	✓	✓	✓	✓

Standard #	Standard	SFY 2021	Quality	Timeliness	Access
Managed Care Operations					
IX.	Practice Guidelines	✓	✓		
X.	Health Information Systems	✓	✓	✓	✓
XI.	QAPI Program	✓	✓	✓	✓
XII.	Disenrollment Requirements and Limitations	✓		✓	✓

Accreditation

The Agency required the plans to be accredited by a national accrediting body. The plans were accredited by NCQA, URAC, or the Accreditation Association for Ambulatory Health Care (AAAHC). Table 2-2 includes the plans' private accreditation status, including the accrediting body and accreditation expiration date for each contracted plan.

Table 2-2—Plan Private Accreditation Status

Plan	Accrediting Body	Expiration Date of Accreditation
Aetna Better Health-C (AET-C)	NCQA	03/25/23
Children's Medical Services-S (CMS-S)	NCQA	02/02/25
Community Care Plan-M (CCP-M)	URAC	12/02/24
DentaQuest (DQT-D)	NCQA	03/23/23
Florida Community Care-L (FCC-L)	AAAHC	12/11/22
Humana-C (HUM-C)	NCQA	12/03/22
Liberty (LIB-D)	URAC	07/01/22
MCNA (MCA-D)	URAC and NCQA	12/01/23
Molina-C (MOL-C)	NCQA	01/22/23
Prestige-M (PRS-M)	NCQA	10/12/24
Simply-C (SHP-C)	NCQA	07/10/22
Sunshine–C (SUN-C)	NCQA	02/02/25
United-C (URA-C)	NCQA	02/06/22
Vivida-M (BST-M)	NCQA	12/08/23

The Agency deemed select review findings from the plans' private national accrediting organization survey, as allowed under the procedures in 42 CFR §422.158, to meet a portion of the compliance review requirements. Table 2-3 indicates the number of elements for each plan identified as meeting the deeming requirements in order to meet a portion of the EQR compliance review requirements.

Table 2-3—Compliance Review Elements Deemed

Standard #	Standard Name	Total Elements in Standard	Number of Elements Deemed													
			AET-C	BST-M	CMS-S	CCP-M	DQT-D	FCC-L	HUM-C	LIB-D	MCA-D	MOL-C	PRS-M	SHP-C	SUN-C	URA-C
I	Enrollment and Disenrollment	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0
II	Member Rights and Confidentiality	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0
III	Member Information	21	15	15	15	15	11	7	15	11	15	15	15	15	15	15
IV	Emergency and Poststabilization Services	12	1	1	1	1	1	0	1	1	1	1	1	1	1	1
V	Adequate Capacity and Availability of Services	16	8	8	8	8	3	6	8	3	8	8	8	8	8	8
VI	Coordination and Continuity of Care	9	5	5	5	5	2	2	5	2	5	5	5	5	5	5
VII	Coverage and Authorization of Services	20	2	2	2	2	1	1	2	1	2	2	2	2	2	2
VIII	Provider Selection	10	2	2	2	2	2	1	2	2	2	2	2	2	2	2
IX	Subcontractual Relationships and Delegation	4	1	1	1	1	1	1	1	1	1	1	1	1	1	1
X	Practice Guidelines	3	3	3	3	3	0	3	3	0	3	3	3	3	3	3
XI	Health Information Systems	20	0	0	0	0	0	0	0	0	0	0	0	0	0	0
XII	Quality Assessment and Performance Improvement	8	4	4	4	4	2	3	4	2	4	4	4	4	4	4
XIII	Grievance and Appeal Systems	28	8	8	8	8	3	0	8	3	8	8	8	8	8	8
XIV	Program Integrity	14	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Score	**180**	**49**	**49**	**49**	**49**	**26**	**24**	**49**	**26**	**49**	**49**	**49**	**49**	**49**	**49**

Note: Standard numbers and names align with the Agency's SFY 2021-2022 Compliance Review Tool

Compliance with Standards Review

The compliance review standards were derived from the requirements as set forth in the *Department of Human Services, Division of Health Care Financing and Policy Request for Proposal No. 3260 for Managed Care*, and all attachments and amendments in effect during the review period of July 1, 2020, through June 30, 2021. To conduct the compliance review, the Agency will follow the guidelines set forth in CMS' EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019 (CMS Protocol 3).[2-1]

The Agency established a timeline and process to ensure that all federal standards are reviewed over the next three-year compliance review cycle (January 1, 2022–December 2024).

2021 Plan Compliance Monitoring and Oversight

The Agency's ongoing monitoring, oversight, and compliance review tool was developed using the federal requirements and the state contract provisions as required under Subpart D of 42 CFR §438 and the quality assessment and performance improvement requirements described in 42 CFR §438.330. The tool was developed for the following lines of business and included all plans: comprehensive, LTC Plus, standard MMA, and specialty. All plans in each line of business were included in the monitoring, oversight, and compliance review process conducted by the Agency. The Agency required any identified deficiencies to be corrected until the plan was determined compliant with requirements.

The monitoring, oversight, and compliance review tool used by the Agency includes all mandatory federal standards and also includes the corresponding state contract requirements. Table 2-4 includes the types of documentation reviewed by the Agency for each plan, by standard, during the Agency's comprehensive monitoring and oversight process.

Table 2-4—Documentation Reviewed by Standard for Compliance with Requirements

Standard #	Standard	CFR	Regulations Included	Documentation Reviewed for Compliance with Requirements
I.	Availability of Services	438.206	438.3 438.68 438.206 438.207	• Contract template checklist • Printable provider directory • Online provider directory • Utilization management (UM) program description tool • Denials, grievances, and appeals system comprehensive compliance review tool

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Dec 20, 2021.

Standard #	Standard	CFR	Regulations Included	Documentation Reviewed for Compliance with Requirements
				• Executed sub review checklist • PCP assignment policies and procedures • Organization chart checklist and staffing plan • Cultural competency checklist • Virtual site visit with plan, as needed
II.	Assurance of Adequate Capacity and Services	438.207	438.207	• Provider network validation file summary report • Provider ration time and distance report findings, LTC two per county report findings • Provider Network Oversight Unit (PNOU) tool for adverse changes
III.	Coordination and Continuity of Care	438.208	438.208	• PCP/primary dental practitioner (PDP) appointment report • Enhanced care coordination report • Transition of care (TOC) report • Enrollee roster report • Quarterly health risk assessment report • Annual enrollee review strategy monitoring tool • Care coordination/case management program description tools • Quarterly enrollee case files • Clinical review summary form • Coordination and continuity of care documentation
IV.	Coverage and Authorization of Services	438.210	422.113 438.211 438.213 438.214 438.114 438.210 438.3 438.404	• UM program description • State-authorized portable order (SAPO) report • DRTS report • Quarterly enrollee case files • Denial, grievance, and appeal system • Enhanced care coordination report • Case management program description • Clinical review summary form • Strategic monitoring • Virtual site visit with plan, as needed
V.	Provider Selection	438.214	438.12 438.102 438.214	• PNOU credentialing committee review tool • PNOU provider non-discrimination policy and procedure review checklist

Standard #	Standard	CFR	Regulations Included	Documentation Reviewed for Compliance with Requirements
			438.608 438.610438.214 42 CFR Part 455 Subpart B State-Determined Requirements	• Provider sanctions and appeals process checklist • Provider terminations and incentives checklist
VI.	Confidentiality	438.224	438.224	• Health Insurance Portability and Accountability Act (HIPAA) requirements checklist • Privacy incidents/breaches reporting form • Draft breach notifications to HHS/Office of Clinical Research (OCR) • HHS/OCR breach notification annual attestation • Strategic monitoring • Virtual site visit with plan, as needed
VII.	Grievance and Appeal Systems	438.228	438.400 438.402 438.406 438.408 438.410 438.414 438.416 438.420 438.424	• Grievance and appeals process checklist • Grievance and appeals template checklist • Monthly SAPO report • DRTS report • Notice of adverse benefit determination (NABD) template • Translation services checklist • Enrollee material checklist • NPAR template • Provider nondiscrimination checklist • Provider handbook checklist • ECGA report
VIII.	Subcontractual Relationships and Delegation	438.230	438.230	• Executed subcontractor checklist
IX.	Practice Guidelines	438.236	438.236	• Denials, grievance and appeals system comprehensive review tool
X.	Health Information Systems	438.242	438.242 45 CFR 164.404 45 CFR 164.408 45 CFR 164.410	• Information management systems checklist • Grievance and appeals process checklist • Encounter data

Standard #	Standard	CFR	Regulations Included	Documentation Reviewed for Compliance with Requirements
XI.	QAPI Program	438.330	438.240 438.330	• Performance measures report • PIP summary forms • Service authorization performance outcomes report • Enhanced care coordination report • Critical incident policies and procedures checklist • Submission tracking log • PIP submission forms
XII.	Disenrollment: Requirements and Limitations*	438.56	438.3 438.52 438.56	• Welcome materials • Strategic monitoring • Grievance and appeals process checklist • Virtual site visit with plan, as needed
XIII.	Enrollee Rights*	438.100	438.10 422.128 438.10 438.100 438.106 438.108 438.110 438.224	• Online link for member materials checklist • Member welcome materials checklist • Enrollee materials checklist • Distribution of member welcome materials • Translation services checklist • Provider terminations and incentives checklist • Quality's healthy behaviors checklist • Provider directory checklist • Online searchable directory checklist • Provider handbook checklist • Provider contract templates checklist • Strategic monitoring • EAC minutes and agendas • Virtual site visit with plan, as needed
XIV.	Emergency and Poststabilization Services*	438.114	422.113 438.10 438.114	• UM program description • SAPO report • Denial, grievance, and appeal system • Clinical review summary form • Strategic monitoring • Virtual site visit with plan, as needed

* Added in the CMS Medicaid Managed Care Rule effective December 14, 2020.

Comprehensive Plans

Table 2-5 presents a summary of the comprehensive plan compliance monitoring review results for the following plans:

- Aetna Better Health of Florida-C
- Humana-C
- Molina-C
- Simply-C
- Sunshine-C
- United-C

Table 2-5—Monitoring, Oversight, and Compliance Scores for the Three-Year Period: SFY 2019–2021

Standard #	Standard Name	CFR	Comprehensive Plans		
			2019	2020	2021
I.	Availability of Services	438.206			100%
II.	Assurance of Adequate Capacity and Services	438.207			100%
III.	Coordination and Continuity of Care	438.208			100%
IV.	Coverage and Authorization of Services	438.210			100%
V.	Provider Selection	438.214			100%
VI.	Confidentiality	438.224			100%
VII.	Grievance and Appeal Systems	438.228			100%
VIII.	Subcontractual Relationships and Delegation	438.230			100%
IX.	Practice Guidelines	438.236			100%
X.	Health Information Systems	438.242			100%
XI.	QAPI Program	438.330			100%
XII.	Disenrollment: Requirements and Limitations*	438.56			100%
XIII.	Enrollee Rights*	438.100			100%
XIV	Emergency and Poststabilization Services	438.114			100%
TOTAL SCORE					**100%**

* Added in the CMS Medicaid Managed Care Rule effective December 14, 2020.

LTC Plus Plan

Table 2-6 presents a summary of the LTC Plus plan compliance monitoring review results for the following plan:

- Florida Community Care-L

Table 2-6—Monitoring, Oversight, and Compliance Scores for the Three-Year Period: SFY 2019–2021

Standard #	Standard Name	CFR	LTC Plans		
			2019	2020	2021
I.	Availability of Services	438.206			100%
II.	Assurance of Adequate Capacity and Services	438.207			100%
III.	Coordination and Continuity of Care	438.208			100%
IV.	Coverage and Authorization of Services	438.210			100%
V.	Provider Selection	438.214			100%
VI.	Confidentiality	438.224			100%
VII.	Grievance and Appeal Systems	438.228			100%
VIII.	Subcontractual Relationships and Delegation	438.230			100%
IX.	Practice Guidelines	438.236			100%
X.	Health Information Systems	438.242			100%
XI.	QAPI Program	438.330			100%
XII.	Disenrollment: Requirements and Limitations*	438.56			100%
XIII.	Enrollee Rights*	438.100			100%
XIV	Emergency and Poststabilization Services	438.114			100%
TOTAL SCORE					**100%**

* Added in the CMS Medicaid Managed Care Rule effective December 14, 2020.

Standard MMA Plans

Table 2-7 presents a summary of the standard MMA plan compliance monitoring review results for the following plans:

- Vivida-M
- Prestige-M
- Miami Children's Health-M
- Community Care Plan-M

Table 2-7—Monitoring, Oversight, and Compliance Scores for the Three-Year Period: SFY 2019–2021

Standard #	Standard Name	CFR	Standard MMA Plans		
			2019	2020	2021
I.	Availability of Services	438.206			100%
II.	Assurance of Adequate Capacity and Services	438.207			100%
III.	Coordination and Continuity of Care	438.208			100%
IV.	Coverage and Authorization of Services	438.210			100%
V.	Provider Selection	438.214			100%
VI.	Confidentiality	438.224			100%
VII.	Grievance and Appeal Systems	438.228			100%
VIII.	Subcontractual Relationships and Delegation	438.230			100%
IX.	Practice Guidelines	438.236			100%
X.	Health Information Systems	438.242			100%
XI.	QAPI Program	438.330			100%
XII.	Disenrollment: Requirements and Limitations*	438.56			100%
XIII.	Enrollee Rights*	438.100			100%
XIV.	Emergency and Poststabilization Services	438.114			100%
TOTAL SCORE					**100%**

* Added in the CMS Medicaid Managed Care Rule effective December 14, 2020.

Specialty Plans

Table 2-8 presents a summary of the specialty plan compliance monitoring review results for the following plans:

- Children's Medical Services-S
- Clear Health-S
- Magellan-S
- Staywell-S
- Sunshine-S

Table 2-8—Monitoring, Oversight, and Compliance Scores for the Three-Year Period: SFY 2019–2021

Standard #	Standard Name	CFR	Comprehensive MMA Plans		
			2019	2020	2021
I.	Availability of Services	438.206			100%
II.	Assurance of Adequate Capacity and Services	438.207			100%
III.	Coordination and Continuity of Care	438.208			100%
IV.	Coverage and Authorization of Services	438.210			100%
V.	Provider Selection	438.214			100%
VI.	Confidentiality	438.224			100%
VII.	Grievance and Appeal Systems	438.228			100%
VIII.	Subcontractual Relationships and Delegation	438.230			100%
IX.	Practice Guidelines	438.236			100%
X.	Health Information Systems	438.242			100%
XI.	QAPI Program	438.330			100%
XII.	Disenrollment: Requirements and Limitations*	438.56			100%
XIII.	Enrollee Rights*	438.100			100%
XIV.	Emergency and Poststabilization Services	438.114			100%
TOTAL SCORE					**100%**

* Added in the CMS Medicaid Managed Care Rule effective December 14, 2020.

Dental Plans

Table 2-9 presents a summary of the dental plan compliance monitoring review results for the following plans:

- DentaQuest of Florida
- Liberty Dental Plan of Florida
- Managed Care of North America

Table 2-9—Monitoring, Oversight, and Compliance Scores for the Three-Year Period: SFY 2019–2021

Standard #	Standard Name	CFR	Dental Plans		
			2019	2020	2021
I.	Availability of Services	438.206			100%
II.	Assurance of Adequate Capacity and Services	438.207			100%
III.	Coordination and Continuity of Care	438.208			100%
IV.	Coverage and Authorization of Services	438.210			100%
V.	Provider Selection	438.214			100%
VI.	Confidentiality	438.224			100%
VII.	Grievance and Appeal Systems	438.228			100%
VIII.	Subcontractual Relationships and Delegation	438.230			100%
IX.	Practice Guidelines	438.236			100%
X.	Health Information Systems	438.242			100%
XI.	QAPI Program	438.330			100%
XII.	Disenrollment: Requirements and Limitations*	438.56			100%
XIII.	Enrollee Rights*	438.100			100%
XIV.	Emergency and Poststabilization Services	438.114			100%
TOTAL SCORE					**100%**

* Added in the CMS Medicaid Managed Care Rule effective December 14, 2020.

Conclusions and Recommendations Related to Quality, Timeliness, and Access

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

Strengths	**Strength:** The Agency provided evidence of follow-up on deficiencies identified during plan readiness reviews and through its regular and ongoing monitoring and oversight of plan performance. There was evidence of ongoing compliance monitoring by various Agency departments, which commenced with a plan readiness review that was coordinated by Medicaid Plan Management Operations. Ongoing monitoring was conducted by various SMEs within the Agency, such as staff from Medicaid Plan Management Operations and PNOU, which enabled a more thorough review of the plans' operational elements.
Weakness and Recommendations	**Weakness:** Although regular monitoring, oversight, and compliance reviews occurred, the Agency did not demonstrate compliance with the CMS Medicaid Managed Care Rule requirements for conducting a comprehensive review every three years. The Agency provided a documented plan to implement plan compliance reviews that included a desk review process, on-site review process, and a process to conduct follow-up on identified deficiencies through plan-implemented corrective action plans (CAPs). **Why the weakness exists:** Based on a misunderstanding between CMS and the Agency, the Agency understood that its comprehensive readiness review process satisfied the three-year compliance review requirements. When additional clarification was received from CMS, the Agency implemented a planning process to conduct plan compliance reviews over a three-year time frame. **Recommendation:** The Agency should implement its planned process to conduct compliance reviews of all plans within the required three-year cycle. The Agency should utilize the tools provided by HSAG to ensure that all standards required in the CMS Medicaid Managed Care Rule are reviewed during the compliance reviews. HSAG recommends that the Agency document compliance review findings, review and approve plan corrective actions, and document the plans' CAP implementation to ensure compliance with the requirements. Complete results of each plan's compliance reviews should be submitted to HSAG annually to demonstrate compliance with conducting compliance reviews.

Performance Measures

3

Objectives

HSAG's role in the validation of performance measures for each plan type was to ensure that validation activities were conducted as outlined in the CMS Protocol 2, cited earlier in this report. HSAG reviewed the LO's independent auditing process to ensure key audit activities were performed, and validated that performance measure indicator rates were collected, reported, and calculated according to the specifications required by the state.

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

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

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

Measures

Table 3-1 shows HSAG's assignment of the HEDIS MY 2020 performance measures into the domains of quality, timeliness, and access.

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

Performance Measure	Quality	Timeliness	Access
Pediatric Care			
Childhood Immunization Status—Combination 2 and *Combination 3*	✓		
Lead Screening in Children	✓	✓	
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and *Continuation and Maintenance Phase*	✓	✓	✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	✓		
Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and *Combination 2 (Meningococcal, Tdap, Human Papillomavirus [HPV])*	✓		
Women's Care			
Cervical Cancer Screening	✓		
Chlamydia Screening in Women—Total	✓		
Breast Cancer Screening	✓		
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Living With Illness			
Comprehensive Diabetes Care—HbA1c Testing, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*	✓		
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total, *Discussing Cessation Medications—Total*, and *Discussing Cessation Strategies—Total*	✓		
Asthma Medication Ratio—Total	✓		
Behavioral Health			
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total and *Engagement of AOD Treatment—Total*	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total	✓	✓	✓
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total	✓	✓	✓
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total and 30-Day Follow-Up—Total	✓	✓	✓

Performance Measure	Quality	Timeliness	Access
Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment	✓		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	✓		✓
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total, Cholesterol Testing—Total, and Blood Glucose and Cholesterol Testing—Total	✓		
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	✓		✓
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓	✓	✓
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services—Total	✓		✓
Appropriate Treatment and Utilization			
Ambulatory Care (per 1,000 Member Months)—ED Visits—Total	NA	NA	NA
Use of Opioids at High Dosage			✓

MMA Program

The Agency required that each plan undergo an NCQA HEDIS Compliance Audit of the performance measures selected for reporting. These audits were performed by NCQA LOs in 2021 on data collected during CY 2020.

Plan Names and Enrollment

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

Results by Domain

The results sections below discuss the statewide average performance as compared to the Agency-identified performance targets and minimum performance targets, which were established based on NCQA's Quality Compass®,[3-1] national Medicaid All Lines of Business 75th and 25th percentiles, respectively, for HEDIS MY 2019, and statewide rate increases or decreases from RY 2020 to RY 2021.

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

When referring to the performance target comparisons, caution should be used between the comparisons due to the impact of the COVID-19 PHE. Factors that may have contributed could include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE.

These established performance targets are inclusive of the national Medicaid trends (i.e., if the rate increased from RY 2020 to RY 2021 that increase will be reflected in the national Medicaid percentiles) and therefore ensure comparability of the Florida Medicaid results for each applicable RY. To interpret how these results compare to national Medicaid trends, if the Florida Medicaid performance measure result met or exceeded the performance target in RY 2020 then did not meet or exceed the performance target in RY 2021, this indicates the Florida Medicaid performance did not follow the national Medicaid trend.

Statewide Results—Pediatric Care

Table 3-2 displays the statewide averages calculated by HSAG for RY 2020 and RY 2021 for all measures in the Pediatric Care domain with the Agency-identified performance targets. Cells shaded in green indicate performance rates that met or exceeded the Agency's applicable RY performance targets. Cells shaded in yellow indicate performance rates that fell below the minimum performance target for the applicable RY. To review the Pediatric Care measure indicator rates by plan, please see the Comparative Analysis section.

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

Measure	Measure Source	RY 2020	RY 2021
Childhood Immunization Status			
Combination 2	HEDIS	78.83%	74.37%
Combination 3	HEDIS	74.40%	70.81%
Lead Screening in Children			
Lead Screening in Children	HEDIS	74.78%	75.56%
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	HEDIS	45.78%	47.65%
Continuation and Maintenance Phase	HEDIS	57.33%	62.67%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile Documentation—Total	HEDIS	89.12%	86.05%
Immunizations for Adolescents			
Combination 1	HEDIS	75.65%	73.72%
Combination 2	HEDIS	38.79%	37.42%

[1] *Due to changes in the technical specifications for this measure, exercise caution when trending rates between RY 2021 and prior years.*

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

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

One of eight (12.5 percent) statewide average rates within the Pediatric Care domain met or exceeded the Agency's applicable RY performance target (*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*), and one statewide average rate fell below the minimum performance target (*Immunizations for Adolescents—Combination 1 [Meningococcal, Tdap]*). One statewide average rate (*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*) demonstrated an increase of more than 5 percentage points from RY 2020 to RY 2021. Additionally, two statewide average rates (*Childhood Immunization Status—Combination 2* and *Combination 3*) demonstrated a decrease of more than 3 percentage points from RY 2020 to RY 2021.

Statewide Results—Women's Care

Table 3-3 displays the statewide averages calculated by HSAG for RY 2020 and RY 2021 for all measures in the Women's Care domain with the Agency-identified performance targets. Cells shaded in yellow indicate performance rates that fell below the minimum performance target for the applicable RY. To review the Women's Care measure indicator rates by plan, please see the Comparative Analysis section.

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

Measure	Measure Source	RY 2020	RY 2021
Cervical Cancer Screening[1]			
Cervical Cancer Screening	HEDIS	58.51%	54.47%
Chlamydia Screening in Women			
Total	HEDIS	64.39%	63.94%
Breast Cancer Screening[1]			
Breast Cancer Screening	HEDIS	60.57%	54.45%
Prenatal and Postpartum Care[1]			
Timeliness of Prenatal Care	HEDIS	91.61%	83.33%
Postpartum Care	HEDIS	74.64%	72.42%

[1] *Due to changes in the technical specifications for this measure, exercise caution when trending rates between RY 2021 and prior years.*

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

None of the five statewide rates in the Women's Care domain met or exceeded the Agency's applicable RY performance targets. Two of five (40.0 percent) statewide average rates fell below the minimum performance target, demonstrating opportunities for statewide improvement in the Women's Care domain. Of note, three statewide average rates (*Breast Cancer Screening*, *Cervical Cancer Screening*, and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*) demonstrated a decline of more than 4 percentage points from RY 2020 to RY 2021.

Statewide Results—Living With Illness

Table 3-4 displays the statewide averages calculated by HSAG for RY 2020 and RY 2021 for all measures in the Living With Illness domain with the Agency-identified performance targets. Cells shaded in green indicate performance rates that met or exceeded the Agency's applicable RY performance targets. Cells

shaded in yellow indicate performance rates that fell below the minimum performance target for the applicable RY. To review the Living With Illness measure indicator rates by plan, please see the Comparative Analysis section.

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

Measure	Measure Source	RY 2020	RY 2021
Comprehensive Diabetes Care			
HbA1c Testing[1]	HEDIS	86.66%	82.37%
*HbA1c Poor Control (>9.0%)**[,1]	HEDIS	42.39%	47.57%
HbA1c Control (<8.0%)[1]	HEDIS	48.89%	45.58%
Eye Exam (Retinal) Performed[1]	HEDIS	55.98%	45.52%
Medical Assistance With Smoking and Tobacco Use Cessation			
Advising Smokers and Tobacco Users to Quit—Total	HEDIS	77.50%	77.11%
Discussing Cessation Medications—Total	HEDIS	53.61%	48.75%
Discussing Cessation Strategies—Total	HEDIS	47.26%	42.73%
Asthma Medication Ratio			
Total	HEDIS	74.67%	73.94%

** Lower rates indicate better performance for this measure.*
[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between RY 2021 and prior years.
Indicates that the performance measure indicator rate for the applicable RY met or exceeded the performance target.
Indicates that the performance measure indicator rate for the applicable RY ranked below the minimum performance target.

One of eight (12.5 percent) statewide average rates within the Living With Illness domain met or exceeded the Agency's applicable RY performance targets (*Asthma Medication Ratio—Total*). Five of eight (62.5 percent) statewide average rates fell below the minimum performance target, demonstrating opportunities for statewide improvement in the Living With Illness domain. Of note, six statewide average rates (*Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control [>9.0%]*, *HbA1c Control [<8.0%]*, and *Eye Exam [Retinal] Performed*; and *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications—Total* and *Discussing Cessation Strategies—Total*) demonstrated a decline of more than 3 percentage points from RY 2020 to RY 2021.

Statewide Results—Behavioral Health

Table 3-5 displays the statewide averages calculated by HSAG for RY 2020 and RY 2021 for all measures in the Behavioral Health domain with the Agency-identified performance targets. Cells shaded in yellow indicate performance rates that fell below the minimum performance target for the applicable RY. To review the Behavioral Health measure indicator rates by plan, please see the Comparative Analysis section.

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

Measure	Measure Source	RY 2020	RY 2021
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]			
Initiation of AOD Treatment—Total	HEDIS	44.15%	46.58%
Engagement of AOD Treatment—Total	HEDIS	7.00%	8.09%
Follow-Up After Hospitalization for Mental Illness[1]			
7-Day Follow-Up	HEDIS	28.44%	30.69%
30-Day Follow-Up	HEDIS	48.25%	50.37%
Follow-Up After ED Visit for Mental Illness[1]			
7-Day Follow-Up—Total	HEDIS	27.40%	27.92%
30-Day Follow-Up—Total	HEDIS	43.03%	42.97%
Follow-Up After ED Visit for AOD Abuse or Dependence[1]			
7-Day Follow-Up—Total	HEDIS	6.19%	6.47%
30-Day Follow-Up—Total	HEDIS	9.42%	9.51%
Antidepressant Medication Management			
Effective Acute Phase Treatment	HEDIS	54.74%	55.62%
Effective Continuation Phase Treatment	HEDIS	39.65%	40.27%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	HEDIS	60.17%	61.13%
Metabolic Monitoring for Children and Adolescents on Antipsychotics			
Blood Glucose Testing—Total	HEDIS	53.61%	47.01%
Cholesterol Testing—Total	HEDIS	40.48%	34.86%
Blood Glucose and Cholesterol Testing—Total	HEDIS	37.72%	31.88%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics			
Total	HEDIS	61.37%	62.71%
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	75.57%	74.53%

[1] *Due to changes in the technical specifications for this measure, exercise caution when trending rates between RY 2021 and prior years.*

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

None of 16 statewide average rates met or exceeded the Agency's applicable RY performance targets in the Behavioral Health domain. Seven of 16 (43.8 percent) statewide average rates fell below the minimum performance target, demonstrating opportunities for statewide improvement in the Behavioral Health domain. Of note, three statewide average rates (*Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*, *Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total*) demonstrated a decline of more than 5 percentage points from RY 2020 to RY 2021.

Statewide Results—Access/Availability of Care

Table 3-6 displays the statewide results calculated by HSAG for RY 2020 and RY 2021 for the measure in the Access/Availability of Care domain with the Agency-identified performance target. Cells shaded in yellow indicate performance rates that fell below the minimum performance target for the applicable RY. To review the Access/Availability of Care measure indicator rates by plan, please see the Comparative Analysis section.

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

Measure	Measure Source	RY 2020	RY 2021
Adults' Access to Preventive/Ambulatory Health Services			
Total	HEDIS	77.44%	73.38%

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

The only statewide average rate in the Access/Availability of Care domain fell below the minimum performance target, demonstrating opportunities for statewide improvement in the Access/Availability of Care domain. Of note, the statewide average rate for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure demonstrated a decline of more than 4 percentage points from RY 2020 to RY 2021.

Statewide Results—Appropriate Treatment and Utilization

Table 3-7 displays the statewide averages calculated by HSAG for RY 2020 and RY 2021 for all measures in the Appropriate Treatment and Utilization domain with the Agency-identified performance targets. Cells shaded in yellow indicate performance rates that fell below the minimum performance target for the applicable RY. To review the Appropriate Treatment and Utilization measure indicator rates by plan, please see the Comparative Analysis section.

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

Measure	Measure Source	RY 2020	RY 2021
Ambulatory Care (per 1,000 Member Months)			
*ED Visits—Total**	HEDIS	73.30	48.51
Use of Opioids at High Dosage			
*Use of Opioids at High Dosage**	HEDIS	12.95%	12.16%

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

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between RY 2021 and prior years.

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

Neither of the two statewide average rates met or exceeded the Agency's applicable RY performance targets in the Appropriate Treatment and Utilization domain, and one statewide average rate fell below the minimum performance target (*Use of Opioids at High Dosage*).

Comparative Analysis—Plan-Specific Results

The Comparative Analysis section displays the plan-specific performance compared to the Agency-identified performance targets. Cells shaded in green indicate performance rates that met or exceeded the Agency's RY 2021 performance targets. Cells shaded in yellow indicate performance rates that fell below the minimum performance target for RY 2021.

Pediatric Care

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

Table 3-8—Pediatric Care Domain Performance Measure Abbreviations

Performance Measure	Abbreviation
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 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
Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)	IMA-1
Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)	IMA-2

Table 3-9 and Table 3-10 show the results for the plans for measures within the Pediatric Care domain with the Agency-identified performance targets. Full plan names are listed in Appendix A.

Table 3-9—Pediatric Care Domain Performance Measure Results

Measure	BST-M	CCP-M	CHA-S	CMS-S	AET-C	HUM-C	LHT-M	MCC-S	MCH-M
CIS-2	3.89%	70.32%	NA	75.18%	75.43%	73.72%	57.91%	NA	46.23%
CIS-3	3.65%	68.13%	NA	71.05%	72.51%	69.34%	54.26%	NA	44.28%
LSC	61.31%	79.08%	NA	77.61%	74.50%	73.24%	59.85%	NA	65.94%
ADD-I	0.00%	38.33%	NA	50.23%	43.56%	42.93%	35.13%	29.63%	40.00%
ADD-C	NA	NA	NA	59.45%	60.42%	60.35%	39.34%	NA	NA
WCC	82.97%	83.94%	94.31%	81.51%	90.75%	88.56%	67.66%	83.94%	78.60%
IMA-1	38.96%	75.18%	NA	74.21%	72.51%	72.51%	54.01%	49.58%	56.69%
IMA-2	18.61%	33.58%	NA	38.44%	37.47%	35.52%	22.38%	19.33%	25.55%

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

Indicates that the performance measure indicator rate for RY 2021 met or exceeded the performance target.

Indicates that the performance measure indicator rate for RY 2021 ranked below the minimum performance target.

Table 3-10—Pediatric Care Domain Performance Measure Results

Measure	MOL-C	PRS-M	SHP-C	STW-C	STW-S	SUN-C	SUN-S	URA-C
CIS-2	88.32%	80.29%	77.37%	73.24%	NR	73.86%	86.37%	72.26%
CIS-3	87.35%	78.10%	73.97%	70.07%	NR	69.81%	79.56%	67.64%
LSC	78.59%	80.78%	78.83%	77.38%	NR	74.27%	79.08%	69.14%
ADD-I	43.34%	43.60%	49.89%	49.11%	49.53%	45.44%	52.55%	46.59%
ADD-C	56.82%	49.21%	67.88%	66.22%	66.18%	62.44%	63.43%	61.54%
WCC	88.32%	91.30%	89.54%	82.77%	85.30%	85.47%	90.32%	88.81%
IMA-1	80.29%	82.00%	80.54%	75.91%	67.88%	66.91%	72.75%	68.86%
IMA-2	47.45%	53.28%	45.01%	36.25%	28.71%	33.33%	36.74%	33.82%

NR indicates that the plan's reported rate was not reported; therefore, the rate is not presented.

Indicates that the performance measure indicator rate for RY 2021 met or exceeded the performance target.

Indicates that the performance measure indicator rate for RY 2021 ranked below the minimum performance target.

Within the Pediatric Care domain, Molina-C, Prestige-M, Simply-C, and Sunshine-S were the highest-performing plans as at least four of each plan's rates met or exceeded the Agency's RY 2021 performance targets. Additionally, at least five plans met or exceeded the Agency's RY 2021 performance targets for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*, *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* measure indicators.

Conversely, Vivida-M, Lighthouse-M, and Miami Children's Health-M were the lowest-performing plans with four or more measure indicator rates falling below the minimum performance target. Of note, three plans (Magellan-S and Staywell-S) had more than one measure rate fall below the minimum performance target. Thirteen of the 16 (81.3 percent) plans with a reportable measure rate fell below the minimum performance target for the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* measure indicator.

Women's Care

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

Table 3-11—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-Pre
Prenatal and Postpartum Care—Postpartum Care	PPC-Pst

Table 3-12 and Table 3-13 show the results for the plans for measures within the Women's Care domain with the Agency-identified performance targets.

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

Measure	BST-M	CCP-M	CHA-S	CMS-S	AET-C	HUM-C	LHT-M	MCC-S	MCH-M
CCS	36.25%	65.21%	61.31%	—	61.31%	57.18%	39.66%	45.50%	40.15%
CHL	52.96%	64.78%	74.59%	49.14%	68.03%	65.94%	48.04%	61.65%	64.86%
BCS	NA	56.33%	50.51%	—	60.24%	54.66%	NA	39.58%	NA
PPC-Pre	82.07%	91.97%	76.70%	77.38%	89.05%	81.27%	77.13%	61.07%	72.75%
PPC-Pst	74.51%	81.02%	68.75%	54.76%	81.02%	73.72%	63.02%	47.69%	66.67%

NA indicates that the plan followed the specifications, but the denominator was too small to report a valid rate.
— indicates that the rate is not presented because the plan was not required to report the measure for RY 2021.

Indicates that the performance measure indicator rate for RY 2021 met or exceeded the performance target.

Indicates that the performance measure indicator rate for RY 2021 ranked below the minimum performance target.

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

Measure	MOL-C	PRS-M	SHP-C	STW-C	STW-S	SUN-C	SUN-S	URA-C
CCS	65.94%	62.28%	55.23%	53.09%	44.77%	57.46%	—	54.01%
CHL	64.84%	72.37%	67.06%	61.75%	66.47%	65.42%	71.54%	60.28%
BCS	62.18%	52.60%	60.76%	53.85%	50.05%	54.12%	—	48.45%
PPC-Pre	88.81%	90.73%	85.64%	85.16%	81.51%	81.27%	71.30%	80.54%
PPC-Pst	75.18%	81.47%	74.45%	74.45%	68.13%	68.13%	70.37%	70.56%

— indicates that the rate is not presented because the plan was not required to report the measure for RY 2021.

Indicates that the performance measure indicator rate for RY 2021 met or exceeded the performance target.

Indicates that the performance measure indicator rate for RY 2021 ranked below the minimum performance target.

Within the Women's Care domain, Aetna Better Health-C and Prestige Health Choice-M were the highest-performing plans with two rates meeting or exceeding the Agency's RY 2021 performance targets. Additionally, six of the 17 (35.3 percent) plans met or exceeded the Agency's RY 2021 performance target for the *Chlamydia Screening in Women—Total* measure.

Conversely, Magellan-S, Lighthouse Health Plan-M, and United-C were the lowest-performing plans with four out of five measure indicator rates falling below the minimum performance target. Additionally, at least eight plans fell below the minimum performance target for the *Cervical Cancer Screening* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicators.

Living With Illness

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

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

Performance Measure	Abbreviation
Comprehensive Diabetes Care—HbA1c Testing	CDC-T
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)	CDC-9
Comprehensive Diabetes Care—HbA1c Control (<8.0%)	CDC-8
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	CDC-E
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
Asthma Medication Ratio—Total	AMR

Table 3-15 and Table 3-16 show the results for the plans for measures within the Living With Illness domain with the Agency-identified performance targets.

