Florida Medicaid

Managed Care
Quality Assessment and Improvement Strategies

2011/2012 Update

Agency for Health Care Administration

Florida Medicaid's quality assessment and improvement strategies reflect a deliberate and systematic approach to planning, designing, assessing, measuring, monitoring and continuously improving the quality of the consumer health care delivery system in Medicaid managed care organizations and prepaid in-patient health plans.

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I. Introduction

A. Overview

Florida's Vision for Quality

> *The Agency for Health Care Administration ensures high quality health care is available to all Medicaid managed care enrollees. The Agency's quality strategies permeate the entire managed care system and move health plans toward higher quality and value in clinical and administrative practices.*

The Florida Medicaid program was created in 1970, and currently covers approximately 3.1 million Floridians. Although initially crafted as a medical care extension for persons who received federally funded cash assistance, during the 42 years the program has operated, the State has exercised options as they became available under federal law to expand Medicaid coverage to categorically related groups in addition to mandatory categorically needy eligibility groups. Further, the State also receives federal matching funds to provide certain optional services, and has sought and received federal waivers to provide services through home and community based programs for individuals who otherwise might be institutionalized.

Medicaid managed care in Florida originated in 1981, when the Palm Beach County Public Health Unit began operating Florida's first Medicaid managed care plan. In 1984, the Health Care Financing Administration (HCFA) selected Florida as one of five states to receive a grant to implement a demonstration program. Between 1984 and 1990, eligible Medicaid recipients were provided with the opportunity to enroll in Medicaid Health Maintenance Organizations (HMOs). Since Medicaid HMOs were not available statewide, many areas of the State were initially left uncovered. In response, Florida developed a primary care case management (PCCM) program as an alternative strategy to expand managed care throughout the state and to provide Medicaid recipients with another managed care option.

The State submitted its original 1915(b) waiver proposal to HCFA (now known as the Centers for Medicare and Medicaid Services, or CMS) in March 1989; it was approved in January 1990. The initial 1915(b) waiver allowed for the implementation of the Medicaid Physician Access System (MediPass), designed as a managed care alternative for Florida Medicaid recipients. Since the first submission, the 1915(b) waiver has evolved into a variety of managed care plans including Managed Care Organizations (MCOs), PCCM Programs, Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs). In general, the State has created a menu of managed care options in which an individual may enroll (HMO, PCCM, Provider Service Network (PSN), Children's Medical Services, etc.). The State has also created special programs specifically for individuals enrolled in MediPass, including the Prepaid Mental Health Plans (PMHPs) and the Disease Management Program.

In June 2002, the U.S. Department of Health and Human Services issued the final rules implementing provisions related to Medicaid managed care enacted by the Balanced Budget Act of 1997 (BBA). These rules required changes in Medicaid managed care contracts and states' quality assessment and improvement strategies.

In 2006, in two geographic areas of the state, Florida embarked on a demonstration project with authority from an 1115 research and demonstration waiver referred to as Medicaid Reform.

This project encourages individual choice of health plan networks, emphasizes personal responsibility for health, and rewards healthy behaviors. The initial waiver period was July 1, 2006 through June 30, 2011. In December 2011, Federal CMS approved the State's three-year waiver extension request, extending the demonstration through June 30, 2014.

During the 2011 Florida Legislative session, the Florida Legislature passed legislation to expand managed care in the Florida Medicaid program. This legislation created the Statewide Medicaid Managed Care (SMMC) program with two components: the Managed Medical Assistance (MMA) program and the Long-Term Care (LTC) managed care program. The MMA program will provide primary and acute medical assistance and related services; and the LTC managed care program will provide long term care services including home and community based services using a managed care model. Implementation of the SMMC program will begin July 1, 2012, with full implementation of the LTC and MMA programs by October 1, 2014.

The Agency will competitively procure health plans (managed care organizations and prepaid inpatient health plans) to provide MMA and LTC services in each of the 11 regions through an Invitation to Negotiate (ITN). The legislation established criteria for preference in reviewing ITN respondents, including accreditation by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body; experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations; availability and accessibility of primary care and specialty physicians in the provider network; establishment of community partnerships with providers that create opportunities for reinvestment in community-based services; commitment to quality improvement; provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes; and documentation of policies for preventing fraud and abuse. An Invitation to Negotiate (ITN) and model contract for LTC Managed Care was issued by the Agency on June 29, 2012.

With the majority of Florida's Medicaid population enrolled in some form of managed care, it is important to build appropriate quality management and improvement practices into managed care contracts and the state's oversight responsibilities. This document is a Quality Assessment and Improvement Strategies (QAIS) update and contains details regarding the significant steps the state has taken, along with its health plan partners and External Quality Review Organization (EQRO), to improve the quality of health care delivered to Medicaid managed care enrollees by MCOs and PIHPs in State Fiscal Year 2011-2012. The document also outlines future plans to continue this improvement process.

Table A provides a list of the MCO and PIHP contracts operated under the Florida Medicaid Program.

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Table A Florida's MCOs & PIHPs June 2012			
Plan Type	**Waiver Authority**	**Number of Contractors**	**Type of Contract**
Managed Care Organizations			
Non-Reform HMOs	1915(b) Managed Care Waiver	18 Contractors	Model Contract
Medicaid Reform Prepaid Health Plans (Includes HMOs, Prepaid PSNs, EPOs & other Licensed Insurers)	1115 Medicaid Reform Waiver	9 HMO Contractors	Model Contract
Non-Reform Prepaid PSNs	1915(b) Managed Care Waiver	2 Contractors	Model Contract
Prepaid Inpatient Health Plans			
Nursing Home Diversion Plans (Includes: HMOs and Other Qualified Providers)	1915(a) Authority and 1915 (c) Home & Community Based Waiver	9 HMO and 9 Other Qualified Provider Contractors	Model Contract
Non-Reform Fee-for-Service PSNs	1915(b) Managed Care Waiver	4 Contractors	Model Contract
Medicaid Reform Fee-for-Service PSNs	1115 Medicaid Reform Waiver	4 Contractors	Model Contract
Prepaid Mental Health Plans (including Specialty Child Welfare Prepaid Mental Health Plan)	1915(b) Managed Care Waiver	6 Prepaid Mental Health Contractors	PMHP contracts are structured differently as they were competitively procured at different times.
Statewide Inpatient Psychiatric Programs	1915(b)(4) SIPP Waiver	14 Contractors	Model Contract

B. Process for Obtaining Enrollee & Stakeholder Input

Background

Since 1995, the state has held periodic public meetings with key stakeholders (i.e., enrollees, other state agencies, advocates, and representatives from managed care industry) to obtain input and public comment on Florida Medicaid's managed care programs. In conjunction with the meetings, Florida Medicaid established a quality improvement workgroup in 2003, which was designed to build partnerships among stakeholders, obtain stakeholder input, and build consensus on the state's QAIS as well as increase stakeholders' understanding of the requirements of the Balanced Budget Act of 1997 for Medicaid managed care plans.

In addition to the public meetings, Florida Medicaid held a conference call in March of 2003 with CMS regional and central office to discuss our QAIS and to identify states and contracts to serve as "models" for Florida's efforts. CMS stressed that common elements exist in all successful programs that include developing and maintaining a good working relationship with the managed care industry and staff dedicated to implementing and maintaining a quality improvement process. Active participation, communication, and dedication are key elements in all phases of development and maintenance of a quality improvement program to ensure enrollees have access to quality health care in managed care programs.

Based on several additional conversations with CMS, the state researched the quality improvement programs in Massachusetts, Missouri, New Jersey, New York, and Rhode Island. Additional states that were reviewed include Maryland, Michigan, Oregon and Texas. Most of these states evaluate plan performance based on a combination of HEDIS (Healthcare Effectiveness Data and Information Set) and CAHPS (Consumer Assessment of Healthcare Providers and Systems) data. Some states also include the results of on-site reviews. Each uses a Peer-Review Organization (PRO) or PRO-like EQRO evaluation as well.

Starting in the summer of 2004, the State began holding public meetings with stakeholders (i.e., enrollees, advocates, other state agencies, and representatives from the managed care industry) to obtain input and public comment on reforming Florida Medicaid. The state incorporated public comment and input on quality improvement among other items into Florida's Section 1115 Medicaid Reform Waiver application which received final approval from CMS on October 19, 2005. The Florida Medicaid program has continued to hold public meetings to obtain input and public comment from stakeholders on Florida's 1115 Medicaid Reform Waiver. The list of the Florida Medicaid Reform public meeting dates including meeting materials is located on the Florida Agency for Health Care Administration's website at:

http://ahca.myflorida.com/Medicaid/medicaid_reform/meetings.shtml

With the implementation of Florida's 1115 Medicaid Reform Waiver, the state established an internal Quality and Performance Standards Team to review and revise Florida Medicaid's standards, policies, and procedures related to quality in managed care. The team was comprised of key staff members who are responsible for the development and maintenance of the various components of the state's managed care program. In October 2006, the team held two workshops that were open to the public to discuss performance measures for the managed care plans and solicit feedback and recommendations from stakeholders. Stakeholders were asked to submit suggestions for health plan performance measures to the Agency and the Quality and Performance Standards Team reviewed and considered these suggestions in developing the list of performance measures that health plans are required to report.

Also established for the purpose of the 1115 Medicaid Reform Waiver was a Continuous Improvement Team. This team organized and conducted public forums in the counties of the demonstration project to obtain feedback on specific aspects of the program. The Continuous Improvement Team gathered input from enrollees, providers and health plans through public meetings on what aspects of managed care, as provided under the 1115 Medicaid Reform Waiver, are working and what areas may need improvements. Public meetings were held to obtain feedback on authorizations and claims processing, lessons learned from the PSNs and HMOs and the Medicaid Encounter Data System. Participants were comprised of providers, advocates, legislative staff, and other managed care stakeholders. The team concluded its work in 2008. The state has used feedback gathered in the meetings as part of its continual quality improvement processes.

During calendar year 2010, the state established an internal Value-Based Purchasing Team, which gathered input from health plans through workshops, conference calls, and in writing regarding how to incentivize plans and providers to improve quality and how to reward high-performing health plans.

Current Formal Process & Methods

The process and method used for gathering input from enrollees and stakeholders on quality assessment and improvement standards in managed care includes: public meetings and workshops, focus groups, conference calls, and advisory panel meetings. The primary focus of past public meetings and workshops was to provide information and obtain input on managed care as provided under the 1115 Medicaid Reform Waiver. However, many issues and improvements suggested were applicable to Florida's entire Medicaid managed care program. The state used the input gathered during these public meetings, relevant to quality assessment and improvement standards, to strengthen the MCO and PIHP quality contract provisions for all MCO and PIHP contracts operated by the state. The state also used the public input to strengthen the state's internal quality assessment and improvement processes with the development of the Quality and Performance Standards Team and the Continuous Improvement Team. A more detailed description of the public process used to gather stakeholder input is provided below in items 1 through 4.

1. Public meetings with the Medicaid Reform Technical Advisory Panel (TAP), as specified in s. 409.91211(7)(a), Florida Statutes, advise the state in the areas of risk-adjusted-rate setting, benefit design, and choice counseling. The panel membership includes representatives from the Florida Association of Health Plans, Provider Service Networks, Office of Insurance Regulation, and a Medicaid consumer representative. The TAP meetings are open to the public. Meeting materials for these meetings may be viewed at the following site:

   http://ahca.myflorida.com/Medicaid/medicaid_reform/tap/tapmeetings.shtml

2. The Agency conducts monthly Technical and Operational Issues conference calls with managed care providers on various managed care issues.

3. As part of its contract with the state, Florida's EQRO, Health Services Advisory Group, holds quarterly meetings with health plan representatives (from HMOs, PSNs, PMHPs, Nursing Home Diversion Plans (NHDPs), and Statewide Inpatient Psychiatric Programs (SIPPs)) to discuss on-going EQRO activities and provide technical assistance as needed in areas of health care quality.

4. The QAIS is posted on the Florida Medicaid website with an email link requesting comments from interested parties.

   http://ahca.myflorida.com/Medicaid/quality_mc/index.shtml

Public Process for Obtaining Input on SMMC

In June 2011, after legislation was passed that created the Statewide Medicaid Managed Care program, the Agency provided public notice in the Florida Administrative Weekly regarding a series of 3-hour public workshops to be held across the state regarding the new legislation. The

3-hour public workshops were held in the 11 Medicaid regions beginning on June 10 and ending June 17, 2011. The public workshops included an overview of the new legislation and included information on:

- What happens before implementation
- Medicaid vs. Medicare
- Evolution of Florida Medicaid delivery systems
- Key points of 2011 legislation
- Why changes are needed
- What statewide Medicaid managed care does not include
- When changes will happen
- Where the program will be implemented
- Who will participate
- Who may volunteer to participate
- What will not participate
- What kinds of health plans can participate
- What to expect
- Timeline of recipient plan choice
- Public input and program improvements
- How to get more information
- How to submit comments

A total of 1,785 people attended the workshops across the state and 348 attendees provided verbal comments during the workshops. Written comments were also accepted at the workshops, via email to an email box that the Agency set up specifically for comments regarding SMMC, and via regular mail to the Agency. As of July 29, 2011, the Agency had received a total of 586 written comments. The majority of verbal and written comments were regarding: health plan quality; confusion regarding participation; network adequacy; appropriate levels of care in Long Term Care; cost sharing requirements; participation by Aging Networks; concern about covered services; hospital systems; and the timeline for implementation. The Agency has continued to solicit comments regarding SMMC through the dedicated email box and regular mail.

The legislation creating SMMC also required the Agency to establish a Long-term Care Managed Care Technical Advisory Workgroup. The purpose of the workgroup was to assist in developing:

- The method of determining Medicaid eligibility pursuant to s. 409.985(3), Florida Statutes (F.S.).
- The requirements for provider payments to nursing homes under s. 409.983(6), F.S.
- The method for managing Medicare coinsurance crossover claims.
- Uniform requirements for claims submissions and payments, including electronic funds transfers and claims processing.
- The process for enrollment of and payment for individuals pending determination of Medicaid eligibility.

The workgroup first met in July 2011 and continued to meet until all recommendations were made, as determined by a consensus vote of workgroup members. The final workgroup meeting was in April 2012.

Additional Information Gathering for SMMC

In addition to obtaining input through the public process described above, the Agency pursued fact-finding discussions with other states and released two Requests for Information (RFIs) to solicit information on approaches to managed care. Agency staff met and/or corresponded with Medicaid staff in Tennessee and Arizona to learn more about the approach to, administration of, and quality standards for their managed care programs. The Agency released two RFIs on the state's Vendor Bid System, one in December 2011 (focused on Long-term Care managed care) and one in July 2012 (focused on Managed Medical Assistance managed care). The RFIs sought information from entities with direct experience in the managed care and long term care industries about best practices and innovations in business models and service delivery for the Medicaid managed care population.

The RFIs may be viewed at the following links:

LTC RFI:
http://myflorida.com/apps/vbs/vbs_www.ad.view_ad?advertisement_key_num=97890

MMA RFI:
http://myflorida.com/apps/vbs/vbs_www.ad.view_ad?advertisement_key_num=102069

C. Strategy Objectives

The priority of the state is to ensure access to quality health care for managed care enrollees and to utilize partnerships between the Agency, its sister agencies (e.g., the Department of Elder Affairs (DOEA), Department of Health (DOH), and Department of Children and Families (DCF)), enrollees, the state's External Quality Review Organization (EQRO), and health plans to improve access, quality, and continuity of care. Florida Medicaid fosters the partnerships for quality improvement through regular meetings with stakeholders, including managed care programs, advocacy groups, and enrollees.