Table 3-15—Living With Illness Domain Performance Measure Results

Measure	BST-M	CCP-M	CHA-S	CMS-S	AET-C	HUM-C	LHT-M	MCC-S	MCH-M
CDC-T	82.39%	79.08%	82.24%	77.68%	82.00%	85.16%	74.10%	76.40%	77.51%
CDC-9*	65.34%	49.39%	38.44%	74.01%	45.99%	35.77%	61.35%	64.23%	75.12%
CDC-8	29.55%	43.55%	59.12%	19.49%	43.80%	53.53%	35.06%	30.66%	20.10%
CDC-E	13.07%	50.85%	43.07%	40.40%	41.61%	60.34%	12.75%	33.09%	6.22%
MSC-A	NA	—	89.81%	—	NA	NA	—	NA	—
MSC-M	NA	—	61.68%	—	NA	NA	—	NA	—
MSC-S	NA	—	54.72%	—	NA	NA	—	NA	—
AMR	79.25%	75.10%	31.82%	86.14%	76.74%	70.67%	73.50%	57.33%	63.27%

** Lower rates indicate better performance for this measure.*
NA indicates that the plan followed the specifications, but the denominator was too small to report a valid rate.
— indicates that the rate is not presented because the plan was not required to report the measure for RY 2021.

Indicates that the performance measure indicator rate for RY 2021 met or exceeded the performance target.

Indicates that the performance measure indicator rate for RY 2021 ranked below the minimum performance target.

Table 3-16—Living With Illness Domain Performance Measure Results

Measure	MOL-C	PRS-M	SHP-C	STW-C	STW-S	SUN-C	SUN-S	URA-C
CDC-T	85.89%	81.75%	81.51%	82.24%	75.18%	82.97%	NA	86.37%
CDC-9*	39.17%	50.85%	38.20%	52.31%	65.21%	52.31%	NA	40.15%
CDC-8	53.04%	41.85%	57.91%	42.09%	28.95%	41.12%	NA	51.09%
CDC-E	55.83%	48.42%	46.96%	40.63%	33.58%	45.99%	NA	46.72%
MSC-A	NA	NA	NA	NA	NA	NA	—	NA
MSC-M	NA	NA	NA	NA	NA	NA	—	NA
MSC-S	NA	NA	NA	NA	NA	NA	—	NA
AMR	79.80%	76.41%	72.10%	73.68%	57.76%	74.20%	80.94%	72.69%

** Lower rates indicate better performance for this measure.*
NA indicates that the plan followed the specifications, but the denominator was too small to report a valid rate.
— indicates that the rate is not presented because the plan was not required to report the measure for RY 2021.

Indicates that the performance measure indicator rate for RY 2021 met or exceeded the performance target.

Indicates that the performance measure indicator rate for RY 2021 ranked below the minimum performance target.

Within the Living With Illness domain, Clear Health-S was the highest-performing plan with half of the reportable measure indicator rates meeting or exceeding the Agency's RY 2021 performance targets. Additionally, 13 plans met or exceeded the Agency's RY 2021 performance target for the *Asthma Medication Ratio—Total* measure indicator.

Conversely, Children's Medical Services-S, Community Care Plan-M, Lighthouse-M, Magellan-S, Miami Children's Health-M, Prestige-M, Staywell-C, Staywell-S, Sunshine-S, and Vivida-M were the lowest-performing plans, with the majority of each plan's reportable measure indicator rates falling below the minimum performance target. Additionally, at least 10 plans fell below the minimum performance target for the *Comprehensive Diabetes Care—HbA1c Testing*, *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed* measure indicators.

Behavioral Health

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

Table 3-17—Behavioral Health Domain Performance Measure Abbreviations

Performance Measure	Abbreviation
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total	IET-I
Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total	IET-E
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	FUH-7
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	FUH-30
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total	FUM-7
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	FUM-30

Performance Measure	Abbreviation
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—Blood Glucose Testing—Total	APM-B
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	APM-C
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	APM-BC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	APP
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD

Table 3-18 and Table 3-19 show the results for the plans for measures within the Behavioral Health domain with the Agency-identified performance targets.

Table 3-18—Behavioral Health Domain Performance Measure Results

Measure	BST-M	CCP-M	CHA-S	CMS-S	AET-C	HUM-C	LHT-M	MCC-S	MCH-M
IET-I	50.00%	29.59%	50.53%	53.35%	40.19%	44.56%	31.69%	52.70%	46.07%
IET-E	11.54%	4.76%	5.83%	9.27%	5.32%	6.42%	2.60%	6.18%	6.28%
FUH-7	15.48%	31.34%	14.60%	45.70%	36.88%	34.50%	0.51%	23.72%	7.89%
FUH-30	26.19%	48.76%	26.77%	69.61%	56.72%	54.72%	2.02%	41.60%	15.79%
FUM-7	NA	27.12%	24.47%	35.11%	27.68%	28.68%	30.61%	22.76%	35.38%
FUM-30	NA	40.68%	35.11%	55.56%	43.75%	45.50%	46.94%	37.31%	49.23%
FUA-7	NA	1.85%	8.18%	0.00%	5.66%	6.04%	4.49%	5.49%	10.00%
FUA-30	NA	7.41%	9.09%	0.00%	5.66%	8.68%	7.87%	7.42%	10.00%
AMM-A	67.74%	43.68%	50.36%	47.57%	58.73%	56.89%	43.17%	52.47%	46.88%
AMM-C	51.61%	32.18%	35.51%	34.05%	42.03%	41.30%	30.22%	39.82%	31.25%
SAA	NA	51.22%	46.99%	64.58%	70.55%	65.23%	NA	56.05%	NA
APM-B	NA	52.94%	NA	50.35%	54.64%	46.61%	38.78%	47.59%	NA
APM-C	NA	38.24%	NA	36.43%	44.33%	34.45%	26.53%	30.87%	NA
APM-BC	NA	35.29%	NA	34.13%	40.72%	31.60%	23.47%	30.23%	NA
APP	NA	48.57%	NA	57.48%	68.27%	62.96%	52.17%	65.55%	NA
SSD	NA	72.95%	94.87%	73.85%	75.18%	80.14%	67.50%	68.39%	NA

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

Indicates that the performance measure indicator rate for RY 2021 met or exceeded the performance target.

Indicates that the performance measure indicator rate for RY 2021 ranked below the minimum performance target.

Table 3-19—Behavioral Health Domain Performance Measure Results

Measure	MOL-C	PRS-M	SHP-C	STW-C	STW-S	SUN-C	SUN-S	URA-C
IET-I	31.53%	46.06%	41.74%	48.47%	53.39%	45.79%	55.33%	38.68%
IET-E	5.88%	6.16%	7.67%	9.26%	9.83%	7.91%	13.65%	6.26%
FUH-7	37.77%	39.92%	34.16%	29.14%	25.74%	32.69%	48.42%	28.90%
FUH-30	59.07%	60.08%	54.73%	48.66%	44.34%	52.72%	73.21%	48.70%
FUM-7	30.00%	25.58%	37.21%	26.75%	26.66%	21.42%	57.47%	23.09%
FUM-30	55.00%	40.70%	51.14%	41.04%	40.33%	36.90%	74.14%	38.35%
FUA-7	6.94%	13.89%	7.69%	6.30%	6.68%	6.47%	2.90%	5.93%
FUA-30	11.11%	17.36%	11.01%	9.51%	9.60%	9.11%	5.80%	11.17%
AMM-A	67.09%	49.61%	59.14%	54.52%	53.72%	57.80%	48.48%	56.14%
AMM-C	52.60%	34.88%	45.54%	38.85%	37.99%	39.90%	36.36%	41.86%
SAA	72.58%	63.02%	69.37%	58.42%	56.22%	69.79%	NA	69.23%
APM-B	48.53%	52.56%	49.82%	43.11%	48.17%	42.26%	53.91%	45.09%
APM-C	36.27%	45.12%	36.49%	31.99%	35.15%	31.14%	44.52%	31.07%
APM-BC	35.29%	43.26%	34.40%	28.24%	32.17%	28.30%	40.29%	29.34%
APP	69.57%	78.26%	67.62%	61.92%	56.53%	64.39%	74.96%	51.04%
SSD	78.31%	78.52%	76.95%	73.41%	71.66%	79.00%	81.16%	75.68%

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

Indicates that the performance measure indicator rate for RY 2021 met or exceeded the performance target.

Indicates that the performance measure indicator rate for RY 2021 ranked below the minimum performance target.

Within the Behavioral Health domain, Children's Medical Services-S, Molina-C, Simply-C, Sunshine-S, and Vivida-M were the highest-performing plans, with at least three measure indicator rates for each plan meeting or exceeding the Agency's RY 2021 performance targets. Additionally, at least five plans with reportable measure indicator rates met the Agency's RY 2021 performance target for the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total* and *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measures.

Conversely, Community Care Plan-M, Lighthouse-M, Magellan-S, Staywell-C, Staywell-S, and United-C were the lowest-performing plans, with at least nine measure indicator rates for each plan falling below the minimum performance target. At least 11 plans fell below the minimum performance target for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications, Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total, Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*, and *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators.

Access/Availability of Care

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

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

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

Table 3-21 and Table 3-22 show the results for the plans for the measure within the Access/Availability of Care domain with the Agency-identified performance target.

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

Measure	BST-M	CCP-M	CHA-S	CMS-S	AET-C	HUM-C	LHT-M	MCC-S	MCH-M
AAP	59.87%	60.83%	85.72%	—	65.77%	77.34%	54.21%	71.31%	50.24%

— indicates that the rate is not presented because the plan was not required to report the measure for RY 2021.

Indicates that the performance measure indicator rate for RY 2021 met or exceeded the performance target.

Indicates that the performance measure indicator rate for RY 2021 ranked below the minimum performance target.

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

Measure	MOL-C	PRS-M	SHP-C	STW-C	STW-S	SUN-C	SUN-S	URA-C
AAP	75.03%	68.48%	73.11%	75.00%	78.58%	65.53%	—	72.89%

— indicates that the rate is not presented because the MMA plan was not required to report the measure for RY 2021.

Indicates that the performance measure indicator rate for RY 2021 ranked below the minimum performance target.

Within the Access/Availability of Care domain, Clear Health-S was the highest-performing plan, meeting or exceeding the Agency's RY 2021 performance target for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator.

Conversely, 12 of the 15 (80.0 percent) plans with a reportable measure rate fell below the minimum performance target for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator.

Appropriate Treatment and Utilization

Table 3-23 shows the performance measure names and associated measure name abbreviations for measures included in the Appropriate Treatment and Utilization domain with the Agency-identified performance targets.

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

Performance Measure	Abbreviation
Ambulatory Care (per 1,000 Member Months)—ED Visits—Total	AMB-E
Use of Opioids at High Dosage	HDO

Table 3-24 and Table 3-25 show the results for the plans for measures within the Appropriate Treatment and Utilization domain with the Agency-identified performance targets.

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

Measure	BST-M	CCP-M	CHA-S	CMS-S	AET-C	HUM-C	LHT-M	MCC-S	MCH-M
AMB-E*	34.30	32.43	119.67	38.28	40.16	46.25	50.20	114.92	34.60
HDO*	13.89%	10.53%	23.31%	NR	13.28%	7.94%	0.00%	11.62%	6.90%

** Lower rates indicate better performance for this measure.*
NR indicates that the plan's reported rate was not reported; therefore, the rate is not presented.

Indicates that the performance measure indicator rate for RY 2021 met or exceeded the performance target.

Indicates that the performance measure indicator rate for RY 2021 ranked below the minimum performance target.

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

Measure	MOL-C	PRS-M	SHP-C	STW-C	STW-S	SUN-C	SUN-S	URA-C
AMB-E*	38.85	37.60	40.59	54.30	111.88	43.02	32.75	46.00
HDO*	10.46%	23.19%	22.21%	11.75%	9.52%	15.68%	NA	10.37%

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

Indicates that the performance measure indicator rate for RY 2021 met or exceeded the performance target.

Indicates that the performance measure indicator rate for RY 2021 ranked below the minimum performance target.

Within the Appropriate Treatment and Utilization domain, Aetna Better Health-C, Children's Medical Services-S, Community Care Plan-M, Humana-C, Miami Children's Health-M, Molina-C, Prestige-M, Simply-C, Sunshine-C, Sunshine-S, United-C, and Vivida-C were the highest-performing plans, meeting or exceeding the Agency's RY 2021 performance target for the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* measure indicator. Additionally, Lighthouse-M met the Agency's RY 2021 performance target for the *Use of Opioids at High Dosage* measure indicator.

Conversely, Clear Health-S and Magellan-S were the lowest-performing plans, with both measure indicators' rates falling below the minimum performance target. Eleven plans fell below the minimum performance target for the *Use of Opioids at High Dosage* measure indicator.

LTC Program

The Agency contracted with seven comprehensive MMA plans and one LTC Plus plan to provide LTC services to Medicaid enrollees. The plans were required to report 15 performance measure indicators for SFY 2020–2021 using CY 2020 data. For four reported LTC MLTSS/HEDIS measures (with a total of 7 measure indicators), the Agency established performance targets of 85 percent for each measure indicator. Plans underwent a PMV audit to ensure that the rates calculated and reported for these measures were valid and accurate. The Agency intended that an NCQA HEDIS Compliance Audit be conducted for all plans. All audits were conducted by LOs.

Table 3-26 displays the LTC program statewide averages for RY 2020 and RY 2021 for all measures in the LTC program with the Agency-identified performance targets. Cells shaded in green indicate performance rates that met or exceeded the Agency's RY 2021 performance targets. To review the LTC measure indicator rates by plan, please see the Comparative Analysis section.

Table 3-26—Florida Medicaid LTC Program Statewide Averages

Measure	Measure Source	RY 2020	RY 2021
LTSS Comprehensive Assessment and Update			
Assessment of Core Elements	MLTSS/ HEDIS	81.44%	87.70%
Assessment of Supplemental Elements	MLTSS/ HEDIS	75.27%	86.22%
LTSS Comprehensive Care Plan and Update			
Care Plan With Core Elements	MLTSS/ HEDIS	78.54%	88.06%
Care Plan With Supplemental Elements	MLTSS/ HEDIS	78.43%	88.04%
LTSS Shared Care Plan With PCP			
LTSS Shared Care Plan With PCP	MLTSS/ HEDIS	83.77%	89.68%
LTSS Reassessment/Care Plan Update After Inpatient Discharge			
Reassessment After Inpatient Discharge	MLTSS/ HEDIS	24.81%	34.44%
Reassessment and Care Plan Update After Inpatient Discharge	MLTSS/ HEDIS	21.15%	26.53%
Screening, Risk Assessment, and Plan of Care to Prevent Future Falls[1]			
Falls Part 1—Screening	MLTSS	92.20%	95.22%
Falls Part 2—Falls Risk Assessment	MLTSS	98.74%	90.43%
Falls Part 2—Plan of Care for Falls	MLTSS	67.48%	53.02%
LTSS Admission to an Institution from the Community[1]			
Short-Term Stay	MLTSS	—	11.70
Medium-Term Stay	MLTSS	—	10.59
Long-Term Stay	MLTSS	—	26.73
LTSS Minimizing Institutional Length of Stay[1]			
LTSS Minimizing Institutional Length of Stay	MLTSS	42.51%	20.91%
LTSS Successful Transition After Long-Term Institutional Stay[1]			
LTSS Successful Transition After Long-Term Institutional Stay	MLTSS	25.34%	14.08%

— Indicates that the RY 2020 rate is not presented because the plans were not required to report the measure until RY 2021.

[1] *Indicates a performance target was not established by the Agency. Rate is displayed for informational purposes only. This symbol may also indicate that NCQA recommended a break in trending; therefore, the RY 2020 rate is not displayed.*

Indicates that the performance measure indicator rate for RY 2021 met or exceeded the performance target.

Of the seven measure indicators for which performance targets were established, five statewide rates in the LTC program met or exceeded the Agency's RY 2021 performance targets. Of the 15 performance measure indicators reported for the LTC program, eight of the statewide rates demonstrated an improvement of more than 3 percentage points from RY 2020 to RY 2021. The statewide rate for the *LTSS Minimizing Institutional Length of Stay* measure declined more than 21 percentage points, and the statewide rate for the *LTSS Successful Transition After Long-Term Institutional Stay* measure declined more than 11 percentage points.

Comparative Analysis—Plan-Specific Results

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

Table 3-27—LTC Performance Measure Abbreviations

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

Table 3-28 shows the results for LTC performance measures reported by the plans.

Table 3-28—LTC Performance Measure Results

Measure	AET-C	FCC-L	HUM-C	MOL-C	SHP-C	STW-C	SUN-C	URA-C
CAU-1	81.27%	94.40%	84.91%	89.54%	98.78%	86.62%	87.83%	78.83%
CAU-2	80.54%	94.40%	82.73%	89.54%	98.78%	75.91%	87.59%	77.62%
CPU-1	99.27%	95.13%	72.99%	98.54%	94.62%	94.40%	95.62%	75.67%
CPU-2	99.27%	95.13%	72.99%	98.54%	94.62%	94.16%	95.62%	75.67%
SCP	99.27%	100.00%	97.81%	96.11%	91.20%	45.36%	89.29%	82.32%
UIC-1	29.51%	22.51%	27.75%	50.85%	60.92%	25.55%	47.93%	24.82%
UIC-2	29.51%	22.51%	18.06%	49.39%	49.65%	16.06%	41.36%	17.27%
PFF-1	93.92%	96.59%	93.97%	99.51%	100.00%	93.19%	96.59%	94.89%
PFF-2	100.00%	77.37%	99.17%	66.10%	100.00%	97.76%	94.57%	100.00%
PFF-3	73.57%	11.68%	98.76%	84.75%	53.64%	47.09%	82.69%	85.00%
AIC-S	21.73	8.48	0.91	44.10	2.70	54.55	3.82	36.42
AIC-M	23.98	19.80	1.13	40.99	8.24	39.71	6.94	16.21
AIC-L	32.59	46.12	68.40	18.31	6.23	46.50	9.15	23.29
MIS	18.50%	32.20%	27.10%	10.81%	30.77%	17.32%	18.94%	21.18%
TIS	34.97%	NA	0.46%	NA	12.65%	59.00%	24.57%	69.08%

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

Indicates that the performance measure indicator rate for RY 2021 met or exceeded the performance target.

Within the LTC program, Florida Community Care-C, Molina-C, Simply-C, and Sunshine-C were the highest-performing plans, with five measure indicator rates meeting or exceeding the Agency's RY 2021 performance targets.

Dental Plans

The Agency contracted with three dental plans to provide dental services to Medicaid enrollees. The plans were required to report 12 performance measure indicators for SFY 2020–2021 using MY 2020 data. The three dental plans were audited by an LO. Plan-specific targets were established for two dental measures included in this report, as discussed in the Comparative Analysis section.

Table 3-29 displays the dental plan statewide averages for RY 2020 and RY 2021.

Table 3-29—Florida Dental Plan Statewide Averages

Measure	Measure Source	RY 2020	RY 2021
Annual Dental Visits[1]			
Total	HEDIS	50.65%	40.34%
Ambulatory Care Sensitive ED Visits for Dental Caries in Adults			
Total	Agency-Defined	8.67	7.07

Measure	Measure Source	RY 2020	RY 2021
Oral Evaluation			
Total	Dental Quality Alliance	39.50%	32.26%
Topical Fluoride for Children at Elevated Caries Risk			
Total	Dental Quality Alliance	32.32%	19.05%
Ambulatory Care Sensitive ED Visits for Dental Caries in Children			
Total	Dental Quality Alliance	1.35	1.01
Follow-Up After ED Visits for Dental Caries in Children			
7 Day Follow-Up—Total	Dental Quality Alliance	34.00%	34.11%
30 Day Follow-Up—Total	Dental Quality Alliance	58.00%	51.94%
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk			
Total	Dental Quality Alliance	31.76%	23.68%
Follow-Up After Dental-Related ED Visits			
Follow-Up After Dental-Related ED Visits	Agency-Defined	58.00%	33.14%
Sealant Receipt on Permanent 1st Molars			
Received a Sealant on At Least One Permanent First Molar Tooth	Medicaid Child Core Set	—	24.69%
Received a Sealant on All Four Permanent First Molars	Medicaid Child Core Set	—	14.67%
Dental Treatment Services[1]			
Total	Dental Quality Alliance	14.14%	14.64%

— Indicates that the RY 2020 rate is not presented because the plans were not required to report the measure until RY 2021.
[1] Indicates a plan-specific target was identified by The Agency.

Two of the 12 statewide rates (*Follow-Up After ED Visits for Dental Caries in Children—7 Day Follow-Up—Total* and *Dental Treatment Services—Total*) demonstrated an improvement of less than 1 percentage point from RY 2020 to RY 2021. When referring to the performance target comparisons, caution should be used between the comparisons due to the impact of the COVID-19 PHE. Factors that may have contributed could include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE.

Comparative Analysis—Plan-Specific Results

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

Table 3-30—Dental Performance Measure Abbreviations

Performance Measure	Abbreviation
Annual Dental Visits—Total	ADV
Ambulatory Care Sensitive ED Visits for Dental Caries in Adults—Total	EDV-A-A
Oral Evaluation—Total	OEV-CH-A
Topical Fluoride for Children at Elevated Caries Risk—Total	TLF-CH-A
Ambulatory Care Sensitive ED Visits for Dental Caries in Children—Total	EDV-CH-A
Follow-Up After ED Visits for Dental Caries in Children—7 Day Follow-Up—Total	EDF-CH-A-7
Follow-Up After ED Visits for Dental Caries in Children—30 Day Follow-Up—Total	EDF-CH-A-30
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk—Total	SEAL
Follow-Up After Dental-Related ED Visits	FUD
Sealant Receipt on Permanent 1st Molars—Received a Sealant on At Least One Permanent First Molar Tooth	SFM-CH-1
Sealant Receipt on Permanent 1st Molars—Received a Sealant on All Four Permanent First Molars	SFM-CH-2
Dental Treatment Services—Total	TRT-CH-A

Table 3-31 shows the results for measures reported by the dental plans. Plan-specific targets were established for only one measure indicator presented in this report: *Annual Dental Visits—Total*. Cells shaded in orange indicate performance rates that fell below the plan-specific performance target for RY 2021.

Table 3-31—Dental Performance Measure Results

Measure	DQT-D	LIB-D	MCA-D
ADV	41.92%	38.99%	38.79%
EDV-A-A	2.17	10.93	10.28
OEV-CH-A	35.19%	29.65%	29.98%
TLF-CH-A	18.16%	20.77%	22.75%
EDV-CH-A	0.36	1.44	1.70
EDF-CH-A-7	35.56%	32.84%	35.44%
EDF-CH-A-30	64.44%	50.00%	48.10%
SEAL	23.01%	23.30%	26.63%
FUD	NA	28.17%	35.16%
SFM-CH-1	22.80%	24.30%	30.61%
SFM-CH-2	13.34%	13.73%	20.24%
TRT-CH-A	15.74%	14.81%	12.03%

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

Indicates that the performance measure indicator rate for RY 2021 fell below the plan-specific performance target.

DentaQuest, Liberty, and MCNA fell below the plan-specific targets identified by the Agency for the *Annual Dental Visits—Total* measure indicator. However, at the time of publication of this report, due to the extenuating circumstances caused by the COVID-19 PHE, the Agency had not decided whether plans will be held to their targets.

Conclusions and Recommendations Related to Quality, Timeliness, and Access

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

MMA Program

Strengths	**Strength:** The comprehensive, standard, and specialty MMA plans provided FARs that contained IS capability findings. For HEDIS MY 2020, all plans were fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.

Pediatric Care

Strengths	**Strength:** The statewide average for the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure indicator met or exceeded the performance target. The results suggest that providers followed up with children after being diagnosed with ADHD through the continuation of their treatment to ensure their medication levels were managed.
Weakness and Recommendations	**Weakness:** The statewide average declined for measures pertaining to the immunizations of children and adolescents, and the indicator rate for *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* fell below the minimum performance target. These results suggest that children and adolescents are not getting the recommended vaccines to reduce risks for contracting preventable diseases. **Why the weakness exists:** Members were not consistently receiving childhood and adolescent immunizations according to the recommended schedules. Healthcare disparities may exist, and parents may not have a comprehensive understanding of the importance of immunization. Factors that may have contributed to the declines during this time include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The COVID-19 PHE also likely deterred individuals from seeking immunizations. **Recommendation:** HSAG recommends that the plans conduct a root cause analysis or focus study to determine why child and adolescent members are not receiving all recommended vaccines. Health plans should consider if there are disparities within their populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, health plans should implement appropriate interventions to improve the immunization rates.

Women's Care

Strengths	**Strength:** None identified.
Weakness and Recommendations	**Weakness:** One of three statewide average rates related to women's preventive screenings fell below the minimum performance targets. Additionally, the statewide average rate of the *Cervical Cancer Screening* measure demonstrated a decline of more than 4 percentage points from RY 2020 to RY 2021, demonstrating women are not receiving timely access to preventive screenings. Early detection of cancer and chlamydia reduces the risk of serious complications or death and can lead to a greater range of treatment options and lower healthcare costs. **Why the weakness exists:** Members were not completing recommended screenings, which may indicate a lack of understanding of healthcare or recommended prevention and screening schedules. Members' lack of participation in screenings may also be a result of a disparity-driven barrier. Factors that may have contributed to the rate declines include screening site closures and the temporary suspension of non-urgent services due to the COVID-19 PHE. **Recommendation:** HSAG recommends that the plans conduct a root cause analysis or focus study to determine why female members are not receiving timely screenings. Health plans should consider if there are disparities within their populations that contributed to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, health plans should implement appropriate interventions to improve utilization related to women's screenings.
	Weakness: The statewide average rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator declined more than 8 percentage points and fell below the minimum performance target. **Why the weakness exists:** Women are not receiving timely and adequate access to prenatal care, which prevents pregnancy-related deaths and creates a foundation for the long-term health and wellbeing of new mothers and their infants. Pregnant members may not understand the importance of prenatal care. Factors that may have contributed to the rate declines include the temporary suspension of non-urgent services due to the COVID-19 PHE. **Recommendation:** HSAG recommends that the plans conduct a root cause analysis or focus study to determine why pregnant members are not obtaining prenatal care. Upon identification of a root cause, health plans should implement appropriate interventions to improve performance related to prenatal care.

Living With Illness

Strengths	**Strength:** The statewide average for the *Asthma Medication Ratio—Total* measure indicator met or exceeded the performance target. The results suggest that members with persistent asthma are receiving recommended care and are better able to control their chronic condition.
Weakness and Recommendations	**Weakness:** The statewide average rates for three of the four *Comprehensive Diabetes Care* measure indicators fell below the minimum performance targets and three measure indicator rates demonstrated a decline of more than 3 percentage points from RY 2020 to RY 2021. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death. **Why the weakness exists:** Members were not receiving services recommended for proper diabetes management. Factors that may have contributed to the declines include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking healthcare services, including diabetic testing. **Recommendation:** HSAG recommends that health plans conduct a root cause analysis or focus study to determine why their members are not receiving timely recommended screenings for diabetes. Upon identification of a root cause, health plans should implement appropriate interventions to improve performance related to the *Comprehensive Diabetes Care* measure.
	Weakness: The statewide average rates for two of the three *Medical Assistance With Smoking and Tobacco Use Cessation* measure indicators fell below the minimum performance targets and demonstrated a decline of more than 4 percentage points from RY 2020 to RY 2021. Smoking and tobacco use are the largest causes of preventable disease and death in the United States. **Why the weakness exists:** When compared to national benchmarks, plan providers may not be advising members who smoke or use tobacco to quit and may not be discussing cessation medications and strategies with their adult members or providing referrals for assistance as much as other providers. A factor that may also have contributed to low performance was the temporary suspension of non-urgent services and in-person PCP appointments due to the COVID-19 PHE. **Recommendation:** HSAG recommends that the plans conduct a root cause analysis or focus study to determine why members are not quitting tobacco use. Upon identification of a root cause, HSAG recommends that the health plans implement appropriate interventions to improve the performance related to smoking cessation. Health plans may consider conducting a focus group to identify barriers that their members are experiencing in quitting tobacco use.

Behavioral Health

Strengths	**Strength:** None identified.
Weakness and Recommendations	**Weakness:** The statewide average for the *Follow-Up After ED Visit for Mental Illness* and the *Follow-Up After ED Visit for AOD Abuse or Dependence* measures fell below the minimum performance targets. Follow-up care by trained mental health clinicians is critical for successful transition out of an ED setting, as well as preventing future admissions. **Why the weakness exists:** The low performance indicates that members accessing the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care. **Recommendation:** HSAG recommends that the plans enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs. HSAG recommends that the plans conduct a root cause analysis to determine why members who access the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, HSAG recommends the health plans increase the use of telehealth services.
	Weakness: The statewide average rates for the three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure indicators declined more than 5 percentage points from RY 2020 to RY 2021. Additionally, the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total* measure indicator rate fell below the minimum performance target. **Why the weakness exists:** This demonstrates that children and adolescent members with ongoing antipsychotic medication are not receiving regular metabolic testing to monitor and reduce the risk for developing serious metabolic complications associated with poor cardiometabolic outcomes in adulthood. Parents may not understand the importance of metabolic monitoring or may have experienced barriers to conducting monitoring due to temporary suspension of non-urgent services and in-person PCP appointments due to the COVID-19 PHE. **Recommendation:** Conduct a root cause analysis or focus study to determine why members are not receiving regular metabolic testing. Upon identification of a root cause, implement appropriate interventions to improve the performance related to metabolic testing.

LTC Program

Strengths	**Strength:** Seven of the 15 statewide rates in the LTC program that could be compared met or exceeded the Agency's RY 2021 performance targets. Eight of the statewide rates demonstrated an improvement of more than 3 percentage points from RY 2020 to RY 2021. The results indicate that the plans have established documentation of in-person comprehensive assessments, comprehensive care plans, and shared care plans to promote the coordination of LTSS. The results also indicate that health plans are conducting assessments and creating care plans with their members within specific measure timelines. In addition, the results indicate members were screened for history of falls and received a risk assessment to prevent future falls.
	Strength: The LTC plans provided FARs that contained IS capability assessment findings. For HEDIS MY 2020, all plans were fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
Weakness and Recommendations	**Weakness:** The statewide average for the *LTSS Minimizing Institutional Length of Stay* measure declined more than 21 percentage points, and the statewide average for the *LTSS Successful Transition After Long-Term Institutional Stay* measure declined more than 11 percentage points from RY 2020 to RY 2021. **Why the weakness exists:** Potential weaknesses may exist due to limited occupancy for members to transfer to a community residence. Additionally, due to fear of contracting COVID-19, members may have chosen to not access transition care, which may have impacted performance outcomes. **Recommendation:** HSAG recommends the plans continue to monitor their rates over time to identify COVID-19 PHE rate impact, ensuring lower quality and access to care is not driven by a non-PHE cause.
	Weakness: The statewide average for the *Screening, Risk Assessment, and Plan of Care to Prevent Future Falls—Falls Part 2—Plan of Care for Falls* measure indicator declined more than 14 percentage points from RY 2020 to RY 2021. **Why the weakness exists:** Potential weaknesses may exist due to screening declines during the COVID-19 PHE, which occurred during MY 2020. Many preventive screenings were negatively affected across the country as states followed orders to reduce the use of non-emergent services in order to slow the spread of COVID-19. Additionally, due to fear of contracting COVID-19, members may have chosen to not access plan of care assessments and transition care, which may have impacted performance outcomes. **Recommendation:** HSAG recommends that the plans continue to monitor their rates over time to identify COVID-19 PHE rate impact, ensuring lower quality and access to care is not driven by a non-PHE cause.

Dental Plans

Strengths	**Strength:** The statewide average for the following measures improved from RY 2020 to RY 2021: • *Follow-Up After ED Visits for Dental Caries in Children—7 Day Follow-Up—Total* • *Dental Treatment Services—Total* The results suggest children received a dental treatment service to prevent one of the most common chronic diseases known as dental caries. Identifying caries early helps prevent progression of decay and crumbling of teeth. Additionally, children visited a dentist within seven days of their ED visit to ensure the wellbeing of oral health for children and to avoid further potential emergency care.
	Strength: The dental plans provided FARs that contained IS capability assessment findings. For MY 2020, all plans were fully compliant with NCQA HEDIS Compliance Audit IS standards that were applicable.
Weakness and Recommendations	Weakness: The statewide average for the following measure indicators declined more than 5 percentage points from RY 2020 to RY 2021: • *Annual Dental Visits—Total* • *Topical Fluoride for Children at Elevated Caries Risk—Total* • *Oral Evaluation—Total* • *Follow-Up After ED Visits for Dental Caries in Children—30 Day Follow-Up—Total* • *Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk—Total* • *Follow-Up After Dental-Related ED Visits* **Why the weakness exists:** Access to dental care including annual visits, evaluations, and follow-up visits may have been impacted with the rapid increase of COVID-19 cases in 2020. Many preventive services, including dental services, were negatively affected across the country as states followed orders to reduce the use of non-emergent services in order to slow the spread of COVID-19. **Recommendation:** HSAG recommends the plans continue to monitor their rates over time to identify PHE rate impact, ensuring lower access to dental care is not driven by a non-PHE cause, and adopt QI strategies to improve rates. If access to care is the reason for lower rates, the plans should also evaluate their networks to ensure enough providers are available for services for members.

Performance Improvement Projects

Introduction

In total, 17 plans submitted PIPs for validation for 2020–2021 (14 health plans and three dental plans). Although 20 plans serve Florida's Medicaid population, the Agency does not require its comprehensive plans to submit separate PIPs for their specialty plans. Therefore, this section does not present validation results for Clear Health-S (a specialty plan operated by Simply-C specialty plan), Staywell-S (a specialty plan operated by Sunshine-C), and Sunshine-S (a specialty plan operated by Sunshine-C).

Plan Names and Enrollment

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

PIP Validation

For SFY 2020–2021, each health plan submitted two PIPs for annual validation—*Administration of the Transportation Benefit* and *Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and ED Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence* (Behavioral Health PIP).

Each dental plan also submitted two PIPs for annual validation—*Coordination of Transportation Services With the SMMC Plans* and *Preventive Dental Services for Children*.

This section presents the results of the SFY 2020–2021 PIP validation process.

High-Level Review

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

Each health plan submitted two PIPs—*Improving Birth Outcomes* and *Reducing PPEs*—for high-level review. The only exceptions were Florida Community Care-L, an LTC Plus plan, and Children's Medical Services-S, a specialty plan. The *Improving Birth Outcomes* PIP was discontinued by Florida Community Care-L and was not initiated by Children's Medical Services-S because the topic was not applicable to the population served by these health plans. Additionally, Florida Community Care-L did not submit the *Reducing PPEs* PIP. At the time of PIP submission, Florida Community Care-L indicated that it was in discussion with the Agency regarding the appropriateness of the PIP data for the population served by the health plan. Children's Medical Services-S did not initiate the statewide *Reducing PPEs* PIP; however, the health plan submitted the *Reducing Asthma Related PPEs for Pediatric Enrollees* PIP for annual validation. Children's Medical Services-S also submitted the *Youth Transitions to Adult Care* PIP for validation.

For high-level review, each dental plan submitted the *Reducing Potentially Preventable Dental-Related ED Visits* PIP.

Additional information and results of the high-level review process are included in Appendix E.

Domains of Care

Table 4-1 lists all PIPs, their associated plans, and the assigned domains of care (quality, timeliness, and/or access to care).

Table 4-1—PIP Topics—Domains of Care

Plan	PIP Name*	Quality	Timeliness	Access
All Health Plans except Children's Medical Services-S and Florida Community Care-L	*Improving Birth Outcomes*	✓	✓	✓
	Reducing PPEs	✓	✓	✓
All Health Plans	*Administration of the Transportation Benefit*		✓	✓
All Health Plans	*Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and ED Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence* (Behavioral Health PIP)	✓	✓	✓
All Dental Plans	*Reducing Potentially Preventable Dental-Related ED Visits*	✓	✓	✓
	Coordination of Transportation Services With the SMMC Plans		✓	✓

Plan	PIP Name*	Quality	Timeliness	Access
	Preventive Dental Services for Children	✓	✓	✓
Children's Medical Services-S	*Youth Transitions to Adult Care*	✓	✓	✓
	Reducing Asthma Related PPEs for Pediatric Enrollees	✓	✓	✓

*All PIPs (including both validated and high-level review PIPs) are listed in this table.

Validation Status

HSAG validated the submitted PIPs as required by the EQRO contract. The outcome of the validation process was an overall validation status finding for each PIP of *Met*, *Partially Met*, or *Not Met*. To determine the overall validation status for each PIP, HSAG evaluated the PIP on a set of standard evaluation elements that align with the three PIP stages—Design, Implementation, and Outcomes—and the steps in CMS' EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019 (CMS Protocol 1).[4-1] HSAG designated some evaluation elements as critical because of their importance in defining a project as valid and reliable.

All PIPs validated for SFY 2020–2021 had progressed to reporting to the Implementation stage (steps 1 through 8). The Outcomes stage (step 9) was assessed for the PIPs where remeasurement data were reported. The health plans did not report remeasurement data for the Behavioral Health PIP, and only three health plans reported remeasurement data for the *Administration of the Transportation Benefit* PIP. Two dental plans reported remeasurement data for both dental PIPs.

Description of Data Obtained

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

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

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 9, 2022.

For the Behavioral Health PIP, the health plans used claims and encounters data to calculate the indicator rates for the selected PIP topic.