The goals and objectives of Florida's Medicaid managed care programs are:

- To promote quality standards of health care within managed care programs by monitoring internal/external processes for improvement opportunities and to assist the managed care plans with the implementation of strategies for improvement.
- To ensure access to quality health care through contract compliance within all managed care programs in the most cost-effective manner.
- To promote the appropriate utilization of services within acceptable standards of medical practice.
- To coordinate quality management activities within the state as well as with external customers.
- To comply with state and Federal regulatory requirements through the development and monitoring of quality improvement policies and procedures.

The Agency has contracted with Health Services Advisory Group (HSAG) as its EQRO since State Fiscal Year (SFY) 2006-2007. The state's MCO and PIHP contracts require the entities to

be subject to annual, external independent review of the quality outcomes, timeliness of, and access to the services covered in accordance with 42 CFR 438.204. The state's EQRO, in compliance with section 1932(c)(2) of the Social Security Act and 42 CFR 438 Subpart E, conducts an annual, independent, external quality review of the outcomes and timeliness of, and access to the services delivered under each MCO and PIHP contract in Florida. The term of the state's contract with HSAG is May 11, 2006 through December 31, 2012. During SFY 2010-11 and SFY 2011-12, the state's EQRO was responsible for the following seven key categories of annual activities:

1. Validation of Performance Improvement Projects (PIPs)
2. Validation of performance measures
3. Review of compliance with access, structural and operations standards
4. Strategic HEDIS Analysis Reports
5. Technical assistance (upon request) related to validation of PIPs, development of performance measures, compliance interviews and related activities, and network adequacy and capacity standards
6. Information dissemination and education
7. Technical report

Each year, HSAG produces an External Quality Review Technical Report for the Agency covering the previous state fiscal year. The report includes: a description of the scope of the EQRO's activities during the state fiscal year; MCO- and PIHP-specific findings regarding the quality and timeliness of, and access to, care and services; and recommendations to the Agency to improve MCO and PIHP compliance with BBA requirements and to improve the quality and timeliness of, and access to, services provided to Florida Medicaid managed care enrollees. The final version of the Technical Report is typically released in October of each year. At the time of this QAIS update, the Technical Report for SFY 2010-11 is the most recent report available.

D. Measurable Goals to Allow an Annual Evaluation

The goal of the state is to develop a model, through the use of performance measure thresholds and benchmarks, to move the entire Florida Medicaid managed care system toward higher quality. Each year, the state will measure the MCOs' and PIHPs' progress within the parameters set forth for this model to evaluate the success of the state's QAIS.

In 2008, the state received the first submission of performance measure data. The Agency subsequently adopted a comprehensive performance improvement strategy with the intent of moving the HMOs and PSNs to a goal of the 75th percentile as listed in the National Committee for Quality Assurance's (NCQA) National Means and Percentiles for Medicaid plans for all Healthcare Effectiveness Data and Information Set (HEDIS) measures.

The performance measure sanction strategy in the 2009-2012 HMO and PSN contracts will be applied to the health plans' performance measure submissions for calendar year 2011, which were submitted to the Agency in July 2012. The key provisions of the sanction strategy are as follows:

- Each performance measure (PM) will be assessed a score based upon its ranking relative to the national percentiles. A 7 point scoring system will be used (0-6).
- The PMs will be placed into PM groups comprised of similar PMs. The PM groups will receive an average PM group score. The PM groups are: Mental Health and Substance Abuse; Well-Child; Prenatal/Postpartum; Chronic Care; Diabetes; and Other Preventive Care.
- Health Plans are required to develop and submit Performance Measure Action Plans (PMAPs) for any HEDIS measures where the plan's score falls below the 50th national percentile. PMs will only be included in determinations of sanctions after the health plan has developed and implemented a PMAP and operated under it for at least one full year.
- For the 2012 performance measure submission, PM group sanctions will be assessed for PM group scores that fall below the equivalent of the 40th national percentile (calculated as a midpoint between the 25th and 50th national percentiles). A health plan may be sanctioned up to $10,000 per PM group score that falls below the 40th national percentile.
- Individual measure sanctions for measures in the Mental Health and Substance Abuse, Chronic Care, and Diabetes groups may be applied if the health plan's rate falls below the equivalent of the 10th national percentile.

Currently the performance improvement and sanction strategies for performance measures are limited to HEDIS measures that are reported by HMOs and PSNs. The Agency is reviewing the Agency-defined performance measure data that are submitted to the Agency by HMOs, PSNs, NHDPs, PMHPs, and SIPPs in order to determine an appropriate performance improvement strategy and sanction strategy for measures for which there are no comparable national benchmarks.

As the full strategy for performance measures is finalized, the state will move forward with incorporating other quality metrics into the overall system evaluation. Likely candidates for inclusion are quality metrics related to compliance reviews, Performance Improvement Projects (PIPs), and encounter data.

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II. Assessment

During SFY 2011-2012, the state assessed the performance of MCOs and PIHPs based on reviews of contract compliance, PIPs, and performance measures. As the Agency's validation of and analyses with encounter data evolve, quality metrics related to and generated from encounter data will be included as well.

A. Quality and Appropriateness of Care and Services

Procedures related to Race, Ethnicity, and Primary Language

The state's Florida Medicaid Management Information System (FMMIS) includes nine separate race codes and 28 available language codes. The system is able to carry two race codes and a separate ethnicity code for each enrollee, if those data fields are provided by the source (DCF, Social Security Administration, or Florida Healthy Kids Corporation). While 28 language codes are already included, the language code table may be modified to include additional language codes.

Race, ethnicity, and primary language (as available) are provided to MCOs and PIHPs for their enrollees. The state requires that MCOs and PIHPs participate in Florida's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. MCOs and PIHPs are required to make all written material available in English, Spanish, and all languages in a plan's service area spoken by approximately five percent (5%) or more of the total population. Upon request, plans must provide, free of charge, interpreters for potential enrollees or enrollees whose primary language is not English.

Enhancements and changes to how race, ethnicity, and primary language are captured in the state's systems are anticipated in the near future. DCF, the state agency that determines Medicaid eligibility, has issued an ITN for its information system. As directed by the legislature, the Agency for Health Care Administration has hired a vendor to conduct a feasibility study to provide recommendations on enhancing or replacing DCF's information system. The final study is to be presented in September 2012. Florida Healthy Kids Corporation is also replacing its Title XXI KidCare Third Party Administrator and system in 2013. These changes and new data collection requirements being developed at the federal level will impact how race, ethnicity, and primary language are captured in the Medicaid enrollment application and eligibility and payment systems.

External Quality Review Activities

States are required to have an EQRO validate PIPs, validate performance measures, and review the state's compliance with access, structure, and operations standards on an annual basis. The EQRO must report on its activities each year in a Technical Report. In addition to these mandatory activities, the Agency has had HSAG perform several optional activities, including strategic HEDIS analysis reports, technical assistance, and information dissemination and education. The annual EQR Technical Report compiles data from the EQRO's activities during the year and draws conclusions related to the quality and timeliness of, and access to, care provided by the state's MCOs and PIHPs. The Agency uses the Technical Report, as well as the EQRO's activity-specific reports, as a resource for assessing health plan performance

and quality improvement. More specific details regarding HSAG's findings are provided in the Improvement section of the QAIS.

Encounter Data

The Agency is required to capture medical services encounter data for all Medicaid covered services in compliance with Title XIX of the Social Security Act, the BBA, 42 CFR 438, and Chapters 409 and 641, F.S. In addition, Section 409.91211(3)(p), F.S., requires a risk-adjusted methodology be a component of the rate setting process for capitated payments to the HMOs and PSNs in the 1115 demonstration. Risk adjustment was phased in over a period of three years, using the Medicaid Rx (MedRx) model.

The Agency is actively working toward using encounter data to assess the quality and appropriateness of care and services. The Agency has undertaken a statistical analysis initiative (using discriminant classification) for monitoring the association between medical services and pharmacological treatments within clinical practice guidelines. This follows the HEDIS measures which are coupled with managed care populations having targeted conditions. Preliminary results for two measures related to Chronic Obstructive Pulmonary Disease (COPD) and Asthma have been completed and are under review. The analyses are being replicated to look at managed care statewide, in and outside of the 1115 demonstration, for SFY 2010-2011 and subsequent years. The Agency is also considering how encounter data may be used to assess quality of care through the Agency for Healthcare Research and Quality's (AHRQ) Prevention Quality Indicator measures.

The Agency has also developed a methodology using encounter data to analyze specialty care and used the methodology to produce baselines for three types of specialty care: orthopedics, neurology, and dermatology. The Agency plans to use the analyses to initiate an encounter data performance improvement project focusing on specialty access. The project will measure health plans' specialty care access and common encounter data transaction errors. The error analysis will be used to improve data quality moving forward.

B. The Level of Contract Compliance of MCOs and PIHPs

Florida's Medicaid managed care programs are required to be in compliance with all Federal and state laws and regulations, as applicable, including: quality assessment and improvement requirements in Title XIX of the Social Security Act; Title 42 CFR 438; procurement requirements for managed care contracts in Title 45 CFR 95, Title 42 CFR 433 Subpart D, Title 42 CFR 447 and Title 42 CFR 434; and in accordance with the privacy requirements in Title 45 CFR Part 160 and 164 Subparts A and E; along with contract and program requirements such as those listed below:

1. Availability and accessibility of services, including emergency and post stabilization of services
2. Coordination and continuity of care
3. Provider selection, credentialing, and re-credentialing
4. Enrollee information
5. Enrollee rights and protections

6. Confidentiality and accuracy of enrollee information
7. Enrollment and disenrollment
8. Grievance systems
9. Subcontractual relationships and delegation
10. Practice guidelines
11. Health information systems
12. Mechanisms to detect both under and over utilization of services
13. Quality assessment and improvement
14. Utilization management
15. Member services
16. Provider services
17. Record keeping
18. Access standards
19. Data availability, accuracy, and reporting

Details on the contract requirements for MCOs and PIHPs are available in Attachment I. The attachment includes descriptions of the requirements and provides references to the contract provisions for each MCO and PIHP type previously listed in Table A.

Agency staff review health plan compliance through on-site surveys and desk reviews. On-site surveys may include reviews of: services; marketing/community outreach; utilization management; quality of care; provider selection; provider coverage; provider records/credentialing; claims processes; grievances and appeals; and financials. Desk reviews are conducted of health plan provider networks; financial reports; medical, behavioral health, and fraud and abuse policies and procedures; quality improvement plans; disease management program materials; and member and provider materials and handbooks. Agency plan analysts also review complaints, grievances, and appeals that are related to the MCOs and PIHPs.

HSAG, the state's EQRO, has developed a compliance database and contract review tool for Agency staff to use to assess MCO and PIHP compliance with state and federal standards. HSAG has refined the contract review tool based on recommendations and suggestions from Agency staff. The tool has been used in on-site surveys for over a year, and HSAG continues to make refinements based on feedback from Agency staff.

<u>Compliance Reviews</u>

HSAG evaluates the Agency's compliance monitoring process and recommends additions or revisions to the process to align the review with federal standards and guidelines. In its Technical Report for SFY 2010-11, HSAG noted that the Agency has significantly enhanced its overall monitoring of compliance review activities to align with CMS protocols for monitoring MCOs and PIHPs. Agency staff for HMOs, PSNs, and PMHPs have developed and refined comprehensive compliance monitoring tools, file review tools, and checklists to assess MCO and PIHP compliance with state and federal standards. HSAG reported that DOEA staff

identified and addressed specific standards within the BBA to be added to DOEA's compliance monitoring of the NHDPs.

As part of its technical assistance to the Agency, HSAG recommended that Agency staff for HMOs, PSNs, and PMHPs complete a full review of all access, structure, and operations standards over a three-year review cycle. The Agency adopted this recommendation, so Agency staff are reviewing one-third of the standards each year. Reviewing standards allows reviewers to determine if the MCOs and PIHPs developed, maintained, and operationalized policies, procedures, and protocols to ensure appropriate and timely access to quality services for the Medicaid population. In SFY 2010-11, Agency staff working with HMOs and PSNs completed the three-year review for all access, structure, and operations standards. PMHP staff completed the second year of their three-year review cycle.

HSAG's findings regarding compliance reviews during SFY 2010-11 are included in the Improvement section of the QAIS (see Section III). As noted previously, HSAG's report on compliance reviews for SFY 2011-12 is not available at the writing of this update.

Performance Improvement Projects (PIPs)

MCOs and PIHPs are contractually required to develop and implement PIPs to improve the quality of health care in targeted areas. As HSAG notes in the Technical Report, PIPs are a key tool in the MCOs' overall quality strategy and provide the framework for monitoring, measuring, and improving the delivery of health care. Health plans are required to submit their PIPs to Agency staff and to the EQRO each year. HSAG reviews PIPs using the CMS validation protocol and evaluates the technical structure of PIPs to ensure that the MCOs and PIHPs have designed, conducted, and reported PIPs in a methodologically sound manner, meeting all state and federal requirements. HSAG also evaluates the implementation of the PIP to determine how well the plan has improved its rates through effective processes.

HMOs and PSNs are required to perform at least four state-approved PIPs while NHDPs, PMHPs, and SIPPs are required to perform at least two PIPs. Each study/project conducted by a plan must include a statistically significant sample of Medicaid lives. One of the four projects must focus on clinical health care disparities or culturally and linguistically appropriate services. Projects must also focus on clinical care and non-clinical areas. Prior to implementation of PIPs, plans are required to provide notification to the state, including the general description, justification, and methodology for each project and documenting the potential for meaningful improvement. Plans are required to report to the state annually on their PIPs. The reports must include the current status of the project including, but not limited to, goals, anticipated outcomes, and ongoing interventions. For more details on contractual requirements for PIPs, see Attachment I.

HSAG's findings regarding PIPs for SFY 2011-12 are included in the Improvement section of the QAIS (see Section III).

Performance Measures

The state sponsored widespread, significant changes to its performance measure process in 2008 and 2009. Beginning in 2008, Medicaid MCOs were required to submit an expanded set of performance measures to Medicaid, with measures being phased in over three years. This was a new process for the PSNs, which had not previously submitted performance measures.

Table B includes the performance measures that were submitted in July 2011 for calendar year 2010.