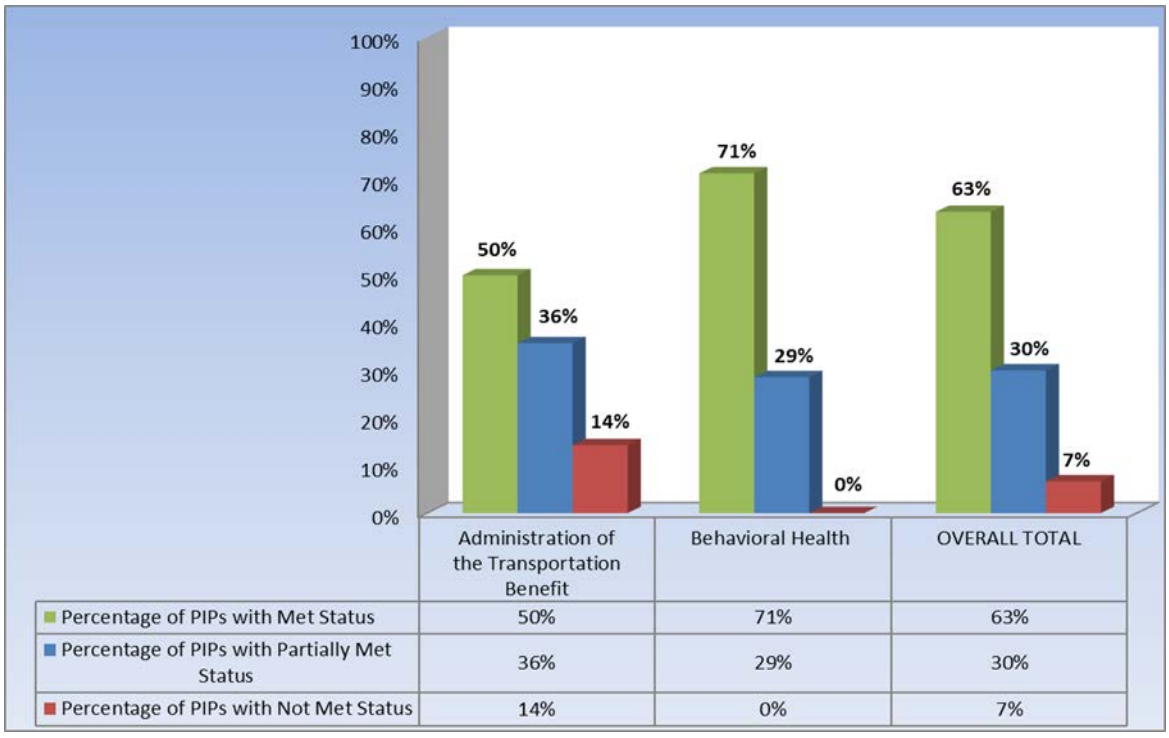
The dental plans used the Agency-provided specifications for the *Coordination of Transportation Services With the SMMC Plans* PIP and CMS Child Core Set *Percentage of Eligibles Who Received Preventive Dental Services* (PDENT-CH) measure specifications for the *Preventive Dental Services for Children*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

Plan PIP Validation Results

Overall PIP Validation Status

Figure 4-1 displays the percentage of plan PIPs receiving a *Met*, *Partially Met*, and *Not Met* overall validation status by PIP topic. A total of 14 plans submitted 30 PIPs. The green bars represent the percentage of PIPs with an overall *Met* validation status, the blue bars represent the percentage of PIPs with a *Partially Met* validation status, and the red bars represent the percentage of PIPs with a *Not Met* validation status.

Figure 4-1—Validation Status of Plan PIPs by PIP Topic



	Administration of the Transportation Benefit	Behavioral Health	OVERALL TOTAL
Percentage of PIPs with Met Status	50%	71%	63%
Percentage of PIPs with Partially Met Status	36%	29%	30%
Percentage of PIPs with Not Met Status	14%	0%	7%

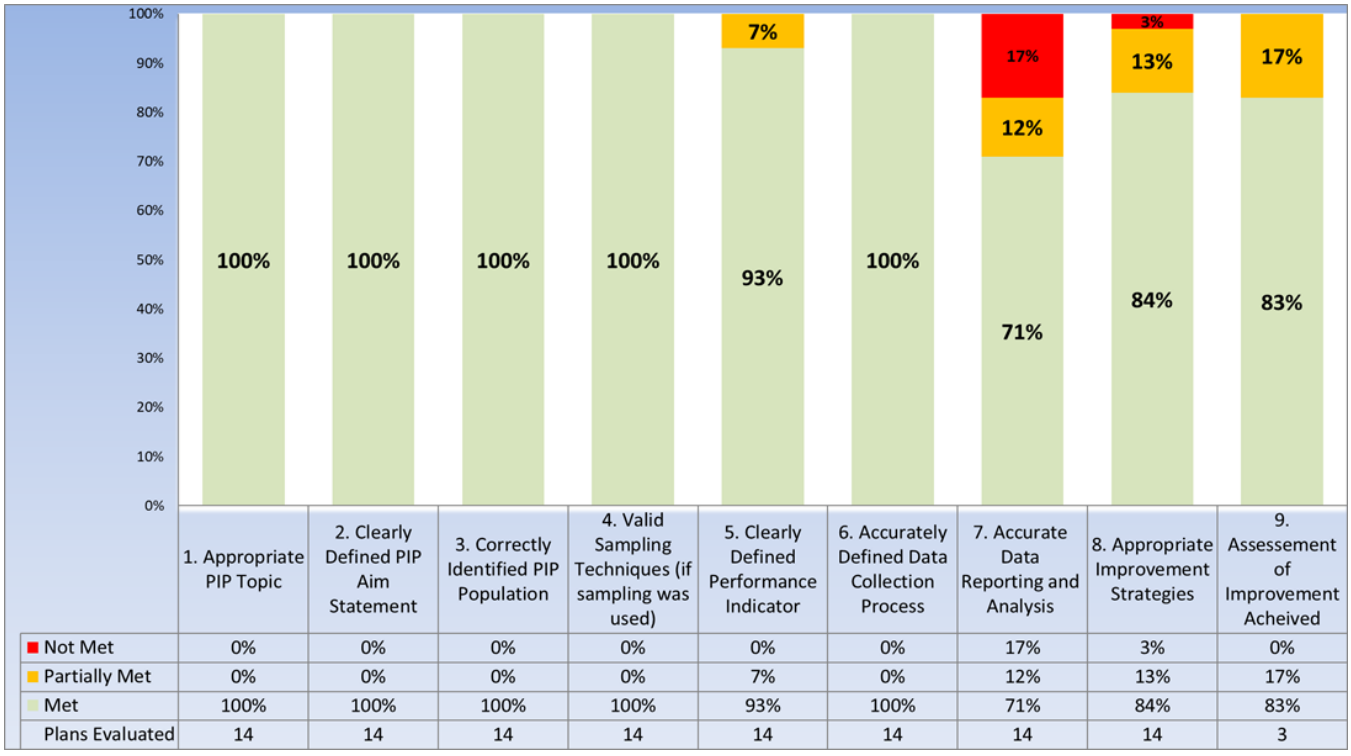
Sixty-three percent (19/30) of PIPs received an overall *Met* validation status. For the *Administration of the Transportation Benefit* PIP, fifty percent received an overall *Met* validation status. There were opportunities for improvement in the documentation of the data, interpretation of results, and improvement strategies. For the Behavioral Health PIP, the plans performed better; however, there were opportunities for improvement in the documentation of the PIP Aim statement, performance indicators, narrative interpretation of baseline data, and an appropriate causal barrier analysis process. In addition to the *Administration of the Transportation Benefit* PIP and Behavioral Health PIP, the two additional PIPs initiated by Children's Medical Services-S were included in the overall total score. Children's Medical Services-S received a *Met* validation status for both of its additional PIPs.

Overall Performance on Each Step of the PIP Validation Tool

The section below describes the overall performance of the plans for both PIPs on each step of the PIP Validation Tool.

Figure 4-2 and Figure 4-3 displays the percentage of evaluation elements achieving a *Met*, *Partially Met*, and *Not Met* validation score on each step of the PIP Validation Tool for the *Administration of the Transportation Benefit* PIP and the Behavioral Health PIP, respectively. Percentage totals may not equal 100 due to rounding.

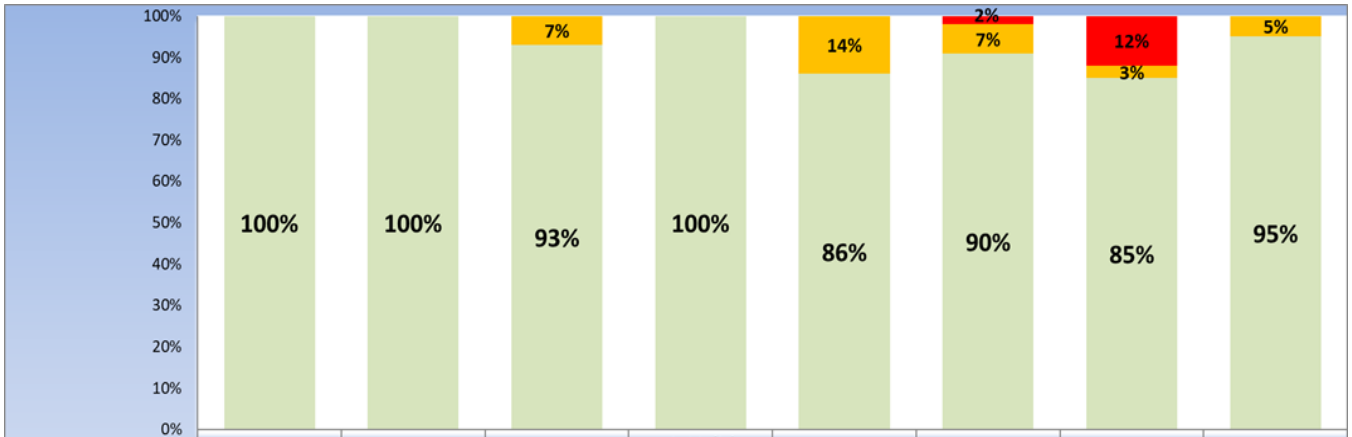
Figure 4-2—Overall Performance on Each Step of the PIP Validation Tool for the *Administration of the Transportation Benefit* PIP



	1. Appropriate PIP Topic	2. Clearly Defined PIP Aim Statement	3. Correctly Identified PIP Population	4. Valid Sampling Techniques (if sampling was used)	5. Clearly Defined Performance Indicator	6. Accurately Defined Data Collection Process	7. Accurate Data Reporting and Analysis	8. Appropriate Improvement Strategies	9. Assessement of Improvement Acheived
Not Met	0%	0%	0%	0%	0%	0%	17%	3%	0%
Partially Met	0%	0%	0%	0%	7%	0%	12%	13%	17%
Met	100%	100%	100%	100%	93%	100%	71%	84%	83%
Plans Evaluated	14	14	14	14	14	14	14	14	3

The plans performed well on steps 1 through 6. The performance demonstrates that most plans followed the Agency-defined specifications and provided accurate documentation. Most opportunities for improvement were noted in Step 7 (Accurate Data Reporting and Analysis) wherein deficiencies were identified in the documentation of the PIP measurement period, accurate data reporting, and data analysis. Three plans (Florida Community Care-L, Magellan-S, and Simply-C) did not report cumulative annual data for the PIP performance indicator. The data were either reported monthly, by transportation vendor, or by line of business. In Step 8 (Appropriate Improvement Strategies), two plans (Miami Children's Health-M and Vivida-M) documented that they did not perform any QI activities because the baseline performance was above the state-mandated goal of 90 percent. Aetna Better Health-C also had an opportunity for improvement in the documentation of its causal barrier analysis process.

Figure 4-3—Overall Performance on Each Step of the PIP Validation Tool for the Behavioral Health PIP



	1. Appropriate PIP Topic	2. Clearly Defined PIP Aim Statement	3. Correctly Identified PIP Population	4. Valid Sampling Techniques (if sampling was used)	5. Clearly Defined Performance Indicator	6. Accurately Defined Data Collection Process	7. Accurate Data Reporting and Analysis	8. Appropriate Improvement Strategies
Not Met	0%	0%	0%	0%	0%	2%	12%	0%
Partially Met	0%	0%	7%	0%	14%	7%	3%	5%
Met	100%	100%	93%	100%	86%	90%	85%	95%
Plans Evaluated	14	14	14	14	14	14	14	14

All 14 plans were evaluated for the Design and Implementation stages (steps 1 through 8) of the Behavioral Health PIP. The opportunities for improvement identified were related to the documentation of the PIP population, PIP performance indicators, data collection process, narrative interpretation of data, and identification and prioritization of barriers and interventions.

Plan-Specific Results

Table 4-2 depicts the plan-specific validation results for the plan PIPs. For SFY 2020–2021, seven of 14 plans received an overall *Met* validation status for the *Administration of the Transportation Benefit* PIP, and 10 plans received an overall *Met* validation status for the Behavioral Health PIP.

Table 4-2—Plan-Specific PIP Validation Results

Plan Name	PIP Name	Validation Status	Percentage Score of Critical Elements Met	Percentage Score of Evaluation Elements Met
Aetna Better Health-C	*Administration of the Transportation Benefit*	*Partially Met*	89%	94%
	Behavioral Health PIP	*Partially Met*	88%	93%
Children's Medical Services-S	*Administration of the Transportation Benefit*	*Met*	100%	100%
	Behavioral Health PIP	*Met*	100%	100%
	Youth Transitions to Adult Care	*Met*	100%	100%
	Reducing Asthma Related PPEs for Pediatric Enrollees	*Met*	100%	100%
Community Care Plan-M	*Administration of the Transportation Benefit*	*Partially Met*	78%	75%
	Behavioral Health PIP	*Partially Met*	75%	80%
Florida Community Care-L	*Administration of the Transportation Benefit*	*Not Met*	75%	60%
	Behavioral Health PIP	*Partially Met*	88%	67%
Humana-C	*Administration of the Transportation Benefit*	*Met*	100%	100%
	Behavioral Health PIP	*Met*	100%	100%
Magellan-S	*Administration of the Transportation Benefit*	*Not Met*	78%	73%
	Behavioral Health PIP	*Met*	100%	80%
Miami Children's Health-M	*Administration of the Transportation Benefit*	*Partially Met*	86%	82%
	Behavioral Health PIP	*Met*	100%	93%

Plan Name	PIP Name	Validation Status	Percentage Score of Critical Elements Met	Percentage Score of Evaluation Elements Met
Molina-C	*Administration of the Transportation Benefit*	*Met*	100%	100%
	Behavioral Health PIP	*Met*	100%	100%
Prestige-M	*Administration of the Transportation Benefit*	*Partially Met*	78%	84%
	Behavioral Health PIP	*Partially Met*	88%	80%
Simply-C	*Administration of the Transportation Benefit*	*Met*	100%	88%
	Behavioral Health PIP	*Met*	100%	100%
Staywell-C	*Administration of the Transportation Benefit*	*Met*	100%	100%
	Behavioral Health PIP	*Met*	100%	100%
Sunshine-C	*Administration of the Transportation Benefit*	*Met*	100%	100%
	Behavioral Health PIP	*Met*	100%	100%
United-C	*Administration of the Transportation Benefit*	*Met*	100%	94%
	Behavioral Health PIP	*Met*	100%	100%
Vivida-M	*Administration of the Transportation Benefit*	*Partially Met*	86%	82%
	Behavioral Health PIP	*Met*	100%	93%

Evaluation Elements

Table 4-3 displays the evaluation elements that were assessed and the performance of the plans on those evaluation elements.

Table 4-3—Overall Performance of the Plans on the PIP Validation Tool Evaluation Elements

PIPs	Administration of the Transportation Benefit				Behavioral Health PIP			
Evaluation Elements	Met	Partially Met	Not Met	NA	Met	Partially Met	Not Met	NA
PIP topic was selected following collection and analysis of data. C*	14	0	0	0	14	0	0	0
PIP has the potential to affect enrollee health, functional status, or satisfaction.	14	0	0	0	14	0	0	0
PIP Aim statement was stated in simple terms and in the recommended X/Y format. C*	14	0	0	0	14	1	0	0
PIP population was accurately and completely defined and captured all enrollees to whom the PIP question(s) applied. C*	14	1	0	0	13	1	0	0
All six evaluation elements related to sampling.	0	0	0	14	0	0	0	14
Performance indicator(s) was well-defined, objective, and measured changes in health or functional status, member satisfaction, or valid process alternatives. C*	13	1	0	0	12	2	0	0
The plan included the basis on which the indicator(s) was developed, if internally developed.	0	0	0	15	0	0	0	14
Clearly defined sources of data and data elements collected for the PIP indicator(s).	14	0	0	0	14	0	0	0
A clearly defined and systematic process for collecting baseline and remeasurement data for the PIP indicator(s). C*	14	0	0	0	14	0	0	0
A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications. C*	0	0	0	14	0	0	0	14

PIPs	Administration of the Transportation Benefit				Behavioral Health PIP			
Evaluation Elements	Met	Partially Met	Not Met	NA	Met	Partially Met	Not Met	NA
The percentage of administrative data completeness following allowable claims lag and the process used to calculate the percentage.	2	0	0	12	10	3	1	0
The plan included accurate, clear, consistent, and easily understood information in the data table. C*	11	3	0	0	14	0	0	0
Included a narrative interpretation of results that addressed all requirements.	11	2	1	0	11	2	1	0
Addressed factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.	8	0	6	0	9	0	4	0
A causal/barrier analysis with a clearly documented team, process/steps, and QI tools. C*	11	3	0	0	12	2	0	0
Barriers that were identified and prioritized based on results of data analysis and/or other QI processes.	10	2	0	0	13	1	0	0
Interventions that were logically linked to identified barriers and have the potential to impact PIP indicator outcomes. C*	10	1	1	0	14	0	0	0
Interventions that were implemented in a timely manner to allow for impact of PIP indicator outcomes.	11	1	0	0	14	0	0	0
An evaluation of effectiveness for each individual intervention. C*	8	1	1	2	2	0	0	12
Interventions that were continued, revised, or discontinued based on evaluation results.	8	1	0	3	1	0	0	13
The remeasurement methodology was the same as the baseline methodology.	2	1	0	0	0	0	0	0

PIPs	Administration of the Transportation Benefit				Behavioral Health PIP			
Evaluation Elements	Met	Partially Met	Not Met	NA	Met	Partially Met	Not Met	NA
"At least one of the following was demonstrated: •Statistically significant improvement over baseline indicator performance (95 percent confidence level, $p < 0.05$). •Significant clinical improvement in processes and outcomes. •Significant programmatic"	3	0	0	0	0	0	0	0
Sustained improvement was demonstrated through repeated measurements over time.	0	0	0	0	0	0	0	0

C* *denotes a critical evaluation element. HSAG has designated some of the evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must receive a Met score. Given the importance of critical elements to the scoring methodology, any critical evaluation element that receives a score of Partially Met or Not Met will result in an overall PIP validation rating of Partially Met or Not Met.*

Plan Performance Indicator Results

For the *Administration of the Transportation Benefit* PIP, most plans reported CY 2019 data as the baseline for the PIP performance indicator(s). Only three plans (Prestige-M, United-C, and Staywell-C) reported CY 2019 data as Remeasurement 1 rates and documented achievement of statistically significant improvement over the baseline. The performance indicator rates as reported by the plans are identified in Table 4-4 below. Nine of the 14 plans reported a CY 2019 rate at or above the state-mandated goal of 90 percent. Five health plans (Aetna Better Health-C, Humana-C, Simply-C, Staywell-C, and Sunshine-C) reported CY 2019 rates below 90 percent.

Table 4-4—Performance Indicator Rates for the Administration of the Transportation Benefit PIP

Health Plan Name	Measurement Period~	Performance Indicator Rate*
Aetna Better Health-C	CY 2019	83.0%
Children's Medical Services-S	CY 2019	90%
Community Care Plan-M	CY 2019	90.1%
Florida Community Care-L^	CY 2019	Access 2 Care—94.3%; Ride2MD—91.2%
Humana-C	CY 2019	85.0%

Health Plan Name	Measurement Period~	Performance Indicator Rate*
Magellan-S^^	CY 2019	96.1%
Miami Children's Health-M	CY 2019	96.1%
Molina-C	CY 2019	97.8%
Prestige-M	CY 2018	94.1%
	CY 2019	97.1%
Simply-C^^^	CY 2019	89.6%
Clear Health-S	CY 2019	88.6%
Staywell-C	CY 2018	84.1%
	CY 2019	87.2%
Sunshine-C	CY 2019	88.9%
United-C	CY 2018	93.3%
	CY 2019	95.0%
Vivida-M	CY 2019	91.5%

^ Florida Community Care-L reported transportation vendor-specific data. HSAG provided feedback that the plan should provide a comprehensive rate in the next submission.

^^ Magellan-S reported monthly rate. The annual rate documented was calculated by HSAG based on the provided monthly rates for 2019.

^^^ Simply-C reported data by line of business for comprehensive and ClearHealth-S population.

~ Three plans reported CY 2018 as the baseline.

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

For the Behavioral Health PIP, the plans reported CY 2019 data as the baseline. The performance indicator rates as reported by the plans are in Table 4-5 below. The plans will be assessed for achievement of statistically significant improvement in the PIP performance indicator outcomes and achievement of clinically significant or programmatically significant improvement after finalized Remeasurement 1 data are reported.

Table 4-5—Performance Indicator Baseline Rates for the Behavioral Health PIP

Health Plan Name	Baseline Measurement Period	7-Day *FUH* Rate*	7-Day *FUM* Rate**	7-Day *FUA* Rate***
Aetna Better Health-C	CY 2019	36.8%	26.5%	4.5%
Children's Medical Services-S	CY 2019	41.9%	40.6%	2.3%
Community Care Plan-M	CY 2019	36.0%	30.2%	3.1%
Florida Community Care-L	CY 2019	11.9%	20.0%	0.0%
Humana-C	CY 2019	36.6%	27.2%	4.4%
Miami Children's Health-M	CY 2019	1.3%	42.1%	16.7%
Molina-C	CY 2019	38.8%	22.6%	5.8%
Prestige-M	CY 2019	31.0%	25.2%	10.7%
Simply-C	CY 2019	15.4%	33.6%	4.9%
Clear Health-S	CY 2019	8.1%	30.1%	5.3%
Sunshine-C	CY 2019	31.3%	25.3%	4.6%
Sunshine-S	CY 2019	45.6%	52.2%	1.3%
Staywell-C	CY 2019	27.5%	25.0%	6.5%
Staywell-S	CY 2019	24.4%	23.4%	7.8%
United-C	CY 2019	29.6%	25.8%	7.7%
Vivida-M	CY 2019	25.0%	1.8%	18.5%

* *Follow-Up After Hospitalization for Mental Illness—7-Days*

** *Follow-Up After ED Visit for Mental Illness—7-Days*

*** *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Days*

Plan Improvement Strategies

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

Table 4-6 displays the interventions as documented by the plans for the *Administration of the Transportation Benefit* PIP, and Table 4-7 displays the interventions for the Behavioral Health PIP.

Table 4-6—Interventions Implemented/Planned for the *Administration of the Transportation Benefit* PIP

Plan Name	Interventions Implemented/Planned
Aetna Better Health-C	• Logisticare schedules "ride along" with transportation providers not meeting timeliness metrics. • Identify member no-shows and distribute a report identifying those members monthly.
Children's Medical Services-S	• New tracking software to track performance of the vendors. • CAPs for providers (transportation vendors) not meeting targets.
Community Care Plan-M	• Placed transportation company on CAP. Health plan required weekly updates to Account Services and monthly updates to health plan Quality Improvement Committee. • Transportation company implemented a ride application that reports trip completion in real time.
Florida Community Care-L	• Evaluated and initiated PIP, capitation on trip volume, and termination of providers (transportation vendors) not meeting targets.
Humana-C	• Targeted on-site visits with Adult Day Care Centers that have the highest volume of LTC membership, provide their own transportation, and do not meet the 90 percent threshold. • Shooter Vehicle Initiative to quickly cover trips in targeted areas.
Magellan-S	• Magellan Complete Care's Network Department conducts quarterly geo-access analysis: retrospective and ongoing for regions 4, 5, and 7, and reports results at the Veyo (transportation vendor) Joint Operating Committee meetings. • VEYO to work with subcontractor(s) drivers to allow for more time for arriving to pick-up point and for transport to scheduled appointment. • Health plan staff to educate enrollees (particularly those with a history of being late three or more times in a three-month period) about the importance of being ready for pick up.
Miami Children's Health-M	• Not Reported (NR)

Plan Name	Interventions Implemented/Planned
Molina-C	• Transportation vendor provides coaching of protocols to the employees who do not abide by the Transportation Manual. • Provide enrollee education during transportation appointments scheduled by Molina representatives (i.e., educating enrollees about average wait time on return ride home). • Transportation vendor will flag and monitor transportation providers with a decrease in on-time performance. A reduction in the number of future trips and services by the providers may be done until improvement is made.
Prestige-M	• Evaluate and initiate PIP, capitation on trip volume, and termination of providers (transportation vendors) not meeting targets.
Simply-C	• Identify and engage enrollees with prior transportation issues.
Staywell-C	• Implemented a new tracking software to track performance of the vendors. • CAPs implemented for transportation vendors not meeting targets.
Sunshine-C	• Enrollee Advocate Escalation Unit will handle real-time enrollee transportation complaints and provide additional collaboration with LogistiCare (vendor). • Use the Secret Shopper program as a random check on courtesy and completeness of the vendor's agents' call interactions with enrollees. • Conduct an "After-Ride" enrollee satisfaction survey. • Provide provider education materials and conduct training. • Provide enrollee education materials. • Provide transportation benefit training for Sunshine Health staff members.
United-C	• Improve network capacity. • Identify underperforming providers, assess network coverage, and adjust volume down immediately. Target bottom tier providers for behavior modification through a) lowered volume, and b) improvement action plans. Target bottom 5% of fleet for replacement/reassignment of volume with random targeted inspections. • Rewarding transportation providers who are performing above expectations with more standing orders. • Escalations and Monitoring: Place four specialists dedicated to recovery and active trip monitoring. Modified cancelation/no-show process to capture trips, which would potentially result in a complaint or missed trip. Implemented new online recommendation-based routing tool. Updated routing plans aimed at reducing recurring complaints.
Vivida-M	• NR

Table 4-7—Interventions Implemented/Planned for the Behavioral Health PIP

Plan Name	Interventions Implemented/Planned
Aetna Better Health-C	• Utilizing Florida's Encounter Notification Service (ENS) to facilitate timely outreach to the enrollee to schedule follow-up visits with eligible providers. • Outreach and education to enrollees to increase awareness of the availability of behavioral health services and help with scheduling seven-day follow-up appointments. • Outreach and education to facilities and providers discharging enrollees without a follow-up appointment scheduled.
Children's Medical Services-S	• Utilize Florida's ENS real-time hospital admission, discharge, and transfer (ADT) data to identify enrollees for outreach to schedule follow-up visits with primary care and/or behavioral health providers. • UM team notifies the primary care manager, back-up care manager, supervisor, and behavioral health manager about admissions and discharges from Crisis Stabilization Units.
Community Care Plan-M	• Improve efforts to obtain real-time hospital admission ED visit notifications through Florida's ENS to facilitate timely outreach to the member to schedule follow-up visits with primary care and behavioral health providers. • Improve discharge planning and care transitions through weekly all department huddles with a focus on behavioral health.
Florida Community Care-L	• Care managers will obtain real-time hospital admission and ED visit notifications through Florida's ENS to facilitate timely outreach to the enrollee by care manager. • Outreach and education to increase awareness of the availability of mental health services. Family caregiver engagement in discharge planning. Arrange for and coordinate community resources as needed. • Upon notification of ED visit or inpatient admission, care manager will determine if enrollee has been diagnosed with or has self-reported mental illnesses, alcohol and other drug abuse, or dependencies. Care manager will reach out to the inpatient facility to assist with follow-up appointment before discharge.
Humana-C	• Improve efforts to obtain real-time hospital admission and ED visit notifications through ENS to facilitate timely outreach to the member to schedule follow-up visits with primary care and behavioral health providers. • Enhance discharge planning, care transitions, and post-discharge care coordination. • Enhance care coordination, education, and member and provider engagement post-ED visit. • Promote telehealth utilization and expansion for seven-day follow-up appointments.

Plan Name	Interventions Implemented/Planned
	• Implement a provider scorecard to enhance provider (hospital) compliance and engagement with coordination of care, transitions, and scheduling of post-discharge appointments.
Magellan-S	• Improve efforts to obtain real-time hospital admission and ED visit notifications through Florida's ENS to facilitate timely outreach to the enrollee to schedule follow-up visits with primary care and behavioral health providers. • The plan care coordinator will confirm member is linked to a primary care or behavioral provider, assist with scheduling of timely follow-up appointment within seven days of discharge, schedule transportation if needed, and call member to verify compliance with appointment. • The Provider Relations Management (PRM) team will improve notifications to local hospitals about the availability of new outpatient community behavioral health providers; the PRM team will provide education to ensure follow-up care occurs within seven days of discharge/ED visit.
Miami Children's Health-M	• Improve efforts to obtain real-time hospital admission and ED-visit notifications through Florida's ENS to facilitate timely outreach to the enrollees to schedule follow-up visits with primary care and behavioral health providers. • Outreach and education to increase awareness of the availability of behavioral health services. • Improve discharge planning and care transitions.
Molina-C	• Identification of additional enrollee information through internal and external tools for enrollees in the discharge, aftercare, and ENS reports. • Outreach and education to increase awareness of the availability of behavioral health services. • Education to high utilizing hospitals and primary care physicians. • Assist with scheduling timely follow-up appointments.
Prestige-M	• Prestige-M UM will utilize Florida's ENS to improve Prestige-M awareness of ED visit and hospital admission information daily in order to prompt the process and alert the Prestige TOC coordinator to review the discharge plan and initiate and coordinate a follow-up appointment. • Identify ED and inpatient providers through collected TOC information and recorded in the benefit and case management system (JIVA). Information is given to the provider network management department for outreach by the assigned account executive with provider education about valid follow-up appointment requirements. TOC coordinator to initiate discharge and will communicate with enrollee and provider to assist with follow-up appointment. • High-risk indicators are established. Flag the members with high-risk indicator(s) per case management record.

Plan Name	Interventions Implemented/Planned
Simply-C	• Improving ENS notifications. • Plan engaged three behavioral health providers who agreed to participate in this test and requested that participating providers contact every member discharged from a behavioral health hospitalization within 24 hours and provide an immediate telehealth behavioral health visit, which will address the *FUH—7-Days* population.
Staywell-C	• Utilize Florida's ENS real-time hospital ADT data to identify members for outreach to schedule follow-up visits with primary care and/or behavioral health providers.
Sunshine-C	• Outreach to members identified as frequent ED utilizers. • Utilize Florida's ENS real-time hospital ADT data to identify members for outreach to schedule follow-up visits with primary care and/or behavioral health providers.
United-C	• Optum Chronic Care Management (CCM) program is designed to support enrollees with behavioral health needs, including those related to member health and substance use. • Optum virtual case health worker (CHW) team: Enrollees discharged for a low-risk behavioral health condition are assigned a virtual CHW, who ensures enrollee has follow-up appointment within the appropriate time frame. • Daily ENS behavioral health custom report to be used by Optum CCM and virtual CHW program. • Behavioral health care management team to begin using portal maintained by Audacious Inquiry (health information exchange). Portal houses enrollee contact information from the most recent ED or hospital visited by the enrollee.
Vivida-M	• Improve efforts to obtain real-time hospital admission and ED-visit notifications through Florida's ENS to facilitate timely outreach to the member to schedule follow-up visits with primary care and behavioral health providers following an ED visit. • Outreach and education to increase awareness of the availability of behavioral health services.

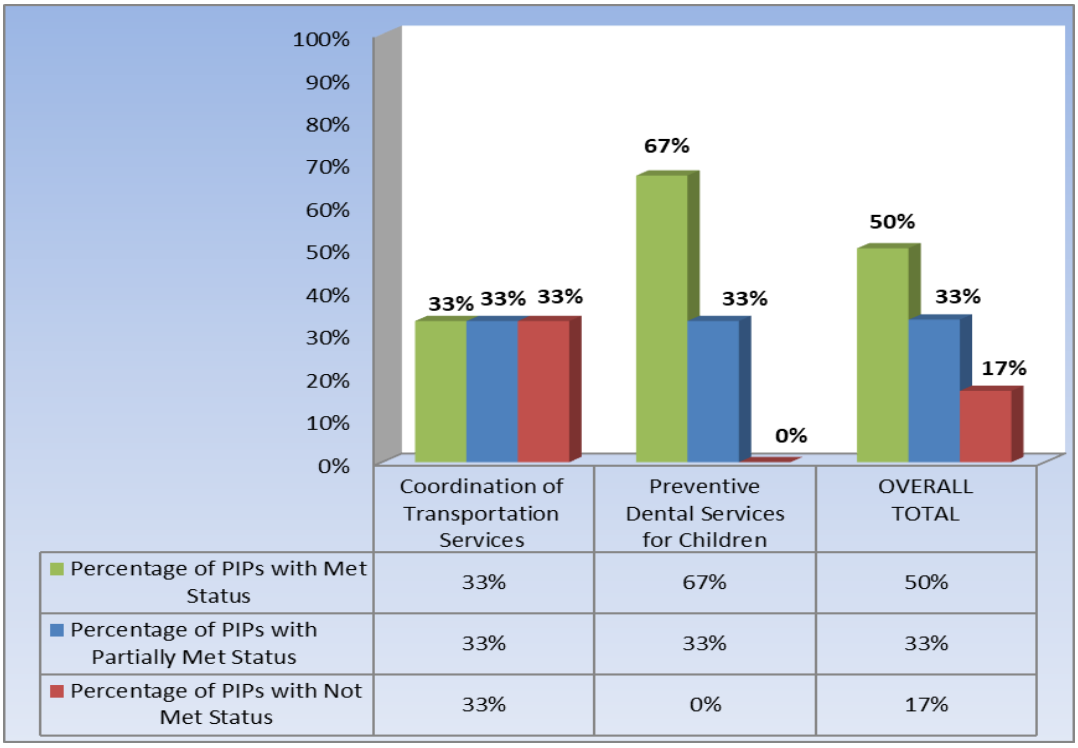
Dental Plans PIP Validation Results

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

Overall Validation Status

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

Figure 4-4—Overall Validation Status of Dental Plans PIPs by PIP Topic



	Coordination of Transportation Services	Preventive Dental Services for Children	OVERALL TOTAL
Percentage of PIPs with Met Status	33%	67%	50%
Percentage of PIPs with Partially Met Status	33%	33%	33%
Percentage of PIPs with Not Met Status	33%	0%	17%

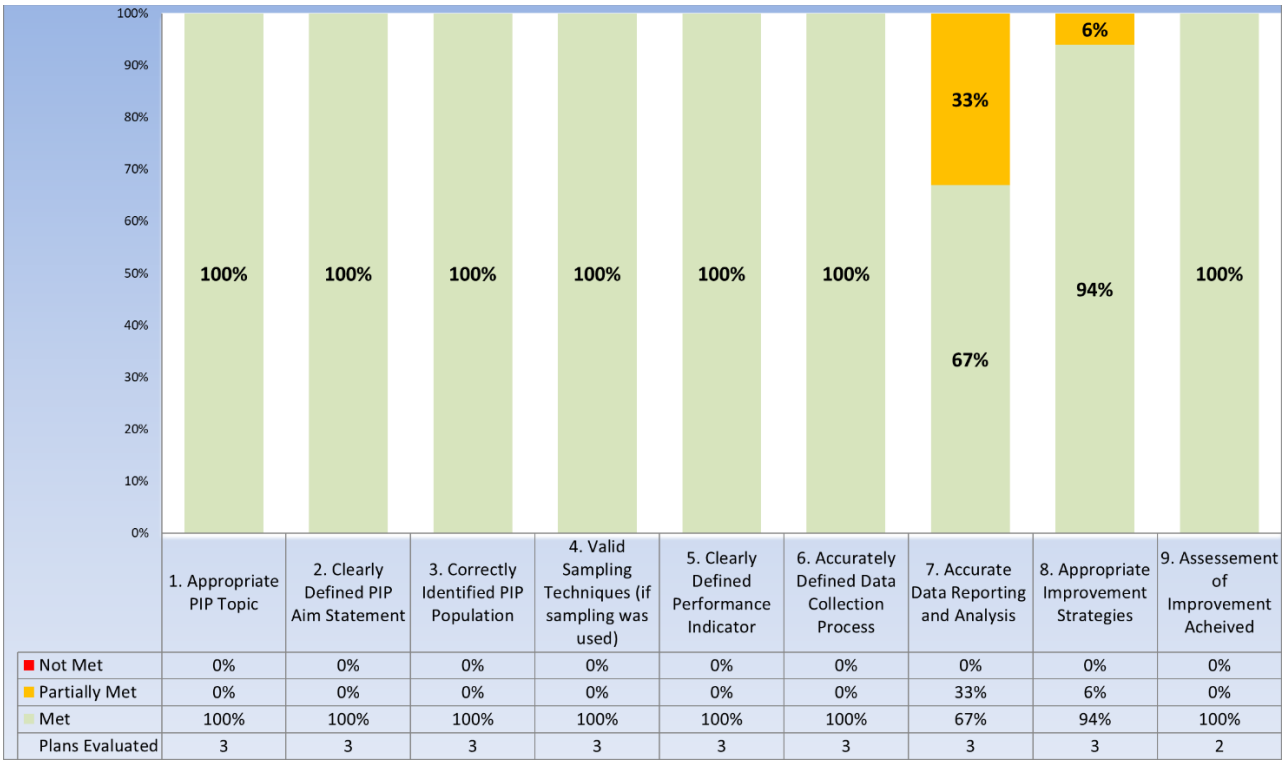
Three dental PIPs (50 percent) received an overall *Met* validation status. For the *Coordination of Transportation Services With the SMMC Plans* PIP, two dental plans (Liberty and DentaQuest) had opportunities for improvement in collecting and reporting accurate data for the PIP performance indicators. For the *Preventive Dental Services for Children* PIP, one dental plan (DentaQuest) did not report the remeasurement data for the PIP performance indicator and, therefore, received a *Partially Met* overall validation status.