Table B
Medicaid Managed Care Performance Measures – HMOs and PSNs

Performance Measure	Measure Type
Adolescent Well Care	HEDIS
Adults' Access to Preventive/Ambulatory Health Services	HEDIS
Ambulatory Care	HEDIS
Annual Dental Visits	HEDIS
Antidepressant Medication Management	HEDIS
BMI Assessment	HEDIS
Breast Cancer Screening	HEDIS
Cervical Cancer Screening	HEDIS
Childhood Immunization Status (Combo 2 and 3)	HEDIS
Chlamydia Screening for Women	HEDIS
Comprehensive Diabetes Care • Hemoglobin A1c (HbA1c) testing • HbA1c poor control • HbA1c control (<8%) • Eye exam (retinal) performed • LDL-C screening • LDL-C control (<100 mg/dL) • Medical attention for nephropathy	HEDIS
Controlling Blood Pressure	HEDIS
Follow-up Care for Children Prescribed ADHD Medication	HEDIS
Follow-Up after Hospitalization for Mental Illness	Agency-Defined
Frequency of HIV Disease Monitoring Lab Tests (CD4 and VL)	Agency-Defined
Highly Active Anti-Retroviral Treatment	Agency-Defined
HIV-Related Medical Visits	Agency-Defined
Immunizations for Adolescents	HEDIS
Lead Screening in Children	HEDIS
Lipid Profile Annually	Agency-Defined
Mental Health Readmission Rate	Agency-Defined
Prenatal Care Frequency	Agency-Defined
Prenatal and Postpartum Care	HEDIS
Pharyngitis – Appropriate Testing related to Antibiotic Dispensing	HEDIS
Transportation Timeliness (TRT)	Agency-Defined
Transportation Availability (TRA)	Agency-Defined
Use of Appropriate Medications for People with Asthma	HEDIS
Use of ACE/ARB Therapy	Agency-Defined
Well-Child Visits in the First 15 Months of Life	HEDIS
Well-Child Visits in the 3-6 Years of Life	HEDIS

Specifications for the Agency-defined measures may be found at the following website:

http://ahca.myflorida.com/Medicaid/quality_mc/index.shtml

HMOs and PSNs are contractually required to report performance measures annually, to submit an attestation that the performance measures report is accurate, and to undergo an NCQA

HEDIS Compliance Audit conducted by an independent, licensed audit organization. HSAG validates the HMOs' and PSNs' performance measures annually using methods that comply with the CMS validation of performance measures protocol. To complete its validation, HSAG combines the findings from the independent audit with additional information collected from the plans.

PMHPs and the Child Welfare PMHP (PMHP) reported four performance measures in SFY 2010-11 (see Table C). Three of the measures were Agency-defined and one was a HEDIS measure. HSAG conducted the validation audits for the PMHPs and Child Welfare PMHP.

Table C
Medicaid Managed Care Performance Measures – PMHPs and Child Welfare PMHP

Performance Measure	Measure Type
Mental Health Utilization – Inpatient, Intermediate, and Ambulatory Services	HEDIS
Follow-up within 7 Days after Acute Care Discharge for a Mental Health Diagnosis	Agency-Defined
Follow-up within 30 Days after Acute Care Discharge for a Mental Health Diagnosis	Agency-Defined
30-day Readmission Rate	Agency-Defined

NHDPs reported four Agency-defined performance measures required by DOEA for SFY 2010-11 (see Table D). The performance measures were developed by HSAG, the Agency, and DOEA. HSAG conducted the validation audits for the NHDPs.

Table D
Medicaid Managed Care Performance Measures – NHDPs

Performance Measure	Measure Type
Disenrollment Rate	Agency-Defined
Retention Rate	Agency-Defined
Voluntary Disenrollment Rate	Agency-Defined
Average Length of Enrollment	Agency-Defined

HSAG's findings regarding performance measure validation and the MCOs' and PIHPs' performance measure results that were reported in SFY 2010-11 are discussed in the Improvement section of the QAIS (see Section III). Calendar year 2011 performance measure results were submitted to the Agency in July 2012 and will be included in the next update to the QAIS.

C. Evolution of Health Information Technology

FMMIS and Encounter Data

In 2008, the state implemented a new Florida Medicaid Management Information System (FMMIS), under contract with a new fiscal agent vendor, EDS, which was then acquired by Hewlett Packard (HP). Features of the new FMMIS include an encounter data system for managed care encounter data and the ability to generate data for pre-programmed quality

measures and utilization metrics. The new FMMIS also offers improved processes and procedures for identifying and transmitting the race, ethnicity, and primary spoken language of MCO and PIHP enrollees.

The state has made significant progress in collecting and reporting managed care encounter data. Analytical measures designed to report the completeness, accuracy, and timeliness of encounter data submissions are currently under development and are being built to accommodate changes accompanying implementation of 5010 X12 standards and the NCPDP D.0 format.

The Agency is preparing existing encounter data to be used in a predictive analysis model designed to determine if MCOs are reliably submitting encounter data. Currently, the model and preliminary results are in the final stages of review within the Agency and incorporate Auto Regressive Integrated Moving Averages (ARIMA) and multivariate statistical analysis. The model analyzes all MCOs using 24 data points (months) and computes predicted encounter volumetrics that are used in trend analyses.

Telemedicine

In 2007, the Children's Medical Services Network (CMS Network), a primary care case management (PCCM) program, implemented telemedicine services for enrollees in order to assure access to specialty services in underserved areas. The CMS Network telemedicine services are provided by approved CMS Network providers to Medicaid children enrolled in the CMS Network statewide. The consulting provider is located at a "hub" site and the enrollee and primary care provider are located at a "spoke" site. The hub sites are limited to Florida's CMS Network offices, academic medical centers, tertiary hospitals, or other sites designated by the CMS Network office. Spoke sites are limited to CMS Network offices or sites designated by the CMS Network office.

Florida Medicaid's Dental Services Handbook has a rule regarding video conferencing between dental hygienists and supervising dentists to deliver oral prophylaxis, topical fluoride application, and oral hygiene instruction. The Agency is also advancing policy to cover telemedicine as a delivery mechanism for certain Medicaid community behavioral health services. A contract amendment was drafted for Medicaid managed care plans to allow for telemedicine for certain behavioral health services. The Agency plans to revise the Medicaid Community Behavioral Health Services Coverage and Limitations Handbook this year to allow for telemedicine. The Agency is revising the Practitioner Services Coverage and Limitations Handbook to include telemedicine policy related to physician consultation services as well.

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III. Improvement

A. Provider Network Verification/Validation

As a result of numerous public forums held in 2007, the state began a validation of provider network files for MCOs and PIHPs operating under Florida's 1915(b) Managed Care Waiver and the 1115 Medicaid Demonstration Waiver. The state received concerns from the public that the accuracy of some of the MCO and PIHP provider network files may contain errors and that these errors could potentially impact enrollees. In response to these concerns, the state required MCOs and PIHPs to submit a certified provider network file. The state then began surveying a sample of providers listed in the provider files to determine if the plan and providers were providing the same information about participation to enrollees.

From March 2008 through March 2009, the Agency administered and conducted eleven monthly provider network validation surveys. Each month, Agency staff pulled a sample of providers across the state, 15 from each health plan, to be surveyed. Additionally, a geographic sample of 117 providers was pulled from each Medicaid Area, one area per month. Medicaid Area Office staff conducted the surveys each month and Medicaid Headquarters staff followed up on any providers who did not confirm participation in the health plan. In the March and April 2008 surveys, 88 percent of the providers confirmed their participation with the health plan from which they were sampled. Beginning with the May 2008 survey, the Agency expanded its follow-up to include all sampled providers who did not complete the survey, not just those who were surveyed and failed to confirm participation with a plan. From May 2008 through March 2009, 97 percent to 100 percent of providers sampled each month were found to have current contracts with the health plans from which they were sampled. The Agency moved to quarterly provider network surveys starting in July 2009, sampling twice as many providers (i.e., 30) from each health plan, stratified by provider type (primary care providers, individual providers, and dentists) where able. The quarterly provider network surveys focused on statewide samples rather than Medicaid Area-focused samples. From July 2009 through May 2010, 95 percent to 98.4 percent of providers sampled each quarter were found to have current contracts with the health plans from which they were sampled. Beginning in SFY 2010-11, the Agency moved to semi-annual surveys. The Agency will use these surveys to continue monitoring the accuracy of the health plans' network files.

As noted in the Assessment section of the QAIS, the Agency has begun exploring how encounter data may be used to assess provider network adequacy. Additionally, the Agency is working with its enrollment broker to develop an automated network verification tool.

B. Performance Measure Improvement Strategy

As noted in the Introduction, initial improvement efforts have been focused on HEDIS measures that are reported by the HMOs and PSNs. For all HEDIS measures where a plan's rate is below the 50th percentile as listed in the NCQA HEDIS National Means and Percentiles for Medicaid plans, plans are required to develop Performance Measure Action Plans. The health plans submit quarterly reports describing their progress with details on the interventions being used to improve care and their performance. Common intervention strategies include enrollee and provider outreach and education, enhanced disease management programs, incentives for

compliance with preventive and routine care, and strengthening the role of quality staff members.

The Agency set the 75th national percentile as the goal for HMOs and PSNs on their HEDIS measures. Through the 2011 submission of performance measures (for calendar year 2010), there has been a steady upward trend for many of the performance measures, though additional progress will be needed to reach the 75th national percentile on all measures. There are several measures where the statewide average results for health plans are very close to or surpass the 75th percentile. For the LDL Screening and Medical Attention for Nephropathy components of the Comprehensive Diabetes Care (CDC) measure, both the Reform and Non-Reform plans are just shy of or above the 75th percentile. For Well Child Visits in the 3rd, 4th, 5th, and 6th years of life, both Non-Reform and Reform plans are within three percentage points of the 75th percentile. For Adult BMI Assessment, Non-Reform plans are just shy of the 75th percentile while Reform plans are above it. On average, Reform plans are also above the 75th percentile for Antidepressant Medication Management (acute) and Follow-up Care for Children Prescribed ADHD Medication (Initiation Phase), and are less than one percentage point below the 75th percentile for Breast Cancer Screening.

The state will continue monitoring the HMOs' and PSNs' performance on HEDIS measures relative to the National Means and Percentiles. As described in the Introduction, the sanction strategy related to HEDIS measures begins with the performance measures that were submitted in July 2012. The plans' progress toward the 75th percentile will be included in the next update to the QAIS.

Performance measure results for the HMOs and PSNs are posted and may be viewed at the following website:

http://ahca.myflorida.com/Medicaid/quality_mc/index.shtml

The state is continuing to work on developing an improvement strategy approach for performance measures that do not have available national benchmarks. This project will include Agency-defined measures for the HMOs and PSNs as well as performance measures for PMHPs and the Child Welfare PMHP, NHDPs, and SIPPs. The EQRO will assist the state with this process.

C. External Quality Review Findings related to PIPs and Performance Measures

During SFY 2011-2012, HSAG validated a total of 150 PIPs across the MCO and PIHP types. In the previous year, 136 PIPs were validated. In addition, HSAG validated selected performance measures reported by the health plans across all model types. The following is a summary of findings for PIPs and performance measures related to quality, access, and timeliness.

HMOs

HSAG reviewed HMO PIPs and performance measures to evaluate the services provided to enrolled members based on quality, access, and timeliness. The HMOs' PIP performance has shown improvement over time. In SFY 2009-10, 22 PIPs were assessed and 50 percent received a Met validation status. Of the 19 PIPs assessed in SFY 2010-11, 68 percent received a Met validation status. In SFY 2011-12, 51 PIPs were assessed and 88 percent of the

evaluation elements received a Met validation status. All Reform and Non-Reform HMOs are required to report performance measures annually to the state. Most of the HMOs have processes in place to support HEDIS performance measure reporting. The Final Audit Reports (FARs) indicated that there were a few of the plans that did not comply with every Information Systems (IS) standard or substandard, but none of the deficiencies resulted in a significant bias to any of the reported rates. With one exception, all of the plans' measures were Reportable, indicating that the plans had sufficient processes in place to collect and aggregate data, and that measure specifications were followed to report valid rates. There was one HMO that received a Not Report designation for its Reform and Non-Reform populations. The auditor indicated three of the measures reported by the HMO were materially biased and that the rates were understated. Though the plan researched the decrease in rates, it could not explain why the rates decreased from the previous year.

PSNs

Overall, the PSNs have demonstrated substantial improvement over time as well. In SFY 2009-10, 33 percent of the PSN PIPs received a Met validation status, while 83 percent received a Met validation status in SFY 2010-11. In SFY 2011-12, HSAG assessed 16 PIPs and 93% of the evaluation elements received a Met validation status. The Agency required all PSNs to report a selected set of HEDIS performance measures as well as Agency-defined measures on an annual basis. HSAG reviewed and validated the audit findings from each health plan's final audit report produced by the licensed auditing organization. While some plans were not fully compliant with all IS standards, the issues did not result in a significant bias to any reported rate. All of the PSNs' performance measures were Reportable.

PMHPs and Child Welfare PMHPs

Overall, the PMHPs and Child Welfare PMHP showed considerable improvement over time for PIPs. In SFY 2009-10, 25 percent of the PIPs received a Met validation status, while 75 percent of the PIPs assessed in SFY 2010-11 received a Met validation status. In SFY 2011-12, 24 PIPs were assessed and 93 percent of the evaluation elements received a Met validation status. For performance measure validation, HSAG conducted the validation activities for the PMHPs and the Child Welfare PMHP. HSAG validated a set of performance measures that AHCA identified and selected for validation. The PMHPs and Child Welfare PMHP all received Fully Compliant audit designations for the three required performance measures. HSAG did not have any issues or concerns with the processes in place to capture data and generate rates. All of the plans understood the measure reporting process, followed the measure specifications, and reported accurate and valid rates.

NHDPs

The NHDPs demonstrated improvement over time in the area of PIP validation. In SFY 2009-10, 13 percent of the PIPs received a Met validation status while in SFY 2010-11, 27 percent received a Met finding. In SFY 2011-12, 32 PIPs were assessed and 78 percent of the evaluation elements received a Met validation status. For performance measure validation, DOEA, in conjunction with the Agency, identified a set of performance measures calculated and reported by the NHDPs for validation. HSAG conducted the validation activities for the NHDPs. All but one of the NHDPs received Fully Compliant designations for the four required performance measures. The NHDPs demonstrated an understanding of the processes by which data are collected and sorted, and how the data are used in performance measure calculation.

SIPPs

In SFY 2010-11, the SIPPs began the Restraint & Seclusion collaborative PIP. The purpose of this PIP was to reduce the use of restraints and seclusion during the members' inpatient stay. Since the SIPPs had been reporting this data prior to SFY 2010-11, the collaborative group determined that the initial PIP submission would report CY 2010 as the baseline. First year results showed that of the 14 PIPs assessed, 14 percent received a Met finding. In SFY 2011-12, 27 PIPs were assessed and 67 percent of the evaluation elements received a Met validation status.

EQRO Recommendations regarding PIPs

In June 2012, HSAG's "Performance Improvement Project Validation Annual Summary Report" for SFY 2011-12 was completed. HSAG made the following recommendations regarding PIPs, which they disseminated to the MCOs and PIHPs. Note that in the recommendations, "MCOs" refers to both MCOs and PIHPs.

- The MCOs that achieved real and sustained improvement through their PIPs should continue to implement effective improvement strategies and monitor the study indicator results for ongoing success.
- The MCOs that did not achieve real and/or sustained improvement in their study indicator results should revisit the causal/barrier analysis process. Based on the causal/barrier analysis results, current interventions should be revised and/or new interventions added.
- The MCOs should prioritize their identified barriers and ensure there is a direct link between each intervention and its associated barrier.
- The MCOs should implement interventions that include system or process changes.
- The MCOs should conduct a "drill-down" type of analysis before and after the implementation of any intervention to determine if any subgroup within the population has a disproportionately lower rate that negatively affected the overall rate. The MCOs should target interventions to the identified subgroups with the lowest study indicator rates, allowing the implementation of more precise, concentrated interventions.
- The MCOs should perform interim evaluations of the results in addition to the formal annual evaluation. Conducting interim measurements and evaluating the results could assist the MCOs in identifying and eliminating barriers that impede improvement. The MCOs should determine if the interventions are having the desired effect or if modifications to current interventions or implementing new interventions are necessary to improve results based on the interim evaluation results.
- The MCOs should verify that all information and results documented in the PIP Summary Form are accurate.
- The MCOs should refer to the PIP Validation Tool and address all Points of Clarification and all Partially Met and Not Met scores in future submissions.
- The MCOs should refer to the PIP Summary Form Completion Instructions to ensure they are addressing all documentation requirements for each applicable evaluation element and activity completed in the PIP Summary Form.