Overall Validation Status

The section below describes the overall performance of the dental plans for both PIPs on each step of the PIP Validation Tool.

Figure 4-5 and Figure 4-6 display the percentage of evaluation elements achieving a *Met*, *Partially Met*, and *Not Met* validation score on each step of the PIP Validation Tool for the *Preventive Dental Services for Children* PIP and the *Coordination of Transportation Services With the SMMC Plans* PIP, respectively. Percentage totals may not equal 100 due to rounding.

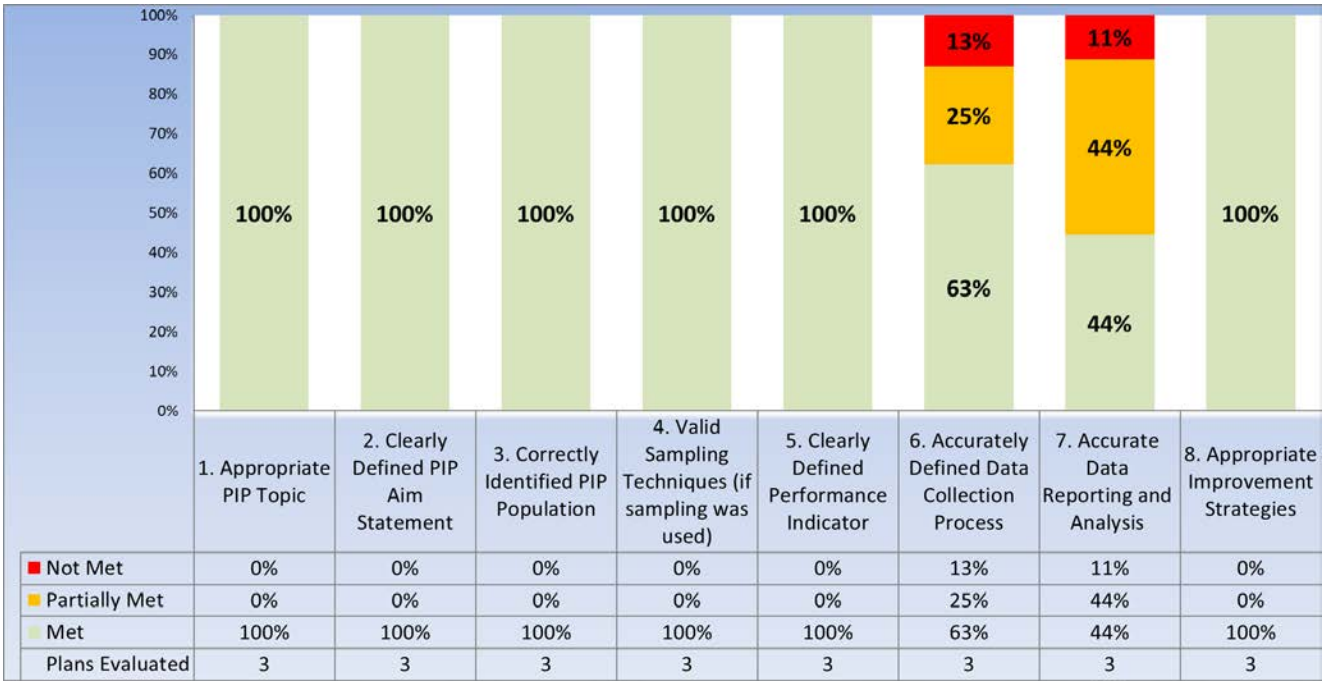
Figure 4-5—Overall Performance on Each Step of the PIP Validation Tool for the *Preventive Dental Services for Children* PIP



	1. Appropriate PIP Topic	2. Clearly Defined PIP Aim Statement	3. Correctly Identified PIP Population	4. Valid Sampling Techniques (if sampling was used)	5. Clearly Defined Performance Indicator	6. Accurately Defined Data Collection Process	7. Accurate Data Reporting and Analysis	8. Appropriate Improvement Strategies	9. Assessement of Improvement Acheived
Not Met	0%	0%	0%	0%	0%	0%	0%	0%	0%
Partially Met	0%	0%	0%	0%	0%	0%	33%	6%	0%
Met	100%	100%	100%	100%	100%	100%	67%	94%	100%
Plans Evaluated	3	3	3	3	3	3	3	3	2

All three dental plans were evaluated for the Design and Implementation stages (steps 1 through 8) of the *Preventive Dental Services for Children* PIP. DentaQuest did not report remeasurement data and was, therefore, not assessed for Step 9 (improvement achieved). Opportunities for improvement were identified in the documentation of data and evaluation of improvement strategies.

Figure 4-6—Overall Performance on Each Step of the PIP Validation Tool for the *Coordination of Transportation Services With the SMMC Plans* PIP



	1. Appropriate PIP Topic	2. Clearly Defined PIP Aim Statement	3. Correctly Identified PIP Population	4. Valid Sampling Techniques (if sampling was used)	5. Clearly Defined Performance Indicator	6. Accurately Defined Data Collection Process	7. Accurate Data Reporting and Analysis	8. Appropriate Improvement Strategies
Not Met	0%	0%	0%	0%	0%	13%	11%	0%
Partially Met	0%	0%	0%	0%	0%	25%	44%	0%
Met	100%	100%	100%	100%	100%	63%	44%	100%
Plans Evaluated	3	3	3	3	3	3	3	3

All three dental plans were evaluated for the Design and Implementation stages (steps 1 through 8) of the *Coordination of Transportation Services With the SMMC Plans* PIP. Opportunities for improvement were identified in the documentation of an accurate data collection process, data reporting, and analysis of results.

Dental Plan-Specific Results

Table 4-8 depicts and compares the dental plan-specific SFY 2020–2021 PIP validation results for the dental PIPs.

Table 4-8—Dental Plan-Specific PIP Validation Results

Dental Plan Name	PIP Name	Validation Status	Percentage Score of Critical Elements Met	Percentage Score of Evaluation Elements Met
DentaQuest	*Coordination of Transportation Services With the SMMC Plans*	*Not Met*	80%	71%
	Preventive Dental Services for Children	*Partially Met*	89%	88%
Liberty	*Coordination of Transportation Services With the SMMC Plans*	*Partially Met*	78%	81%
	Preventive Dental Services for Children	*Met*	100%	89%

Dental Plan Name	PIP Name	Validation Status	Percentage Score of Critical Elements Met	Percentage Score of Evaluation Elements Met
MCNA	*Coordination of Transportation Services With the SMMC Plans*	*Met*	100%	100%
	Preventive Dental Services for Children	*Met*	100%	100%

For SFY 2020–2021, one dental plan received an overall *Met* validation status for the *Coordination of Transportation Services With the SMMC Plans* PIP and two dental plans received an overall *Met* validation status for the *Preventive Dental Services for Children* PIP.

Evaluation Elements

Table 4-9 displays the evaluation elements that were assessed and the performance of the dental plans on those evaluation elements.

Table 4-9—Overall Performance of the Dental Plans on the PIP Validation Tool Evaluation Elements

PIPs	*Coordination of Transportation Services With the SMMC Plans*				*Preventive Dental Services for Children*			
Evaluation Elements	Met	Partially Met	Not Met	NA	Met	Partially Met	Not Met	NA
PIP topic was selected following collection and analysis of data. C*	3	0	0	0	3	0	0	0
PIP has the potential to affect enrollee health, functional status, or satisfaction.	3	0	0	0	3	0	0	0
PIP question(s) was stated in simple terms and in the recommended X/Y format. C*	3	0	0	0	3	0	0	0
PIP population was accurately and completely defined and captured all enrollees to whom the PIP question(s) applied. C*	3	0	0	0	3	0	0	0
All six evaluation elements related to sampling.	0	0	0	3	0	0	0	3
PIP indicator(s) was well-defined, objective, and measured changes in health or functional status, member satisfaction, or valid process alternatives. C*	3	0	0	0	3	0	0	0

PIPs	*Coordination of Transportation Services With the SMMC Plans*				*Preventive Dental Services for Children*			
Evaluation Elements	**Met**	**Partially Met**	**Not Met**	**NA**	**Met**	**Partially Met**	**Not Met**	**NA**
The dental plan included the basis on which the indicator(s) was developed, if internally developed.	0	0	0	3	0	0	0	3
Clearly defined sources of data and data elements collected for the PIP indicator(s).	2	1	0	0	3	0	0	0
A clearly defined and systematic process for collecting baseline and remeasurement data for the PIP indicator(s). C*	2	1	0	0	3	0	0	0
A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications. C*	0	0	1	2	0	0	0	3
The percentage of administrative data completeness following allowable claims lag and the process used to calculate the percentage.	1	0	0	2	3	0	0	0
The dental plan included accurate, clear, consistent, and easily understood information in the data table. C*	1	2	0	0	2	1	0	0
Included a narrative interpretation of results that addressed all requirements.	1	2	0	0	2	1	0	0
Addressed factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.	2	0	1	0	2	1	0	0
A causal/barrier analysis with a clearly documented team, process/steps, and QI tools. C*	3	0	0	0	3	0	0	0
Barriers that were identified and prioritized based on results of data analysis and/or other QI processes.	3	0	0	0	3	0	0	0

PIPs	Coordination of Transportation Services With the SMMC Plans				Preventive Dental Services for Children			
Evaluation Elements	Met	Partially Met	Not Met	NA	Met	Partially Met	Not Met	NA
Interventions that were logically linked to identified barriers and have the potential to impact PIP indicator outcomes. C*	3	0	0	0	3	0	0	0
Interventions that were implemented in a timely manner to allow for impact of PIP indicator outcomes.	3	0	0	0	3	0	0	0
An evaluation of effectiveness for each individual intervention. C*	2	0	0	1	3	0	0	0
Interventions that were continued, revised, or discontinued based on evaluation results.	1	0	0	2	2	1	0	0
The remeasurement methodology was the same as the baseline methodology.	0	0	0	0	2	0	0	0
"At least one of the following was demonstrated: •Statistically significant improvement over baseline indicator performance (95 percent confidence level, $p < 0.05$). •Significant clinical improvement in processes and outcomes. •Significant programmatic"	0	0	0	0	2	0	0	0
Sustained improvement was demonstrated through repeated measurements over time.	0	0	0	0	0	0	0	0

C* *denotes a critical evaluation element. HSAG has designated some of the evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must receive a Met score. Given the importance of critical elements to the scoring methodology, any critical evaluation element that receives a score of Partially Met or Not Met will result in an overall PIP validation rating of Partially Met or Not Met.*

Dental Plan PIP Study Indicator Results

For the *Preventive Dental Services for Children* PIP, three dental plans reported baseline and two dental plans reported Remeasurement 1 rates for the PIP performance indicator. Liberty and MCNA were assessed for achievement of statistically significant improvement, clinically significant improvement, or programmatically significant improvement in the PIP outcomes. Both dental plans documented a decline

in the remeasurement rates; however, the dental plans provided intervention evaluation data-driven evidence of significant clinical or programmatic improvement in PIP outcomes. The dental plans documented that the COVID-19 PHE-related provider office closures and limited staff availability may have led to a decline in the overall PIP performance indicator rate.

For the *Coordination of Transportation Services With the SMMC Plans* PIP, the dental plans reported finalized baseline CY 2019 rates and interim Remeasurement 1 CY 2020 rates for the PIP performance indicator(s). The dental plans will be assessed for achievement of improvement after finalized Remeasurement 1 data are reported. The data reported by Liberty and DentaQuest did not appear to be in accordance with the defined specifications. Liberty reported its inability to collect Performance Indicator 1 data. HSAG identified that Liberty was not capturing accurate data elements, which may have been the reason for Liberty's inability to collect the data.

The PIP performance indicators' rates as reported by the dental plans are displayed in Table 4-10 and Table 4-11.

Table 4-10—Performance Indicator Rates for the *Preventive Dental Services for Children* PIP

Dental Plan Name	Measurement Period	Performance Indicator Rate*
DentaQuest	Federal Fiscal Year (FFY) 2019	36.3%
	FFY 2020	NR
Liberty	FFY 2019	34.4%
	FFY 2020	34.4%
MCNA	FFY 2019	36.0%
	FFY 2020	31.1%

* Performance Indicator: The percentage of enrollees 1 to 20 years of age that had at least one preventive dental service during the MY.

Table 4-11—Performance Indicator Rates for the *Coordination of Transportation Services With the SMMC Plans* PIP

Dental Plan Name	Measurement Period^	Performance Indicator 1 Rate*	Performance Indicator 2 Rate**
DentaQuest	CY 2019	96.3%	95.2%
	CY 2020	NR	NR

Dental Plan Name	Measurement Period^	Performance Indicator 1 Rate*	Performance Indicator 2 Rate**
Liberty	CY 2019	NR	9.8%
	CY 2020	NR	23.4%
MCNA	CY 2019	100%	62.0%
	CY 2020	100%	49.0%

^ Two dental plans reported interim CY 2020 data as available at the time of PIP submission.

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

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

Dental Plan Improvement Strategies

Table 4-12 displays the interventions as documented by the dental plans for the *Preventive Dental Services for Children* PIP, and Table 4-13 displays the interventions for the *Coordination of Transportation Services With the SMMC Plans* PIP.

Table 4-12—Interventions Implemented/Planned for the *Preventive Dental Services for Children* PIP

Dental Plan Name	Interventions Implemented/Planned
DentaQuest	• Healthy Behavior Program to encourage enrollees to receive preventive treatment; also offering a $20 Walmart gift card to enrollees receiving preventive dental care within 180 days of enrollment.
Liberty	• 1st Tooth, 1st Birthday campaign, which includes outreach to parents/guardians and providers to promote awareness of the American Academy of Pediatric Dentistry's (AAPD's) recommendation to "Get it Done in Year One." • Enrollee incentive programs to motivate enrollees to seek preventive dental care. • A tiered payment incentive for primary dental providers. • Pilot a Florida-based "Early Smiles program" in lowest utilizing regions that allows the plan to provide preventive dental services and help to navigate children to a dental home through school-based partnerships, and use of mobile dentistry outreach, education, and treatment in collaboration with county school districts and the Florida Department of Education.
MCNA	• Member service representatives (MSRs) offer assistance with scheduling an appointment when an alert is triggered in the DentalTrac™ system during inbound calls that indicates the enrollee is overdue for a preventive dental visit.

Dental Plan Name	Interventions Implemented/Planned
	• Send text messages once a month to enrollees who have no claims history on file for preventive services. • Generate a Quarterly Provider Profiling Report that shows providers how they are performing against their peers. • Provide monthly enrollee rosters of children who have not received a preventive dental service in the current RY to primary care dentists/dental homes. • Targeted provider relations outreach to dentists who, based on dental record review, have not completed the AAPD preventive care requirements. • Real-time preventive dental service gaps visible to providers at the time of eligibility verification in MCNA's provider portal.

Table 4-13—Interventions Implemented/Planned for the *Coordination of Transportation Services With the SMMC Plans* PIP

Dental Plan Name	Interventions Implemented/Planned
DentaQuest	• Tracking and reporting enrollee transportation requests. • Created and distributed an informational sheet on DentaQuest contact information to SMMC dental health plan liaisons.
Liberty	• Include information in enrollee handbook, provider reference guide, Liberty Dental Plan website, and any newsletters. • Live outreach to non-utilizing enrollees to inform them of transportation availability. • Liberty customer service representative to act as liaison to coordinate with, or on behalf of, enrollee with transportation vendor directly.
MCNA	• Inbound Education and Assistance—MSRs and case management educate and assist enrollees with scheduling transportation to their dental appointments through inbound calls. • Provider Portal Banner—Eligibility screen in the provider portal that reminds providers that enrollees can receive transportation assistance. • Enrollee Portal Alerts—Enrollees will be notified that transportation is a covered benefit for dental appointments. • Member Outreach for Missed Appointments—Collaborate with Community Care Plan-M for monthly data exchange of enrollees who miss more than two scheduled transportation trips to a dental appointment.

Strengths, Opportunities for Improvement, and Recommendations

Program Level

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

Strengths	**Strength**: The PIPs had a sound design, were methodologically sound, and aligned with Agency-defined specifications.
	Strength: The plans used appropriate causal/barrier analysis tools and processes to identify and prioritize barriers. Most plans developed and implemented targeted interventions to actively engage the enrollees or providers to improve quality, timeliness, and access to care.
	Strength: For the *Administration of the Transportation Benefit* PIP, all three plans (Prestige-M, United-C, and Staywell-C) that progressed to reporting Remeasurement 1 rates demonstrated statistically significant improvement over the baseline.
	Strength: For the *Preventive Dental Services for Children* PIP, two dental plans provided intervention evaluation data-driven evidence of clinically significant or programmatically significant improvement in PIP outcomes.
Weakness and Recommendations	**Weakness:** For the *Administration of the Transportation Benefit* PIP, most opportunities for improvement were related to the documentation of accurate PIP performance indicator data. **Why the weakness exists:** Three plans (Florida Community Care-L, Magellan-S, and Simply-C) did not report cumulative annual data for the PIP performance indicator, as required. The data were either reported monthly, by transportation vendor, or by line of business. **Recommendation:** Plans should report accurate annual PIP performance data in accordance with the Agency-defined specifications and approved methodology. The reported data should be comparable across all measurement periods.
	Weakness: For the *Administration of the Transportation Benefit* PIP, two plans (Miami Children's Health-M and Vivida-M) documented that they did not perform any QI activities because the baseline performance was above the state-mandated goal of 90 percent. **Why the weakness exists:** The plans implied that they did not need to perform QI activities since they were performing above the state-mandated goal. **Recommendation:** For the PIPs, where the baseline rate for the PIP performance indicators was above the state-mandated goals, the plans should consult with the Agency to receive guidance for next steps. Unless otherwise approved by the Agency, the plans should continue with the PIP QI activities.

Weakness and Recommendations	
	Weakness: For the *Coordination of Transportation Services With the SMMC Plans* PIP, the PIP performance indicator data reported by Liberty and DentaQuest were not in accordance with the Agency-defined specifications. **Why the weakness exists:** The dental plans did not capture accurate data elements as described in their approved data collection plan. The dental plans did not seek guidance from the Agency or HSAG prior to the PIP submission due date for data-related issues. **Recommendation:** For difficulties and challenges related to data collection, the dental plans must seek technical assistance from the Agency and/or HSAG prior to the annual PIP submission due date rather than documenting the issues in the PIP Submission Form and not reporting data.
	Weakness: For the *Preventive Dental Services for Children* PIP, there was a decline or no improvement in the PIP performance indicator rate, despite the intervention evaluation data-driven evidence of clinically significant or programmatically significant improvement in PIP outcomes. **Why the weakness exists:** The dental plans documented that the COVID-19 PHE-related provider office closures and limited staff availability may have led to the noted decline in the overall PIP performance indicator rate. **Recommendation:** In addition to offering telehealth appointments, the dental plans should consider addressing other social determinants of health that prevent the enrollees from seeking preventive dental care. Additionally, the interventions determined as successful during the Plan-Do-Study-Act (PDSA) cycles should be expanded to the entire eligible population served by the dental plan to impact the plan-wide rate.

Overall Assessment of Progress in Meeting EQRO Recommendations

Program-Level Assessment

During previous years, HSAG made recommendations in the annual reports for each of the activities that were conducted. Table 5-1 is a summary of the follow-up actions per activity that the Agency completed in response to HSAG's recommendations during SFY 2019–2020.

Table 5-1—HSAG Recommendations with Agency Actions

HSAG Recommendation	Agency Action
Performance Improvement Projects	
The Agency must continue to communicate with the plans and HSAG regarding the state-mandated PIP requirements and any changes made to the Agency-defined specifications.	The Agency established a PIP communication plan with HSAG to ensure that HSAG and the health plans were aware of any changes made to PIP submissions and requirements.
For the Behavioral Health PIP, the Agency may want to consider revising calendar year (CY) 2020 as the baseline for the project. The three PIP performance indicators for the Behavioral Health PIP were revised in CY 2020 by HEDIS to include telehealth services as a numerator-compliant visit. Revising the baseline to CY 2020 would ensure a comparable baseline and remeasurement data.	The Agency is considering revising calendar year (CY) 2020 as the baseline for the project.
For the health plans that recently announced mergers and acquisitions, the Agency must communicate with the health plans and HSAG about any revisions that need to be made to the PIP baseline measurement period.	The Agency has implemented processes to communicate with the health plans experiencing mergers or acquisitions and HSAG about any revisions that need to be made to the PIP baseline measurement period.
Performance Measure Validation	
The Agency should conduct root cause analyses for the low access to care rates to determine the nature and scope of the issue (e.g., are the issues related to barriers to accessing care, a lack of family planning service providers, or the need for improved community outreach and education). Once the root causes are identified, the	The Agency is considering which approach to use in having health plans conduct root cause analyses to determine the nature and scope of the issue.

HSAG Recommendation	Agency Action
Agency should work with providers and enrollees to establish potential performance improvement strategies and solutions to increase the access to care rates. Improvement in these rates may also result in improvement related to the quality of care provided, as evidenced by poor performance in the outpatient setting related to other performance measure domains.	
The Agency should focus efforts on identifying the factors contributing to the low rates for Living With Illness measures (e.g., are the barriers related to accessing outpatient care and pharmacies; or the need for provider training, investigation of prescribing patterns, or the need for improved community outreach and education) and implement strategies to improve the care for enrollees with diabetes. Additionally, the Agency may consider exploring whether there are opportunities for the plans to enhance their care management services for individuals with diabetes.	The Agency is considering which approach to use in having health plans focus efforts on identifying the factors contributing to the low rates for Living With Illness measures, including the measures for services for individuals diagnosed with diabetes.
It may be beneficial for the Agency to work with plans to development an enhanced discharge process plan to improve the rates for the behavioral health follow-up indicators. This may include improving communication between the staff at discharge and the next provider prior to discharge, engaging family or caregivers of those being discharged, and engaging pharmacy partners to provide medication supply prior to discharge. The Agency and the plans may find it beneficial to evaluate other potential barriers to enrollees receiving timely and appropriate follow-up, by evaluating whether factors such as the provider networks or transportation services are possibly contributing to the lower rates.	The Agency encouraged plans to develop enhanced discharge process plans to improve rates for the behavioral health follow-up indicators as part of their annual PIP submissions. The topic of the most recent behavioral health PIP for all plans is improving 7-day behavioral health follow-up rates.
HSAG recommends that improvement efforts be focused on behavioral health measures where a majority of the plans required to report the measure fell below the Agency's performance targets in RY 2020, as listed below. • *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* • *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* • *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* • *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	The Agency has in progress improvement efforts focused on behavioral health measures where a majority of the plans required to report the measures fell below the Agency's performance targets in RY 2020.

EQRO Recommendation Progress

HSAG Recommendation	Agency Action
Encounter Data Validation	
The comparative analysis results for both the non-emergency transportation and dental encounters indicate a high degree of complete and accurate data. HSAG recommends that the Agency continue its current efforts in monitoring encounter data submissions and addressing any identified data issues with the CNET and dental plans' encounter file submissions.	The Agency has in progress continuing efforts in monitoring encounter data submissions and addressing any identified data issues with the CNET and dental plans' encounter file submissions.
Consider developing standards for the measures included in the comparative analysis. In collaboration with HSAG, the Agency may consider developing and implementing processes to evaluate the plans' performance and provide results to the plans for initial feedback to ensure the plans understand the measures evaluated and eventually the associated standards. These standards can potentially be included as part of the validation of the plans' encounter data to assess and monitor the plans' performance in submitting complete and accurate encounter data to the Agency.	The Agency is considering developing standards for the measures included in the comparative analysis. The Agency is considering developing and implementing processes to evaluate the plans' performance and provide results to the plans for initial feedback to ensure the plans understand the measures evaluated and eventually the associated standards.
[Transportation/dental record review] To ensure the plans' accountability for record-keeping and documentation requirements, the Agency may consider strengthening and/or enforcing its contract requirements with the plans regarding provision of oversight activities in this area. For example, while the Agency Rule 59G-1.054 Recordkeeping and Documentation Requirements stipulate that providers must retain records related to services rendered to Florida Medicaid enrollees for a period of at least five years from the date of service, one plan noted that it is only able to maintain three months of records on-site, and all other records after 90 days are kept off-site. This scenario caused delays in HSAG receiving the requested documentation from the plan. HSAG recommends the Agency work with the plan(s) to ensure documentation and/or records are easily accessible when requested.	The Agency is exploring revisions to contracts to require timely responses to requests for records.
[Transportation/dental record review] Since the results of the record review are dependent on the plans' submission of complete and accurate supporting documentation, HSAG recommends the Agency consider setting record submission standards to ensure the plans are more responsive in procuring requested records. By having the plans submit complete and accurate documentation and/or records, results will be more representative of the actual documentation available.	The Agency is considering setting record submission standards to ensure the plans are more responsible in procuring requested records.

Plan-Specific Assessment

Appendix F contains a summary of the follow-up actions per activity that the plans completed in response to HSAG's SFY 2019–2020 recommendations. Please note that the responses in this section were provided by the plans and have not been edited or altered by HSAG.

Appendix A. Plan Names/Abbreviations

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

COMPREHENSIVE PLANS

- Coventry Health Care of Florida, Inc. DBA Aetna Better Health of Florida, Inc. (*Aetna Better Health-C / AET-C*)
- Humana Medical Plan, Inc. (*Humana-C / HUM-C*)
- Molina Healthcare of Florida, Inc. (*Molina-C / MOL-C*)
- Simply Healthcare Plan, Inc. (*Simply-C / SHP-C*)
- Wellcare of Florida DBA Staywell Health Plan of Florida, Inc. (*Staywell-C / STW-C*)
- Sunshine State Health Plan, Inc. (*Sunshine-C / SUN-C*)
- United Healthcare of Florida, Inc. (*United-C / URA-C*)

SPECIALTY PLANS

- Children's Medical Services Network-Staywell (Children with Chronic Conditions) (*Children's Medical Services-S / CMS-S*)
- Clear Health Alliance (HIV/AIDS Specialty Plan) (*Clear Health-S / CHA-S*)
- Magellan Complete Care (Serious Mental Illness Specialty Plan) (*Magellan-S / MCC-S*)
- Staywell (Serious Mental Illness Specialty Plan) (*Staywell-S / STW-S*)
- Sunshine State Health Plan, Inc. (Child Welfare Specialty Plan) (*Sunshine-S / SUN-S*)

*Florida True Health/Prestige Health Choice changed its name during the reporting period (effective July 1, 2021) to AmeriHealth Caritas Florida, Inc., but will be referred to as Prestige Health Choice (PRS-M) throughout this report.

MANAGED MEDICAL ASSISTANCE (MMA) PLANS

- Best Care Assurance DBA Vivida Health (*Vivida-M / BST-M*)
- Florida True Health/Prestige Health Choice (*Prestige-M / PRS-M*)*
- Lighthouse Health Plan (*Lighthouse-M / LHT-M*)
- Miami Children's Health Plan (*Miami Children's Health-M / MCH-M*)
- South Florida Community Care Network, DBA Community Care Plan (*Community Care Plan-M / CCP-M*)

LONG-TERM CARE (LTC) PLUS PLAN

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

DENTAL PLANS

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

Plan Enrollment

Table B-1 displays the Medicaid managed care enrollment for each plan as of June 30, 2021.[B-1]

Table B-1—Plan Enrollment as of June 30, 2021

Plan	Enrollment
Comprehensive Plans	
Aetna Better Health-C	147,032
Humana-C	622,081
Molina-C	116,535
Simply-C	615,578
Staywell-C	906,477
Sunshine-C	598,209
United-C	306,707
MMA Plans	
Miami Children's Health Plan-M	Acquired by Simply Healthcare Plan, Inc. as of 5/1/2021
Vivida-M	20,590
Prestige-M	105,550
Community Care Plan-M	52,435
Specialty Plans	
Children's Medical Services-S	80,683
Clear Health-S	12,023
Magellan-S	24,762
Staywell-S	133,598
Sunshine-S	38,538
LTC Plus Plan	
Florida Community Care-L	11,795
Dental Plans	
DentaQuest	1,745,492
Liberty	1,335,590
MCNA	953,825

[B-1] Agency for Health Care Administration. Florida Statewide Medicaid Monthly Enrollment Report. Available at: https://ahca.myflorida.com/medicaid/finance/data_analytics/enrollment_report/index.shtml. Accessed on: Mar 9, 2022.

PMV Methodology

HSAG followed two technical methods: one method for the MMA program and one method for the LTC program. For the MMA program, HSAG requested the performance measure report and the FAR generated by the LO for each plan. These documents, which were used and/or generated by the plans and their auditors during the NCQA HEDIS Compliance Audit, were reviewed by HSAG to verify the extent to which critical audit steps were followed during the audit.

MMA Program

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

Table C-1—Key PMV Steps Performed by HSAG for the Plans

PMV Step	Associated Activities Performed by HSAG
Pre-On-Site Visit Call/Meeting	HSAG verified that the LOs addressed key topics such as timelines and on-site review dates.
HEDIS Roadmap Review	HSAG examined the completeness of the Roadmap and looked for evidence in the FARs that the LOs completed a thorough review of all Roadmap components.
Software Vendor	If a plan used a software vendor to produce measure indicator rates, HSAG assessed whether the plan contracted with a vendor that achieved NCQA Measure Certification[SM,C-1] for the reported HEDIS measure. Where applicable, the NCQA Measure Certification letter was reviewed to ensure that each measure was under the scope of certification. Otherwise, HSAG examined whether source code review was conducted by the LOs (see next step).
Source Code Review	HSAG ensured that if a software vendor with HEDIS Certified Measures[SM, C-2] was not used, the LOs reviewed the plan's programming language for HEDIS measures. For all non-HEDIS measures, HSAG ensured that the LOs reviewed the plan's programming language. Source code review was used to determine compliance with the performance measure definitions, including accurate numerator and denominator identification, sampling, and algorithmic compliance (ensuring that rate calculations were performed correctly, medical record and administrative data were combined appropriately, and numerator events were counted accurately).

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

PMV Step	Associated Activities Performed by HSAG
Primary Source Verification	HSAG verified that the LOs conducted appropriate checks to ensure that records used for performance measure reporting match with the primary data source. This step occurs to determine the validity of the source data used to generate the measure indicator rates.
Supplemental Data Validation	If the plan used any supplemental data for reporting, the LO was to validate the supplemental data according to NCQA's guidelines. HSAG verified whether the LO was following the NCQA-required approach while validating the supplemental database.
Convenience Sample Validation	HSAG verified that, as part of the medical record review validation (MRRV) process, the LOs identified whether the plan was required to prepare a convenience sample, and if not, whether specific reasons were documented.
MRRV	HSAG examined whether the LOs performed a re-review of a random sample of medical records based on NCQA MRRV protocol to ensure the reliability and validity of the data collected.
Plan Quality Indicator Data File Review	The plans are required to submit a plan quality indicator data file for the submission of audited rates to the Agency. The file should comply with the Agency-specified reporting format and contain the denominator, numerator, and reported rate for each performance measure. HSAG evaluated whether there was any documentation in the FAR to show that the LOs performed a review of the plan quality indicator data file.

LTC Program

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

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

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

- Verify that key audit elements were performed by the plan's LO to ensure the audit was conducted in compliance with NCQA policies and procedures.
- Examine evidence that the auditors completed a thorough review of the Roadmap components associated with calculating and reporting performance measures outlined by the Agency.
- Identify that, regarding plans for which an NCQA HEDIS Compliance Audit was performed, the IS standards (systems, policies, and procedures) applicable for performance measure reporting were reviewed and results were documented by the auditor.

- Evaluate the auditor's description and audit findings regarding data systems and processes associated with performance measure production for plans for which NCQA HEDIS Compliance Audit procedures were not referenced in the FAR.

Validation Audit

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

- Compare the audit designation results listed in the FAR to the actual rates reported in the performance measure report to ensure that the designation is appropriately applied.
- Assess the accuracy of the rate calculated based on the denominator and numerator for each measure.
- Evaluate data reasonableness for measures with similar eligible populations.

PIP Validation Methodology

In its annual PIP validation, HSAG used CMS Protocol 1. HSAG's validation of PIPs includes two key components of the QI process:

1. Evaluation of the technical structure of the PIP. This step ensures that the health and dental plans design, conduct, and report PIPs in a methodologically sound manner, meeting all State and federal requirements. HSAG's validation determines whether the PIP design (e.g., PIP question, population, PIP indicator(s), sampling techniques, and data collection methodology/processes) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring improvement.
2. Evaluation of the implementation of the PIP. Once a PIP is designed, its effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the plans improve outcomes, quality, timeliness, and access to care provided to its enrollees by implementing effective QI processes.

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

Description of Data Obtained

For SFY 2020–2021, all PIPs had progressed through the Implementation stage (steps 1 through 8). HSAG obtained the data needed to conduct the PIP validation from each plan's PIP Submission Form. Each plan completed the form for PIP activities conducted during the MY and submitted it to HSAG for validation. The PIP Submission Form presents instructions for documenting information related to each of the steps

in CMS Protocol 1. The plans could also attach relevant supporting documentation with the PIP Submission Form.

The health plans used the Agency-provided specifications to calculate the performance indicator rates of the *Administration of the Transportation Benefit* PIP and used HEDIS specifications for reporting the *FUH*, *FUM*, and *FUA* measures for the Behavioral Health PIP.

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

Evaluation of the Implementation of the PIP

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

- Step 1—Review the Selected PIP Topic
- Step 2—Review the PIP Aim Statement
- Step 3—Review the Identified PIP Population
- Step 4—Review the Sampling Method
- Step 5—Review the Selected PIP Variables and Performance Measures
- Step 6—Review the Data Collection Procedures
- Step 7—Review the Data Analysis and Interpretation of PIP Results
- Step 8—Assess the Improvement Strategies
- Step 9—Assess the Likelihood that Significant and Sustained Improvement Occurred

Each evaluation element within a given step will be given a score of *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed* based on the PIP documentation. *Not Applicable* is used for those situations in which the evaluation element does not apply to the PIP. For example, in Step 4, if the plan did not use sampling techniques, HSAG would score the evaluation elements in Step 4 as *Not Applicable*. HSAG uses the *Not Assessed* scoring designation when the PIP has not progressed to a particular step.

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

Met = high confidence/confidence in the reported findings.

Partially Met = low confidence in the reported findings.

Not Met = reported findings are not credible.

HSAG has designated some of the evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must receive a *Met* score. Given the importance of critical elements to the scoring methodology, any critical element that receives a score of *Not Met* will result in an overall PIP validation rating of *Not Met*. A PIP that accurately documents CMS Protocol 1 requirements has high validity and reliability. Validity is the extent to which the data collected for a PIP measure its intent. Reliability is the extent to which an individual can reproduce the PIP results. For each completed PIP, HSAG assesses threats to the validity and reliability of PIP findings and determines when a PIP is no longer credible.

HSAG assigns each PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the sum of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*. The outcome of these calculations determines the validation status of *Met*, *Partially Met*, and *Not Met*.

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

Introduction

This section summarizes an assessment of each health plan's strengths and weaknesses for the quality, timeliness, and access to healthcare services furnished to Medicaid beneficiaries and recommendations for improving the quality of healthcare services furnished by each health plan, as required by 42 CFR §438.364. HSAG utilized the same method for aggregating and analyzing data for this section as described in the Executive Summary.

Plan-Specific Conclusions

Comprehensive Health Plans

Aetna Better Health-C

Strengths

Related to Quality

- Provided FARs that contained IS capability findings; fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
- Met or exceeded the Agency's RY 2021 performance target for the following measures related to quality:
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*
  - *Chlamydia Screening in Women—Total*
  - *Asthma Medication Ratio—Total*
- Five measure indicator rates for the LTC program met or exceeded the Agency's RY 2021 performance targets.

Related to Timeliness and Access

- Met or exceeded the Agency's RY 2021 performance target for the following measures related to access and timeliness:
  - *Prenatal and Postpartum Care—Postpartum Care*
  - *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*

Weaknesses and Recommendations

Weakness: Related to **quality, timeliness, and access**, rates for the *Follow-Up After ED Visit for Mental Illness* and the *Follow-Up After ED Visit for AOD Abuse or Dependence* measures fell below the minimum performance target.