EQRO Recommendations regarding Performance Measures

In January 2012, HSAG's submitted the "2011-2012 Validation of Performance Measures" final report to the Agency. The report contained the following recommendations, which were disseminated to the MCOs and PIHPs.

- HMOs and PSNs could benefit from allocating resources to increase the use of supplemental administrative data. Supplemental data allow plans to use data besides claims and encounters to determine the numerator, optional exclusions, or required exclusions for measures. For plans that are not already doing so, using hybrid reporting to report measures where claims and encounter data are not complete will help to improve performance.
- PMHPs and Child Welfare PMHP should consider adding resources to aid in automating processes to reduce the risk of user error, including performance measure query generation, a query to identify discrepancies in the member discharge dates between systems. Efforts should continue to increase the electronic submission of data from providers.
- Where possible, the NHDPs should continue to work toward the full automation of the performance measure reporting process. All NHDPs should ensure the performance measure processes are fully documented and that data security and storage processes are up-to-date.

D. External Quality Review Findings related to Compliance Review

Annually, the EQRO produces a Review of Compliance with Access, Structure, and Operations Standards report, based on the information the Agency obtains from its compliance review activities. In SFY 2010-11, HSAG reviewed the Agency's review of compliance for HMOs, PSNs, and PMHPs.

HMOs and PSNs

In SFY 2010-11, the Agency reviewed six access, structure, and operations standards for compliance: Case Management/Care Coordination; Utilization Management; Quality Improvement Program; Medical Records; Grievance and Appeals; and Administration and Management. The average compliance scores across HMOs varied from 80 percent for Administration and Management to 99 percent for Medical Records. Overall, HMOs' scores for Quality Improvement Program and Utilization Management were strong as well. Average compliance scores across PSNs varied from 95 percent for Administration and Management to 100 percent for Medical Records. Overall, PSNs' scores were strong for all six standards.

File reviews were also completed for Administrative Staff, Appeals, Care Management/Care Coordination, Denials, Grievances, and Medical Records. The average scores across HMOs ranged from 75 percent for Care Management/Care Coordination to 94 percent for Denials. Average scores across PSNs ranged from 89 percent for Administrative Staff files to 100 percent for Denials.

PMHPs

In SFY 2010-11, Agency PMHP staff completed the second year of a three-year review cycle for all access, structure, and operations standards. Seven standards were reviewed:

Administrative Compliance; Utilization Management; Targeted Case Management; Provider Network/Credentialing/Access to Services; Quality Improvement Program; Grievances and Appeals; and Outreach. The average compliance scores for PMHPs ranged from 74 percent for Network/Credentialing/Access to Services to 95 percent for Grievances and Appeals.

File reviews were completed for Appeals, Denials, Grievances, Case Management, Clinical, Claims, Non-Physician Credentialing, and Physician Credentialing. The average scores across PMHPs ranged from 76 percent for Case Management files to 99 percent for Denials.

E. Other Quality Improvement Initiatives

Since the state's last QAIS update, the Agency has engaged in two new quality improvement initiatives: a Children's Health Insurance Program Reauthorization Act (CHIPRA) Demonstration Grant and an Emergency Department Collaborative initiative that the EQRO is coordinating.

<u>CHIPRA Demonstration Grant</u>

CHIPRA, signed into law in February 2009, is a reauthorization of the 1997 amendment to the Social Security Act that created Title XXI, the Children's Health Insurance Program (CHIP). The CHIPRA legislation creates a broad quality mandate for children's health care and authorizes the Centers for Medicare and Medicaid Services (CMS) to implement health care quality initiatives for both CHIP and Medicaid programs. Section 401(d) of CHIPRA authorizes CMS to award grants to no more than 10 states or combinations of states "to evaluate promising ideas for improving the quality of children's health care" under Medicaid or CHIP, including projects to:

- Experiment with and evaluate the use of quality measures for children's health care (Category A)
- Promote the use of Health Information Technology in measuring and improving children's health (Category B)
- Support and evaluate innovative, provider-based models (medical home) for delivering children's health care (Category C)
- Demonstrate the impact of the model pediatric Electronic Health Record format (Category D)
- Experiment with other means to improve children's health care (Category E)

Florida, as the lead state, and Illinois received a grant award for work in Categories A, B, C, and E totaling nearly $11.2 million for the states to split as needed. The grant was awarded in February 2010 and ends in February 2015. Both states have workgroups comprised of state staff, subject matter experts, private professionals, advocates, stakeholders, and project management.

For Category A, Florida is working to collect, aggregate, and report measures of children's health quality using multiple existing data sources from various children's programs across state agencies. Several of the children's core set measures have been added to the list of required measures for HMOs and PSNs as well. For Category B, the state is ensuring that ongoing statewide health information exchange (HIE) and health IT efforts support the goal of improving child health quality and enhance provider-based systems of care. For Category C, Florida is

providing training and technical assistance to 20 child-serving practice sites to implement practice redesigns and to strengthen these practices' medical home features, particularly for children with special health care needs. Category E activities are being conducted through an existing public-private partnership, the Florida Perinatal Quality Collaborative, which is focused on population-based, data-driven perinatal quality improvement. Numerous stakeholders working on perinatal care in Florida have created a forum for sharing data, experiences from past initiatives, and new ideas to address problems in birth outcomes and infant health.

Emergency Department Collaborative

Beginning in 2011 and continuing through 2012, the EQRO has facilitated an Emergency Department collaborative project. The project, operating in Duval and Broward counties, is a voluntary collaborative project involving health plans and community partners, and is based on a modification of a model developed by the Institute for Healthcare Improvement. The objectives of the collaborative to reduce avoidable emergency department visits include:

- Improving care coordination and quality of care by directing users of the emergency department to the most appropriate care setting;
- Improving the effectiveness and efficiency of a community's health care resources by reducing emergency department visits that do not require an ED level of expertise and resource intensity;
- Promoting meaningful alternatives to emergency department utilization in an effort to build on the relationship between patients and primary care providers;
- Supporting improved communication between primary care providers, health care systems, emergency department providers, community providers, and HMOs/PSNs to facilitate shared patient information resulting in improved continuity of care;
- Establishing a collaborative to reduce avoidable ED visits with the HMO/PSN and work with local stakeholders to identify community-specific initiatives based on established best practices; and
- Implementing initiatives that have been identified by the collaborative.

During the last two quarters of SFY 2011-12, the health plans continued to review their data and identified a number of target groups, referred to as "patient streams," which appear to be high drivers of avoidable emergency department services. An algorithm developed by New York University is used to identify conditions for which an emergency department visit may have been avoided, either through earlier primary care intervention or through access to non-emergency department care settings. Collaborative groups have been developing interventions targeted to the particular issues of each patient stream and are strengthening community partnerships and infrastructure to reduce unnecessary utilization.

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IV. Review of Quality Strategy

A. Periodic Reviews of Quality Strategies

The state will conduct an annual review of the effectiveness of the QAIS during the fourth quarter of each calendar year following receipt and review of the EQRO Technical Report and the annual managed care program reporting.

B. Definition of Significant Change to Quality Strategies

The following events indicate a need for a review of the QAIS that includes gathering of stakeholder input:

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

C. Timeframes for Updating Quality Strategies

The state will update the QAIS on an annual basis.

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V. Achievements and Opportunities

A. Achievements

In the past six years, Florida has made significant progress in improving the quality processes of its managed care system. Infrastructure is now in place to implement and measure the quality of care delivered to Medicaid managed care enrollees. Achievements since the initial quality strategy was developed include:

- Implementation and engagement of the External Quality Review Organization;
- Selection and reporting of HEDIS measures by MCOs and PIHPs;
- Development and reporting of performance measure specifications for MCOs and PIHPs;
- Selection of performance goals and implementation of a performance improvement strategy;
- Maturation of the PIPs with technical assistance from the EQRO;
- Statewide Collaborative PIPs for each MCO and PIHP plan type;
- Implementation of a new fiscal agent system; and
- Implementation of the Medicaid Encounter Data System.

As described in Section III. Improvement, the MCOs' and PIHPs' performance regarding PIPs and many performance measures has improved over time. HSAG has noted that the Agency has significantly enhanced the overall monitoring of compliance review activities. The Agency will continue to work with its partners to move the MCOs and PIHPs to higher quality in clinical and administrative practices.

B. Opportunities – Transitioning to Statewide Medicaid Managed Care: New Medicaid Managed Care Enhanced Accountability and Performance Standards

As the state implements the SMMC program (described in the Introduction), the Agency has established enhanced accountability and performance standards. Some of the new standards are being implemented in the HMO and PSN contracts for the September 2012 – August 2015 period as well. As noted in the introduction, the SMMC program has two key components: the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) Managed Care program. The LTC Managed Care quality strategy is being addressed in a document that will be an attachment to the QAIS. The enhanced accountability and performance standards in the 2012-15 managed care contracts and that are statutorily required for the MMA program are provided below.

General/Transition Requirements

- Requires current health plans to participate in the provision of data and assist the Agency as necessary for the successful transition of enrollees from the current managed care program to the new Statewide Medicaid Managed Care program (SMMC). [September 2012-15 contract requirement]

- Specifies that when the new SMMC program rolls out, the Agency will cease enrolling recipients, voluntary or through mandatory assignment, in the respective roll-out regions covered under the existing health plan's contract. [September 2012-15 contract requirement]
- Requires the ability to transition from ICD-9 codes to the new ICD-10 codes. [September 2012-15 contract requirement]

Preferred Drug List Requirements

- Requires that preferred drug list changes are reviewed and approved by the plan's Pharmacy & Therapeutics (P & T) committee. [July 2012 contract general amendment]
- Requires posting of the plan's preferred drug list on the plan's website and ensuring the list is updated within 24 hours of any change. [Statutorily required 2014 SMMC contract requirement]

Provider Network Requirements

- Requires the establishment of a program to encourage enrollees to establish a relationship with their primary care provider. [Statutorily required 2014 SMMC contract requirement]
- Requires coordination with inpatient and outpatient facilities to ensure that prescribed medications are listed on the plan's preferred drug list or the provider has submitted the appropriate documentation to complete the authorization process for non-formulary drugs. [September 2012-15 contract requirement]
- Ensures that clinical documentation requirements of the Florida Medicaid handbooks are included in behavioral health clinical records. [September 2012-15 contract requirement]
- Requires the use of the Agency's newly created standardized clinical (inpatient and outpatient) and mental health targeted case management tools when reviewing behavioral health provider records. [September 2012-15 contract requirement]
- Requires an annual behavioral health provider audit report to ensure provider records were audited and results were provided to the Agency as well as ensuring that providers were included in the creation of the behavioral health provider audit review schedule. [September 2012-15 contract amendment]
- Requires plans to establish and maintain an electronic database of contracted providers, including licensure or registration information, location and hours of operation, specialty credentials, performance indicators, etc. [Statutorily required 2014 SMMC contract requirement]
- Requires quarterly reporting of the number of enrollees assigned to each primary care provider. [Statutorily required 2014 SMMC contract requirement]
- Requires plans to contract with certain essential providers for at least a year. [Statutorily required 2014 SMMC contract requirement]
- Adds cardiovascular surgery, orthopedics and orthopedic surgery, rheumatology, and physical, respiratory, and speech therapies as pediatric specialist requirements for the provider network. [September 2012-15 contract requirement]
- Requires termination of providers (that were terminated from the Agency) within five calendar days of notice from the Agency (new timeframe specification). [September 2012-15 contract requirement]

- Adds additional provider contract specifications: acknowledgement by the provider of its duty to supervise and be responsible for the service provided and for claims preparation and submission, and to ensure such services were actually furnished and were medically necessary; specifying that failure to cooperate in reviews and audits may result in immediate termination of the contract and requiring providers to comply with the terms of the health plan's provider handbook. [September 2012-15 contract requirement]
- Requires physician compensation to equal or exceed Medicare rates for similar services and requires sanctions for failure to meet this performance requirement after two years of continuous operation. [Statutorily required 2014 SMMC contract requirement]
- Specifies additional handbook requirements regarding procedures for reporting of suspected fraud and abuse. [September 2012-15 contract requirement]

Quality Requirements

- Requires monitoring the quality and performance of participating providers. [Statutorily required 2014 SMMC contract requirement]
- Requires programs and procedures to improve pregnancy outcomes and infant health. [Statutorily required 2014 SMMC contract requirement]
- Specifies that the submission of incomplete or inaccurate performance measure data is considered deficient and is subject to penalties, and provides notice to the plan that the Agency may refer such cases to Medicaid Program Integrity for review. [September 2012-15 contract requirement]
- Requires accreditation within one year of contract execution. [Statutorily required 2014 SMMC contract requirement]

Administration and Management Requirements

- Specifies adequate staffing and information system capability to ensure the ability to manage financial transactions, recordkeeping, data collection and other administrative functions. [September 2012-15 contract requirement]
- Requires compliance with the Agency's reporting requirements for the Medicaid Encounter Data System. In addition, the Agency will fine plans $5,000 per day for each day of noncompliance beginning on the 31st day. The Agency is required to notify the plan on the 31st day that the Agency will initiate contract termination procedures on the 90th day unless the plan comes into compliance. [Statutorily required 2014 SMMC contract requirement]
- Participation in an achieved savings rebate program. [Statutorily required 2014 SMMC contract requirement]
- Specifies that the fraud and abuse compliance plan include a description of the methods for verifying with members whether services billed by providers were received. [September 2012-15 contract requirement]
- Specifies liquidated damages for failure to meet certain contract requirements. [September 2012-15 contract requirement]
- Establishment of a five-year contract. [Statutorily required 2014 SMMC contract requirement]

- Specifies that, upon receipt of a plan's request for termination or withdrawal, the Agency will remove the plan from receipt of new voluntary enrollments, assignments and reinstatements. [September 2012-15 contract requirement]
- Requires financial penalties for plans that leave a region or reduce enrollment levels, including reimbursing the Agency for the cost of enrollment changes and other transition activities. Requires for departing provider service networks, a per-enrollee penalty of up to three months' payment and requires continuation of services for up to 90 days; requires all other plans to pay a penalty of 25 percent of their minimum surplus requirement pursuant to s. 641.225(1), F.S. See s. 409.967(2)(h)1., F.S. [Statutorily required 2014 SMMC contract requirement]
- Requires plans to provide at least 180 days notice before withdrawing from a region. See s. 409.967(2)(h)1., F.S. [Statutorily required 2014 SMMC contract requirement]
- Requires the Agency to terminate a plan's contracts in all regions if a plan leaves a region before the end of the contract term. See s. 409.967(2)(h)1., F.S. [Statutorily required 2014 SMMC contract requirement]

Attachment I
Managed Care Contract Provisions

A. External Quality Review Requirements

As noted in the Introduction, the state's MCO and PIHP contracts require the entities to be subject to annual, external independent review of the quality outcomes, timelines of, and access to, the services covered in accordance with 42 CFR 438.204. The reference to the contract provisions which incorporate this requirement can be found by contract in Table 1.

Table 1
External Quality Review
42 CFR 438 Subpart E

Plan Type	Contract Provision
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section VIII A.1.f, A.5
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Sections 2.4.3 and 2.4.4
PMHP Area 1	Attachment I, Section 2.45
PMHP Areas 2, 3, 4, 8, and 9	Attachment I, Section D.55
PMHP Areas 5 and 7	Attachment D, Section D.56
PMHP Area 6	Attachment I, Section 2.45
PMHP Area 11	Attachment I, Section B.56
Child Welfare Specialty PMHP	Attachment I, Sections D.22 and D.54
Statewide Inpatient Psychiatric Program	Attachment II, Section D.22

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

MCO/PIHP Requirements

1. Availability of Services

The state's MCO and PIHP contracts require the entities to comply with all applicable Federal and state laws, rules, and regulations including but not limited to: all access to care standards in Title 42 Code of Federal Regulations (CFR) chapter IV, subchapter C; Title 45 CFR 95, General Grants Administration Requirements; chapter 409 and as applicable part I and III of chapter 641, Florida Statutes, in regard to managed care. MCO and PIHP access to care contract requirements are summarized in this section. The table following each standard provides the location where this requirement can be found in each of the state's MCO and PIHP contracts.

(a) Maintains and Monitors a Network of Appropriate Providers

The state's MCO and PIHP contracts require each entity to establish and maintain a network of appropriate providers that is sufficient to provide adequate access to all services covered under each entity's contract for the enrolled population in accordance with section 1932(b)(7) of the Social Security Act (as enacted by section 4704(a) of the Balanced Budget Act of 1997). The entities are required to make available and accessible facilities, service locations, service sites,

and personnel sufficient to provide the covered services. The entities are required to provide adequate assurances, with respect to a service area, and demonstrate the capacity to serve the expected enrollment in such service area, including assurances that the entity: offers an appropriate range of services; offers access to preventive and primary care services for the populations expected to be enrolled in such service area; and maintains a sufficient number, mix, and geographic distribution of providers of services. Each entity's network of appropriate providers must be supported by written agreements.

The state requires the MCOs and PIHPs to submit provider network information to enable the state to monitor each plan's compliance with required provider network composition and primary care provider to member ratios, and for other uses the state deems pertinent. The state also reviews and approves plan provider networks to ensure each plan establishes and maintains a network of appropriate providers that is in compliance with 42 CFR 438.206(b)(1) and chapters 409 and 641, F.S. The state conducts the initial provider network review prior to the plan becoming operational and annually thereafter to ensure compliance with all applicable Federal and state regulations.

The state requires the MCOs and PIHPs to furnish services up to the limits specified by the Florida Medicaid program. The plans are responsible for contracting with providers who meet all provider and service and product standards specified in the state's Medicaid Services Coverage and Limitations handbooks and fee schedules and the plans' provider handbooks, which must be incorporated in all plan subcontracts by reference, for each service category covered by the plan. Exceptions exist where different standards are specified elsewhere in the contract or if the standard is waived in writing by the state on a case-by-case basis when the member's medical needs would be equally or better served in an alternative care setting or using alternative therapies or devices within the prevailing medical community. For health plans that operate under the Florida Medicaid 1115 Reform waiver and choose to offer a customized benefit package, the customized benefit package must also meet state standards for actuarial equivalency and sufficiency.

The state requires MCOs and PIHPs to make emergency medical care available on a 24 hours a day, seven days a week basis. The entities are required to assure that primary care physician services and referrals to specialty physicians are available on a timely basis, to comply with the following standards: urgent care - within one day; routine sick patient care - within one week; and well care - within one month. The plans are required to have telephone call policies and procedures that shall include requirements for call response times, maximum hold times, and maximum abandonment rates. The primary care physicians and hospital services provided by the plans are available within 30 minutes typical travel time, and specialty physicians and ancillary services must be within 60 minutes typical travel time from the member's residence. For rural areas, if the plan is unable to contract with specialty or ancillary providers who are within the typical travel time requirements, the state may waive, in writing, these requirements. The plans are required to allow each enrollee to choose his or her health care professional, to the extent possible and appropriate. Each plan is required to provide the state with documentation of compliance with access requirements no less frequently than the following: (a) at the time it enters into a contract with the state; and (b) at any time there has been a significant change in the plan's operations that would affect adequate capacity and services, including but not limited to: (1) changes in plan services, benefits, geographic service area, or payments; and (2) enrollment of a new population in the plan.

The reference to the contract provisions which incorporates the state's MCO and PIHP delivery network requirements can be found by contract in Table 2.

Table 2 **Delivery Network Requirements** 42 CFR 438.206(b)(1)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section VII, A.1, A.2, B.1, F. 1 and 2
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.8.1, b.
PMHP Area 1	Attachment I, Sections 2.2-2.4
PMHP Areas 2, 3, 8 and 9	Attachment I, Sections D.22, D.23, and D.26
PMHP Area 4 and Child Welfare Specialty PMHP	Attachment I, Sections D.23 and D.26
PMHP Areas 5 and 7	Attachment D, Section D. 24, A.1.
PMHP Area 6	Attachment I, Sections 2.2-2.4
PMHP Area 11	Attachment I, Section B.24
Statewide Inpatient Psychiatric Program	Attachment II, Section D.2, C.5.

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

The state requires MCOs and PIHPs to provide female enrollees direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive care services which is in addition to the enrollee's designated source of primary care if that source is not a woman's health specialist. The state requires the entities to offer each member a choice of primary care physicians which includes women's health specialists. The reference to the contract provision which incorporates this requirement can be found by contract in Table 3.

Table 3 **Direct Access to Women's Health Specialist** 42 CFR 438.206(b)(2)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section VII, B.2.c.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	N/A
PMHP, All Areas, and Child Welfare Specialty PMHP	N/A
Statewide Inpatient Psychiatric Program	Attachment II, Section D.12, OO.

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

The state requires each MCO and PIHP to have a procedure for enrollees to obtain a second medical opinion from a qualified health care professional within the network, or arrange for the ability of the enrollee to obtain a second opinion outside the network, and requires the plan to be responsible for payment of such services. The plans are required to clearly state the procedure for obtaining a second medical opinion in the member handbook. In addition, the plan's second opinion procedure is required to be in compliance with section 641.51, F.S., and 42 CFR 438.206(3)(b). The reference to the contract provision which incorporates this requirement can be found by contract in Table 4.

Table 4 Second Opinion Requirement 42 CFR 438.206(b)(3)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section VIII, B.1.a.(3)
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	N/A
PMHP Area 1	Attachment I, Section 2.2
PMHP Areas 2, 3, 4, 8, and 9	Attachment I, Section D.21, C.
PMHP Areas 5 and 7	Attachment D, Section D.22, C.
PMHP Area 6	Attachment I, Section 2.2
PMHP Area 11(FA606 & FA607)	Attachment I, Sections B.22, C.(FA607) and D.21, C. (FA606)
Child Welfare Specialty PMHP	Attachment I, Section D.21, 3.
Statewide Inpatient Psychiatric Program	Attachment II, Section D.12, PP.

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

The state requires MCOs or PIHPs that are unable to provide medically necessary services covered under the contract to a particular enrollee to adequately and timely cover these services outside of the network for the enrollee for as long as the MCO or PIHP is unable to provide them in compliance with 42 CFR 438.206(b)(4). The reference to the contract provision which incorporates this requirement can be found by contract in Table 5.

Table 5 Outside the Network 42 CFR 438.206(b)(4)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section VII, A.7.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.8.2
PMHP Area 1	Attachment I, Section 2.9
PMHP Areas 2, 3, 4, 8, and 9	Attachment I, Section D.27
PMHP Areas 5 and 7	Attachment D, Sections D.27, O. and D.28
PMHP Area 6	Attachment I, Section 2.10
PMHP Area 11	Attachment I, Section B.28
Child Welfare Specialty PMHP	Attachment I, Section D.27
Statewide Inpatient Psychiatric Program	Attachment II, Section D.11, X.

(e) Coordination with Out of Network Providers with Respect to Payment.

The state requires the plans to coordinate with out-of-network providers with respect to payment and to ensure that cost to the enrollee is no greater than it would be if the covered services were furnished within the network. The reference to the contract provision which incorporates this requirement can be found by contract in Table 6.

Table 6 Coordination with Outside the Network Providers 42 CFR 438.206(b)(5)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section V, A.3.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.8.2
PMHP Area 1	Attachment I, Section 2.9
PMHP Areas 2, 3, 4, 8, and 9	Attachment I, Section D.27
PMHP Areas 5 and 7	Attachment D, Section D.27, O.
PMHP Area 6	Attachment I, Section 2.10
PMHP Area 11	Attachment I, Section B.28
Child Welfare Specialty PMHP	Attachment I, Section D.27
Statewide Inpatient Psychiatric Program	Attachment II, Section D.12, RR.

(f) Demonstration of Providers' Credentialing.

The state requires the MCOs and PIHPs to establish and verify credentialing and recredentialing criteria for all professional providers and that, at a minimum, the plan providers meet the state's Medicaid participation standards. The capitated PSNs are required to apply for accreditation, with a state approved accreditation organization, one year after operation as a capitated entity, and within one year of application to become accredited. The state licensed capitated plans are required to be accredited within one (1) year of the organization's receipt of its certificate of authority under part I of chapter 641, Florida Statutes, and to maintain accreditation by an accreditation organization approved by the state, as a condition of doing business in the state. The following are some of the provisions in chapter 641, Florida Statutes, related to licensed capitated plan's provider credentialing:

- Section 641.495 (5), Florida Statutes, provides that the plan shall exercise reasonable care in assuring that delivered health care services are performed by appropriately licensed providers.
- Section 641.495 (6), Florida Statutes, provides that the plan shall have a system for verification and examination of the credentials of each of its providers. The organization shall maintain in a central file the credentials, including a copy of the current Florida license, of each of its physicians.
- Section 641.51(2), Florida Statutes, provides that the plan shall have an ongoing internal quality assurance program for its health care services. The program shall include, but not be limited to, the following:

  (a) A written statement of goals and objectives which stress health outcomes as the principal criteria for the evaluation of the quality of care rendered to subscribers;

  (b) A written statement describing how state-of-the-art methodology has been incorporated into an ongoing system for monitoring of care which is individual case oriented and, when implemented, can provide interpretation and analysis of patterns of care rendered to individual patients by individual providers;

  (c) Written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided; and

(d) A written plan for providing review of physicians and other licensed medical providers which includes ongoing review within the organization.

Prior to contracting, the state reviews the MCOs' and PIHPs' written policies and procedures for credentialing of providers to ensure compliance with all applicable Federal and state regulations. The reference to the contract provision which incorporates this requirement can be found by contract in Table 7.

Table 7 Provider Credentialing 42 CFR 438.206(b)(6)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section VII, H.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.12.4.1, 2.12.4.3
PMHP Area 1	Attachment I, Sections 2.5, B. and 2.19
PMHP Areas 2, 3, 4, and 9	Attachment I, Section D.23, B.
PMHP Areas 5 and 7	Attachment I, Section D.24, B.
PMHP Area 6	Attachment I, Sections 2.5, B. and 2.20
PMHP Area 8	Attachment I, Section D.38
PMHP Area 11	Attachment I, Sections B.24, B(FA607) and D.23, B.(FA606)
Child Welfare Specialty PMHP	Attachment I, Sections D.23, 2. And D.38
Statewide Inpatient Psychiatric Program	Attachment II, Section D.13

(g) Timely Access to Care.

The state requires the MCOs and PIHPs to: (1) meet the state's timely access to care and services, taking into account the urgency of the need for services; (2) ensure that the network of providers offers hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees; (3) make services included in the contract available 24 hours a day, 7 days a week, when medically necessary; (4) establish mechanisms to ensure compliance by providers; (5) monitor providers regularly to determine compliance, and (6) take corrective action if there is a failure to comply. Prior to contracting with an MCO or PIHP, the state assures the plan's ability to comply with Federal and state timely access requirements. The state conducts annual reviews of the plans to ensure on-going compliance with the timely access requirements of chapter 409 and 641, F.S., and 42 CFR 438.206(c). The reference to the contract provisions which incorporate these requirements can be found by contract in Table 8.

The MCOs and PIHPs are required to ensure that appropriate services are available as follows:

- *Emergency* – immediately upon presentation or notification; in addition the plans are required to maintain sufficient medical staff available 24 hours per day to handle emergency care inquiries;
- *Urgent Care* – within one day;
- *Routine Sick Patient Care* – within one week;

- *Well Care* – within one month;
- *Pregnancy Related Care* – Within 30 calendar days of enrollment, the plans are required to advise members of and ensure the availability of, a screening for all members known to be pregnant or who advise the plan that they may be pregnant. The plan shall refer pregnant members and members reporting they may be pregnant for appropriate prenatal care;
- *Health Risk Assessment* – the plans are required to contact each new member at least two times, if necessary, within 90 calendar days of enrollment, to urge scheduling of an initial appointment with the primary care provider for the purpose of a health risk assessment; and
- *Frail/Elderly program enrollees* – the plans are required to contact each new member within five days of enrollment and develop a plan of care. This program is only available through an HMO in Miami-Dade County. The program is funded with 1915(b)(3) savings in the 1915(b) Managed Care waiver.

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

Plan Type	Contract Provision
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section VII. B.1.a.(1) and F.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.8.1, 2.8.5
PMHP Area 1	Attachment I, Sections 2.5, 2.16, and 2.23
PMHP Areas 2, 3, 4, 8, and 9	Attachment I, Sections D.23, A.
PMHP Areas 5 and 7	Attachment D, Sections D.24 A., D.24 A.2.c., D.24 A.2
PMHP Area 6	Attachment I, Section 2.17
PMHP Area 11	Attachment I, Section B.24
Child Welfare Specialty PMHP	Attachment I, Section D.23
Statewide Inpatient Psychiatric Program	Attachment II, Section D.2, C.5

(h) Cultural Considerations.

The state requires the MCOs and PIHPs to participate in Florida's efforts to promote the delivery of service in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The plans are required to assure that appropriate foreign language versions of all materials are developed and available to members and potential members. The plans are required to provide interpreter services in person where practical, but otherwise by telephone, for applicants or members whose primary language is a foreign language. Foreign language versions of materials are required if, as provided annually by the state, the population speaking a particular foreign (non-English) language in a county is greater than five percent.

The state requires the plans to ensure that all marketing, pre-enrollment, member, disenrollment, and grievance materials developed for the Medicaid population adhere to the following policies and procedures, among others:

a. All materials developed for the Medicaid population must be at or near the fourth-grade comprehension level so that the materials are understandable (in accordance with section 1932(a)(5) of the Social Security Act as enacted by section 4701 of the Balanced Budget

Act of 1997), and be available in alternative communication methods (such as large print, video or audio recordings, or Braille) appropriate for persons with disabilities; and

b. The plan shall assure that appropriate foreign language versions of all materials are developed and available to members and potential members. The plan shall provide interpreter services in person where practical, but otherwise by telephone, for applicants or members whose primary language is a foreign language. Foreign language versions of materials are required if, as provided annually by the Agency, the population speaking a particular foreign (non-English) language in a county is greater than five percent.