Why Weakness Exists: The low performance indicates that members accessing the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care.

Weaknesses and Recommendations

Recommendation: Enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.

Conduct a root cause analysis to determine why members who access the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, HSAG recommends the health plans increase the use of telehealth services.

Weakness: Related to **quality**, rates for three of the four *Comprehensive Diabetes Care* measure indicators fell below the minimum performance targets.

Why Weakness Exists: Members were not receiving services recommended for proper diabetes management. Factors that may have contributed to the declines include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking testing.

Recommendation: Conduct a root cause analysis or focus study to determine why members are not receiving timely recommended screenings for diabetes. Upon identification of a root cause, implement appropriate interventions to improve performance.

Weakness: Adult members were not always **accessing** services to obtain preventive care as indicated by the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure rate, which did not meet the minimum performance target.

Why Weakness Exists: Although adults appear to have access to PCPs for preventive and ambulatory services, these members are not consistently utilizing preventive and ambulatory services, which can significantly reduce nonurgent ED visits and support the overall health of the member.

Recommendation: Conduct a root cause analysis or focus study to determine why members does not consistently access preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.

Weakness: Aetna Better Health-C failed to meet the minimum performance target for the following individual measure indicators; however, no trends were identified and therefore no analysis is provided regarding why the weakness exists.

- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Use of Opioids at High Dosage*

Humana-C

Strengths	**Related to Quality** • Provided FARs that contained IS capability findings; fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0. • Met or exceeded the Agency's RY 2021 performance target for the following measures related to quality: – *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* – *Asthma Medication Ratio—Total* • Four measure indicator rates for the LTC program met or exceeded the Agency's RY 2021 performance targets. **Related to Timeliness and Access** • None identified.
Weaknesses and Recommendations	**Weakness:** Related to **quality, timeliness, and access**, rates for the *Follow-Up After ED Visit for Mental Illness* and the *Follow-Up After ED Visit for AOD Abuse or Dependence* measures fell below the minimum performance target. **Why Weakness Exists:** The low performance indicates that members accessing the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care. **Recommendation:** Conduct a root cause analysis to determine why members who access the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, HSAG recommends the health plans increase the use of telehealth services. **Weakness:** Humana-C failed to meet the minimum performance target for the following individual measure indicators; however, no trends were identified and therefore no analysis is provided regarding why the weakness exists. • *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* • *Comprehensive Diabetes Care—HbA1c Testing* • *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total* • *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total*

Molina-C

Strengths

Related to Quality

- Provided FARs that contained IS capability findings; fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
- Met or exceeded the Agency's RY 2021 performance target for the following measures related to quality:
  - *Childhood Immunization Status*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*
  - *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)*
  - *Asthma Medication Ratio—Total*
  - *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*
  - *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*
- Seven measure indicator rates for the LTC program met or exceeded the Agency's RY 2021 performance targets.

Related to Timeliness and Access

- Met or exceeded the Agency's RY 2021 performance target for the following measure related to access and timeliness:
  - *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*

Weaknesses and Recommendations

Weakness: Related to **quality, timeliness, and access**, rates for the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total* and *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total* measure indicators fell below the minimum performance target.

Why Weakness Exists: Low performance indicates adults and adolescents 13 years of age and older with a new episode of AOD dependence did not initiate treatment or medication-assisted treatment (MAT) within 14 days of diagnosis or did not have two or more additional AOD services or MAT within 34 days of the initiation visit.

Recommendation: Conduct a root cause analysis to determine why members with a new episode of AOD dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions.

Weakness: Adult members were not always **accessing** services to obtain preventive care as indicated by the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure rate, which did not meet the minimum performance target.

Why Weakness Exists: Although adults appear to have access to PCPs for preventive and ambulatory services, these members are not consistently utilizing preventive and ambulatory services, which can significantly reduce nonurgent ED visits and support the overall health of the member.

Weaknesses and Recommendations

Recommendation: Conduct a root cause analysis or focus study to determine why members do not consistently access preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.

Weakness: Molina-C failed to meet the minimum performance target for the following individual measure indicators; however, no trends were identified and therefore no analysis is provided regarding why the weakness exists.

- *Comprehensive Diabetes Care—HbA1c Testing*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Use of Opioids at High Dosage*

Simply-C

Strengths

Related to Quality

- Provided FARs that contained IS capability findings; fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
- Met or exceeded the Agency's RY 2021 performance target for the following measures related to quality:
  - *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*
  - *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)*
  - *Chlamydia Screening in Women—Total*
  - *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
  - *Asthma Medication Ratio—Total*
  - *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*
  - *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*
- Seven measure indicator rates for the LTC program met or exceeded the Agency's RY 2021 performance targets.

Related to Timeliness and Access

- Met or exceeded the Agency's RY 2021 performance target for the following measures related to access and timeliness:
  - *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
  - *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*
  - *Prenatal and Postpartum Care—Postpartum Care*

Weaknesses and Recommendations

Weakness: Adult members were not always **accessing** services to obtain preventive care as indicated by the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure rate, which did not meet the minimum performance target.

Why Weakness Exists: Although adults appear to have access to PCPs for preventive and ambulatory services, these members are not consistently utilizing preventive and ambulatory services, which can significantly reduce nonurgent ED visits and support the overall health of the member.

Recommendation: Conduct a root cause analysis or focus study to determine why members do not consistently access preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.

Weaknesses and Recommendations

Weakness: Simply-C failed to meet the minimum performance target for the following individual measure indicators; however, no trends were identified and therefore no analysis is provided regarding why the weakness exists.

- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Use of Opioids at High Dosage*

Staywell-C

Strengths	**Related to Quality** • Provided FARs that contained IS capability findings; fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0. • Related to **quality**, met or exceeded the Agency's RY 2021 performance target for *Chlamydia Screening in Women—Total*. • Five measure indicator rates for the LTC program met or exceeded the Agency's RY 2021 performance targets.
	Related to Timeliness and Access • Met or exceeded the Agency's RY 2021 performance target for the following measures related to access and timeliness: – *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* – *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total*
Weaknesses and Recommendations	**Weakness:** Related to **quality**, rates for *Breast Cancer Screening* and *Cervical Cancer Screening* failed to meet the minimum performance target. **Why Weakness Exists:** Women are not receiving timely access to screenings for breast or cervical cancer. Early detection reduces the risk of dying from cancer and can lead to a greater range of treatment options and lower healthcare costs. **Recommendation:** Conduct a root cause analysis or focus study to determine why female members are not receiving timely screenings for breast and cervical cancer. Upon identification of a root cause, implement appropriate interventions to improve performance.
	Weakness: Related to **quality, timeliness, and access**, rates for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators failed to meet the minimum performance target. **Why Weakness Exists:** Women are not receiving timely and adequate access to prenatal and postpartum care, which prevent pregnancy-related deaths and create a foundation for the long-term health and wellbeing of new mothers and their infants. **Recommendation:** Conduct a root cause analysis or focus study to determine why pregnant members are not receiving timely prenatal and postpartum care. Upon identification of a root cause, implement appropriate interventions to improve performance.
	Weakness: Related to **quality, timeliness, and access**, rates for six measure indicators related to follow-up after hospitalization or ED visits for mental illness or AOD abuse or dependence failed to meet minimum performance targets. **Why Weakness Exists:** Members who are hospitalized or visited the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care. **Recommendation:** Health plans should lead a program-wide focus group that includes members and key community stakeholders to identify barriers/facilitators to members

Weaknesses and Recommendations

accessing follow-up care. Health plans may also valuate the impact of the COVID-19 PHE and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.

Weakness: Related to **quality**, rates for all four *Comprehensive Diabetes Care* measure indicators fell below the minimum performance targets.

Why Weakness Exists: Members were not receiving services recommended for proper diabetes management. Factors that may have contributed to the declines include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking testing.

Recommendation: Conduct a root cause analysis or focus study to determine why members are not receiving timely recommended screenings for diabetes. Upon identification of a root cause, implement appropriate interventions to improve performance.

Weakness: Staywell-C failed to meet the minimum performance target for the following individual measure indicators; however, no trends were identified and therefore no analysis is provided regarding why the weakness exists.

- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total*
- *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*

Sunshine-C

Strengths

Related to Quality

- Provided FARs that contained IS capability findings; fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
- Met or exceeded the Agency's RY 2021 performance target for the following measures related to quality:
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*
  - *Asthma Medication Ratio—Total*
- Met or exceeded the Agency's RY 2021 performance target for *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total.*
- Seven measure indicator rates for the LTC program met or exceeded the Agency's RY 2021 performance targets.

Related to Timeliness and Access

- Met or exceeded the Agency's RY 2021 performance target for the following measures related to access and timeliness:
  - *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
  - *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*

Weaknesses and Recommendations

Weakness: Related to **quality, timeliness, and access**, rates for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators failed to meet the minimum performance target.

Why Weakness Exists: Women are not receiving timely and adequate access to prenatal and postpartum care, which prevent pregnancy-related deaths and create a foundation for the long-term health and wellbeing of new mothers and their infants.

Recommendation: Conduct a root cause analysis or focus study to determine why pregnant members are not receiving timely prenatal and postpartum care. Upon identification of a root cause, implement appropriate interventions to improve performance.

Weakness: Related to **quality**, rates for all four *Comprehensive Diabetes Care* measure indicators fell below the minimum performance targets.

Why Weakness Exists: Members were not receiving services recommended for proper diabetes management. Factors that may have contributed to the declines include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking testing.

Recommendation: Conduct a root cause analysis or focus study to determine why members are not receiving timely recommended screenings for diabetes. Upon identification of a root cause, implement appropriate interventions to improve performance.

Weaknesses and Recommendations	
	Weakness: Related to **quality, timeliness, and access**, rates for four measure indicators related to follow-up after ED visits for mental illness or AOD abuse or dependence failed to meet minimum performance targets. **Why Weakness Exists:** Members who visited the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care. **Recommendation:** Health plans should lead a program-wide focus group that includes members and key community stakeholders to identify barriers/facilitators to members accessing follow-up care. Health plans may also valuate the impact of the COVID-19 PHE and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.
	Weakness: Related to **quality**, rates for all three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure indicators fell below the minimum performance target. **Why the weakness exists:** Children and adolescent members with ongoing antipsychotic medication are not receiving regular metabolic testing to monitor and reduce the risk for developing serious metabolic complications associated with poor cardiometabolic outcomes in adulthood. Parents may not understand the importance of metabolic monitoring or may have experienced barriers to conducting monitoring due to temporary suspension of non-urgent services and in-person PCP appointments due to the COVID-19 PHE. **Recommendation:** Conduct a root cause analysis or focus study to determine why members are not receiving regular metabolic testing. Upon identification of a root cause, implement appropriate interventions to improve the performance related to metabolic testing.
	Weakness: Adult members were not always **accessing** services to obtain preventive care as indicated by the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure rate, which did not meet the minimum performance target. **Why Weakness Exists:** Although adults appear to have access to PCPs for preventive and ambulatory services, these members are not consistently utilizing preventive and ambulatory services, which can significantly reduce nonurgent ED visits and support the overall health of the member. **Recommendation:** Conduct a root cause analysis or focus study to determine why members do not consistently access preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.
	Weakness: Sunshine-C failed to meet the minimum performance target for the following individual measure indicators; however, no trends were identified and therefore no analysis is provided regarding why the weakness exists. • *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* • *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total* • *Use of Opioids at High Dosage*

United-C

Strengths

Related to Quality

- Provided FARs that contained IS capability findings; fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
- Met or exceeded the Agency's RY 2021 performance target for the following measures related to quality:
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*
  - *Asthma Medication Ratio—Total*
- Met or exceeded the Agency's RY 2021 performance target for *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total.*

Related to Timeliness and Access

- Met or exceeded the Agency's RY 2021 performance target for the following measures related to access and timeliness:
  - *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
  - *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*

Weaknesses and Recommendations

Weakness: Related to **quality, timeliness, and access**, rates for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators failed to meet the minimum performance target.

Why Weakness Exists: Women are not receiving timely and adequate access to prenatal and postpartum care, which prevent pregnancy-related deaths and create a foundation for the long-term health and wellbeing of new mothers and their infants.

Recommendation: Conduct a root cause analysis or focus study to determine why pregnant members are not receiving timely prenatal and postpartum care. Upon identification of a root cause, implement appropriate interventions to improve performance.

Weakness: Related to **quality, access, and timeliness**, rates for the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total* and *Engagement of AOD Treatment—Total* measure indicators fell below the minimum performance targets.

Why Weakness Exists: Low performance indicates adults and adolescents 13 years of age and older with a new episode of AOD dependence did not initiate treatment or MAT within 14 days of diagnosis or did not have two or more additional AOD services or MAT within 34 days of the initiation visit.

Recommendation: Conduct a root cause analysis to determine why members with a new episode of AOD dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions.

Weaknesses and Recommendations	
	Weakness: Related to **quality**, rates for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure fell below the minimum performance target. **Why the weakness exists:** Children and adolescent members with ongoing antipsychotic medication are not receiving regular metabolic testing to monitor and reduce the risk for developing serious metabolic complications associated with poor cardiometabolic outcomes in adulthood. Parents may not understand the importance of metabolic monitoring or may have experienced barriers to conducting monitoring due to temporary suspension of non-urgent services and in-person PCP appointments due to the COVID-19 PHE. **Recommendation:** Conduct a root cause analysis or focus study to determine why members are not receiving regular metabolic testing. Upon identification of a root cause, implement appropriate interventions to improve the performance related to metabolic testing.
	Weakness: Related to **quality**, rates for *Breast Cancer Screening* and *Cervical Cancer Screening* failed to meet the minimum performance target. **Why Weakness Exists:** Women are not receiving timely access to screenings for breast or cervical cancer. Early detection reduces the risk of dying from cancer and can lead to a greater range of treatment options and lower healthcare costs. **Recommendation:** Conduct a root cause analysis or focus study to determine why female members are not receiving timely screenings for breast and cervical cancer. Upon identification of a root cause, implement appropriate interventions to improve performance.
	Weakness: Adult members were not always **accessing** services to obtain preventive care as indicated by the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure rate, which did not meet the minimum performance target. **Why Weakness Exists:** Although adults appear to have access to PCPs for preventive and ambulatory services, these members are not consistently utilizing preventive and ambulatory services, which can significantly reduce nonurgent ED visits and support the overall health of the member. **Recommendation:** Conduct a root cause analysis or focus study to determine why members are not consistently access preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.
	Weakness: Related to **quality, timeliness, and access**, rates for three measure indicators related to *follow-up after hospitalization or ED* visits for mental illness failed to meet minimum performance targets. **Why Weakness Exists:** Members who are hospitalized or visited the ED for mental illness are not accessing or receiving timely follow-up care. **Recommendation:** Health plans should lead a program-wide focus group that includes members and key community stakeholders to identify barriers/facilitators to members accessing follow-up care. Health plans may also valuate the impact of the COVID-19 PHE and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.

Weaknesses and Recommendations

Weakness: United-C failed to meet the minimum performance target for the following individual measure indicators; however, no trends were identified and therefore no analysis is provided regarding why the weakness exists.

- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Use of Opioids at High Dosage*

Specialty Plans

Children's Medical Services-S

Strengths

Related to Quality

- Provided FARs that contained IS capability findings; fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
- Met or exceeded the Agency's RY 2021 performance target for the following measures related to quality:
  - *Asthma Medication Ratio—Total*
  - *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*

Related to Timeliness and Access

- Met or exceeded the Agency's RY 2021 performance target for the following measures related to access and timeliness:
  - *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*
  - *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total*
  - *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*

Weaknesses and Recommendations

Weakness: Related to **quality, timeliness, and access**, rates for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators failed to meet the minimum performance target.

Why Weakness Exists: Women are not receiving timely and adequate access to prenatal and postpartum care, which prevent pregnancy-related deaths and create a foundation for the long-term health and wellbeing of new mothers and their infants.

Recommendation: Conduct a root cause analysis or focus study to determine why pregnant members are not receiving timely prenatal and postpartum care. Upon identification of a root cause, implement appropriate interventions to improve performance.

Weakness: Related to **quality**, rates for all four *Comprehensive Diabetes Care* measure indicators fell below the minimum performance targets.

Why Weakness Exists: Members were not receiving services recommended for proper diabetes management. Factors that may have contributed to the declines include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The requirement to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking testing.

Recommendation: Conduct a root cause analysis or focus study to determine why members are not receiving timely recommended screenings for diabetes. Upon identification of a root cause, implement appropriate interventions to improve performance.

Weaknesses and Recommendations	
	Weakness: Related to **quality, timeliness, and access**, rates for the *Follow-Up After ED Visit for AOD Abuse or Dependence* measure fell below the minimum performance targets. **Why Weakness Exists:** Members who visit the ED for AOD abuse or dependence are not accessing or receiving timely follow-up care. **Recommendation:** Health plans should lead a program-wide focus group that includes members and key community stakeholders to identify barriers/facilitators to members accessing follow-up care. Health plans may also valuate the impact of the COVID-19 PHE and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.
	Weakness: Related to **quality**, rates for the *Antidepressant Medication Management* measure fell below the minimum performance targets. **Why Weakness Exists:** Adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication did not remain on their antidepressant medications. **Recommendation:** Conduct a root cause analysis or focus study to determine why members are not remaining on their medication. Upon identification of a root cause, implement appropriate interventions to improve performance.
	Weakness: Children's Medical Services-S failed to meet the minimum performance target for the following individual measure indicators; however, no trends were identified and therefore no analysis is provided regarding why the weakness exists. • *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* • *Chlamydia Screening in Women—Total* • *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

Clear Health Alliance-S

Strengths

Related to Quality

- Provided FARs that contained IS capability findings; fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
- Met or exceeded the Agency's RY 2021 performance target for the following measures related to quality:
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*
  - *Chlamydia Screening in Women—Total*
  - *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
  - *Medical Assistance With Smoking and Tobacco Use Cessation*
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

Related to Timeliness and Access

- Met or exceeded the Agency's RY 2021 performance target for the following measures related to access and timeliness:
  - *Adults' Access to Preventive/Ambulatory Health Services—Total*
  - *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total*

Weaknesses and Recommendations

Weakness: Related to **quality, timeliness, and access**, rates for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators failed to meet the minimum performance target.

Why Weakness Exists: Women are not receiving timely and adequate access to prenatal and postpartum care, which prevent pregnancy-related deaths and create a foundation for the long-term health and wellbeing of new mothers and their infants.

Recommendation: Conduct a root cause analysis or focus study to determine why pregnant members are not receiving timely prenatal and postpartum care. Upon identification of a root cause, implement appropriate interventions to improve performance.

Weakness: Related to **quality, timeliness, and access**, rates for four measure indicators related to follow-up after hospitalization or ED visits for mental illness failed to meet minimum performance targets.

Why Weakness Exists: Members who are hospitalized or visited the ED for mental illness are not accessing or receiving timely follow-up care.

Recommendation: Health plans should lead a program-wide focus group that includes members and key community stakeholders to identify barriers/facilitators to members accessing follow-up care. Health plans may also valuate the impact of the COVID-19 PHE and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.

Weaknesses and Recommendations

Weakness: Clear Health Alliance-S failed to meet the minimum performance target for the following individual measure indicators; however, no trends were identified and therefore no analysis is provided regarding why the weakness exists.

- *Breast Cancer Screening*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Asthma Medication Ratio—Total*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total*
- *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*
- *Use of Opioids at High Dosage*

Magellan-S

Strengths	**Related to Quality** • Provided FARs that contained IS capability findings; fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
	Related to Timeliness and Access • Met or exceeded the Agency's RY 2021 performance target for the following measure related to access and timeliness: – *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total*
Weaknesses and Recommendations	**Weakness:** Related to **quality, timeliness, and access**, rates for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators failed to meet the minimum performance target. **Why Weakness Exists:** Women are not receiving timely and adequate access to prenatal and postpartum care, which prevent pregnancy-related deaths and create a foundation for the long-term health and wellbeing of new mothers and their infants. **Recommendation:** Conduct a root cause analysis or focus study to determine why pregnant members are not receiving timely prenatal and postpartum care. Upon identification of a root cause, implement appropriate interventions to improve performance.
	Weakness: Related to **quality**, rates for all four *Comprehensive Diabetes Care* measure indicators fell below the minimum performance targets. **Why Weakness Exists:** Members were not receiving services recommended for proper diabetes management. Factors that may have contributed include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking testing. **Recommendation:** Conduct a root cause analysis or focus study to determine why members are not receiving timely recommended screenings for diabetes. Upon identification of a root cause, implement appropriate interventions to improve performance.
	Weakness: Related to **quality**, rates for the *Breast Cancer Screening* and *Cervical Cancer Screening* measures failed to meet the minimum performance target. **Why Weakness Exists:** Women are not receiving timely access to screenings for breast or cervical cancer. Early detection reduces the risk of dying from cancer and can lead to a greater range of treatment options and lower healthcare costs. **Recommendation:** Conduct a root cause analysis or focus study to determine why female members are not receiving timely screenings for breast and cervical cancer. Upon identification of a root cause, implement appropriate interventions to improve performance.

Weaknesses and Recommendations	
	Weakness: Rates for the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* measure indicators failed to meet the minimum performance targets. **Why Weakness Exists:** Immunization declines may have coincided with the rapid increase of COVID-19 cases in 2020. Factors that may have contributed to the declines during this time include site closures and the temporary suspension of nonurgent services due to the COVID-19 PHE. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking healthcare services, including immunizations. **Recommendation:** Conduct a root cause analysis or focus study to determine why child members are not receiving all recommended vaccines. Upon identification of a root cause, implement appropriate interventions to improve the performance.
	Weakness: Related to **quality**, rates for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure fell below the minimum performance targets. **Why the weakness exists:** Children and adolescent members with ongoing antipsychotic medication are not receiving regular metabolic testing to monitor and reduce the risk for developing serious metabolic complications associated with poor cardiometabolic outcomes in adulthood. Parents may not understand the importance of metabolic monitoring or may have experienced barriers to conducting monitoring due to temporary suspension of non-urgent services and in-person PCP appointments due to the COVID-19 PHE. **Recommendation:** Conduct a root cause analysis or focus study to determine why members are not receiving regular metabolic testing. Upon identification of a root cause, implement appropriate interventions to improve the performance related to metabolic testing.
	Weakness: Related to **quality, timeliness, and access**, rates for six measure indicators related to follow-up after hospitalization or ED visits for mental illness or AOD abuse or dependence failed to meet minimum performance targets. **Why Weakness Exists:** Members who are hospitalized or visited the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care. **Recommendation:** Health plans should lead a program-wide focus group that includes members and key community stakeholders to identify barriers/facilitators to members accessing follow-up care. Health plans may also valuate the impact of the COVID-19 PHE and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.
	Weakness: Magellan-S failed to meet the minimum performance target for the following individual measure indicators; however, no trends were identified and therefore no analysis is provided regarding why the weakness exists. • *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* • *Asthma Medication Ratio—Total*

Weaknesses and Recommendations

- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*
- *Use of Opioids at High Dosage*

Staywell-S

Strengths	**Related to Quality** • Provided FARs that contained IS capability findings; fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0. • Met or exceeded the Agency's RY 2021 performance target for the following measures related to quality: – *Chlamydia Screening in Women—Total* **Related to Timeliness and Access** • Met or exceeded the Agency's RY 2021 performance target for the following measures related to access and timeliness: – *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* – *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total*
Weaknesses and Recommendations	**Weakness:** Related to **quality**, rates for *Breast Cancer Screening* and *Cervical Cancer Screening* failed to meet the minimum performance target. **Why Weakness Exists:** Women are not receiving timely access to screenings for breast or cervical cancer. Early detection reduces the risk of dying from cancer and can lead to a greater range of treatment options and lower healthcare costs. **Recommendation:** Conduct a root cause analysis or focus study to determine why female members are not receiving timely screenings for breast and cervical cancer. Upon identification of a root cause, implement appropriate interventions to improve performance. **Weakness:** Related to **quality, timeliness, and access**, rates for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators failed to meet the minimum performance target. **Why Weakness Exists:** Women are not receiving timely and adequate access to prenatal and postpartum care, which prevent pregnancy-related deaths and create a foundation for the long-term health and wellbeing of new mothers and their infants. **Recommendation:** Conduct a root cause analysis or focus study to determine why pregnant members are not receiving timely prenatal and postpartum care. Upon identification of a root cause, implement appropriate interventions to improve performance. **Weakness:** Rates for the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* measure indicators failed to meet the minimum performance targets. **Why Weakness Exists:** Immunization declines may have coincided with the rapid increase of COVID-19 cases in 2020. Factors that may have contributed include site closures and the temporary suspension of nonurgent services due to the COVID-19 PHE. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking healthcare services, including immunizations.

Weaknesses and Recommendations

Recommendation: Conduct a root cause analysis or focus study to determine why child members are not receiving all recommended vaccines. Upon identification of a root cause, implement appropriate interventions to improve the performance.

Weakness: Related to **quality**, rates for all four *Comprehensive Diabetes Care* measure indicators fell below the minimum performance target.

Why Weakness Exists: Members were not receiving services recommended for proper diabetes management. Factors that may have contributed to the declines include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking testing.

Recommendation: Conduct a root cause analysis or focus study to determine why members are not receiving timely recommended screenings for diabetes. Upon identification of a root cause, implement appropriate interventions to improve performance.

Weakness: Related to **quality, timeliness, and access**, rates for six measure indicators related to follow-up after hospitalization or ED visits for mental illness or AOD abuse or dependence failed to meet minimum performance targets.

Why Weakness Exists: Members who are hospitalized or visited the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care.

Recommendation: Health plans should lead a program-wide focus group that includes members and key community stakeholders to identify barriers/facilitators to members accessing follow-up care. Health plans may also valuate the impact of the COVID-19 PHE and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.

Weakness: Staywell-S failed to meet the minimum performance target for the following individual measure indicators; however, no trends were identified and therefore no analysis is provided regarding why the weakness exists.

- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total*
- *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

Sunshine-S

Strengths

Related to Quality

- Provided FARs that contained IS capability findings; fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
- Met or exceeded the Agency's RY 2021 performance target for the following measures related to quality:
  - *Childhood Immunization Status—Combination 2* and *Combination 3*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*
  - *Chlamydia Screening in Women—Total*
  - *Asthma Medication Ratio—Total*
  - *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
  - *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
  - *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*
  - *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*

Related to Timeliness and Access

- Met or exceeded the Agency's RY 2021 performance target for the following measures related to access and timeliness:
  - *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*
  - *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total*

Weaknesses and Recommendations

Weakness: Related to **quality, timeliness, and access**, rates for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators failed to meet the minimum performance target.

Why Weakness Exists: Women are not receiving timely and adequate access to prenatal and postpartum care, which prevent pregnancy-related deaths and create a foundation for the long-term health and wellbeing of new mothers and their infants.

Recommendation: Conduct a root cause analysis or focus study to determine why pregnant members are not receiving timely prenatal and postpartum care. Upon identification of a root cause, implement appropriate interventions to improve performance.

Weakness: Related to **quality, timeliness, and access**, rates for the *Follow-Up After ED Visit for AOD Abuse or Dependence* measure fell below the minimum performance targets.

Weaknesses and Recommendations

Why Weakness Exists: Members who visit the ED for AOD abuse or dependence are not accessing or receiving timely follow-up care.

Recommendation: Health plans should lead a program-wide focus group that includes members and key community stakeholders to identify barriers/facilitators to members accessing follow-up care. Health plans may also valuate the impact of the COVID-19 PHE and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.

Weakness: Sunshine-S failed to meet the minimum performance target for the following individual measure indicators; however, no trends were identified and therefore no analysis is provided regarding why the weakness exists.

- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*

Managed Medical Assistance Plans

Vivida-M

Strengths

Related to Quality

- Provided FARs that contained IS capability findings; fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
- Met or exceeded the Agency's RY 2021 performance target for the following measures related to quality:
  - *Asthma Medication Ratio—Total*
  - *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*
  - *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*

Related to Timeliness and Access

- Met or exceeded the Agency's RY 2021 performance target for the following measure related to access and timeliness:
  - *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total*

Weaknesses and Recommendations

Weakness: Related to **quality, timeliness, and access**, rates for the *Follow-Up After Hospitalization for Mental Illness* measure failed to meet minimum performance targets.

Why Weakness Exists: Members who are hospitalized for mental illness are not accessing or receiving timely follow-up care.

Recommendation: Health plans should lead a program-wide focus group that includes members and key community stakeholders to identify barriers/facilitators to members accessing follow-up care. Health plans may also valuate the impact of the COVID-19 PHE and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.

Weakness: Related to **quality**, rates for all four *Comprehensive Diabetes Care* measure indicators fell below the minimum performance target.

Why Weakness Exists: Members were not receiving services recommended for proper diabetes management. Factors that may have contributed include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking testing.

Recommendation: Conduct a root cause analysis or focus study to determine why members are not receiving timely recommended screenings for diabetes. Upon identification of a root cause, implement appropriate interventions to improve performance.

Weakness: Rates for the *Childhood Immunization Status—Combination 2* and *Combination 3*, and *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* measure indicators failed to meet the minimum performance targets.

Weaknesses and Recommendations

Why Weakness Exists: Immunization declines may have coincided with the rapid increase of COVID-19 cases in 2020. Factors that may have contributed include site closures and the temporary suspension of nonurgent services due to the COVID-19 PHE. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking healthcare services, including immunizations.

Recommendation: Conduct a root cause analysis or focus study to determine why child members are not receiving all recommended vaccines. Upon identification of a root cause, implement appropriate interventions to improve the performance.

Weakness: Vivida-M failed to meet the minimum performance target for the following individual measure indicators; however, no trends were identified and therefore no analysis is provided regarding why the weakness exists.

- *Lead Screening in Children*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*
- *Cervical Cancer Screening*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Use of Opioids at High Dosage*

Prestige-M

Strengths	**Related to Quality** • Provided FARs that contained IS capability findings; fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0. • Met or exceeded the Agency's RY 2021 performance target for the following measures related to quality: – *Childhood Immunization Status—Combination 2* and *Combination 3* – *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* – *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* – *Chlamydia Screening in Women—Total* – *Prenatal and Postpartum Care—Postpartum Care* – *Asthma Medication Ratio—Total* – *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* – *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* **Related to Timeliness and Access** • None identified.
Weaknesses and Recommendations	**Weakness:** Related to **quality**, rates for all four *Comprehensive Diabetes Care* measure indicators fell below the minimum performance target. **Why Weakness Exists:** Members were not receiving services recommended for proper diabetes management. Factors that may have contributed include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking testing. **Recommendation:** Conduct a root cause analysis or focus study to determine why members are not receiving timely recommended screenings for diabetes. Upon identification of a root cause, implement appropriate interventions to improve performance. **Weakness:** Related to **quality, timeliness, and access**, rates for the *Follow-Up After ED Visit for Mental Illness* measure failed to meet minimum performance targets. **Why Weakness Exists:** Members who visit the ED for mental illness are not accessing or receiving timely follow-up care. **Recommendation:** Health plans should lead a program-wide focus group that includes members and key community stakeholders to identify barriers/facilitators to members accessing follow-up care. Health plans may also valuate the impact of the COVID-19 PHE and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.

Weaknesses and Recommendations	**Weakness:** Prestige-M failed to meet the minimum performance target for the following individual measure indicators; however, no trends were identified and therefore no analysis is provided regarding why the weakness exists. • *Breast Cancer Screening* • *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total* • *Antidepressant Medication Management—Effective Acute Phase Treatment* • *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* • *Adults' Access to Preventive/Ambulatory Health Services—Total* • *Use of Opioids at High Dosage*

Miami Children's Health-M

Strengths	**Related to Quality** • Provided FARs that contained IS capability findings; fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0. • Met or exceeded the Agency's RY 2021 performance target for the following measure related to quality: − *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* **Related to Timeliness and Access** • None identified.
Weaknesses and Recommendations	**Weakness:** Related to **quality, timeliness, and access**, rates for *Follow-Up After Hospitalization for Mental Illness* failed to meet minimum performance targets. **Why Weakness Exists:** Members who are hospitalized for mental illness are not accessing or receiving timely follow-up care. **Recommendation:** Health plans should lead a program-wide focus group that includes members and key community stakeholders to identify barriers/facilitators to members accessing follow-up care. Health plans may also valuate the impact of the COVID-19 PHE and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable. **Weakness:** Related to **quality, timeliness, and access**, rates for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators failed to meet the minimum performance target. **Why Weakness Exists:** Women are not receiving timely and adequate access to prenatal and postpartum care, which prevent pregnancy-related deaths and create a foundation for the long-term health and wellbeing of new mothers and their infants. **Recommendation:** Conduct a root cause analysis or focus study to determine why pregnant members are not receiving timely prenatal and postpartum care. Upon identification of a root cause, implement appropriate interventions to improve performance. **Weakness:** Related to **quality**, rates for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure fell below the minimum performance targets. **Why the weakness exists:** Children and adolescent members with ongoing antipsychotic medication are not receiving regular metabolic testing to monitor and reduce the risk for developing serious metabolic complications associated with poor cardiometabolic outcomes in adulthood. Parents may not understand the importance of metabolic monitoring or may have experienced barriers to conducting monitoring due to temporary suspension of non-urgent services and in-person PCP appointments due to the COVID-19 PHE. **Recommendation:** Conduct a root cause analysis or focus study to determine why members are not receiving regular metabolic testing. Upon identification of a root cause, implement appropriate interventions to improve the performance related to metabolic testing.

Weaknesses and Recommendations	
	Weakness: Related to **quality**, rates for all four *Comprehensive Diabetes Care* measure indicators fell below the minimum performance targets. **Why Weakness Exists:** Members were not receiving services recommended for proper diabetes management. Factors that may have contributed include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking testing. **Recommendation:** Conduct a root cause analysis or focus study to determine why members are not receiving timely recommended screenings for diabetes. Upon identification of a root cause, implement appropriate interventions to improve performance.
	Weakness: Rates for the *Childhood Immunization Status—Combination 2* and *Combination 3*, and *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* measure indicators failed to meet the minimum performance targets. **Why Weakness Exists:** Immunization declines may have coincided with the rapid increase of COVID-19 cases in 2020. Factors that may have contributed include site closures and the temporary suspension of nonurgent services due to the COVID-19 PHE. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking healthcare services, including immunizations. **Recommendation:** Conduct a root cause analysis or focus study to determine why child members are not receiving all recommended vaccines. Upon identification of a root cause, implement appropriate interventions to improve the performance.
	Weakness: Miami Children's Health-M failed to meet the minimum performance target for the following individual measure indicators; however, no trends were identified and therefore no analysis is provided regarding why the weakness exists. • *Cervical Cancer Screening* • *Adults' Access to Preventive/Ambulatory Health Services—Total* • *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total* • *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total*

Community Care Network-M

Strengths	**Related to Quality** • Provided FARs that contained IS capability findings; fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0. • Met or exceeded the Agency's RY 2021 performance target for the following measures related to quality: – *Asthma Medication Ratio—Total* – *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* **Related to Timeliness and Access** • Met or exceeded the Agency's RY 2021 performance target for the following measure related to access and timeliness: – *Prenatal and Postpartum Care—Postpartum Care*
Weaknesses and Recommendations	**Weakness:** Related to **quality**, rates for all four *Comprehensive Diabetes Care* measure indicators fell below the minimum performance targets. **Why Weakness Exists:** Members were not receiving services recommended for proper diabetes management. Factors that may have contributed include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking testing. **Recommendation:** Conduct a root cause analysis or focus study to determine why members are not receiving timely recommended screenings for diabetes. Upon identification of a root cause, implement appropriate interventions to improve performance. **Weakness:** Related to **quality, timeliness, and access**, rates for the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total* and *Engagement of AOD Treatment—Total* measure indicators fell below the minimum performance targets. **Why Weakness Exists:** Low performance indicates adults and adolescents 13 years of age and older with a new episode of AOD dependence did not initiate treatment or MAT within 14 days of diagnosis or did not have two or more additional AOD services or MAT within 34 days of the initiation visit. **Recommendation:** Conduct a root cause analysis to determine why members with a new episode of AOD dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. **Weakness:** Related to **quality, timeliness, and access**, rates for four measure indicators related to follow-up after ED visits for mental illness or AOD abuse or dependence failed to meet minimum performance targets. **Why Weakness Exists:** Members who visited the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care.

Weaknesses and Recommendations

Recommendation: Health plans should lead a program-wide focus group that includes members and key community stakeholders to identify barriers/facilitators to members accessing follow-up care. Health plans may also valuate the impact of the COVID-19 PHE and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.

Weakness: Related to **quality**, rates for the *Antidepressant Medication Management* measure fell below the minimum performance targets.

Why Weakness Exists: Adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication did not remain on their antidepressant medications.

Recommendation: Conduct a root cause analysis or focus study to determine why members are not remaining on their medication. Upon identification of a root cause, implement appropriate interventions to improve performance.

Weakness: Community Care Network-M failed to meet the minimum performance target for the following individual measure indicators; however, no trends were identified and therefore no analysis is provided regarding why the weakness exists.

- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Use of Opioids at High Dosage*

Long-Term Care Plus Plan

Florida Community Care-L

Strengths	**Related to Quality** • Provided FARs that contained IS capability findings; fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0. • Met or exceeded the Agency's RY 2021 performance target for the following measures related to quality: – *LTSS Comprehensive Assessment and Update—Assessment of Core Elements* – *LTSS Comprehensive Care Plan and Update—Assessment of Supplemental Elements* – *LTSS Shared Care Plan With PCP* – *Screening, Risk Assessment, and Plan of Care to Prevent Future Falls—Falls Part 1—Screening*
Weaknesses and Recommendations	**Weakness:** None identified.

Dental Plans

DentaQuest of Florida

Strengths	**Related to Quality** • Provided FARs that contained IS capability findings; fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
Weaknesses and Recommendations	**Weakness:** Rates for the *Annual Dental Visits—Total* and *Dental Treatment Services—Total* measures fell below the plan-specific performance targets. **Why the weakness exists:** Access to dental care may have been impacted with the rapid increase of COVID-19 cases in 2020. Many preventive services, including dental services, were negatively affected across the country as states followed orders to reduce the use of non-emergent services in order to slow the spread of COVID-19. **Recommendation:** Continue to monitor rates over time to identify PHE rate impact, ensuring lower access to dental care is not driven by a non-PHE cause, and adopt QI strategies to improve rates. If access to care is the reason for lower rates, the dental plan should also evaluate its network to ensure enough providers are available for services for members.

Liberty Dental Plan of Florida

Strengths	**Related to Quality** • Provided FARs that contained IS capability findings; fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
Weaknesses and Recommendations	**Weakness:** Rates for the *Annual Dental Visits—Total* and *Dental Treatment Services—Total* measures fell below the plan-specific performance targets. **Why the weakness exists:** Access to dental care may have been impacted with the rapid increase of COVID-19 cases in 2020. Many preventive services, including dental services, were negatively affected across the country as states followed orders to reduce the use of non-emergent services in order to slow the spread of COVID-19. **Recommendation:** Continue to monitor rates over time to identify PHE rate impact, ensuring lower access to dental care is not driven by a non-PHE cause, and adopt QI strategies to improve rates. If access to care is the reason for lower rates, the dental plan should also evaluate its network to ensure enough providers are available for services for members.

Managed Care of North America

Strengths	**Related to Quality** • Provided FARs that contained IS capability findings; fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
Weaknesses and Recommendations	**Weakness:** Rates for the *Annual Dental Visits—Total* and *Dental Treatment Services—Total* measures fell below the plan-specific performance targets. **Why the weakness exists:** Access to dental care may have been impacted with the rapid increase of COVID-19 cases in 2020. Many preventive services, including dental services, were negatively affected across the country as states followed orders to reduce the use of non-emergent services in order to slow the spread of COVID-19. **Recommendation:** Continue to monitor rates over time to identify PHE rate impact, ensuring lower access to dental care is not driven by a non-PHE cause and adopt QI strategies to improve rates. If access to care is the reason for lower rates, the dental plan should also evaluate its network to ensure enough providers are available for services for members.

Appendix E. PIP High-Level Review Results

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

For SFY 2020–2021, the health and dental plans had progressed to reporting remeasurement data. The Agency provided statewide Remeasurement 1 rates by region and population served (i.e., specialty plans) for each high-level review PIP to the health and dental plans. HSAG reviewed the PIP indicators' rates and assessed whether the plans achieved the contractually agreed upon goals.

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

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

Health Plan Name	Regions Served	Regions Where *Improving Birth Outcomes* PIP Goal Was Met			Regions Where *Reducing PPEs* PIP Goal Was Met		
		Primary C-Section Rate	Preterm Delivery Rate	NAS per 1,000 Live Births	Potentially Preventable Admissions (PPAs) per 1,000 Enrollee Months	Potentially Preventable Readmissions (PPRs) per 1,000 Hospital Admissions	Potentially Preventable ED Visits (PPVs) per 1,000 Enrollee Months
Aetna Better Health-C	6,7,11	7,11	None	6,11	11	6,11	6,7,11
Community Care Plan-M	10	NR	NR	NR	10	10	10
Florida Community Care-L*	All regions	Not Applicable (NA)	NA	NA	NR	NR	NR
Humana-C	All regions	1,8,11	1,4	1,2,4,6,10	All regions except 1	All regions	All regions except 10 and 11
Magellan-S	4,5,7	4,5,7	None	NR	None	None	4,7
Miami Children's Health-M	9,11	None	11	None	9,11	9,11	9,11
Molina-C	8,11	8,11	8	11	8	8,11	None
Prestige-M	9,11	11	11	9,11	9,11	9,11	9,11
Simply-C	5,6,7,10,11	5,6,7,11	None	5,6,7,10	5,6,7,10,11	5,6,7,10,11	5,6,7,10,11
ClearHealth-S**	All regions	NA	2,3,4,6,7,9,10,11	NA	1,2,8,9	8,9	1,2,3,8,9

Appendix E.

Health Plan Name	Regions Served	Regions Where *Improving Birth Outcomes* PIP Goal Was Met			Regions Where *Reducing PPEs* PIP Goal Was Met		
		Primary C-Section Rate	Preterm Delivery Rate	NAS per 1,000 Live Births	Potentially Preventable Admissions (PPAs) per 1,000 Enrollee Months	Potentially Preventable Readmissions (PPRs) per 1,000 Hospital Admissions	Potentially Preventable ED Visits (PPVs) per 1,000 Enrollee Months
Staywell-C	All regions except 10	All regions except 2 and 9	None	1,2,3,4,6, 8	All regions	All regions	All regions
Staywell-S	All regions	All regions except 1 and 2	None	NR	All regions	1,2,3,4,9	All regions
Sunshine-C	All regions	2,3,4,6,7	3,4	All regions except 11	All regions except 1 and 2	All regions	All regions
Sunshine-S	All regions	7,8,9,11	2,4,6,7,8	NR	All regions	1,8	All regions
United-C	3,4,6,11	3,4	4	3,4,6	3,4,6,11	3,4,6,11	3,4,6,11
Vivida-M	8	None	None	None	8	8	8

* The plan did not submit the *Reducing PPEs* PIP.
** For the *Reducing PPEs* PIP, ClearHealth-S reported Remeasurement 1 rates for all regions; however, the baseline and goals were determined for regions 1, 2, 3, 8, and 9 only.
NA: Not applicable because the PIP was not initiated by the plan.
NR: The data were not reported in the PIP Submission Form.

For the *Reducing PPEs* PIP, Community Care Plan-M, Miami Children's Health-M, Prestige-M, Simply-C, Staywell-C, United-C, and Vivida-M met the goals for all three performance indicators in all regions served.

For the *Improving Birth Outcomes* PIP, none of the plans met all goals in all regions served.

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

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

Plan Name	Measurement	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
Primary C-Section Rate												
Aetna Better Health-C	CY 2016						16.39%	17.10%				26.43%
	10/1/2018-9/30/2019						18.59%	15.26%				24.66%
Community Care Plan-M	CY 2016										19.11%	
	10/1/2018-9/30/2019										NR	
Humana-C	CY 2016	16.90%	18.45%	17.67%	17.34%	16.87%	16.39%	17.10%	15.76%	18.00%	19.11%	26.43%
	10/1/2018-9/30/2019	14.24%	18.33%	24.94%	18.78%	19.12%	19.37%	26.90%	14.61%	27.04%	20.90%	22.82%
Magellan-S	CY 2016				17.34%	16.87%		17.10%				
	10/1/2018-9/30/2019				9.40%	12.10%		14.80%				
Miami Children's Health -M	CY 2016									18.00%		26.43%
	10/1/2018-9/30/2019									20.12%		44.26%
Molina-C	CY 2016								15.76%			26.43%
	10/1/2018-9/30/2019								14.92%			24.79%
Prestige-M	CY 2016									18.00%		26.43%
	10/1/2018-9/30/2019									18.86%		23.39%
Simply-C	CY 2016					16.87%	16.39%	17.10%			19.11%	26.43%
	10/1/2018-9/30/2019					15.38%	16.03%	16.32%			20.47%	25.68%
Clear Health-S	CY 2016	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	10/1/2018-9/30/2019	42.86%	0.00%	20.00%	0.00%	25.00%	33.33%	20.00%	0%	38.46%	14.29%	13.51%
Staywell-C	CY 2016	16.90%	18.45%	17.67%	17.34%	16.87%	16.39%	17.10%	15.76%	18.00%	19.11%	26.43%
	10/1/2018-9/30/2019	12.84%	18.66%	15.81%	16.50%	14.69%	13.85%	14.84%	13.99%	22.26%	N/A	19.51%
Staywell-S	CY 2016	16.90%	18.45%	17.67%	17.34%	16.87%	16.39%	17.10%	15.76%	18.00%	19.11%	26.43%
	10/1/2018-9/30/2019	16.67%	18.13%	14.14%	11.71%	14.47%	12.16%	14.29%	13.06%	14.21%	12.50%	12.02%
Sunshine-C	CY 2016	16.90%	18.45%	17.67%	17.34%	16.87%	16.39%	17.10%	15.76%	18.00%	19.11%	26.43%
	10/1/2018-9/30/2019	16.79%	14.19%	16.47%	16.60%	17.34%	14.50%	15.75%	15.95%	19.17%	19.18%	24.92%
Sunshine-S	CY 2016	16.90%	18.45%	17.67%	17.34%	16.87%	16.39%	17.10%	15.76%	18.00%	19.11%	26.43%
	10/1/2018-9/30/2019	NR	66.67%	25.00%	62.50%	30.00%	23.08%	7.14%	11.11%	10.00%	25.00%	10.00%
United-C	CY 2016			17.67%	17.34%		16.39%					26.43%
	10/1/2018-9/30/2019			15.33%	16.42%		17.00%					26.66%
Vivida-M	CY 2016								15.76%			
	10/1/2018-9/30/2019								17.50%			
Pre-Term Delivery Rate												
Aetna Better Health-C	CY 2016						9.31%	9.56%				9.33%
	10/1/2018-9/30/2019						12.93%	14.59%				9.92%
Community Care Plan-M	CY 2016										11.41%	
	10/1/2018-9/30/2019										NR	
Humana-C	CY 2016	10.85%	9.73%	10.21%	10.88%	9.53%	9.31%	9.56%	8.62%	8.65%	11.41%	9.33%
	10/1/2018-9/30/2019	9.71%	12.92%	10.83%	9.72%	12.35%	11.82%	12.48%	10.49%	9.86%	12.02%	10.67%
Magellan-S	CY 2016				10.88%	9.53%		9.56%				
	10/1/2018-9/30/2019				13.80%	15.50%		14.30%				
Miami Children's Health-M	CY 2016									8.65%		9.33
	10/1/2018-9/30/2019									11.83%		8.20%
Molina-C	CY 2016								8.62%			9.33%
	10/1/2018-9/30/2019								8.16%			9.30%
Prestige-M	CY 2016									8.65%		9.33%
	10/1/2018-9/30/2019									10.83%		8.75%
Simply-C	CY 2016					9.53%	9.31%	9.56%			11.41%	9.33%
	10/1/2018-9/30/2019					12.29%	11.65%	12.16%			14.15%	11.65%
Clear Health-S	CY 2016	10.85%	18.45%	17.67%	17.34%	16.87%	16.39%	17.10%	15.76%	18.00%	19.11%	26.43%
	10/1/2018-9/30/2019	28.57%	0.00%	10.00%	0.00%	25.00%	12.50%	8.00%	50.00%	7.69%	14.29%	24.32%
Staywell-C	CY 2016	10.85%	9.73%	10.21%	10.88%	9.53%	9.31%	9.56%	8.62%	8.65%	11.41%	9.33%
	10/1/2018-9/30/2019	13.23%	11.17%	11.82%	11.57%	11.14%	11.63%	12.06%	10.78%	12.41%	N/A	12.06%
Staywell-S	CY 2016	10.85%	9.73%	10.21%	10.88%	9.53%	9.31%	9.56%	8.62%	8.65%	11.41%	9.33%
	10/1/2018-9/30/2019	11.33%	11.54%	13.87%	18.92%	13.16%	17.34%	16.88%	14.69%	18.95%	21.43%	15.85%
Sunshine-C	CY 2016	10.85%	9.73%	10.21%	10.88%	9.53%	9.31%	9.56%	8.62%	8.65%	11.41%	9.33%
	10/1/2018-9/30/2019	14.89%	14.84%	8.99%	10.18%	11.56%	11.78%	9.93%	10.55%	11.34%	13.82%	10.79%
Sunshine-S	CY 2016	10.85%	9.73%	10.21%	10.88%	9.53%	9.31%	9.56%	8.62%	8.65%	11.41%	9.33%
	10/1/2018-9/30/2019	NR	0.00%	12.50%	0.00%	30.00%	7.69%	7.14%	0.00%	10.00%	18.75%	15.00%
United-C	CY 2016			10.21%	10.88%		9.31%					9.33%
	10/1/2018-9/30/2019			12.31%	10.56%		14.43%					9.65%
Vivida-M	CY 2016								8.62%			
	10/1/2018-9/30/2019								8.75%			

Plan Name	Measurement	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
NAS per 1,000 Live Births												
Aetna Better Health-C	CY 2016						13.5	17				1.6
	10/1/2018-9/30/2019						10.6	18.52				0.99
Community Care Plan-M	CY 2016										10.4	
	10/1/2018-9/30/2019										NR	
Humana-C	CY 2016	28.9	17.4	30.7	42.3	44.1	13.5	17	27.1	12.9	10.4	1.6
	10/1/2018-9/30/2019	20.58	16.45	38.94	37.18	61.62	11.33	30.07	32.41	13.47	5.18	3.5
Magellan-S	CY 2016				42.3	44.1		17				
	10/1/2018-9/30/2019				NR	NR		NR				
Miami Children's Health-M	CY 2016									12.9		1.6
	10/1/2018-9/30/2019									23.12		5.52
Molina-C	CY 2016								27.1			1.6
	10/1/2018-9/30/2019								27.47			1.12
Prestige-M	CY 2016									12.9		1.6
	10/1/2018-9/30/2019									10.92		1.38
Simply-C	CY 2016					44.1	13.5	17			10.4	1.6
	10/1/2018-9/30/2019					32.5	9.18	15.64			4.73	4.1
Clear Health-S	CY 2016	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	10/1/2018-9/30/2019	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Staywell-C	CY 2016	28.9	17.4	30.7	42.3	44.1	13.5	17	27.1	12.9	10.4	1.6
	10/1/2018-9/30/2019	9.06	10.81	21.63	22.59	50.97	10.37	16.74	19.89	30.99	N/A	2.85
Staywell-S	CY 2016	28.9	17.4	30.7	42.3	44.1	13.5	17	27.1	12.9	10.4	1.6
	10/1/2018-9/30/2019	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sunshine-C	CY 2016	28.9	17.4	30.7	42.3	44.1	13.5	17	27.1	12.9	10.4	1.6
	10/1/2018-9/30/2019	22.58	13.45	21.62	24.04	32.84	10.78	8.35	20.78	12.31	4.20	2.78
Sunshine-S	CY 2016	28.9	17.4	30.7	42.3	44.1	13.5	17	27.1	12.9	10.4	1.6
	10/1/2018-9/30/2019	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
United-C	CY 2016			30.7	42.3		13.5					1.6
	10/1/2018-9/30/2019			25.55	33.64		13.1					2.57
Vivida-M	CY 2016								27.1			
	10/1/2018-9/30/2019								31.4			

* The performance indicator(s) rates documented in the table is reflective of the rates reported by the plans in the PIP submission. The remeasurement rates for the measurement period of October 1, 2018, through September 30, 2019, are indicated in green font when the goal was met and in red font when the goal was not met.

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

Plan Name	Measurement	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
PPAs per 1,000 Enrollee Months												
Aetna Better Health-C	SFY 15/16						1.95	2.08				1.69
	10/1/2018-9/30/2019						1.9	2.26				1.29
Community Care Plan-M	SFY 15/16										1.72	
	10/1/2018-9/30/2019										0.91	
Humana-C	SFY 15/16	1.64	1.88	2.06	2.08	2.2	1.99	2.16	1.93	2.07	1.74	1.94
	10/1/2018-9/30/2019	1.15	1.05	1.23	1.11	1.22	1.23	1.07	1.09	1.1	0.84	0.92
Magellan-S	SFY 15/16				1.81	2.06		2.08				
	10/1/2018-9/30/2019				4.38	4.26		4.92				
Miami Children's Health -M	SFY 15/16									2.11		1.69
	10/1/2018-9/30/2019									1.27		1.04
Molina-C	SFY 15/16								1.93			1.94
	10/1/2018-9/30/2019								0.87			1.66
Prestige-M	SFY 15/16									2.11		1.69
	10/1/2018-9/30/2019									1.01		1.13
Simply-C	SFY 15/16					2.06	1.95	2.08			1.72	1.69
	10/1/2018-9/30/2019					1.16	1.08	1.34			1.01	0.94
Clear Health-S	SFY 15/16	1.49	1.71	1.95					1.83	2.11		
	10/1/2018-9/30/2019	0.95	1.09	1.99	1.06	0.88	1.04	1.41	0.95	0.88	0.77	0.62
Staywell-C	SFY 15/16	1.49	1.71	1.95	1.81	2.06	1.95	2.08	1.83	2.11	1.72	1.69
	10/1/2018-9/30/2019	0.74	1.25	1.28	1.2	1.16	1.18	1.12	1.06	1.02	NR	0.85
Staywell-S	SFY 15/16	1.49	1.71	1.95	1.81	2.06	1.95	2.08	1.83	2.11	1.72	1.69
	10/1/2018-9/30/2019	0.79	1.22	1.27	1.13	1.36	1.41	1.23	0.81	1.09	0.95	0.93
Sunshine-C	SFY 15/16	1.49	1.71	1.95	1.81	2.06	1.95	2.08	1.83	2.11	1.72	1.69
	10/1/2018-9/30/2019	1.47	1.73	1.62	1.52	1.87	1.47	1.9	1.63	1.75	1.49	1.63
Sunshine-S		1.49	1.71	1.95	1.81	2.06	1.95	2.08	1.83	2.11	1.72	1.69
	10/1/2018-9/30/2019	0.4	0.43	1.59	1.04	0.51	0.46	0.96	0.99	0.41	0.46	0.52
United-C	SFY 15/16			1.95	1.81		1.95					1.69
	10/1/2018-9/30/2019			1.59	1.36		1.66					1.19
Vivida-M	SFY 15/16								1.83			
	10/1/2018-9/30/2019								0.96			
PPRs per 1,000 Hospital Admissions												
Aetna Better Health-C	SFY 15/16						83.17	86.2				89.54
	10/1/2018-9/30/2019						41.7	74.05				48.53
Community Care Plan-M	SFY 15/16										93.13	
	10/1/2018-9/30/2019										60.76	
Humana-C	SFY 15/16	89.11	79.18	88.96	88.85	87.73	85.87	88.89	80.95	101.45	98.95	98.35
	10/1/2018-9/30/2019	54.06	28.91	71.43	45.21	50.2	47.33	53.61	48.66	63.12	57.31	62.89
Magellan-S	SFY 15/16				89.37	85.46		86.2				
	10/1/2018-9/30/2019				133.96	132.83		156.21				
Miami Children's Health -M	SFY 15/16									94.81		89.54
	10/1/2018-9/30/2019									56.71		83.03
Molina-C	SFY 15/16								80.95			98.35
	10/1/2018-9/30/2019								58.67			55.68
Prestige-M	SFY 15/16									94.81		89.54
	10/1/2018-9/30/2019									47.38		59.05
Simply-C	SFY 15/16					85.46	83.17	86.2			93.13	89.54
	10/1/2018-9/30/2019					56.7	53.43	69.08			54.57	52.34
Clear Health-S	SFY 15/16	94.57	77.27	89.97					76.88	94.81		
	10/1/2018-9/30/2019	98.03	77.39	110.86	59.64	88.61	86.62	87.18	49.95	86.44	103.6	92.6
Staywell-C	SFY 15/16	94.57	77.27	89.97	89.37	85.46	83.17	86.2	76.88	94.81	93.13	89.54
	10/1/2018-9/30/2019	41.73	46.96	55.98	54.8	58.41	51.05	64.39	52.18	62.05	NR	65.93
Staywell-S	SFY 15/16	94.57	77.27	89.97	89.37	85.46	83.17	86.2	76.88	94.81	93.13	89.54
	10/1/2018-9/30/2019	75.54	69.22	74.44	79.04	88.34	83.45	96.27	78.21	86.6	103.84	91.43
Sunshine-C	SFY 15/16	94.57	77.27	89.97	89.37	85.46	83.17	86.2	76.88	94.81	93.13	89.54
	10/1/2018-9/30/2019	43.08	46.95	53.03	50.92	46.65	49.89	54.5	40.72	55.25	55.46	52.39
Sunshine-S	SFY 15/16	94.57	77.27	89.97	89.37	85.46	83.17	86.2	76.88	94.81	93.13	89.54
	10/1/2018-9/30/2019	77.69	108.05	113.94	103.07	116.72	116.61	129.77	71.43	124.2	136.96	124.46
United-C	SFY 15/16			89.97	89.37		83.17					89.54
	10/1/2018-9/30/2019			55.57	50.42		49.73					45.93
Vivida-M	SFY 15/16								76.88			
	10/1/2018-9/30/2019								59.4			

Plan Name	Measurement	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
PPVs per 1,000 Enrollee Months												
Aetna Better Health-C	SFY 15/16						25.76	26.19				19.51
	10/1/2018-9/30/2019						10.81	10.52				10.75
Community Care Plan-M	SFY 15/16										23.46	
	10/1/2018-9/30/2019										10.11	
Humana-C	SFY 15/16	14.58	12.15	11.16	12.16	10.33	11.57	12.48	10.09	10.49	8.6	8.75
	10/1/2018-9/30/2019	13.29	9.95	9.46	9.36	8.19	10.03	9.69	8.81	8.66	10.27	8.78
Magellan-S	SFY 15/16				26.56	23.24		26.19				
	10/1/2018-9/30/2019				24.3	23.97		24.01				
Miami Children's Health -M	SFY 15/16									23.77		19.51
	10/1/2018-9/30/2019									9.69		9.32
Molina-C	SFY 15/16								10.09			8.75
	10/1/2018-9/30/2019								10.54			11.17
Prestige-M	SFY 15/16									23.77		19.51
	10/1/2018-9/30/2019									9.43		10
Simply-C	SFY 15/16					23.24	25.76	26.19			23.46	19.51
	10/1/2018-9/30/2019					10.05	10.29	10.66			10.83	8.83
Clear Health-S	SFY 15/16	30.98	26.12	24.76					22.4	23.77		
	10/1/2018-9/30/2019	15.65	12.52	13.3	11.15	11.21	13.5	11.81	8.76	12.57	14.27	11.26
Staywell-C	SFY 15/16	30.98	26.12	24.76	26.56	23.24	25.76	26.19	22.4	23.77	23.46	19.51
	10/1/2018-9/30/2019	14.19	11.71	11.2	11.64	9.71	11.19	10.67	9.06	8.95	NR	9.55
Staywell-S	SFY 15/16	30.98	26.12	24.76	26.56	23.24	25.76	26.19	22.4	23.77	23.46	19.51
	10/1/2018-9/30/2019	19.22	14.36	14.45	14.17	15.88	15.74	15.35	13.05	16.1	17.73	12.71
Sunshine-C	SFY 15/16	30.98	26.12	24.76	26.56	23.24	25.76	26.19	22.4	23.77	23.46	19.51
	10/1/2018-9/30/2019	11.55	12.25	10.24	11.09	8.26	9.64	10.14	8.58	8.97	10.17	8.39
Sunshine-S	SFY 15/16	30.98	26.12	24.76	26.56	23.24	25.76	26.19	22.4	23.77	23.46	19.51
	10/1/2018-9/30/2019	10.44	8.33	7.98	8.69	7.66	8.25	7.89	7.31	6.72	8.51	8.86
United-C	SFY 15/16			24.76	26.56		25.76					19.51
	10/1/2018-9/30/2019			11.64	12.31		10.67					9.03
Vivida-M	SFY 15/16								22.4			
	10/1/2018-9/30/2019								9.69			

* The performance indicator(s) rates documented in the table is reflective of the rates reported by the plans in the PIP submission. The remeasurement rates for the measurement period of October 1, 2018, through September 30, 2019, are indicated in green font when the goal was met and in red font when the goal was not met.

[+] Florida Community Care-L did not submit a PIP for SFY 2020–2021.

Table E-4—Performance Indicator Rates by Region for Reducing Potentially Preventable Dental-Related ED Visits PIP*

Plan Name	Measurement	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11	Statewide
Preventable Dental ED Visits per 1,000 Enrollee Months													
DentaQuest	SFY 16/17	0.4565	0.3779	0.3764	0.319	0.2499	0.2797	0.2703	0.2282	0.2134	0.2234	0.1214	0.2584
	10/1/2018-9/30/2019	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	0.2454
Liberty	SFY 16/17	0.4565	0.3779	0.3764	0.319	0.2499	0.2797	0.2703	0.2282	0.2134	0.2234	0.1214	0.2584
	10/1/2018-9/30/2019	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	0.2717
MCNA	SFY 16/17	0.4565	0.3779	0.3764	0.319	0.2499	0.2797	0.2703	0.2282	0.2134	0.2234	0.1214	0.2584
	10/1/2018-9/30/2019	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	0.2294

* The remeasurement rates for the measurement period of October 1, 2018, through September 30, 2019, are indicated in green font when the goal was met and in red font when the goal was not met.

For the *Reducing Potentially Preventable Dental-Related ED Visits* PIP, the three dental plans provided statewide remeasurement rates. Only one plan (MCNA) met the goal for the statewide rate.

Appendix F. Plan-Specific Progress in Meeting EQRO Recommendations

This Appendix provides a summary of the follow-up actions per activity that the plans reported completing in response to HSAG's SFY 2019–2020 recommendations.

Comprehensive Health Plans

Aetna Better Health-C

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendation
HSAG recommended the following: • Plans use active, innovative improvement strategies and interventions that have the potential to directly impact study indicator outcomes for each PIP. The interventions tested should not only address barriers to study indicator data collection but also barriers to delivery and access to care. • Plans must have a process in place for evaluating the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
Response
a. Describe initiatives implemented based on recommendations: o Aetna Better Health of Florida (Aetna) selected the following 10 key measures below the 50th percentile (based on HEDIS MY2020 results) to focus interventions and initiatives in 2021-2022. Aetna follows the progress and measures the effectiveness of each intervention via monthly interim HEDIS data. The 10 key measures selected include: o Well Child Visit (WCV) o Immunizations for Adolescents (IMA) – Combo 2 o Breast Cancer Screening (BCS) o Cervical Cancer Screening (CCS) o Comprehensive Diabetes Care (CDC) - A1c & eye exams o Prenatal & Post-Partum Care (PPC) - both indicators o Follow-Up care for Children Prescribed ADHD Medication (ADD- initiation phase) o Follow-Up care after Hospitalization for Mental Illness (FUH- 7-day) o Follow-Up after Emergency Dept Visit for Mental Illness (FUM- 7-day) o Follow-Up after Emergency Dept Visit for Alcohol and other Drug Abuse or Dependence (FUA- 7-day)
o Aetna conducts live telephonic outreach to plan members without a claim for the particular service assessed by the HEDIS measure. Our outreach efforts focus on educating members about the importance of preventive services, addressing, and removing barriers to care, and assisting members to access the recommended health care services in a timely manner. Aetna also

incorporates text and IVR messaging to members for several of these measures in addition to live telephonic outreach.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): o As of September 2021, the interim rates show three of the 10 key measures selected for outreach improved and exceeded the rates reported in July 2021 for HEDIS MY2020. The 3 measures are: o ADD-initiation o FUM- 7-day o FUA- 7-day o As of September 2021, the interim data shows 2 of the 10 key measures selected for outreach improved and met or exceeded the 50th percentile: o IMA-Combo 2 o ADD-Initiation o As of September 2021, the interim data shows Aetna is well on the way to meet and/or exceed the 50th percentile for nearly all the key measures involved in our outreach efforts.
c. Identify any barriers to implementing initiatives: o The COVID-19 pandemic had a huge impact on the HEDIS MY 2020 rates (reported in July2021). Social distancing and other safety restrictions, compounded by reduced or limited practitioner office hours, and fear of getting sick deterred members from seeking the recommended preventive care in 2020. The high infection and mortality rates along with COVID-19 vaccination hesitancy have been ongoing for most of 2021 and continue to negatively impact HEDIS rates. Members are slowly returning to see their physicians for routine preventive care (including resuming child and adolescent well care visits).
Recommendation
HSAG recommended the following: • Plans should seek enrollee input during the PIP process for the identification of barriers in order to better understand enrollee-related barriers toward access to care. Seeking member input may also identify opportunities to improve member experience of care.
Response
a. Describe initiatives implemented based on recommendations: • Aetna seeks input from members and their experience of care from several sources, including member complaints & grievances, and satisfaction surveys such as the annual CAHPS survey. • Aetna implemented an action plan for improvement to address areas of opportunities identified from the 2021 CAHPS survey results and correlated the survey results with its member complaints & grievance data in developing the action plan. No particular issues or patterns were identified among member complaints/grievances. Aetna reviews and updates the action plan quarterly and evaluates progress through the Quality committee every quarter. • Aetna reviews member complaints and grievance data quarterly via the Quality committee structure; identifying and addressing trends and patterns among key types of issues, including access/availability of network providers and quality of care.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- The volume of member complaints and grievances remains low in 2021; less than 3/1000 members (internal threshold). There has been no need to implement corrective action with any of the network providers because of trends/patterns with access/availability or quality of care in 2021.
- Aetna showed improved CAHPS survey scores from 2020 to 2021 with the following composites:
  - Rating of personal doctor (Adult survey)
  - Rating of specialist (Child survey)
  - Rating of all health care (Adult & Child survey)
  - Rating of health plan (Adult & Child survey)
  - Getting care needed (Adult & Child survey)
- Aetna's 2021 CAHPS survey results met/exceeded NCQA's national average for all composites, except:
  - Getting care needed (Adult & Child survey)
  - Getting care quickly (Adult & Child survey)
  - Coordination of care (Adult survey)
  - How well doctors communicate (Adult & Child survey)
  - Customer Service (Child survey)
- For the Child with Chronic Condition portion of the CAHPS survey, Aetna was at or just below the national average across all 5 composites.

c. Identify any barriers to implementing initiatives:

- The COVID-19 pandemic impacted the CAHPS survey results as it reflected the member experience during the pandemic (limited/restricted access to providers, social distancing requirements, limited in-person encounters, fear of getting sick, etc.)

Recommendation

HSAG recommended the following:

- Plans must follow the Agency's direction regarding the measurement periods and report the data in accordance with Agency-defined specifications.
- Plans must address all documentation requirements outlined in the PIP Completion Instructions for each completed step of the PIP process.
- Plans should use quality improvement science tools and processes such as process mapping, failure modes effects analysis, and Plan-Do-Study-Act (PDSA) cycles as part of their improvement strategies.

Response

a. Describe initiatives implemented based on recommendations:

- Aetna incorporates the Agency's directions and recommendations to report the data in accordance with Agency-defined specifications.
- Aetna makes every effort to address all documentation requirement outlined in the PIP Reporting Summary and Completion Instructions when completing each step of the PIP process.

- Aetna requests Technical Assistance from HSAG as needed, to ensure a full understanding of the PIP reporting requirements and clear interpretation of the PIP Completion Instructions.
- Aetna uses PDSA cycles as part of our quality improvement strategy documented in our PIPs.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- PIP #1 - Birth Outcomes: showed some improvements year-over year:
  - C-Sections: Did not change significantly year-over-year across the 3 Regions served
  - Pre-Term Deliveries: Improved slightly in 2 of the 3 Regions served
  - NAS: Did not show improvement year-over-year across the 3 Regions served
- PIP #2 – Potentially Preventable Events (PPEs): Has not yet been submitted to the Agency at the time of this report
- PIP #3 – Timeliness of Non-Urgent Transportation: improved by 5 percentage points year-over-year.
- PIP #4 - 7-day Follow-up After Hospitalizations and/or ED Visits for People with Behavioral Health Conditions or Substance Abuse Disorder:
  - FUH: Did not change significantly year-over-year
  - FUM: Improved slightly year-over-year
  - FUA: Improved slightly year-over-year

c. Identify any barriers to implementing initiatives:

- PIP #1 – Birth Outcomes:
  - Late notification of pregnancy to the health plan
  - Missed/omitted recommended prenatal visits due to restricted access/availability and/or fear of COVID-19
  - Misconceptions, cultural beliefs about risks associated with C-sections
  - Members unaware/uneducated about risks of pregnancy, preterm labor, and C-section
  - Challenging to identify pregnant members with substance abuse
- PIP #2 – PPEs:
  - High ED utilization/members with recurring, preventable ED visits
  - Limited success with outreach to high ED utilizers
  - Unavailable or limited extended/weekend office hours for primary care
- PIP #3 – Timely Transportation:
  - Member no show for scheduled pick-up
  - Traffic delays
  - Scheduling errors/misunderstanding
  - Decreased driver workforce because of COVID-19 pandemic
- PIP #4 – 7-Day Follow-up after Hospitalization or ED visit for BH or SA:
  - Facilities discharge member without a scheduled follow-up appointment
  - Members not aware of 7-day follow-up recommendations
  - No reminder system to schedule appointments
  - Hospital staff challenged to search health plan's Provider Directory to locate a BH provider and assist with appointment scheduling
  - Provider access/availability (few appointments available for new patients; age restrictions)

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation
HSAG recommended the following: • Plans conduct a focused review to identify the barriers members are experiencing in receiving care for chronic conditions, such as comprehensive diabetes care and asthma. HSAG recommends that the plans identify best practices that have demonstrated success in improving the management of chronic conditions, promote positive health outcomes, and reduce overall Medicaid spending. • Plans consider assigning members diagnosed with a chronic condition to a medical home with a provider who has expertise in the member's diagnosis and has demonstrated successful outcomes for members with the chronic condition. HSAG also recommends consideration of other interventions such as increased use of telehealth for monitoring and managing chronic care.
Response
a. Describe initiatives implemented based on recommendations: • Aetna reviewed and updated its Integrated Care Management (ICM) and Population Health Programs which focuses on a holistic approach to case management and member education towards self-management of chronic conditions • Aetna's ICM program is designed to identify members at-risk who may benefit from care management services • The UM and ICM teams work hand in hand to identify high-risk members. Members at higher risk are engaged to recognize their personal strengths and barriers, determine health goals, and develop interventions to help them meet those goals. Based on their needs, members receive ongoing support and services through integrated case rounds, interdisciplinary care team meetings, scheduled contacts, and ad hoc communications. • Aetna continues its efforts to enlist providers in value-based contracting and serve as a medical home for our members.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • From 2Q2020 to 2Q2021: o ED visits/1000 decreased 23.3% o ED Cost/visit increased by 4.71% • Data for 3Q2021 is not yet available due to claims lag.
c. Identify any barriers to implementing initiatives: • COVID-19 pandemic (social distancing restrictions, limited access/availability of office visits (limited office hours, limited after hour availability in evenings and weekends)). • Some members do not know who their PCP is or do not see PCP regularly. • Members unaware of Aetna's 24 health information line, that offers access to a team of registered nurses who provide information on a variety of physical and behavioral health topics. • Members unaware/forget about using urgent care centers vs ED when applicable.

Humana-C

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendation
HSAG recommended the following: • Plans use active, innovative improvement strategies and interventions that have the potential to directly impact study indicator outcomes for each PIP. The interventions tested should not only address barriers to study indicator data collection but also barriers to delivery and access to care. • Plans must have a process in place for evaluating the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
Response
a. Describe initiatives implemented based on recommendations: • Humana Healthy Horizons' improvement strategies and intervention determinations are made collaboratively by key business areas through the review of data, barrier analysis, identification of best practices, and potential impacts to study indicator compliance. The need for identification and focus on high-risk membership, member engagement and knowledge deficits, lack of provider coordination of care, and transportation barriers were identified. Innovative interventions that were implemented to positively impact care delivery and access include enhanced targeted case, disease, and utilization management programs, education of inpatient and outpatient providers to improve communication and collaboration, promotion and resource support of telehealth services, and identification and addressing of member social determinants of health. Additionally, remote care monitoring is being implemented to further mitigate barriers to timely access to care and services. • Key business areas meet on an ongoing basis to review and analyze intervention and outcome data and determine improvement progress. Next steps are determined based on the progress evaluation and the need to address any implementation barriers that are identified. Changes may include modifications to the interventions to address additional or changed barriers, or the implementation of new interventions.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • New innovative PIP interventions were implemented in early 2021 and are being tracked and trended monthly/quarterly to determine effectiveness. Outcomes will be evaluated after a full year of data has been collected.
c. Identify any barriers to implementing initiatives: • High volume of Unable to Contact members. • The COVID-19 pandemic caused delays in implementation of interventions.
Recommendation
HSAG recommended the following: • Plans should seek enrollee input during the PIP process for the identification of barriers in order to better understand enrollee-related barriers toward access to care. Seeking member input may also identify opportunities to improve member experience of care.