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

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

Plan Type	Contract Provision
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section IV, A.2., Section VIII, A.4
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Sections 2.8.1, 2.1.1.6 (3)
PMHP Area 1	Attachment I, Sections 1.1 V., 2.14, 2.16
PMHP Areas 2, 3, and 4	Attachment I, Sections D.35, C.
PMHP Areas 5 and 7	Attachment D, Sections D.19, D.20, and D.23 E.b.
PMHP Area 6	Attachment I, Section 2.1
PMHP Area 8	Attachment I, Section D.35, C.
PMHP Area 9	Attachment I, Section D.35, C.
PMHP Area 11	Attachment I, Section B.20, J.
Child Welfare Specialty PMHP	Attachment I, Sections D.23 and D.35, (3)
Statewide Inpatient Psychiatric Program	Attachment II, Sections D.11, Y. and D.12, H. & T.

2. Assurances of Adequate Capacity and Services

(a) Offers an Appropriate Range of Preventive, Primary Care, and Specialty Service.

Prior to contracting with the state, the MCOs and PIHPs are required to submit documentation that demonstrates the plan: (1) offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of enrollees for the service area; and (2) maintains a network of appropriate providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. The plans are required to submit provider network information that is used by the state to monitor the plan's compliance with required provider network composition and primary care provider to enrollee ratios, and for other uses deemed pertinent. The reference to the contract provision which incorporates this requirement can be found by contract in Table 10.

Table 10 Documentation of Adequate Capacity & Services 42 CFR 438.207(b)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section VII, A.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.8
PMHP Area 1	Attachment I, Section 2.5
PMHP Areas 2, 3, 8, and 9	Attachment I, Sections D.20, D.21, D.22
PMHP Area 4	Attachment I, Sections D.20. D.21, D.22
PMHP Areas 5 and 7	Attachment D, Section D.24
PMHP Area 6	Attachment I, Section 2.42
PMHP Area 11	Attachment I, Section B.24
Child Welfare Specialty PMHP	Attachment I, Section D.23
Statewide Inpatient Psychiatric Program	Attachment II, Section D.8

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

The state requires the MCOs and PIHPs to provide the state documentation of compliance with access requirements specified in 42 CFR 438.207(c) that are no less frequent than the following:

a. At the time it enters into a contract with the Agency for Health Care Administration.

b. At any time there has been a significant change in the plan's operations that would affect adequate capacity and services, including but not limited to:

    1. Changes in plan services, benefits, geographic service area, or payments.

    2. Enrollment of a new population in the plan.

If a plan intends to withdraw services from a county, the state requires the plan to provide written notice to its enrollees in that county at least 60 calendar days prior to the last day of service. The notice shall contain the same information as required for a notice of termination according to the contract. The plan is required to provide written notice of the withdrawal to all subcontractors in the county.

The state conducts annual reviews of the plan's network of providers to ensure compliance with Federal and state access to care standards. The reference to the contract provision which incorporates this requirement can be found by contract in Table 11.

Table 11 Sufficient Network of Providers 42 CFR 438.207(c)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section VII, C.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.8.2
PMHP Area 1	Attachment I, Section 2.42
PMHP Areas 2, 3, 8, and 9	Attachment I, Sections D.20 and D.21
PMHP Area 4	Attachment I, Section D.20 and D.21
PMHP Areas 5 and 7	Attachment D, Section D.24
PMHP Area 6	Attachment I, Section 2.5
PMHP Area 11	Attachment I, Section B.24
Child Welfare Specialty PMHP	Attachment I, Section D.23
Statewide Inpatient Psychiatric Program	Attachment II, Section D.12, M.

3. Coordination and Continuity of Care

(a) Ongoing Source of Primary Care

Pursuant to 42 CFR 428.208(b), the state requires the MCOs and PIHPs to implement procedures to ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and whom the plan has formally designated as primarily responsible for coordinating the health care services furnished to the enrollee. The MCOs and PIHPs are required to offer each member a choice of primary care physicians. After making a choice, each member shall have a single primary care physician. The plan shall inform members of the following: (1) their primary care physician assignment, (2) their ability to choose a different primary care provider, (3) a list of providers from which to make a choice, and (4) the procedures for making a change. The reference to the contract provision which incorporates this requirement can be found by contract in Table 12.

Table 12 On-going Source of Primary Care 42 CFR 438.208(b)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section IV, A.3.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Sections 2.1.1.14, 2.1.1.5.
PMHP Area 1	Attachment I, Section 2.8
PMHP Areas 2 and 3	Attachment I, Sections D.21 and D.22
PMHP Area 4	Attachment I, Sections D.21 and D.22
PMHP Areas 5 and 7	Attachment D, Section D.27
PMHP Area 6	Attachment I, Section 2.9
PMHP Area 8	Attachment I, Section D.22
PMHP Area 9	Attachment I, Sections D.22
PMHP Area 11	Attachment I, Section B.24
Child Welfare Specialty PMHP	Attachment I, Section D.23
Statewide Inpatient Psychiatric Program	Attachment II, Section D.12, WW.

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

Pursuant to 42 CFR 428.208(b), the state requires the MCOs and PIHPs to implement procedures to coordinate the services the plan furnishes to the enrollee with the services the enrollee receives from any other managed care entity during the same period of enrollment. The reference to the contract provision which incorporates this requirement can be found by contract in Table 13.

Table 13
Coordination of Services
42 CFR 438.208(b)

Plan Type	Contract Provision
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section VIII, B.2.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.1.1.14 (1) a.
PMHP Area 1	Attachment I, Section 2.8
PMHP Areas 2 and 3	Attachment I, Section D.26
PMHP Area 4	Attachment I, Section D.26
PMHP Areas 5 and 7	Attachment D, Section D.27
PMHP Area 6	Attachment I, Section 2.9
PMHP Area 8	Attachment I, Section D.26
PMHP Area 9	Attachment I, Section D.26, B
PMHP Area 11	Attachment I, Section B.27
Child Welfare Specialty PMHP	Attachment I, Section D.24
Statewide Inpatient Psychiatric Program	Attachment II, Section D.11, E.

(c) Sharing of Identification and Assessment Information to Prevent Duplication of Services for Individuals with Special Health Care Needs.

Pursuant to 42 CFR 428.208(b), the state requires the MCOs and PIHPs to implement procedures to share with other managed care entities serving the enrollee with special health care needs the results of its identification and assessment of the enrollee's needs to prevent duplication of those activities. The reference to the contract provision which incorporates this requirement can be found by contract in Table 14.

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

Plan Type	Contract Provision
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section VIII, B.2.j.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.1.1.14 b.
PMHP Area 1	Attachment I, Sections 2.4, K. and 2.8
PMHP Areas 2, 3, 4, 8, and 9	Attachment I, Section D.22, J.
PMHP Areas 5 and 7	Attachment D, Section D.27, L.
PMHP Area 6	Attachment I, Section 2.9
PMHP Area 11	Attachment I, Section B.23, J.
Child Welfare Specialty PMHP	Attachment I, Section D.22 (7)
Statewide Inpatient Psychiatric Program	Attachment II, Section D.2, C.4.

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

Pursuant to 42 CFR 428.208(b), the state requires the plans to implement procedures to ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR Part 160 and 164 Subparts A and E, to the extent that they are applicable. Pursuant to 42 CFR 438.224 and consistent with 42 CFR 431 subpart F, the state requires, through its contracts, that for medical records and any other health and enrollment information that identifies a particular enrollee, uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable. The references to the contract provisions which incorporate these requirements can be found by contract in Table 15.

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

Plan Type	Contract Provision
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section VII, J.2., Section VIII, B.2.k.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.1.1.14 a.
PMHP Area 1	State Standard Contract, Item R and Attachment IV
PMHP Areas 2, 3, 6, 8, 9, and 11	State Standard Contract, Item R
PMHP Area 4	State Standard Contract, Item S
PMHP Areas 5 and 7	State Standard Contract, Item S
Child Welfare Specialty PMHP	State Standard Contract, Item S
Statewide Inpatient Psychiatric Program	State Standard Contract, Item Q

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

The state requires the MCOs and PIHPs to implement mechanisms for identifying, assessing and ensuring the existence of a treatment plan for individuals with special health care needs. Mechanisms include evaluation of health risk assessments, claims data, and, if available, CPT/ICD-9 codes. The plans are required to implement a process for receiving and considering provider and enrollee input. The plan's treatment plan for an enrollee determined to need a course of treatment or regular care monitoring must be developed by the enrollee's primary care provider with enrollee participation and in consultation with any specialists caring for the enrollee; approved by the plan in a timely manner if this approval is required; and developed in accordance with any applicable state quality assurance and utilization review standards. Pursuant to 42 CFR 438.208(c)(4), for enrollees with special health care needs determined through an assessment by appropriate health care professionals (consistent with 42 CFR 438.208(c)(2)) to need a course of treatment or regular care monitoring, each plan must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs. The reference to the contract provision which incorporates this requirement can be found by contract in Table 16.

Table 16 Additional Services for Individuals with Special Health Care Needs 42 CFR 438.208(c)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section VIII, B.2.d. and e.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.1.1.14 b.
PMHP Area 1	Attachment I, Section 2.4, K.
PMHP Areas 2, 3, 4, 8, and 9	Attachment I, Section D.22.J
PMHP Areas 5 and 7	Attachment D, Section D.23. J.
PMHP Area 6	Attachment I, Section 2.4
PMHP Area 11	Attachment I, Section B.23, J.
Child Welfare Specialty PMHP	Attachment I, Section D.22 (7)
Statewide Inpatient Psychiatric Program	Attachment II, Section D.12, XX.

4. Coverage and authorization of services

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

The state requires the MCOs and PIHPs to comply with all the provisions of the contract and its amendments, if any, and to act in good faith in the performance of the contract provisions. The plans are required to develop and maintain written policies and procedures to implement the provisions of this contract. The plans are required to agree by contract that failure to comply with these provisions may result in the assessment of penalties and/or termination of the contract in whole or in part, as set forth in the contract. The plans are required to comply with all pertinent state rules in effect throughout the duration of the contract.

The state requires the MCOs and PIHPs to comply with all current state handbooks noticed in or incorporated by reference in rules relating to the provision of services set forth in the contract. The plans are required to comply with the limitations and exclusions in the state handbooks unless otherwise specified by the contract. In no instance may the limitations or exclusions imposed by the plan be more stringent than those specified in the handbooks. Pursuant to 42 CFR 438.210(a), the plan must furnish services up to the limits specified by the Medicaid program. The plan may exceed these limits. Service limitations shall not be more restrictive than the Florida fee-for-service program, pursuant to 42 CFR 438.210(a), except as approved by the state and authorized in Florida's 1115 Medicaid Reform waiver or other applicable waivers.

The state allows the plans to offer services to enrolled Medicaid recipients in addition to those covered services specified in the contract, Quality and Benefit Enhancements or Quality Enhancements. These services must be specifically defined in regards to amount, duration and scope, and must be approved in writing by the state prior to implementation.

The state requires the plans to have a quality improvement program that ensures enhancement of quality of care and emphasizes quality patient outcomes. The state may restrict the plan's enrollment activities if acceptable quality improvement and performance indicators based on HEDIS and other outcome measures to be determined by the state are not met. Such restrictions may include the termination of mandatory assignments.

The state allows the MCOs and PIHPs not operated under Florida's 1115 Medicaid Reform waiver to provide optional services that are rendered within Medicaid guidelines at the option of the plan and the state. The plans are required to specify the optional services to be covered by the plan. The state also allows the plans to provide expanded services, which the state defines as those offered by the plan and approved by the state as follows: (a) services in excess of the amount, duration and scope of those listed under the contract under Covered Services and Optional Services; and (b) services and benefits not listed in the contract as a Covered Service or Optional Service.

For MCOs and PIHPs that operate under Florida's 1115 Medicaid Reform waiver with a state approved customized benefit package, the plans are required to provide all mandatory and specified optional services in the contract and as approved by the state. The Reform health plans are required to submit their customized benefit package for state approval prior to contracting. The plans are required to provide all medically necessary services to pregnant women and children.

Plan members who require services available through Medicaid but not covered by the plan's contract may receive these services through the existing Medicaid fee-for-service reimbursement system. The MCOs and PIHPs are required to determine the need for these services and refer the member to the appropriate service provider. The plans may request the assistance of the local Medicaid Field Office for referral to the appropriate service setting.

The MCOs and PIHPs are required to consult the DCF office to identify appropriate methods of assessment and referral, for plan members requiring long term care institutional services, institutional services for persons with developmental disabilities or state hospital services. The plans are responsible for transition and referral to appropriate service providers, including helping the member to obtain an attending physician. Members requiring these services shall be disenrolled from the plan in accordance with the state approved disenrollment procedures.

The state requires the MCOs and PIHPs to have a quality improvement and quality utilization program which includes, among others items, a service authorization system. The state approves the plans' written services authorization system policies and procedures. The plans are required to maintain written confirmation of all denials of authorization to providers. The reference to the contract provisions which incorporates these requirements can be found by contract in Table 17.

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Table 17 Coverage of Services 42 CFR 438.210(a)(1)(2)(3)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section II, D.8., Section V, A., B., E., and H.17., Section VIII.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.8.1
PMHP Area 1	Attachment I, Sections 2.2 - 2.4
PMHP Areas 2, 3, 4, and Child Welfare Specialty PMHP	Attachment I, Sections D.20, D.21 and D.22
PMHP Areas 5 and 7	Attachment D, Sections D.21-D.23, and D.25
PMHP Area 6	Attachment I, Sections 2.2 - 2.4
PMHP Areas 8 and 9	Attachment I, Sections D.20, D.21, D.35
PMHP Area 11	Attachment I, Sections B.20 - B.23
Statewide Inpatient Psychiatric Program	Attachment II, Section D.12, G.

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

The state requires that the MCO and PIHP contracts define the term "medically necessary or medical necessity" as "services provided in accordance with 42 CFR section 438.210(a)(4) and as defined in section 59G-1.010(166), Florida Administrative Code, to include that medical or allied care, goods, or services furnished or ordered must:

a. Meet the following conditions:
    1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
    2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
    3. Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
    4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide; and
    5. Be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee's caretaker, or the provider.
b. "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
c. The fact that a provider has prescribed, recommended, or approved medical or allied goods, or services does not, in itself, make such care, goods or services medically necessary, a medical necessity, or a covered service."

The reference to the contract provisions which incorporate this requirement can be found by contract in Table 18.

Table 18 Medically Necessary Services 42 CFR 438.210(a)(4)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section I, A.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 1.1.2
PMHP Area 1	Attachment I, Section 1.1, GGG.
PMHP Areas 2, 3, 4, 8, and 9	Attachment I, Section D.21
PMHP Areas 5 and 7	Attachment D, Section D.22
PMHP Area 6	Attachment I, Section 1.1, HHH.1-3
PMHP Area 11	Attachment I, Section B.22
Child Welfare Specialty PMHP	Attachment I, Section D.22 (2)
Statewide Inpatient Psychiatric Program	Attachment II, Sections D.1, A. and D.2, A.

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

The state requires the MCOs and PIHPs to comply with the following prior authorization requirements for family planning services:

- Pursuant to 42 CFR 431.51 (b), the plan shall allow each member to obtain family planning services from any participating Medicaid provider and require no prior authorization for such services. If the member receives services from a non-plan Medicaid provider, then the plan must reimburse at the Medicaid reimbursement rate, unless another payment rate is negotiated. This requirement is not applicable to Florida's Nursing Home Diversion waiver, Statewide Inpatient Psychiatric Programs, or Prepaid Mental Health Plan contractors.