Response
a. Describe initiatives implemented based on recommendations: • Humana Healthy Horizons collects qualitative and quantitative data from members through member satisfaction and experience surveys, case management interactions, member advisory committees, and complaints, grievances, and appeals to identify barriers and opportunities to improve care access and the experience of care.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Data collection and analysis contributed to improved identification of member barriers to access to care and the integration of innovative strategies into PIP interventions to address the issues.
c. Identify any barriers to implementing initiatives: • No identified barriers at this time.
Recommendation
HSAG recommended the following: • Plans must follow the Agency's direction regarding the measurement periods and report the data in accordance with Agency-defined specifications. • Plans must address all documentation requirements outlined in the PIP Completion Instructions for each completed step of the PIP process. • Plans should use quality improvement science tools and processes such as process mapping, failure modes effects analysis, and Plan-Do-Study-Act (PDSA) cycles as part of their improvement strategies.
Response
a. Describe initiatives implemented based on recommendations: • Humana Healthy Horizons follows the PIP methodologies provided by the Agency for all PIPs. Humana Healthy Horizons has had technical assistance calls with HSAG and Agency to ensure measurement periods and methodologies continue to align. • Humana Healthy Horizons utilizes the PIP Completion Instructions while completing the HSAG PIP template. • Humana Healthy Horizons has committed to completing annual causal/barrier analysis each year. Quality improvement science tools and processes used include failure modes effects analysis, Plan-Do-Study-Act (PDSA) cycles, fishbone diagrams, brainstorming, and data mining.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Humana Healthy Horizons is aligned with the Agency's defined measurement periods and defined methodologies. • Humana Healthy Horizons received a "Met" score for both PIPs in the final validation from HSAG in April 2021. • Humana Healthy Horizons is able to identify barriers, prioritize identified barriers, and implement interventions that will impact the Study Indicators.
c. Identify any barriers to implementing initiatives: • There are no identified barriers at this time.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation
HSAG recommended the following: • Plans conduct a focused review to identify the barriers members are experiencing in receiving care for chronic conditions, such as comprehensive diabetes care and asthma. HSAG recommends that the plans identify best practices that have demonstrated success in improving the management of chronic conditions, promote positive health outcomes, and reduce overall Medicaid spending. • Plans consider assigning members diagnosed with a chronic condition to a medical home with a provider who has expertise in the member's diagnosis and has demonstrated successful outcomes for members with the chronic condition. HSAG also recommends consideration of other interventions such as increased use of telehealth for monitoring and managing chronic care.
Response
a. Describe initiatives implemented based on recommendations: • Humana Healthy Horizons conducted data review and analysis, which identified Chronic Obstructive Pulmonary Disease (COPD), Asthma, Heart Failure (HF), Diabetes and Sickle Cell Disease (SCD) as high-risk top driver admission diagnoses. A focused review identified the barriers these populations are experiencing in receiving care. Interventions to address the barriers include engagement and education enhancements to the care and disease management programs targeting these populations, and improved discharge planning, care transition, and post discharge care coordination processes. In addition, strategies to improve access to urgent care, Primary Care Physician (PCP) appointments, and telehealth services are continuing to be developed. • The need for chronic condition monitoring is being further addressed through interventions that support and facilitate network provider telehealth adoption to increase member telehealth access and utilization, and the implementation of remote care monitoring. Remote Care monitoring, which includes in-home urgent care, will be implemented in Q4 2021 targeting members identified with high utilization or low PCP encounters for real time chronic condition management. This intervention will improve member knowledge and awareness, which is critical to facilitation of early intervention, adherence to treatment plans, and appropriate utilization of medical services. In turn, this will empower members to self-monitor and manage chronic conditions, and minimize ER and inpatient utilization.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Performance improvement was noted related to reduction in hospital admissions and increased PCP follow up appointments for all populations. Specifically, for diabetes, results indicated that from March 2020-July 2021, there was a 19% reduction in inpatient admissions post engagement into case management and 93% had a PCP visit within the past year. The HEDIS performance measure Comprehensive Diabetes Care showed the following improvements when comparing measurement year (MY) 2019 to MY2020: CDC-HbA1c<8 (+3.85%), CDC-HbA1c Testing (+5.41%), and CDC-Eye Exam (+0.17%). Interventions will continue that include a diabetes self-management program based on health coaching with a Certified Diabetes Educator targeting diabetic members who have an A1c level greater than 8, and member outreach campaigns through a contracted vendor. • New innovative PIP interventions were implemented in early 2021 and are being tracked and trended monthly/quarterly to determine effectiveness. Outcomes will be evaluated after a full year of data has been collected.
c. Identify any barriers to implementing initiatives: • High volume of Unable to Contact members. • The COVID-19 pandemic caused delays in implementation of interventions.

Molina-C and Magellan-S

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendation
HSAG recommended the following: • Plans use active, innovative improvement strategies and interventions that have the potential to directly impact study indicator outcomes for each PIP. The interventions tested should not only address barriers to study indicator data collection but also barriers to delivery and access to care. • Plans must have a process in place for evaluating the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
Response
a. Describe initiatives implemented based on recommendations: • The utilization of various data sources including 3M data, predictive modeling, utilization reports to evaluate current performance and identify areas of opportunity. The health plan uses this data as a guide to plan new interventions and monitor existing interventions.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The health plan has noted improvement in re-admission rates and emergency room utilization and have also seen improvement in birth outcomes. These initiatives will continue to be closely tracked by the health plan and focus on monitoring for further improvement.
c. Identify any barriers to implementing initiatives: • Engaging at risk members in their healthcare requires ongoing follow-up with the member and their assigned providers to ensure compliance with prescribed care.
Recommendation
HSAG recommended the following: • Plans should seek enrollee input during the PIP process for the identification of barriers in order to better understand enrollee-related barriers toward access to care. Seeking member input may also identify opportunities to improve member experience of care.
Response
a. Describe initiatives implemented based on recommendations: • Molina Healthcare's Transportation Vendor (Access2Care) reviewed its complaints related to access to care and based on issues reported, hired additional dispatch personnel. Furthermore, an extra 50+ transportation vendors were credentialed throughout 2020 to cover regions with high utilization. Trip response time issues were also addressed by offering trips to transportation providers with higher on-time-performance ratings before all other transportation providers.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Initiatives implemented throughout 2020 resulted in significant improvement of transportation services by the end of 2020.
c. Identify any barriers to implementing initiatives: • One barrier to hiring additional staff was a lack of qualified applicants. From 2020 and continuing through 2021, hiring additional employees and/or retaining quality employees has been a challenge. In addition, some barriers expressed by transportation vendors included the inability to multi-load

passengers due to the pandemic and accepting more trips than feasible due to failure to read portal correctly. Refresher portal trainings via WebEx were provided when needed.
Recommendation
HSAG recommended the following: • Plans must follow the Agency's direction regarding the measurement periods and report the data in accordance with Agency-defined specifications. • Plans must address all documentation requirements outlined in the PIP Completion Instructions for each completed step of the PIP process. • Plans should use quality improvement science tools and processes such as process mapping, failure modes effects analysis, and Plan-Do-Study-Act (PDSA) cycles as part of their improvement strategies.
Response
a. Describe initiatives implemented based on recommendations: • The health plan has and will continue to align goals and measurements with those provided by the Agency in relation to the PIPs.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • Barriers have not been identified in relation to completing the health plan's PIPs.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation
HSAG recommended the following: • Plans conduct a focused review to identify the barriers members are experiencing in receiving care for chronic conditions, such as comprehensive diabetes care and asthma. HSAG recommends that the plans identify best practices that have demonstrated success in improving the management of chronic conditions, promote positive health outcomes, and reduce overall Medicaid spending. • Plans consider assigning members diagnosed with a chronic condition to a medical home with a provider who has expertise in the member's diagnosis and has demonstrated successful outcomes for members with the chronic condition. HSAG also recommends consideration of other interventions such as increased use of telehealth for monitoring and managing chronic care.
Response
a. Describe initiatives implemented based on recommendations: • The health plan utilizes member data to identify members with chronic conditions and also plans interventions for these members based on risk acuity. Interventions include outreach to members to complete comprehensive assessments and develop individualized plans of care.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Member education regarding chronic conditions and access to specialized care management programs to facilitate coordination of care needs have improved through planed initiatives. The health plan's implemented initiatives will continue to be monitored.
c. Identify any barriers to implementing initiatives: • All identified members with a chronic condition are outreached by the health plan for engagement in a care management program. Lack of contact information impacts member engagement in these programs.

Simply-C and Miami Children's Health-M

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendation
HSAG recommended the following: • Plans use active, innovative improvement strategies and interventions that have the potential to directly impact study indicator outcomes for each PIP. The interventions tested should not only address barriers to study indicator data collection but also barriers to delivery and access to care. • Plans must have a process in place for evaluating the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
Response
a. Describe initiatives implemented based on recommendations: • In addition to the two Performance Improvement Projects (PIPs) validated by HSAG, SHP-C also submits its Birth Outcomes and Potentially Preventable Events (PPE) PIPs for a high-level review. SHP-C continues to address HSAG's feedback for these PIPs and can provide an update on all activities upon request. SHP-C will be submitting its PPE PIP prior to the December 16th deadline. <u>Behavioral Health (BH) PIP:</u> • PIP Topic Change: SHP-C's BH Screening PIP submitted in 2019 satisfied all validation requirements. However, considering the effects of the pandemic and 2019 HEDIS data for 7-Day Follow-Up after ED and hospitalization measures, the Agency determined that the behavioral health PIP topics needed to be amended to allow for a more collaborative and streamlined approach for addressing behavioral health. SHP-C shares the Agency's vision and priorities and supports these statewide efforts. o New PIP Topic: Improving 7-day Follow-up After Hospitalizations for People with Behavioral Health Conditions and Emergency Department Visits for People with Behavioral Health Conditions and/or Substance Use Disorder (SUD). o Bi-weekly interdepartmental meetings with the SHP-C's BH partner to develop, plan and review interventions and evaluate impact on rates. o Use of BH Telehealth providers to complete priority outreach within 7 and 30 days of discharge. ▪ Member engagement rates as well as completed 7 and 30-day follow-up visits being tracked monthly. o Incorporating BH Telehealth information into PCP toolkit and sharing with Providers o Member Gift Card program for FUM 7-Day and 30-Day Follow-Up o A new Follow-Up After Discharge Assessment; approved by a National Committee for Quality Assurance (NCQA) approved HEDIS auditor ▪ Following a member's discharge from an ED/Inpatient psychiatric event within 7 and 30 days post-discharge. ▪ Designed to enhance the discharge process, improve member engagement, and reduce ED/Hospital events • Partnered with the Agency's Encounter Notification System (ENS) vendor, Audacious Inquiry (AINQ) to develop customized alerts in ENS for SHP-C's Behavioral Health population.

- All behavioral health diagnoses are included.
- Separate break-out for the PIP's performance indicators (FUH, FUM, FUA)
- Social Determinants of Health (SDOH)
  - SHP-C provides AINQ with housing status information based on Homeless Management Information System (HMIS) data. Shelter addresses are also provided in order to capture housing status.
  - SDOH-related Z codes were also provided to AINQ.
- Emergency Medical Services (EMS) Alerts
  - SHP-C has added this as a real-time report.
  - This alert captures all treat and release incidents where the patient declines to go to the hospital.
  - Provided AINQ with Case Manager and PCP information.

<u>Transportation PIP:</u>

- SHP-C meets monthly with its transportation partners to develop, plan and review interventions and evaluate impact on rates.
  - Vendors' actions plans are implemented to address all areas not meeting/exceeding standards. This includes vendor-related causes for appointment tardiness.
- Member Outreach and Engagement
  - Identifying and engaging members with prior transportation issues.
- Transportation Management Dashboard
  - SHP-C is collaborating with its transportation vendors on utilizing an effective predictive modeling strategy to predict future late trips due to provider tardiness and immediately have additional providers on standby.
  - Tracking the number of trips impacted and the % of those Leg A trips that arrived on time.

For all of SHP-C's PIPs:

- In addition to regional break-out, the plan conducts additional analysis of its data to identify and address healthcare disparities based on race/ethnicity. A Population Health workgroup has been established to develop, plan, and implement interventions to address healthcare disparities for each PIP population.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- SHP-C reported to NCQA a significant increase across all BH PIP performance indicators:

Key BH Measure	2019	2020
FUH 30-Day	28.49%	54.73%
FUH 7-Day	15.36%	34.16%
FUM 30-Day	50.06%	51.14%
FUM 7-Day	33.63%	37.21%
FUA 30-Day	7.79%	11.01%
FUA 7-Day	4.87%	7.69%
IET - Initiation	33.15%	41.74%
IET - Engagement	4.65%	7.67%

- During the COVID-19 pandemic the Plan has seen an increase in Telehealth utilization which has resulted in an improvement in its follow-up rates for ED and hospitalization.

- Gift Card Program: Early improvement seen in members completing a 7-day follow-up visit after an ED event.
- Transportation: SHP-C has seen a significant improvement in Leg A trips that arrive on-time to their scheduled appointment since 2019.

c. Identify any barriers to implementing initiatives:
- Lack of accurate and complete member contact information.
- For members with behavioral health SHP-C has identified a link to socio-economic factors such as homelessness.
- The overall impact of the pandemic on mental health, worsened by the apprehension over in-person visits and limited socialization has hindered the Plan from potential further improvement.

Recommendation

HSAG recommended the following:

- Plans should seek enrollee input during the PIP process for the identification of barriers in order to better understand enrollee-related barriers toward access to care. Seeking member input may also identify opportunities to improve member experience of care.

Response

a. Describe initiatives implemented based on recommendations:
- Enrollee Advisory Committee:
  - In 2019 SHP-C conducted Enrollee Advisory Committees for all lines of business. During the committees member input and feedback were collected to address any barriers to improving overall access to care. Behavioral Health education was conducted during these meetings.
  - In 2020 and 2021, SHP-C planned to have at least one quarterly meeting encompassing all advisory committees. However, due to COVID-19 all Enrollee Advisory Committees were temporarily suspended to protect enrollees and associates.
  - At this time, SHP-C is measuring the level of risk and will be resuming the committees as soon as possible. SHP-C continues to follow CMS and State recommendations.
- SHP-C implemented a standardized system for all of its PIP workgroups that captures and monitors enrollee input/feedback to drive intervention planning and modifications as needed.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Through the Enrollee Advisory Committee SHP-C is able to capture enrollee input and feedback to support the Plan's efforts towards addressing issues related to overall enrollee satisfaction, grievances, health needs and strategies.
- Due to the increase of TH utilization during the pandemic SHP-C is analyzing TH versus face-to-face utilization.

c. Identify any barriers to implementing initiatives:
- None as it relates to seeking enrollee input. Attendees have always been encouraged and willing to share input and feedback during the Enrollee Advisory Committees.

Recommendation

HSAG recommended the following:

- Plans must follow the Agency's direction regarding the measurement periods and report the data in accordance with Agency-defined specifications.
- Plans must address all documentation requirements outlined in the PIP Completion Instructions for each completed step of the PIP process.

- Plans should use quality improvement science tools and processes such as process mapping, failure modes effects analysis, and Plan-Do-Study-Act (PDSA) cycles as part of their improvement strategies.

Response

a. Describe initiatives implemented based on recommendations:
   - SHP-C has sought technical assistance regularly from HSAG and the Agency regarding all current PIP requirements.
   - SHP-C PIP submissions were in alignment with the Agency's direction regarding measurement periods and reporting of data.
   - All documentation requirements for SHP-C's PIPs were satisfied, and a complete description of its Quality Improvement activities and formal process based on the Plan-Do-Study-Act (PDSA) cycles as part of its improvement strategies was included.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - N/A

c. Identify any barriers to implementing initiatives:
   - N/A

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

Recommendation

HSAG recommended the following:

- Plans conduct a focused review to identify the barriers members are experiencing in receiving care for chronic conditions, such as comprehensive diabetes care and asthma. HSAG recommends that the plans identify best practices that have demonstrated success in improving the management of chronic conditions, promote positive health outcomes, and reduce overall Medicaid spending.
- Plans consider assigning members diagnosed with a chronic condition to a medical home with a provider who has expertise in the member's diagnosis and has demonstrated successful outcomes for members with the chronic condition. HSAG also recommends consideration of other interventions such as increased use of telehealth for monitoring and managing chronic care.

Response

- Describe initiatives implemented based on recommendations:
- Multiple interventions in place to address the needs of SHP-C members with chronic conditions.
- As availability permits it is SHP-C's practice to assign members to medical homes
- Camillus House and Housing Waiver Program
  - Camillus House shelter beds, Housing Waiver program and Aunt Bertha PIP tied to incentivizing providers.
- BH Education was conducted during Enrollee Advisory Committees.
  - Services available through the Plan were presented.
  - Concerns over stigmas and barriers to care were addressed.
- Within the Behavioral Health Domain SHP-C is addressing those measures that fell below the minimum performance target for IET-I/E, FUH-7/30-Day, FUA 7/30-Day, FUM 7/30-Day.
  - Bi-weekly interdepartmental meetings with BH partner to develop, plan and review interventions and evaluate impact on rates.
  - Use of BH Telehealth provider to complete priority outreach within 7 and 30 days of discharge.
    - Member engagement rates as well as completed 7 and 30-day follow-up visits being tracked monthly.

- Incorporating BH Telehealth information into PCP toolkit and sharing with Providers.
- Member Gift Card program for FUM 7-Day and 30-Day Follow-Up
- A new Follow-Up After Discharge Assessment (approved by an NCQA approved HEDIS auditor)
  - Following a member's discharge from an ED/Inpatient psychiatric event within 7 and 30 days post-discharge.
  - Designed to enhance the discharge process, improve member engagement, and reduce ED/Hospital events
- Significant increase in TH usage as a result of the COVID pandemic

- SHP-C was the first health plan in FL to partner with the Department of Health on an Asthma Home Visit Pilot.
  - Visits are currently conducted virtually due to COVID-19.
  - Due to the success of the pilot in Region 11, SHP-C is currently working on an expansion agreement with Seminole, Orange, and Gadsden counties.
- Multiple text campaigns in place that address HEDIS care gaps.
- SHP-C utilizing its vendor portal that allows the Plan to implement targeted text campaigns and prevent member abrasion.

a. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- The plan implemented targeted interventions in 2020 and 2021 to address these populations and the table below illustrates the improvement seen for SHP-C across the aforementioned BH metrics:

Key BH Measure	2019	2020
FUH 30-Day	28.49%	54.73%
FUH 7-Day	15.36%	34.16%
FUM 30-Day	50.06%	51.14%
FUM 7-Day	33.63%	37.21%
FUA 30-Day	7.79%	11.01%
FUA 7-Day	4.87%	7.69%
IET - Initiation	33.15%	41.74%
IET - Engagement	4.65%	7.67%

- Successful reduction of ED and Hospital events for the Asthma Home Visit Pilot population.
- Telemonitoring Program – Reduction seen in Admissions, Readmissions and ED Visits, as well as average length of stay for program participants.
- SHP-C provided nearly 600,000 telehealth visits to members across every region of Florida.

b. Identify any barriers to implementing initiatives:

- Lack of accurate and complete member contact information.
- The overall impact of the pandemic on mental health, worsened by the apprehension over in-person visits and limited socialization has hindered the Plan from potential further improvement.

Sunshine-C, Sunshine-S, and Staywell-S

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendation
HSAG recommended the following: • Plans use active, innovative improvement strategies and interventions that have the potential to directly impact study indicator outcomes for each PIP. The interventions tested should not only address barriers to study indicator data collection but also barriers to delivery and access to care. • Plans must have a process in place for evaluating the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
Response
a. Describe initiatives implemented based on recommendations: • Sunshine Health implemented a 24/7 telemedicine program to increase access to urgent physicians outside of the emergency department with the goal of reducing Potentially Preventable Emergency Department Visits (PPVs). • Sunshine Health utilizes the corporate Emergency Department High-Utilizer report to identify members in need of follow-up care after an Emergency Department visit with the goal of reducing PPVs. • Sunshine Health utilizes Florida's Encounter Notification Service (ENS) real-time hospital admit-discharge-transfer (ADT) data to identify members needing outreach to offer education and assistance with scheduling follow up visits after behavioral health (BH) inpatient admissions and emergency department (ED) visits.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • For dates of service 1/1/2021 – 9/30/2021, there were 650,870 Medicaid telemedicine claims. By comparison, for dates of service 10/1/2018 – 9/5/2019, there were 5,126 Medicaid telemedicine claims. • For dates of service 3/1/2021 – 7/31/2021: o 4,634 members with mental health inpatient admits were identified through ENS and authorization data; outreach was attempted on 99% and contact was successful with 41%. o 387 members with mental health ED visits were identified through ENS and authorization data; outreach was attempted on 83% and contact was successful with 59%.
c. Identify any barriers to implementing initiatives: • When reviewing August 2021 data, it was determined that of the 860 discharges reported, only 79 of those discharges were located on the ENS report. Many members are not found on the ENS report. Others are on the ENS report sporadically, meaning if they had three admits during the month, the ENS file might capture only one of the three, not the others. Not all providers report into the ENS and some do not report into it consistently.

Recommendation
HSAG recommended the following: • Plans should seek enrollee input during the PIP process for the identification of barriers in order to better understand enrollee-related barriers toward access to care. Seeking member input may also identify opportunities to improve member experience of care.
Response
a. Describe initiatives implemented based on recommendations: • Sunshine Health has already incorporated efforts to seek enrollee input by utilizing a telephonic After-Ride Satisfaction Survey focused on the member's total transportation experience, including the driver's performance, vehicle cleanliness, and ease of scheduling. Information received in the surveys is utilized to improve services.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None identified.
c. Identify any barriers to implementing initiatives: • Some members/guardians are busy and do not have the time or desire to provide input.
Recommendation
HSAG recommended the following: • Plans must follow the Agency's direction regarding the measurement periods and report the data in accordance with Agency-defined specifications. • Plans must address all documentation requirements outlined in the PIP Completion Instructions for each completed step of the PIP process. • Plans should use quality improvement science tools and processes such as process mapping, failure modes effects analysis, and Plan-Do-Study-Act (PDSA) cycles as part of their improvement strategies.
Response
a. Describe initiatives implemented based on recommendations: • Sunshine Health designated a PIP Manager to ensure elements outlined in the validation summaries, Agency feedback, and PIP completion instructions are addressed as appropriate. • Sunshine Health designated a PIP Manager to ensure the PDSA cycle continues to occur, and applicable tools are utilized.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None identified.
c. Identify any barriers to implementing initiatives: • None identified.

2. **Prior Year Recommendation from the EQR Technical Report for Performance Measures:**
Recommendation
HSAG recommended the following: • Plans conduct a focused review to identify the barriers members are experiencing in receiving care for chronic conditions, such as comprehensive diabetes care and asthma. HSAG recommends that the plans identify best practices that have demonstrated success in improving the management of chronic conditions, promote positive health outcomes, and reduce overall Medicaid spending. • Plans consider assigning members diagnosed with a chronic condition to a medical home with a provider who has expertise in the member's diagnosis and has demonstrated successful outcomes for members with the chronic condition. HSAG also recommends consideration of other interventions such as increased use of telehealth for monitoring and managing chronic care.
Response
a. Describe initiatives implemented based on recommendations: • Sunshine Health is developing care gap reports for endocrinologists to assist with visibility into needed diabetes care. • Sunshine Health is conducting a barrier analysis to determine causes of chronic disease management care gaps. The identified barriers will be linked to best practices for evaluation and determination of interventions to develop or continue. • Sunshine Health currently supports network providers in achieving recognition as a Patient Centered Medical Home (PCMH) or a Patient Centered Specialty Practice (PCSP). Sunshine Health is reviewing the current process to determine how more members with chronic conditions can be connected with available PCMH or PCSP providers.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None identified.
c. Identify any barriers to implementing initiatives: • Some of the data systems do not interface necessitating manual intervention. Additionally, there were internal company changes in reporting platforms, data sources, and data coding language.

United-C

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendation
HSAG recommended the following: • Plans use active, innovative improvement strategies and interventions that have the potential to directly impact study indicator outcomes for each PIP. The interventions tested should not only address barriers to study indicator data collection but also barriers to delivery and access to care. • Plans must have a process in place for evaluating the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
Response
a. Describe initiatives implemented based on recommendations: • United Healthcare has implemented initiatives that are innovative and that have the potential to directly impact study indicators outcomes for each PIP. Metrics are tracked throughout the year and programs are continuously evaluated to guide strategy. A few example initiatives that have been implemented and evaluated for improvement are listed below: 1. Behavioral Health (BH) PIP Frequent Admitters List & BH Provider meetings- Following a targeted approach, the health plan reached out to BH providers from the FUH metric to connect in regards to members who fall in the metric multiple times in a year, and year over year. Providers were educated about health plan resources and connected with BH Case Management Program to help with care coordination. The project has been documented as a PDSA and outcomes will be evaluated at the end of the year. 2. Birth Outcomes Obstetrical Risk Assessment Form (OBRAF) Incentives: Program evaluation showed that members who engaged in Healthy First Steps (HFS) Case Management in their 1st trimester had significant better birth outcomes than members who engaged in 2nd and 3rd trimester. United Healthcare is implementing OBRAF Incentives to encourage OB/GYN providers to screen and refer high risk pregnant members as soon as possible to HFS Case Management program. 3. Potentially Preventable Events (PPEs): Clinical Case Management Program was evaluated to ensure members at high risk of PPEs were identified and referred to this program. In addition to using a high-risk predictive model, criteria wase expanded to include members with 5 or more ER visits, 3 or more inpatient admissions and members with any readmissions within a 12-month period. 4. Transportation PIP Champions Program: Transportation vendor has engaged facilities with standing orders for dialysis, and Substance Use treatment and matched them with transportation providers. Initiatives were developed based on analysis that identified these types of trips significantly impacting on-time performance.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Initiatives under BH PIP and Birth Outcomes PIP will be evaluated once sufficient data is available. • Under the PPE PIP, the number of members identified and enrolled in the program has double since criteria modifications were made and the health plan has successfully maintained PPE rates below the expected (3M internal data). • Transportation vendor showed a significant improvement in the Leg A trips on-time metric, reaching goal of 90% trip on time for Q3 2021. The Health plan is monitoring for sustained improvement.

c. Identify any barriers to implementing initiatives:
- For these initiatives that focus on improving timely access to care, the major barrier is low member engagement in services and supportive programs. (Low member engagement could be due to high chronicity in the case of BH conditions, members not perceiving as important to engage in program, members not having social supports to engage in program or services).

Recommendation

HSAG recommended the following:

- Plans should seek enrollee input during the PIP process for the identification of barriers in order to better understand enrollee-related barriers toward access to care. Seeking member input may also identify opportunities to improve member experience of care.

Response

a. Describe initiatives implemented based on recommendations:
- UnitedHealthcare is seeking input from members in the MMA Advisory Committee (MAC) to support PIP process. The Committee was established during 2021.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- The initial meeting had low member participation and no access to care issues were identified. The Health Plan is working to increase member participation.

c. Identify any barriers to implementing initiatives:
- The major barrier is the low member participation in the MMA Advisory Committee. The Health Plan is working on a strategy to increase participation rate such as collaborating with Community Organization to help engage Medicaid member in conversations around access of care.

Recommendation

HSAG recommended the following:

- Plans must follow the Agency's direction regarding the measurement periods and report the data in accordance with Agency-defined specifications.
- Plans must address all documentation requirements outlined in the PIP Completion Instructions for each completed step of the PIP process.
- Plans should use quality improvement science tools and processes such as process mapping, failure modes effects analysis, and Plan-Do-Study-Act (PDSA) cycles as part of their improvement strategies.

Response

a. Describe initiatives implemented based on recommendations:
- UnitedHealthcare reviewed PIP documentation/process and made sure to include measurement periods in accordance with Agency-defined specifications, provided complete documentation per PIP completion instructions for each step of the PIP process, and used quality improvement tools such as Prioritization Worksheet, failure modes effect analysis, and PDSA cycles as part of improvement strategies.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- United Healthcare received validation status score of 100% for BH PIP and 94% for Transportation PIP (with 100% met in critical elements for both PIPs). Birth Outcomes and PPEs high level feedback showed inclusion of required documentation. (2020-2021 PIP Validation/Feedback)

c. Identify any barriers to implementing initiatives:
- No barriers have been identified in this area.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation
HSAG recommended the following: • Plans conduct a focused review to identify the barriers members are experiencing in receiving care for chronic conditions, such as comprehensive diabetes care and asthma. HSAG recommends that the plans identify best practices that have demonstrated success in improving the management of chronic conditions, promote positive health outcomes, and reduce overall Medicaid spending. • Plans consider assigning members diagnosed with a chronic condition to a medical home with a provider who has expertise in the member's diagnosis and has demonstrated successful outcomes for members with the chronic condition. HSAG also recommends consideration of other interventions such as increased use of telehealth for monitoring and managing chronic care.
Response
a. Describe initiatives implemented based on recommendations: • UnitedHealthcare is implementing a new care management model designed to improve management of chronic conditions, promote positive health outcomes, and reduce overall Medicaid spend. The new care model includes: o A powerful identification and stratification algorithm that identifies the most impactable population focused on driving quality and affordability. o Improved staffing model based on research and experience to drive higher member engagement and meaningful outcomes (interdisciplinary teams include CHWs, RNs, BH and other SMEs such as pharmacist and Housing Navigator). Personalized member engagement emphasizing in person and virtual visit. o Evidence-based condition specific interventions that incorporate the latest insight into impacting health through a readiness to change framework (conditions include Diabetes and COPD and others). • The case management team currently performs clinical rounds with primary care providers who are providing care to our members with chronic conditions. • In addition to implementing the new case management model, Quality has promoted the use of telehealth for monitoring Adult Chronic conditions such as Asthma and Diabetes throughout 2020 and 2021 with Primary Care Providers. • The Health plan is actively working to increase member participation in MMA Advisory and is committed to gathering more information around barriers members experience in receiving care for chronic conditions.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • New care model was implemented on November 15th, 2021. Program will be monitored for outcomes. • Health plan captured an increase of telehealth utilization in 2020 which has remained high in 2021.
c. Identify any barriers to implementing initiatives: • Although Telehealth utilization increased, PCPs mentioned to our team that they did not feel comfortable using telehealth for conditions such as Asthma and Diabetes since they will have to rely on symptoms reported by the member or on basic glucose level test.

Specialty Plans

Children's Medical Services-S

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendation
HSAG recommended the following: • Plans use active, innovative improvement strategies and interventions that have the potential to directly impact study indicator outcomes for each PIP. The interventions tested should not only address barriers to study indicator data collection but also barriers to delivery and access to care. • Plans must have a process in place for evaluating the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
Response
a. Describe initiatives implemented based on recommendations: • In order to be responsive to member needs during the COVID-19 pandemic, CMS Health Plan changed the outreach and education methodologies originally planned. • CMS Health Plan utilizes Florida's Encounter Notification Service (ENS) real-time hospital admit-discharge-transfer (ADT) data to identify members needing outreach to offer education and assistance with scheduling follow up visits with mental health providers following behavioral health (BH) inpatient admissions and emergency department (ED) visits. • CMS Health Plan is developing a monitoring dashboard to track interventions and study indicators with regular data refreshes for timely visibility into performance and increased ability to initiate actions to impact outcomes. • CMS Health Plan conducts collaborative interdepartmental meetings to evaluate PIP progress, discuss barriers, and determine next steps.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Of the 147 members that received asthma education material outreach in December 2020, 90 (61%) did not have an ED visit or inpatient admission from 1/1/2021 – 8/2/2021. • From 2/1/2021 – 7/31/2021, there were: o 165 members identified with BH inpatient admits through ENS data. Outreach was attempted on 152 (92%) of those members, successful contact was made with 114 (69%), and 24 (15%) successfully completed a BH follow-up appointment. o 82 members identified with BH ED visits through ENS data. Outreach was attempted on 66 (80%) of those members, successful contact was made with 49 (60%), and 8 (10%) of members successfully completed a BH follow-up appointment.
c. Identify any barriers to implementing initiatives: • Many members are not found on the ENS report. Others are on the ENS report sporadically, meaning if they had three admits during the month, the ENS file might capture only one of the three, but not the others. Not all providers report into the ENS and some do not report into it consistently. • Some of the data systems do not interface necessitating manual intervention. Additionally, there were internal company changes in reporting platforms, data sources, and data coding language.

- It can be challenging to coordinate schedules for meeting participation, especially when multiple participants are needed from different time zones.

Recommendation

HSAG recommended the following:

- Plans should seek enrollee input during the PIP process for the identification of barriers in order to better understand enrollee-related barriers toward access to care. Seeking member input may also identify opportunities to improve member experience of care.

Response

a. Describe initiatives implemented based on recommendations:
   - CMS Health Plan incorporated PIP-related barrier inquiries into member meetings and individual interactions.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - N/A

c. Identify any barriers to implementing initiatives:
   - Some member/guardians are busy with ongoing care and do not have the time or desire to provide input.
   - It is challenging to capture ad-hoc information due to the system structure and reporting configuration. Implementing reporting for data requests that were not planned when the system was developed can be difficult depending upon the item. Some fields are reportable, while others are more challenging (such as open text entries) and require additional effort to extract data.

Recommendation

HSAG recommended the following:

- Plans must follow the Agency's direction regarding the measurement periods and report the data in accordance with Agency-defined specifications.
- Plans must address all documentation requirements outlined in the PIP Completion Instructions for each completed step of the PIP process.
- Plans should use quality improvement science tools and processes such as process mapping, failure modes effects analysis, and Plan-Do-Study-Act (PDSA) cycles as part of their improvement strategies.

Response

a. Describe initiatives implemented based on recommendations:
   - CMS Health Plan designated a PIP Manager to ensure elements outlined in the validation summaries, Agency feedback, and PIP completion instructions are addressed as appropriate.
   - CMS Health Plan designated a PIP Manager to ensure the PDSA cycle continues to occur, and applicable tools are utilized.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - N/A

c. Identify any barriers to implementing initiatives:
   - None identified.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation
HSAG recommended the following: • Plans conduct a focused review to identify the barriers members are experiencing in receiving care for chronic conditions, such as comprehensive diabetes care and asthma. HSAG recommends that the plans identify best practices that have demonstrated success in improving the management of chronic conditions, promote positive health outcomes, and reduce overall Medicaid spending. • Plans consider assigning members diagnosed with a chronic condition to a medical home with a provider who has expertise in the member's diagnosis and has demonstrated successful outcomes for members with the chronic condition. HSAG also recommends consideration of other interventions such as increased use of telehealth for monitoring and managing chronic care.
Response
a. Describe initiatives implemented based on recommendations: • CMS Health Plan is developing care gap reports for endocrinologists to assist with visibility into diabetes care needs. • CMS Health Plan's did not focus on additional initiatives for asthma due to the success experienced with current initiatives related to the CMS Health Plan Asthma PIP. In 2020, for the 10,912 members with asthma age 5-18 years, 95.4% did not have an asthma-related emergency department visit and 99.4% did not have an asthma-related hospital admission. • CMS Health Plan members are already assigned to medical homes with providers that have expertise in their conditions and utilize telehealth to monitor and manage chronic care.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None identified.
c. Identify any barriers to implementing initiatives: • Some of the data systems do not interface necessitating manual intervention. Additionally, there were internal company changes in reporting platforms, data sources, and data coding language.

Clear Health-S

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:

Recommendation

HSAG recommended the following:

- Plans use active, innovative improvement strategies and interventions that have the potential to directly impact study indicator outcomes for each PIP. The interventions tested should not only address barriers to study indicator data collection but also barriers to delivery and access to care.
- Plans must have a process in place for evaluating the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

Response

a. Describe initiatives implemented based on recommendations:

- For Clear Health Alliance the PIPs are submitted with Simply Healthcare Plans as comprehensive documents as requested by the Agency. (See initiatives described in Simply section.)

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- CHA-S reported to NCQA an improvement in 6 of 8 BH PIP performance indicators:

Key BH Measure	2019	2020
FUH 30-Day	12.60%	26.41%
FUH 7-Day	8.12%	13.30%
FUM 30-Day	43.01%	35.11%
FUM 7-Day	30.10%	24.46%
FUA 30-Day	8.55%	9.09%
FUA 7-Day	5.26%	8.18%
IET - Initiation	47.14%	50.35%
IET - Engagement	4.74%	5.72%

- During the COVID-19 pandemic the Plan has seen an increase in Telehealth utilization which has resulted in an improvement in its follow-up rates for ED and hospitalization.
- Gift Card Program to address barriers to improving FUM metrics: Early improvement seen in members completing a 7-day follow-up visit after an ED event.
- Transportation: CHA-S has seen a significant improvement in Leg A trips that arrive on-time to their scheduled appointment since 2019.

c. Identify any barriers to implementing initiatives:

- Lack of accurate and complete member contact information.
- For members with behavioral health CHA-S has identified a link to socio-economic factors such as homelessness.
- The overall impact of the pandemic on mental health, worsened by the apprehension over in-person visits and limited socialization has hindered the Plan from potential further improvement.

Recommendation
HSAG recommended the following: • Plans should seek enrollee input during the PIP process for the identification of barriers in order to better understand enrollee-related barriers toward access to care. Seeking member input may also identify opportunities to improve member experience of care.
Response
a. Describe initiatives implemented based on recommendations: • Enrollee Advisory Committee: o In 2019 CHA-S conducted Enrollee Advisory Committees for all lines of business. During the committees member input and feedback were collected to address any barriers to improving overall access to care. Behavioral Health education was conducted during these meetings. o In 2020 and 2021, CHA-S planned to have at least one quarterly meeting encompassing all advisory committees. However, due to COVID-19 all Enrollee Advisory Committees were temporarily suspended to protect enrollees and associates. o At this time, CHA-S is measuring the level of risk and will be resuming the committees as soon as possible. CHA-S continues to follow CMS and State recommendations. • CHA-S implemented a standardized system for all of its PIP workgroups that captures and monitors enrollee input/feedback to drive intervention planning and modifications as needed.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Through the Enrollee Advisory Committee CHA-S is able to capture enrollee input and feedback to support the Plan's efforts towards addressing issues related to overall enrollee satisfaction, grievances, health needs and strategies. • Due to the increase of TH utilization during the pandemic CHA-S is analyzing TH versus face-to-face utilization.
c. Identify any barriers to implementing initiatives: • None as it relates to seeking enrollee input. Attendees have always been encouraged and willing to share input and feedback during the Enrollee Advisory Committees.
Recommendation
HSAG recommended the following: • Plans must follow the Agency's direction regarding the measurement periods and report the data in accordance with Agency-defined specifications. • Plans must address all documentation requirements outlined in the PIP Completion Instructions for each completed step of the PIP process. • Plans should use quality improvement science tools and processes such as process mapping, failure modes effects analysis, and Plan-Do-Study-Act (PDSA) cycles as part of their improvement strategies.
Response
a. Describe initiatives implemented based on recommendations: • CHA-S regularly seeks technical assistance from HSAG and the Agency regarding all current PIP requirements. • CHA-S PIP submissions were in alignment with the Agency's direction regarding measurement periods and reporting of data.

- All documentation requirements for CHA-S' PIPs were satisfied, and a complete description of its Quality Improvement activities and formal process based on the Plan-Do-Study-Act (PDSA) cycles as part of its improvement strategies was included.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- N/A

c. Identify any barriers to implementing initiatives:
- N/A

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

Recommendation

HSAG recommended the following:

- Plans conduct a focused review to identify the barriers members are experiencing in receiving care for chronic conditions, such as comprehensive diabetes care and asthma. HSAG recommends that the plans identify best practices that have demonstrated success in improving the management of chronic conditions, promote positive health outcomes, and reduce overall Medicaid spending.
- Plans consider assigning members diagnosed with a chronic condition to a medical home with a provider who has expertise in the member's diagnosis and has demonstrated successful outcomes for members with the chronic condition. HSAG also recommends consideration of other interventions such as increased use of telehealth for monitoring and managing chronic care.

Response

a. Describe initiatives implemented based on recommendations:
- Multiple interventions in place to address the needs of CHA-S members with chronic conditions.
- As availability permits it is CHA-S' practice to assign members to medical homes
- Camillus House and Housing Waiver Program
- Camillus House shelter beds, Housing Waiver program and Aunt Bertha PIP tied to incentivizing providers.
- BH Education was conducted during Enrollee Advisory Committees.
- Services available through the Plan were presented.
- Concerns over stigmas and barriers to care were addressed.
- Within the Behavioral Health Domain CHA-S is addressing those measures that fell below the minimum performance target for IET-I/E, FUH-7/30-Day, FUA 7/30-Day, FUM 7/30-Day.
    - Bi-weekly interdepartmental meetings with BH partner to develop, plan and review interventions and evaluate impact on rates.
    - Use of BH Telehealth provider to complete priority outreach within 7 and 30 days of discharge.
        - Member engagement rates as well as completed 7 and 30-day follow-up visits being tracked monthly.
    - Incorporating BH Telehealth information into PCP toolkit and sharing with Providers.
    - Member Gift Card program for FUM 7-Day and 30-Day Follow-Up
    - A new Follow-Up After Discharge Assessment (approved by an NCQA approved HEDIS auditor)
        - Following a member's discharge from an ED/Inpatient psychiatric event within 7 and 30 days post-discharge.

- Designed to enhance the discharge process, improve member engagement, and reduce ED/Hospital events
- Significant increase in TH usage as a result of the COVID pandemic

- Multiple text campaigns in place that address HEDIS care gaps.
- CHA-S utilizing its vendor portal that allows the Plan to implement targeted text campaigns and prevent member abrasion.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- The Plan implemented targeted interventions in 2020 and 2021 to address these populations and the table below illustrates the improvement seen for CHA-S across 6 of 8 BH metrics:

Key BH Measure	2019	2020
FUH 30-Day	28.49%	54.73%
FUH 7-Day	15.36%	34.16%
FUM 30-Day	50.06%	51.14%
FUM 7-Day	33.63%	37.21%
FUA 30-Day	7.79%	11.01%
FUA 7-Day	4.87%	7.69%
IET - Initiation	33.15%	41.74%
IET - Engagement	4.65%	7.67%

- Telemonitoring Program – Reduction seen in Admissions, Readmissions and ED Visits, as well as average length of stay for program participants.
- SHP-C provided nearly 600,000 telehealth visits to members across every region of Florida.

c. Identify any barriers to implementing initiatives:

- Lack of accurate and complete member contact information.
- The overall impact of the pandemic on mental health, worsened by the apprehension over in-person visits and limited socialization has hindered the Plan from potential further improvement.

* Note that several specialty plans' responses were included by the comprehensive plans under which the specialty plans operate (see comprehensive plans' responses above).

Managed Medical Assistance Plans

Vivida-M

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendation
HSAG recommended the following: • Plans use active, innovative improvement strategies and interventions that have the potential to directly impact study indicator outcomes for each PIP. The interventions tested should not only address barriers to study indicator data collection but also barriers to delivery and access to care. • Plans must have a process in place for evaluating the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
Response
a. Describe initiatives implemented based on recommendations: • FL Cell phone initiative: Members are given a Verizon smart phone with unlimited talk/text/data to incentive them to stay connected with their Care Manager, encouraged to go to their OP appointments, and stay medication compliant. The phones are given to inpatient facilities to provide to the member upon discharge. When looking at social determinants of health it became clear that one of the difficulties in following up with members and ensuring that they show up to their scheduled appointments is the inability to contact the member. Cell phones among the Medicaid population is roughly that of the general public. However, when doing an analysis of high utilizers, many do not have cell phones or any contact information and case managers are left to waiting for the member to show back up at a hospital. This initiative should improve follow up rates and performance measures as listed below. • Gold Program: Vivida introduced a gold card program in the 4th quarter that allows providers offering services to members with high risk pregnancies to bypass authorizations for certain services. The goal is to improve timeliness to care and member access by lifting prior authorization requirements for any outpatient, ambulatory and imaging services.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • This is a new initiative, but we will monitor success by measuring the utilization of telehealth services, follow up after hospitalization for mental health services (FUH) 7-day measure, and the utilization of medication compliance applications. • Gold Card is a new implementation so improvements are to be determined.
c. Identify any barriers to implementing initiatives: • None identified at this time.
Recommendation
HSAG recommended the following: • Plans should seek enrollee input during the PIP process for the identification of barriers in order to better understand enrollee-related barriers toward access to care. Seeking member input may also identify opportunities to improve member experience of care.
Response

a. Describe initiatives implemented based on recommendations:
- Planned initiation of Maternity Care Program surveys pre and post to establish a baseline for what needs prospective mothers and have to determine whether the program successfully met those needs.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- This is a new initiative, results pending.

c. Identify any barriers to implementing initiatives:
- During pre-mortem analysis, barriers identified included: non-completion of surveys and program drop out so pre-surveys may not have a corresponding post survey.

Recommendation

HSAG recommended the following:

- Plans must follow the Agency's direction regarding the measurement periods and report the data in accordance with Agency-defined specifications.
- Plans must address all documentation requirements outlined in the PIP Completion Instructions for each completed step of the PIP process.
- Plans should use quality improvement science tools and processes such as process mapping, failure modes effects analysis, and Plan-Do-Study-Act (PDSA) cycles as part of their improvement strategies.

Response

a. Describe initiatives implemented based on recommendations:
- There was a change in quality leadership and all previous requirements and documentation changes have been noted. The quality team currently utilizes improvement tools such as A3s, PDSAs, FMEAs, pre-mortems, and process maps as part of all improvement strategies.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- To be determined.

c. Identify any barriers to implementing initiatives:
- No barriers identified.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

Recommendation

HSAG recommended the following:

- Plans conduct a focused review to identify the barriers members are experiencing in receiving care for chronic conditions, such as comprehensive diabetes care and asthma. HSAG recommends that the plans identify best practices that have demonstrated success in improving the management of chronic conditions, promote positive health outcomes, and reduce overall Medicaid spending.
- Plans consider assigning members diagnosed with a chronic condition to a medical home with a provider who has expertise in the member's diagnosis and has demonstrated successful outcomes for members with the chronic condition. HSAG also recommends consideration of other interventions such as increased use of telehealth for monitoring and managing chronic care.

Response

a. Describe initiatives implemented based on recommendations:
- Plan utilized the CAHPS Child CCC survey. This survey analyzes access to prescription medicines, specialized services, and coordination of care for children with chronic conditions. These measures within the CCC population fell within our CAHPS goal, however further information is needed to

identify specific areas of improvement. Vivida will implement a detailed telephonic survey for members adult and pediatric with chronic conditions to better identify member barriers. With the information received we will utilize implementation science to integrate research evidence and best practice to promote improved health outcomes and reduce spending and barriers.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The CAHPS Child CCC survey was a baseline and the new initiative is pending.
c. Identify any barriers to implementing initiatives: • Pre-Mortem identifies potential barriers as survey refusals and member non-compliance with future state initiatives.

Prestige-M

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendation
HSAG recommended the following: • Plans use active, innovative improvement strategies and interventions that have the potential to directly impact study indicator outcomes for each PIP. The interventions tested should not only address barriers to study indicator data collection but also barriers to delivery and access to care. • Plans must have a process in place for evaluating the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
Response
a. Describe initiatives implemented based on recommendations: • Regularly scheduled meetings have been put into place to address interventions. Deep dives into cause and effect diagrams to determine barriers to care for members.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None at this time have been seen.
c. Identify any barriers to implementing initiatives: • Feedback from members and providers on what would assist in positive outcomes has been challenging to gather. Providers are not responsive to inquiries and members are not sharing information on what could impact their outcomes.
Recommendation
HSAG recommended the following: • Plans should seek enrollee input during the PIP process for the identification of barriers in order to better understand enrollee-related barriers toward access to care. Seeking member input may also identify opportunities to improve member experience of care.
Response
a. Describe initiatives implemented based on recommendations: • Instituted the Member Advisory Committee in November 2021. Provider survey sent out in September 2021 to illicit information on barriers to care.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None to report at this time.
c. Identify any barriers to implementing initiatives: • Providers did not respond to the surveys. Member attendance at the Member Advisory Committee was minimal (3 members attended).
Recommendation
HSAG recommended the following: • Plans must follow the Agency's direction regarding the measurement periods and report the data in accordance with Agency-defined specifications. • Plans must address all documentation requirements outlined in the PIP Completion Instructions for each completed step of the PIP process.

• Plans should use quality improvement science tools and processes such as process mapping, failure modes effects analysis, and Plan-Do-Study-Act (PDSA) cycles as part of their improvement strategies.
Response
a. Describe initiatives implemented based on recommendations: • Developed a fishbone diagram to identify barriers in accessing services. Majority indicated a need for voice of customer to truly understand the issues at large.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None at this time.
c. Identify any barriers to implementing initiatives: • Providers did not respond to the surveys.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation
HSAG recommended the following: • Plans conduct a focused review to identify the barriers members are experiencing in receiving care for chronic conditions, such as comprehensive diabetes care and asthma. HSAG recommends that the plans identify best practices that have demonstrated success in improving the management of chronic conditions, promote positive health outcomes, and reduce overall Medicaid spending. • Plans consider assigning members diagnosed with a chronic condition to a medical home with a provider who has expertise in the member's diagnosis and has demonstrated successful outcomes for members with the chronic condition. HSAG also recommends consideration of other interventions such as increased use of telehealth for monitoring and managing chronic care.
Response
a. Describe initiatives implemented based on recommendations: • Member Advisory Committee and Provider Outreach surveys to gather voice of customer.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None at this time.
c. Identify any barriers to implementing initiatives: • Challenges gaining voice of customer. Both provider and member outreach attempts have not been useful in getting a better understanding.

Community Care Network-M

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendation
HSAG recommended the following: • Plans use active, innovative improvement strategies and interventions that have the potential to directly impact study indicator outcomes for each PIP. The interventions tested should not only address barriers to study indicator data collection but also barriers to delivery and access to care. • Plans must have a process in place for evaluating the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
Response
a. Describe initiatives implemented based on recommendations: • Use many tools to determine priorities and test interventions: FMEA and PDSA.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • PPE admissions decreased from 1.72 per 1000 to 0.91 per 1000. • PPE readmissions decreased from 93.13 per 1000 to 60.76 per 1000. • PPE ED visits decreased from 23.46 per 1000 to 10.11 per 1000. • Birth Outcomes: primary c-section decreased from 19.11% to 16.67%.
c. Identify any barriers to implementing initiatives: • N/A
Recommendation
HSAG recommended the following: • Plans should seek enrollee input during the PIP process for the identification of barriers in order to better understand enrollee-related barriers toward access to care. Seeking member input may also identify opportunities to improve member experience of care.
Response
a. Describe initiatives implemented based on recommendations: • Case managers and Care Coordination staff routinely query enrollees about factors that block engagement in care or closure of care gap. Each barrier is discussed with the enrollee/caregiver to mitigate lack of engagement or closure of care gap. Barriers are shared with Quality team and Clinical Analytics as part of rapid cycle improvement.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Difficult to discern improvement from enrollee input due to other interventions in place.
c. Identify any barriers to implementing initiatives: • Transportation is provided but underutilized for older enrollees because they prefer family members drive them which is then dependent on family's availability during business hours. • Enrollee fails to see benefit of follow up care. • Enrollees opt out of program or do not answer the phone/text.

Recommendation
HSAG recommended the following: • Plans must follow the Agency's direction regarding the measurement periods and report the data in accordance with Agency-defined specifications. • Plans must address all documentation requirements outlined in the PIP Completion Instructions for each completed step of the PIP process. • Plans should use quality improvement science tools and processes such as process mapping, failure modes effects analysis, and Plan-Do-Study-Act (PDSA) cycles as part of their improvement strategies.
Response
a. Describe initiatives implemented based on recommendations: • Health literacy for enrollees. Coordinated care and clear communication among providers, patients, families to promote accessible, coordinated, and optimal care. • PPE provider, patients, and family materials are coordinated as part of workgroup activities. • Inpatient behavioral health follow up is based on direct communication one on one with the enrollee or discharging facility. • Follow up after ED visit – enrollee visit date is shared with assigned provider.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Follow up after ED visit for mental illness rate has increased from 1.85% to 26.19% for 7-day.
c. Identify any barriers to implementing initiatives: • Discharging facility does not always follow through with setting up appointment for post discharge care.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation
HSAG recommended the following: • Plans conduct a focused review to identify the barriers members are experiencing in receiving care for chronic conditions, such as comprehensive diabetes care and asthma. HSAG recommends that the plans identify best practices that have demonstrated success in improving the management of chronic conditions, promote positive health outcomes, and reduce overall Medicaid spending. • Plans consider assigning members diagnosed with a chronic condition to a medical home with a provider who has expertise in the member's diagnosis and has demonstrated successful outcomes for members with the chronic condition. HSAG also recommends consideration of other interventions such as increased use of telehealth for monitoring and managing chronic care.
Response
a. Describe initiatives implemented based on recommendations: • Sent out text messaging and hard copy postcards to children, adolescents, and adult members telling them that their PCP office was open, clean, and safe after the pandemic peak. Messaging included the opportunity for telehealth visits and the incentive for enrollees completing an annual well exam. • Implemented telehealth program with Blueberry for asthma and dermatologic issues. • Assigned highest risk strategy members for asthma, diabetes, and hypertension to a single group that provides on-going monitoring including medication adherence, blood sugars, and blood pressure.

• Health plan staff made calls to enrollees as Covid vaccines rolled out to schedule vaccine administration, arrange transportation, if necessary, and remind enrollees to schedule annual health exam. • Implemented incentive program for providers to close AAP gaps.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Good increases in Well Child visits but less than expected for adult and chronic care visits especially when lab tests were ordered.
c. Identify any barriers to implementing initiatives: • Older enrollees anxious about telehealth and the ability to connect over phone and receive care. • During Covid pandemic, a number of Lab draw stations were closed as resources were moved to Covid testing sites. Appointment times were difficult to obtain if you did not have computer access. • Older enrollees did not feel comfortable accessing public or taxi transportation to medical visits due to pandemic.

Long Term Care Plus Plans

Florida Community Care-L

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendation
HSAG recommended the following: • Plans use active, innovative improvement strategies and interventions that have the potential to directly impact study indicator outcomes for each PIP. The interventions tested should not only address barriers to study indicator data collection but also barriers to delivery and access to care. • Plans must have a process in place for evaluating the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
Response
a. Describe initiatives implemented based on recommendations: • Florida Community Care (FCC) will adopt the following new interventions: o Transportation: (1) Conduct an enrollee satisfaction survey after completion of pick- up; (2) Have our Care Manager Assistants (CMAs)) manage concurrent enrollee transportation complaints and work with our transportation vendor as needed for timely resolution. o Behavioral Health – Care Managers to work with Behavioral Health (BH) vendor by providing enrollee contact information upon notification that enrollee discharge from the hospital to ensure follow up. BH vendor is also provided with the PCP information for enrollees. Information is derived from enrollee and/or caregiver and the Event Notification System (ENS). o PPE – FCC met with the Agency for Healthcare Administration (Agency) and have submitted a Year over Year proposal because as an LTC+ plan our members have complex medical needs and meet PASSR requirements for long term care placement. Also, the vast majority of the plan's members have Medicare as the primary payer for Medical Care Thus the ability to significantly influence the acute care needs of this majority of its members is limited by Medicare choice and payment policies. o FCC has a weekly Quality Improvement Workgroup that includes barriers, interventions, and outcomes discussions of Performance Improvement Projects (PIPs).
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • FCC is currently working through the data and will present the results at our quarterly Quality Improvement Committee (QIC) in 2022.
c. Identify any barriers to implementing initiatives: • Enrollees are not open to surveys. • ENS does not have all the necessary data completed as a result there are missed opportunities in setting up follow up appointments in a timely manner. • Enrollees may not mention hospitalization in a timely manner.
Recommendation
HSAG recommended the following:

- Plans should seek enrollee input during the PIP process for the identification of barriers in order to better understand enrollee-related barriers toward access to care. Seeking member input may also identify opportunities to improve member experience of care.

Response

a. Describe initiatives implemented based on recommendations:
   - Ask specific questions regarding barriers with transportation and MH access to care at Enrollee Advisory Committee meetings.
   - CMAs to conduct real time survey with a least 1 question that captures access barriers.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - N/A

c. Identify any barriers to implementing initiatives:
   - Low attendance at Enrollee Advisory Committee meetings.
   - High percentage of refusals for survey.
   - Data challenges with enrollee contact information.

Recommendation

HSAG recommended the following:

- Plans must follow the Agency's direction regarding the measurement periods and report the data in accordance with Agency-defined specifications.
- Plans must address all documentation requirements outlined in the PIP Completion Instructions for each completed step of the PIP process.
- Plans should use quality improvement science tools and processes such as process mapping, failure modes effects analysis, and Plan-Do-Study-Act (PDSA) cycles as part of their improvement strategies.

Response

a. Describe initiatives implemented based on recommendations:
   - FCC reviewed the PIP validation comments and recommendations and has complied with the measurement periods and all Agency defined specifications and instructions. FCC adheres to the Plan-Do-Study Act (PDSA) cycle for all improvement initiatives.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - N/A

c. Identify any barriers to implementing initiatives:
   - Challenging to implement initiatives that demonstrate significant impact due to small population.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

Recommendation

HSAG recommended the following:

- Plans conduct a focused review to identify the barriers members are experiencing in receiving care for chronic conditions, such as comprehensive diabetes care and asthma. HSAG recommends that the plans identify best practices that have demonstrated success in improving the management of chronic conditions, promote positive health outcomes, and reduce overall Medicaid spending.
- Plans consider assigning members diagnosed with a chronic condition to a medical home with a provider who has expertise in the member's diagnosis and has demonstrated successful outcomes for members with the chronic condition. HSAG also recommends consideration of other interventions such as increased use of telehealth for monitoring and managing chronic care.

Response
a. Describe initiatives implemented based on recommendations: • FCC conducts a comprehensive assessment of members with diabetes, asthma and other conditions who have gaps in care and have designed targeted interventions that address access barriers. • FCC increased awareness and encouraged telemedicine for BH services and utilized three vendors to provide in home/in facility care to close gaps in care.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The data will be analyzed and presented at the QIC in 2022.
c. Identify any barriers to implementing initiatives: • Low leverage with Primary Care Physicians (PCPs) because of the low number of Medicaid-only members enrolled in LTC+ Plan.

Dental Plans

DentaQuest of Florida

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendation
HSAG recommended the following: • Plans use active, innovative improvement strategies and interventions that have the potential to directly impact study indicator outcomes for each PIP. The interventions tested should not only address barriers to study indicator data collection but also barriers to delivery and access to care. • Plans must have a process in place for evaluating the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
Response
a. Describe initiatives implemented based on recommendations: • For PIP addressing ED utilization for non-traumatic dental, members who had more than one ED visit in a 6 month period of time were referred to Case Management (CM). Members receive outreach within 7 days of ED visit and are offered assistance to schedule a dental appointment. Having a subsequent visit would indicate there are other circumstances that may need attention to correct this behavior and/or the presenting dental issue has not been resolved. Through the case management program members receive the individual support and follow up to motivate behavior change and eliminate any existing barriers to their care. • For members that had an ED visit after seeing the dentist, a record review was conducted by a dental hygienist and a dentist to determine if there were opportunities or mechanisms when introduced would prevent the member from going to the ED. The two diagnosis codes that resulted in subsequent visits to the ED were 1) problem focused exam or 2) extraction. This information has provided valuable insight into future interventions that begin with the provider. The insight gained through this record review will inform the provider-based interventions during FY22. • We continue to explore innovative improvement strategies for our transportation and preventive dental visit PIP through using QI tools such as fishbone diagrams. As we progress through the measurement year and through discussions with our PIP team, we will implement and report on these strategies in our FY22 PIP write up.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The initiatives described in (a) are recent and this information will be used to develop interventions that are provider focused to prevent future ED visits related to recent extractions and problem focused exam. We will identify a measurement strategy as part of the intervention plan.
c. Identify any barriers to implementing initiatives: • Potential barriers are resistance from providers and lack of engagement from the member. Pain management, post op education, and referrals are being considered for initiatives. The provider would need to be agreeable to conducting requested education or developing a referral process. From the member side, members would need to be receptive to the instruction which could include appropriate pain management. There are also members who use dental issues as a pathway to obtain opiates which is another potential barrier.

Recommendation
HSAG recommended the following: • Plans should seek enrollee input during the PIP process for the identification of barriers in order to better understand enrollee-related barriers toward access to care. Seeking member input may also identify opportunities to improve member experience of care.
Response
a. Describe initiatives implemented based on recommendations: • We conduct a survey for members who call to inquire about the transportation benefit. While this is helpful for our transportation PIP it is designed to identify the gap in knowledge surrounding the transportation benefit. The data gathered is still in the early stages and as we build the volume of data collected will be able to use this to make necessary improvements as well as address the existing knowledge gaps. • Apart from the information gathered specific to the transportation PIP, some of the feedback from members has not been systematic or designed to elicit information that can be applied to current projects or to improve the member experience. The information we have is gathered during individual outreach calls and while helpful does not provide the type of data that is gathered systematically to gain insight into larger scale barriers or opportunities to improve the member's experience. During FY2022 we will develop and conduct member survey to better understand the enrollee's barriers to care and implement initiatives.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • We recently began collecting survey data around the transportation PIP used to identify knowledge gaps. The data collected thus far has not been robust enough to determine where an improvement should be made. The data we collect is specific to transportation and is ongoing. As we gather more data, we will be able to identify opportunities to make improvements and adjustments. • Initiatives while not currently in place will be implemented in FY22 in response to a survey developed specifically to identify barriers to care and improve member experience.
c. Identify any barriers to implementing initiatives: • When soliciting member input and feedback, a structured survey can create resistance due to personal experience and stigma associated with surveys. With that in mind, being able to obtain aggregate actionable data from members may be difficult. We will continue to solicit feedback and incorporate member experience into our PIP planning along with a more structured scientific survey. • The survey may not provide the information or results that are actionable to impact access to care or member experience. The quality of the survey and data may not provide the insight intended. In this instance, we would re-examine the survey and evaluate future action.
Recommendation
HSAG recommended the following: • Plans must follow the Agency's direction regarding the measurement periods and report the data in accordance with Agency-defined specifications. • Plans must address all documentation requirements outlined in the PIP Completion Instructions for each completed step of the PIP process. • Plans should use quality improvement science tools and processes such as process mapping, failure modes effects analysis, and Plan-Do-Study-Act (PDSA) cycles as part of their improvement strategies.

Response
a. Describe initiatives implemented based on recommendations: • Our PIP documentation follows the guidelines and timeframes established by the Agency. We participate in the training provided by HSAG and take advantage of the TA calls. For example, when we misinterpreted the measurement criteria for our transportation PIP we were unable to calculate a remeasurement. We requested a TA call and met with HSAG to understand how we could correct our error to keep the PIP moving forward and measure accurately. • We routinely use fishbone diagrams and process mapping to assist in identifying our improvement strategies and PDSA cycles are our routine approach with our improvement strategies especially in determining whether to abandon, adopt or adapt an intervention. While we have not previously utilized FMEA for these PIPs it is a tool that we will evaluate and use for this current FY 2022 PIP cycle.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • As a result of the TA call, we are now re-baselining our transportation PIP measure so that we can measure the effectiveness of our improvement efforts to gain the intended results. • For our PDENT PIP, our PDSA cycle was helpful when we measured the impact of a provider recall letter and member post card. Both of these interventions were ineffective and therefore will not be used to drive preventive visit results in future cycles. This was an example of abandoning the test of change. IVR calls demonstrated effectiveness and will be a consideration for future interventions and inclusion in the PDSA cycle.
c. Identify any barriers to implementing initiatives: • Currently we have not experienced barriers, nor do we anticipate experiencing barriers to implementing quality improvement tools or following the direction from HSAG on completing PIPs. HSAG has been very accommodating and helpful both with their training, communication and availability for assistance.

Liberty Dental Plan of Florida

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendation
HSAG recommended the following: • Plans use active, innovative improvement strategies and interventions that have the potential to directly impact study indicator outcomes for each PIP. The interventions tested should not only address barriers to study indicator data collection but also barriers to delivery and access to care. • Plans must have a process in place for evaluating the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
Response
a. Describe initiatives implemented based on recommendations: • LIBERTY continued to enhance its existing interventions as well as work to implement new interventions. Some of our interventions that were utilized during our remeasurement period are as follows: 1. Text Message Outreach: Outreach campaign that targeted non-utilizers of preventive care with a focus on each study indicator population group. 2. Pay for Performance Initiative: Initiative that reimburses primary care dentists for conducting dental assessments, making dental referrals, and providing fluoride varnish. 3. Healthy Behaviors Program: Enrollee incentive program aimed at motivating enrollees to seek preventive and/or annual dental care via an online portal registration. • Additionally, LIBERTY continuously validates and assess each intervention by utilizing our internal data warehouse and member information system (MIS) to monitor the effectiveness and performance of each intervention initiative. From here, LIBERTY can refine, adapt, or complete each specific intervention depending on its monitored performance.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • LIBERTY recorded the following results for each mentioned intervention above from the most recent remeasurement period: 1. Text Message Outreach: Outreach campaigns showed that LIBERTY sent out a total of 1,315,272 successful messages to non-utilizing enrollees from Aug 2019 to Sep 2020. Results indicated that dental health outcomes were improved with an overall preventive utilization rate of 21.4% from the Q4 2019 campaign and 30.4% from the Q3 2020 Campaign. 2. Pay for Performance Initiative: LIBERTY launched its Provider Performance intervention campaign that focused on instituting dental assessments, making dental referrals, and providing fluoride varnish to its Medicaid Child population groups. LIBERTY's data results show that there was an average of 735,305 total eligible children per month from August 2019 and December 2019 and an average of 134,592 total claims paid per month because of this bonus program. This intervention produced a success rate of 18% on average when completed. 3. Healthy Behaviors Program: From the completed outreach, 6.3% of the enrollees clicked on the applicable registration link to the Healthy Behavior Program Landing page. Ultimately, the plan saw new enrollment into the HBP increase from only 2 new enrollees experienced in Q3 2020 to 250 new enrollments experienced in Q4 2020.

c. Identify any barriers to implementing initiatives:

- Long-lasting Effects of COVID-19. Anxiety, fear, stress and loneliness are among the many emotions that people are experiencing as a result of the COVID-19 pandemic and its effects. Social Determinants of Health (SDOH) have been exasperated by the pandemic and members are dealing with many internal/external influences, making non-emergent care low on their priority list.
- Office Closures/ Limited Scheduling. Throughout the previous 12 months, there were varying directives and guidance provided by state and local authorities, the CDC and ADA regarding increased safety measures, required closures and limited practices for dental facilities. Separately, many offices experienced a direct impact to both administrative and clinical staff, as well economic hardships forcing closures or reduced office hours.

Recommendation

HSAG recommended the following:

- Plans should seek enrollee input during the PIP process for the identification of barriers in order to better understand enrollee-related barriers toward access to care. Seeking member input may also identify opportunities to improve member experience of care.

Response

a. Describe initiatives implemented based on recommendations:

- LIBERTY developed and implemented a performance improvement program that is aimed at improving access to care, utilization, and preventive services. Community Smiles is one of LIBERTY's intervention programs that is focused on identifying SDOH for our members. Our community smiles program was developed and is a referral program to connect our members to free and low-cost community resources to address needs such as food insecurity, housing, lack of transportation.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- LIBERTY completed a 365 day look back and reported that from June 2020 to June 2021, there were a total of 40,200 unique searches reported on the Community Smiles program. 35% of all searches were associated with Housing assistance, where roughly 20% of searches were associated with Health/Dental concerns and 19% were associated with Food/Food Delivery assistance. LIBERTY was also able to identify that the top 5 counties utilizing the search program were Miami Dade, Orange, Hillsborough, Duval, and Broward.

c. Identify any barriers to implementing initiatives:

- Although LIBERTY can obtain member input and identifying trends that are sourced from its Community Smiles Program, it is 100% reliant on voluntary data and requires the population to list any barriers encountered due to social determinants of health. This presents a barrier to certain members that do not have access or are not able to access our Community Smiles program.

Recommendation

HSAG recommended the following:

- Plans must follow the Agency's direction regarding the measurement periods and report the data in accordance with Agency-defined specifications.
- Plans must address all documentation requirements outlined in the PIP Completion Instructions for each completed step of the PIP process.
- Plans should use quality improvement science tools and processes such as process mapping, failure modes effects analysis, and Plan-Do-Study-Act (PDSA) cycles as part of their improvement strategies.

Response
a. Describe initiatives implemented based on recommendations: • LIBERTY implemented a multistep and multi-department review process to ensure each PIP submission includes all required elements, all Agency-defined specifications, and is inclusive of the correct measurement periods prior to final submission. LIBERTY also utilized various quality improvement science tools such as Plan-Do-Study-Act (PDSA) worksheets as well as Failure Mode Effects Analysis (FMEA) Tables in conjunction to its submission to help support its overall quality improvement strategy.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • LIBERTY has noted that each PIP submission has been reviewed and submitted timely without any issues.
c. Identify any barriers to implementing initiatives: • LIBERTY did not encounter any barriers with implementing the following quality improvement tools and internal review processes for each PIP submission.

Managed Care of North America

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendation
HSAG recommended the following: Plans use active, innovative improvement strategies and interventions that have the potential to directly impact study indicator outcomes for each PIP. The interventions tested should not only address barriers to study indicator data collection but also barriers to delivery and access to care. • Plans must have a process in place for evaluating the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
Response
a. Describe initiatives implemented based on recommendations: • MCNA implements proactive, data-driven, innovative improvement strategies and interventions with the greatest potential to directly impact study indicator outcomes for each PIP. MCNA's interventions are mindful to not only address barriers to study indicator data collection, but also barriers to delivery and access to care. MCNA continues to maintain and optimize work streams for evaluating the performance of each intervention and its impact on the study indicators. Intervention outcomes are reported quarterly to the Quality Improvement Committee (QIC) for feedback and suggestions. In doing so, MCNA affirms a philosophical framework for continual refinement of improvement strategies while determining the effectiveness of a given intervention.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • There were no barriers identified.
Recommendation
HSAG recommended the following: • Plans should seek enrollee input during the PIP process for the identification of barriers in order to better understand enrollee-related barriers toward access to care. Seeking member input may also identify opportunities to improve member experience of care.
Response
a. Describe initiatives implemented based on recommendations: • MCNA seeks enrollee input during the PIP process for the identification of barriers to better understand enrollee-related barriers toward access to care. MCNA's pursuit of enrollee input during the PIP process allows one to identify opportunities to improve member experience of care while gaining a personal insight into barriers toward access to care. MCNA's pursuit of enrollee input is manifested in data mining the AHRQ's Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and MCNA's proprietary Member Satisfaction survey responses. Further, data driven insight is manifested in monitoring dispositions documented via the enterprise member complaint ledger.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: There were no barriers identified.

Recommendation
HSAG recommended the following: • Plans must follow the Agency's direction regarding the measurement periods and report the data in accordance with Agency-defined specifications. • Plans must address all documentation requirements outlined in the PIP Completion Instructions for each completed step of the PIP process. • Plans should use quality improvement science tools and processes such as process mapping, failure modes effects analysis, and Plan-Do-Study-Act (PDSA) cycles as part of their improvement strategies.
Response
a. Describe initiatives implemented based on recommendations: • MCNA's 2021 PIP submission incorporated HSAG's recommendations and followed the Agency's direction regarding the measurement periods and reported the data in accordance with the Agency's defined specifications, addressed the documentation requirement outlined in the PIP instructions, and submitted PDSAs with the PIP document.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • There were no barriers identified.

Appendix G. EQR Technical Report Requirements

Table G-1 lists the required and recommended elements for the EQR technical report, per 42 CFR §438.364 and recent CMS technical report feedback received by states. Table G-1 identifies the page number where the corresponding information that addresses each element is located in the EQR technical report.

Table G-1—EQR Technical Report Elements

	Required Elements	Page Number
1	The state submitted its EQR technical report by April 30.	May 31, 2022 submission extension request acknowledged by CMS.
2	All eligible Medicaid and CHIP plans are included in the report.	2; Appendix A; Appendix B
3	Required elements are included in the report:	
3a	Describe the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity.	5
3b	An assessment of the **strengths and weaknesses of each MCO, PIHP, PAHP and PCCM entity** with respect to (a) quality, (b) timeliness, and (c) access to the healthcare services furnished by each MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR §438.310[c][2]) furnished to Medicaid and/or CHIP beneficiaries. Contain specific recommendations for improvement of identified weaknesses.	Appendix D
3c	Describe how the state can **target goals and objectives in the quality strategy**, under 42 CFR §438.340, to better support improvement in the quality, timeliness, and access to healthcare services furnished to Medicaid and/or CHIP enrollees.	11–12
3d	Recommends improvements to the quality of healthcare services furnished by each MCO.	Appendix D
3e	Provides state-level recommendations for performance improvement.	11–12
3f	Ensures methodologically appropriate, comparative information about all MCOs.	Appendix C
3g	Assesses the degree to which each MCO has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR.	Appendix F
4	Validation of PIPs: A description of **PIP interventions** associated with each state-required PIP topic for the current EQR review cycle, and the following for the validation of PIPs: **objectives, technical**	

	Required Elements	Page Number
	methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.	
4a	**Interventions.**	77–81
4b	• **Objectives.**	101
4c	• **Technical methods of data collection and analysis.**	Appendix C, 101–103
4d	• **Description of data obtained.**	66; 101–102; Appendix E
4e	• **Conclusions drawn from the data.**	91–92
5	Validation of performance measures: A description of **objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.**	
5a	• **Objectives.**	36
5b	• **Technical methods of data collection and analysis.**	Appendix C, 99–101;
5c	• **Description of data obtained.**	36; 38–58 Appendix C, 99–101
5d	• **Conclusions drawn from the data.**	58–63
6	Review for compliance: 42 CFR §438.358(b)(1)(iii) (cross-referenced in CHIP regulations at 42 CFR §457.1250[a]) requires the technical report include information **on a review, conducted within the previous three-year period**, to determine each MCO's, PIHP's, PAHP's or PCCM's compliance with the standards set forth in Subpart D and the QAPI requirements described in 42 CFR §438.330. Additional information that needs to be included for compliance is listed below:	
6a	• **Objectives.**	26
6b	• **Technical methods of data collection and analysis.**	24–34
6c	• **Description of data obtained.**	24–34
6d	• **Conclusions drawn from the data.**	35
7	**Each remaining activity** included in the technical report must include a **description of the activity** and the following information:	
7a	• **Objectives.**	NA
7b	• **Technical methods of data collection and analysis.**	NA
7c	• **Description of data obtained.**	NA
7d	• **Conclusions drawn from the data.**	NA