The state requires the MCOs and PIHPs to comply with the following prior authorization requirements:

- For enrollees voluntarily enrolling, Title XXI MediKids and for enrollees who have been automatically reinstated due to regaining Medicaid eligibility, the plan shall honor any written documentation of prior authorization of ongoing covered services for a period of 10 calendar days after the effective date of enrollment or until the plan's primary care physician assigned to that member reviews the member's treatment plan, whichever comes first. The Title XXI MediKids provision is not applicable to Florida's Nursing Home Diversion waiver contractors or Statewide Inpatient Psychiatric Programs.
- For enrollees that the state has assigned, the plan shall honor any written documentation of prior authorization of ongoing services for a period of one month after the effective date of enrollment or until the plan's primary care physician assigned to that member reviews the member's treatment plan, whichever comes first.
- For both voluntary and assigned members, written documentation of prior authorization of ongoing services includes the following, provided that the services were prearranged prior to enrollment in the plan:
    1. Prior existing orders;
    2. Provider appointments, surgeries; and
    3. Prescriptions (including prescriptions at non-participating pharmacies).

The plans cannot delay service authorization if written documentation is not available in a timely manner; however, the plan is not required to pay claims for which it has received no written documentation. The plans shall not deny claims submitted by a non-contracting provider solely based on the period between the date of service and the date of clean claim submission unless that period exceeds 365 days.

The plans are responsible for payment of covered services to the existing treating provider at a prior negotiated rate or lesser of the provider's usual and customary rate or the established Medicaid fee-for-service rate for such services until the plan is able to evaluate the need for ongoing services.

The plans are required to comply with the following prior authorization requirements as they relate to out-of-plan non-emergency services:

- The plan shall provide timely approval or denial of authorization of out-of-plan use through the assignment of a prior authorization number, which refers to and documents the approval. A plan may not require paper authorization as a condition of receiving treatment if the plan has an automated authorization system. Written follow up documentation of the approval must be provided to the out-of-plan provider within one business day from the request for approval.

The state requires the plan's quality improvement program to include the following, among others:

- The plan must develop and have in place utilization management policies and procedures that include protocols for prior approval and denial of services, hospital discharge planning, physician profiling, and retrospective review of both inpatient and ambulatory claims meeting pre-defined criteria.
- The plan's service authorization systems shall provide authorization numbers, effective dates for the authorization, and written confirmation to the provider of denials, as appropriate. Pursuant to 42 CFR 438.210(b)(3), any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

The state requires the utilization management program to be consistent with 42 CFR 456 and include, but not be limited to, the following service authorization requirements:

- Service authorization protocols for prior authorization and denial of services; the process used to evaluate prior and concurrent authorization; mechanisms to ensure consistent application of review criteria for authorization decisions; consultation with the requesting Provider when appropriate; Hospital discharge planning; physician profiling; and a retrospective review of both inpatient and ambulatory claims, meeting the predefined criteria below. The MCOs and PIHPs are responsible for ensuring the consistent application of review criteria for authorization decisions and consulting with the requesting Provider when appropriate.

  (1) The Health Plan must have written approval from the Agency for its Service Authorization protocols and for any changes to the original protocols.

(2) The Health Plan's Service Authorization systems shall provide the authorization number and effective dates for authorization to Participating Providers and non-participating Providers.

(3) The Health Plan's Service Authorization systems shall provide written confirmation of all denials of authorization to providers. (See 42 C.F.R. 438.210(c)).

i. The Health Plan may request to be notified, but shall not deny claims payment based solely on lack of notification, for the following:

(a) Inpatient emergency admissions (within ten (10) days);

(b) Obstetrical care (at first visit);

(c) Obstetrical admissions exceeding forty-eight (48) hours for vaginal delivery and ninety-six (96) hours for caesarean section; and

(d) Transplants.

ii. The Health Plan shall ensure that all decisions to deny a Service Authorization request, or limit a service in amount, duration, or scope that is less than requested, are made by Health Care Professionals who have the appropriate clinical expertise in treating the Enrollee's condition or disease. (See 42 C.F.R. 438.210(b)(3))

(4) Only a licensed psychiatrist may authorize a denial for an initial or concurrent authorization of any request for Behavioral Health Services. The psychiatrist's review shall be part of the UM process and not part of the clinical review, which may be requested by a Provider or the Enrollee, after the issuance of a denial.

(5) The Health Plan shall provide post authorization to County Health Departments (CHD) for the provision of emergency shelter medical screenings provided for clients of DCF.

(6) Health Plans with automated authorization systems may not require paper authorization as a condition of receiving treatment.

The state requires the plans to comply with the following prior authorization requirement as it relates to foster care:

- If the voluntary applicant is recognized to be in foster care by the plan, and is dependent, prior to enrollment the plan must receive written authorization from (1) a parent, (2) a legal guardian, or (3) the Department of Children and Families (DCF), or DCF's delegate. If a parent is unavailable, the plan shall obtain authorization from the DCF.

The state requires the plans to provide to enrollees the plan's authorization and referral process upon request:

- A detailed description of the plan's authorization and referral process for health care services which shall include reasons for denial of services based on moral or religious grounds as required by section 1932(b)(3), Social Security Act (enacted in section 4704 of the Balanced Budget Act of 1997).
- A detailed description of the plan's process used to determine whether health care services are medically necessary.
- Policies and procedures relating to the plan's prescription drug benefits program.
- The decision-making process used for approving or denying experimental or investigational medical treatments.

The contract provisions which incorporate the prior authorization requirements can be found by contract in Table 19.

Table 19 **Service Authorization Policies & Procedures.** 42 CFR 438.210(b)(d)(1)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section IV, A.8.c. and d., Section V, H.8. and 9.d., Section VII, B.3., Section VIII, Section IX, C.2.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.3
PMHP Area 1	Attachment I, Sections 1.1 and 2.16.1
PMHP Areas 2, 3, 4, 8, 9, and Child Welfare Specialty PMHP	Attachment I, Section D.35
PMHP Areas 5 and 7	Attachment D, Section D.36
PMHP Area 6	Attachment I, Section 2.17
PMHP Area 11	Attachment I, Section B.36
Statewide Inpatient Psychiatric Program	Attachment II, Sections D.12, AA. And D.22, B.

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

The state requires the plan's quality improvement program to comply with 42 CFR 438.210(b)(3). Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease. The reference to the contract provision which incorporates this requirement can be found by contract in Table 20.

Table 20 **Appropriate Health Care Professional / Denial of Services** 42 CFR 438.210(b)(3)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section VIII, B.1.a.(4)(e)
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.3
PMHP Area 1	Attachment I, Section 2.16.1
PMHP Areas 2, 3, 4, 8, 9, and Child Welfare Specialty PMHP	Attachment I, Section D.35
PMHP Areas 5 and 7	Attachment D, Section D.36
PMHP Area 6	Attachment I, Section 2.9
PMHP Area 11	Attachment I, Section D.35
Statewide Inpatient Psychiatric Program	Attachment II, Section D.12, YY.5

C. Detailed information related to access to care standards

1. Florida's Mechanisms to Identify Persons with Special Health Care Needs.

The state requires the MCOs and PIHPs to implement mechanisms for identifying, and ensuring the existence of a treatment plan for individuals with special health care needs. Mechanisms shall include evaluation of health risk assessments, claims data, and, if available CPT/ICD-9 codes. The plans are required to implement a process for receiving and considering provider and enrollee input. In accordance 42 CFR 438.208(c)(3), a treatment plan for an enrollee determined to need a course of treatment or regular care monitoring must be developed by the enrollee's care provider with enrollee participation and in consultation with any specialists caring for the enrollee; approved by the plan in a timely manner if this approval is required; and developed in accordance with any applicable state quality assurance and utilization review standards.

Pursuant to 42 CFR 438.208(c)(4), for enrollees with special health care needs determined through an assessment by appropriate health care professionals (consistent with 42 CFR 438.208(c)(2)) and who need a course of treatment or regular care monitoring, the state requires each plan to have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

The state requires the MCOs and PIHPs to assess new members using a health risk assessment tool to identify persons with special health care needs. The MCO and PIHP contracts provide the following definition for Individuals with Special Health Care Needs - November 6, 2000 Report to Congress - Individuals with special health care needs are adults and children who daily face physical, mental, or environmental challenges that place at risk their health and ability to fully function in society. They include, for example, individuals with mental retardation or related conditions; individuals with serious chronic illnesses such as Human Immunodeficiency Virus (HIV), schizophrenia, or degenerative neurological disorders; individuals with disabilities from many years of chronic illness such as arthritis, emphysema or diabetes; and children and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care. The state requires the MCOs and PIHPs to provide case management.

The state requires the plans to have an ongoing quality improvement (QI) program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes in service performance to its Medicaid population. The plan's written policies and procedures shall address components of effective health care management including but not limited to anticipation, identification, monitoring, measurement, evaluation of enrollee's health care needs, and effective action to promote quality of care. The plans are required to define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success. The plan and its quality improvement program are required to demonstrate in their care management how specific interventions better manage care and impact healthier patient outcomes. The goal shall be to provide comprehensive, high quality, accessible, cost effective, and efficient health care to Medicaid enrollees.

The state requires the plans to provide a written descriptive QI program that identifies FTE staff specifically trained to handle the Medicaid business and delineates how staffing is organized to

interact and resolve problems, define measures and expectations, and demonstrate the process for decision making (i.e., selection of projects and interventions) and reevaluation. The reference to the contract provision which incorporates this requirement can be found by contract in Table 21.

Table 21 **Identification of Persons with Special Health Care Needs** 42 CFR 438.208(c)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section IV, A.8(a), Section VIII, B.2.d, e., and j.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.1.1.14 b, c, and d.
PMHP Area 1	Attachment I, Section 2.4, K.
PMHP Areas 2, 3, 4, 8, and 9	Attachment I, Section D.22.J
PMHP Areas 5 and 7	Attachment D, Section D.23. J.
PMHP Area 6	Attachment I, Section 2.4, K.
PMHP Area 11	Attachment I, Section B.23, J.
Child Welfare Specialty PMHP	Attachment I, Section D.22 (7)
Statewide Inpatient Psychiatric Program	Attachment II, Sections D.10, F (8), D.11, D., and D.12, G.

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

The state requires the MCOs and PIHPs to develop a treatment plan for plan enrollees who are determined to need a course of treatment or regular care monitoring by the enrollee's care provider with enrollee participation and in consultation with any specialists caring for the enrollee. The treatment plan is required to be approved by the plan in a timely manner if approval is required, and the treatment plan must be developed in accordance with any applicable state quality assurance and utilization review standards.

The state requires, for enrollees voluntarily enrolling, Title XXI MediKids and for enrollees who have been automatically reinstated due to regaining Medicaid eligibility, that the plan honor any written documentation of prior authorization of ongoing covered services for a period of 10 calendar days after the effective date of enrollment or until the plan's primary care physician assigned to that member reviews the member's treatment plan, whichever comes first. The Title XXI MediKids provision is not applicable to the state's Nursing Home Diversion waiver contractors.

The reference to the contract provisions which incorporates this requirement can be found by contract in Table 22.

Table 22 Treatment Plan Standard 42 CFR 438.208(c)(3)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section IV, A.8.a. and Section VIII, B.2.e.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.1.1.14 b.
PMHP Area 1	Attachment I, Section 2.4, K.
PMHP Areas 2, 3, 4, 8, and 9	Attachment I, Section D.22.J
PMHP Areas 5 and 7	Attachment D, Section D.23. J.
PMHP Area 6	Attachment I, Section 2.4
PMHP Area 11	Attachment I, Section B.23, J.
Child Welfare Specialty PMHP	Attachment I, Section D.22 (7)
Statewide Inpatient Psychiatric Program	Attachment II, Section D.11, D.

Standards for Structure and Operations and Contract Provisions

1. Provider Selection

The state requires the MCOs and PIHPs to comply with the requirements specified in 42 CFR 438.214, which include: selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination. The state requires the plans to have written policies and procedures and a description of its policies and procedures for selection and retention of providers following the state's policy for credentialing and recredentialing as specified in 42 CFR 438.214(a), 42 CFR 438.214(b)(1), and 42 CFR 438.214(b)(2). The state requires each plan to demonstrate that its providers are credentialed as specified in 42 CFR 438.206(b)(6), during the initial contract application process and during the annual on-site surveys and desk reviews. The state requires that the MCOs and PIHPs provider selection policies and procedures not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment as specified in 42 CFR 438.214(c). The state requires the plans to not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act as specified in 42 CFR 438.214(d). The reference to the contract provisions which incorporate this requirement can be found by contract in Table 23.

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Table 23 Provider Selection and Retention, Credentialing and Recredentialing, Nondiscrimination, and Excluded Providers 42 CFR 438.12(a)(2), 42 CFR 438.214(a)-(d), 42 CFR 438.206(b)(6)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section VII, D.1.c, D.2.e. and m., and H.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.12.4.1.
PMHP Area 1	Attachment I, Section 2.23
PMHP Areas 2, 8, and 9	Attachment I, Section D.23, B.
PMHP Areas 3 and 4	Attachment I, Sections D.23, B. and Amendment #8, Attachment VIII-1
PMHP Areas 5 and 7	Attachment I, Section C.22
PMHP Area 6	Attachment 29
PMHP Area 11	Attachment I, Sections B.24, B.(FA607) and D.23, B.(FA606)
Child Welfare Specialty PMHP	Attachment I, Sections D.23, 2., D.38, and Amendment No. 7, Attachment VI-2
Statewide Inpatient Psychiatric Program	Attachment II, Sections D.11, D.13, and D.22, A. 2 (b)

2. Enrollee Information.

The state requires the MCOs and PIHPs to make available the following items to members upon request:

(a) A detailed description of the plan’s authorization and referral process for health care services which shall include reasons for denial of services based on moral or religious grounds as required by section 1932(b)(3), Social Security Act (enacted in section 4704 of the Balanced Budget Act of 1997).

(b) A detailed description of the plan’s process used to determine whether health care services are medically necessary.

(c) A description of the plan’s quality improvement program.

(d) Policies and procedures relating to the plan’s prescription drug benefits program.

(e) Policies and procedures relating to the confidentiality and disclosure of the member’s medical records.

(f) The decision-making process used for approving or denying experimental or investigational medical treatments.

(h) A detailed description of the plan’s credentialing process.

The state requires that immediately upon the assigned recipient’s enrollment in the plan, the plan must provide new enrollees the new member materials as provided below along with the required member information and member notification as specified in the plan’s contract:

a. A request for the following information, including updates to this information: assigned member's name, address (home and mailing), county of residence, telephone number, social security number; a completed, signed and dated release form authorizing the plan to release medical information to the Federal and state governments or their duly appointed agents; and, for enrollees in Agency areas where behavioral health care has been implemented, current behavioral health care provider information.

b. A notice that members who lose eligibility and are disenrolled shall be automatically reenrolled in the plan if eligibility is regained within 60 days (for non-Reform health plans) or within 180 days (for Reform health plans).

c. Each mailing shall include a postage paid, pre-addressed return envelope. The mailing envelope shall include a request for address correction.

d. The initial mailing may be combined with the primary care physician assignment notification. Each mailing shall be documented in the plan's records.

The state requires that plan's member service handbook include the following information:

- Terms and conditions of enrollment including the reinstatement process;
- A description of the open enrollment process;
- Description of services provided, including limitations and general restrictions on provider access, exclusions and out-of-plan use;
- Procedures for obtaining required services, including second opinions;
- The toll-free telephone number of the statewide Consumer Call Center;
- Emergency services and procedures for obtaining services both in and out of the plan's service area; the extent to which, and how, after-hours and emergency coverage are provided;
- Procedures for enrollment, including member rights and procedures; grievance system components; member rights and procedures for disenrollment; procedures for filing a "good cause change" request, including the state's toll-free telephone number for the enrollment and disenrollment services contractor;
- Information regarding newborn enrollment, including the mother's responsibility to notify the plan and the mother's Department of Children and Families caseworker of the newborn's birth and assignment of pediatricians and other appropriate physicians;
- Member rights and responsibilities, including the extent to which, and how, enrollees may obtain benefits from out-of-network providers and the right to obtain family planning services from any participating Medicaid provider without prior authorization for such services;
- The choices of approved nursing facilities, if applicable (Frail/Elderly Program is operated under Florida's 1915(b) Managed Care Waiver only);
- Information on emergency transportation and non-emergency transportation, counseling and referral services available under the plan and how to access these;
- Information that interpretation services and alternative communications systems are available, free of charge, for all foreign languages, and how to access these services;
- Information that post-stabilization services are provided without prior authorization; and other post stabilization care services rules set forth in 42 CFR 422.113(c);
- Information that services will continue upon appeal of a suspended authorization and that the enrollee may have to pay in case of an adverse ruling;

- Information regarding the health care advance directives pursuant to chapter 765, Florida Statutes., 42 CFR 422.128;
- Cost sharing, if any;
- Information that enrollees may obtain from the plan information regarding quality performance indicators, including aggregate enrollee satisfaction data; and how and where to access any benefits that are available under Florida Medicaid's State Plan but are not covered under the contract, including any cost sharing, and how transportation is provided;
- For a counseling or referral service that the plan does not cover because of moral or religious objections, the plan need not furnish information on how and where to obtain the service; and
- Written information regarding advance directives provided by the plan must reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change.

The state requires the plans to provide enrollee information in accordance with 42 CFR 438.10(f), including notification to enrollees at least on an annual basis of their right to request and obtain information.

The reference to the contract provisions which incorporate this requirement can be found by contract in Table 24.

Table 24 **Enrollee Information** Section 1932(b)(3), of Social Security Act and 42 CFR 438.10(f)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section IV, A.2.c., A.3., A.6. and A.7.a.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.1.1.
PMHP Area 1	Attachment I, Sections 2.12, 2.13
PMHP Areas 2, 3, 4, 8, 9, andChild Welfare Specialty PMHP	Attachment I, SectionD.17
PMHP Areas 5 and 7	Attachment D, Section D.18
PMHP Area 6	Attachment I, Section 2.22
PMHP Area 11	Attachment I, Section B. 17
Statewide Inpatient Psychiatric Program	Attachment II, Section D.12, VV.

3. Confidentiality

During the initial MCO and PIHP contract application process, the state ensures the plans establish and implement procedures consistent with Federal and state regulations including confidentiality requirements in 45 CFR parts 160 and 164 and 42 CFR 438.224. The Health Plan shall have a policy to ensure the confidentiality of medical records in accordance with 42 CFR, Part 431, Subpart F. This policy shall also include confidentiality of a minor's consultation, examination, and treatment for a sexually transmissible disease in accordance with s. 384.30(2), F.S.

The state conducts annual on-site surveys and desk reviews to ensure the plans maintain procedures consistent with state and Federal regulations. The reference to the contract provisions which incorporates this requirement can be found by contract in Table 25.

Table 25 **Confidentiality** 45 CFR parts 160 and 164, 42 CFR 438.224	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section VII, J.2.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Main Contract, Item 18
PMHP Area 1	State Standard Contract, Item T
PMHP Areas 2, 3, 4, 8, 9,and Child Welfare Specialty PMHP	State Standard Contract, Item S
PMHP Areas 5 and 7	State Standard Contract, Item T
PMHP Area 6	State Standard Contract, Item T and Attachment 29
PMHP Area 11	State Standard Contract, Item R
Statewide Inpatient Psychiatric Program	State Standard Contract, Item Q

4. Enrollment & Disenrollment

The state or its agent is responsible for all enrollment, including enrollment into the plan, disenrollment, and outreach and education activities. The state requires the plans to coordinate with the state or its agent as necessary for all enrollment and disenrollment functions. The state also requires the plans to accept Medicaid recipients without restriction and in the order in which the recipients enroll. The state specifies in the plan's contract that the plan cannot discriminate against Medicaid recipients on the basis of religion, gender, race, color, age, or national origin, and shall not use any policy or practice that has the effect of discriminating on the basis of religion, gender, race, color, or national origin, or on the basis of health, health status, pre-existing condition, or need for health care services. The plans are required to accept new enrollees throughout the contract period up to the authorized maximum enrollment levels approved in each plan's contract.

Prior to or upon enrollment, the state requires the plans to provide the following information to all new enrollees:

(1) A written notice providing the actual date of enrollment, and the name, telephone number and address of the enrollee's primary care provider assignment.

(2) Notification that Enrollees can change their Health Plan selection, subject to Medicaid limitations.

(3) Enrollment materials regarding PCP choice as described in the Health Plan contract.

(4) New Enrollee Materials as described in the Health Plan contract.

The state requires the plans to comply with the following general disenrollment requirements which are specified in each MCO and PIHP's contract:

a. If the plan's contract is renewed, the enrollment status of all enrollees shall continue uninterrupted.

b. The plan shall ensure that it does not restrict the enrollee's right to disenroll voluntarily in any way.

c. The plan or its agents shall not provide or assist in the completion of a disenrollment request or assist the Agency's choice counselor/enrollment broker in the disesnrollment process.

d. The plan shall ensure that enrollees that are disenrolled and wish to file an appeal have the opportunity to do so. All enrollees shall be afforded the right to file an appeal except for the following reasons for disenrollment:

   (1) Moving out of the Service Area;

   (2) Loss of Medicaid eligibility; and

   (3) Enrollee death.

e. An enrollee may submit to the state or its agent a request to disenroll from the plan without cause during the ninety (90) calendar day change period following the date of the enrollee's initial enrollment with the plan, or the date the state or its agent sends the enrollee notice of the enrollment, whichever is later. An enrollee may request disenrollment without cause every twelve (12) months thereafter.

f. The effective date of an approved disenrollment shall be the last calendar day of the month in which disenrollment was made effective by the state or its agent, but in no case shall disenrollment be later than the first (1st) calendar day of the second month following the month in which the enrollee or the plan files the disenrollment request. If the state or its agent fails to make a disenrollment determination within this timeframe, the disenrollment is considered approved.

g. The plan shall keep a daily written log or electronic documentation of all oral and written enrollee disenrollment requests and the disposition of such requests. The log shall include the following:

   (1) The date the request was received by the plan;

   (2) The date the enrollee was referred to the state's choice counselor/enrollment broker or the date of the letter advising the enrollee of the disenrollment procedure, as appropriate; and

   (3) The reason that the enrollee is requesting disenrollment.

h. The plan shall send to the state or its agent a monthly summary report of all submitted disenrollment requests. This report must specify the reason for such disenrollment requests. It shall be reconciled to the plan enrollment report processed by the state or its agent for the applicable month and shall be reviewed by the state or its agent for compliance with acceptable reasons for disenrollment. The state may reinstate enrollment for any enrollee whose reason for disenrollment is not consistent with established guidelines.

The state specifies the following regarding involuntary disenrollment in the MCO and PIHP contracts:

a. With proper written documentation, the following are acceptable reasons for which the plan shall submit involuntary disenrollment requests to the state:

   1. Enrollee has moved out of the service area;

2. Enrollee death;
3. Determination that the enrollee is ineligible for enrollment based on the criteria specified in the plan's contract regarding excluded populations; and
4. Fraudulent use of the enrollee ID card.

b. The plan shall promptly submit such disenrollment requests to the state. In no event shall the plan submit the disenrollment request at such a date as would cause the disenrollment to be effective later than forty-five (45) calendar days after the plan's receipt of the reason for involuntary disenrollment. The plan shall ensure that involuntary disenrollment documents are maintained in an identifiable enrollee record.

c. If the plan submitted the disenrollment request for one of the above reasons, the plan shall verify that the information is accurate.

d. If the plan discovers that an ineligible enrollee has been enrolled, then it shall request disenrollment of the enrollee and shall notify the enrollee in writing that the plan is requesting disenrollment and the enrollee will be disenrolled in the next contract month, or earlier if necessary. Until the enrollee is disenrolled, the plan shall be responsible for the provision of services to that enrollee.

e. On a monthly basis, the plan shall review its ongoing enrollment report to ensure that all enrollees are residing in the plan's authorized service area. For enrollees with out-of-service area addresses on the enrollment report, the plan shall notify the enrollee in writing that the enrollee should contact the choice counselor/enrollment broker to choose another plan, or other managed care option available in the enrollee's new service area, and that the enrollee will be disenrolled.

f. The plan may submit involuntary disenrollment requests to the state or its Agent for assigned enrollees who meet both of the following requirements:

   (1) The plan was unable to contact the enrollee by mail, phone, or personal visit within the first three (3) months of enrollment; and

   (2) The enrollee did not use plan services within the first three (3) months of enrollment. Such disenrollments shall be submitted in accordance with the reporting Requirements specified in the plan's contract. The plan shall maintain documentation of its inability to contact the enrollee and that it has no record of providing services to the enrollee, or to another family unit member, in the enrollee's file.

g. The plan may submit an involuntary disenrollment request to the state or its Agent after providing to the enrollee at least one (1) verbal warning and at least one (1) written warning of the full implications of his/her failure of actions:

   (1) For an enrollee who continues not to comply with a recommended plan of health care or misses three (3) consecutive appointments within a continuous six (6) month period. Such requests must be submitted at least sixty (60) calendar days prior to the requested effective date.

   (2) For an enrollee whose behavior is disruptive, unruly, abusive or uncooperative to the extent that his or her enrollment in the plan seriously impairs the organization's ability to furnish services to either the enrollee or other enrollees. This section of the plan's contract does not apply to enrollees with mental health diagnoses if the enrollee's behavior is attributable to the mental illness.

h. The state may approve such requests provided that the plan documents that attempts were made to educate the enrollee regarding his/her rights and responsibilities, assistance which would enable the enrollee to comply was offered through case management, and it has

been determined that the enrollee's behavior is not related to the enrollee's medical or behavioral condition. All requests will be reviewed on a case-by-case basis and subject to the sole discretion of the state. Any request not approved is final and not subject to dispute or appeal.

i. The plan shall not request disenrollment of an enrollee due to:

   (1) Health diagnosis;

   (2) Adverse changes in an enrollee's health status;

   (3) Utilization of medical services;

   (4) Diminished mental capacity;

   (5) Pre-existing medical condition;

   (6) Uncooperative or disruptive behavior resulting from the enrollee's special needs (with the exception of g.2 above);

   (7) Attempt to exercise rights under the plan's grievance system; or

   (8) Request of one (1) primary care provider to have an enrollee assigned to a different provider out of the plan.

The state requires the MCOs and PIHPs to ensure that all community outreach, pre-enrollment, enrollee, disenrollment, and grievance materials developed for the Medicaid population adhere to the following policies and procedures:

a. All materials developed for the Medicaid population must be at or near the fourth-grade comprehension level so that the materials are understandable (in accordance with section 1932(a)(5) of the Social Security Act as enacted by section 4701 of the Balanced Budget Act of 1997), and be available in alternative communication methods (such as large print, video or audio recordings, or Braille) appropriate for persons with disabilities.

b. The plan shall assure that appropriate foreign language versions of all materials are developed and available to members and potential members. The plan shall provide interpreter services in person where practical, but otherwise by telephone, for applicants or members whose primary language is a foreign language. Foreign language versions of materials are required if, as provided annually by the Agency, the population speaking a particular foreign (non-English) language in a county is greater than five percent.

c. Marketing for enrollment to any potential members or conducting pre-enrollment activities, with limited exceptions, is prohibited for Florida health plans. The plan must develop and implement a written plan designed to control the actions of its community outreach representatives. For each new contract period, the plan shall submit to the state, for written approval, its community outreach materials no later than 60 calendar days before the start of the next contract period, and, for any changes in the community outreach materials, no later than 30 calendar days prior to implementation.

The state specifies the following requirements in the MCO and PIHP contracts:

- Prohibited marketing, enrollment and disenrollment activities and practices,
- Permitted activities under the supervision of the Agency for Health Care Administration regarding marketing, enrollment and disenrollment,
- Requirements for the Community Outreach Notification Process,

- Requirements for Provider Compliance,
- Requirements for Community Outreach Representatives,
- Pre-enrollment activities and requirements,
- Enrollment activities and requirements,
- Behavioral Health enrollment activities and requirements,
- Newborn enrollment activities and requirements,
- Enrollment levels,
- Disenrollment requirements,
- Voluntary disenrollment requirements,
- Involuntary disenrollment requirements, and
- Frail/Elderly disenrollment requirements (this program is operated under Florida's 1915(b) managed care waiver only).

The MCOs and PIHPs are prohibited by contract from engaging in the following non-exclusive list of marketing activities:

a. Marketing for enrollment to any potential members or conducting any pre-enrollment activities not expressly allowed by the state.
b. Any of the prohibited practices or activities listed in s. 409.912, F.S.
c. Engaging in activities not expressly allowed by the state for the purpose of recruitment or enrollment.
d. In accordance with sections 409.912 and 409.91211, F.S., practices that are discriminatory, including, but not limited to, attempts to discourage enrollment or reenrollment on the basis of actual or perceived health status.
e. Direct or indirect Cold Call Marketing for solicitation of Medicaid recipients, either by door-to-door, telephone or other means, in accordance with section 4707 of the Balanced Budget Act of 1997, and section 409.912, F.S.
f. In accordance with section 409.912, F.S., activities that could mislead or confuse Medicaid recipients, or misrepresent the plan, its marketing representatives, or the state. No fraudulent, misleading, or misrepresentative information shall be used in marketing, including information regarding other governmental programs. Statements that could mislead or confuse include, but are not limited to, any assertion, statement or claim (whether written or oral) that:
   (1) The Medicaid recipient must enroll in the plan in order to obtain Medicaid, or in order to avoid losing Medicaid benefits;
   (2) The plan is endorsed by any federal, state or county government, the State, or CMS, or any other organization which has not certified its endorsement in writing to the plan;
   (3) Marketing representatives are employees or representatives of the federal, State or county government, or of anyone other than the plan or the organization by whom they are reimbursed;
   (4) The state or county recommends that a Medicaid recipient enroll with the plan; and/or

(5) A Medicaid recipient will lose benefits under the Medicaid program or any other health or welfare benefits to which the recipient is legally entitled, if the recipient does not enroll with the plan.

g. Granting or offering of any monetary or other valuable consideration for enrollment.

h. Offers of insurance, such as but not limited to, accidental death, dismemberment, disability or life insurance.

i. Enlisting the assistance of any employee, officer, elected official or agent of the state in recruitment of Medicaid recipients except as authorized in writing by the state.

j. Offers of material or financial gain to any persons soliciting, referring or otherwise facilitating Medicaid recipient enrollment. The plan shall ensure that its staff do not market the plan to Medicaid recipients at any location including state offices or DCF ACCESS centers.

k. Giving away promotional items in excess of $5.00 retail value. Items to be given away shall bear the plan's name and shall only be given away at health fairs or other general public events. In addition, such promotional items must be offered to the general public and shall not be limited to Medicaid recipients.

l. Providing any gift, commission, or any form of compensation to the choice counselor/enrollment broker, including the choice counselor/enrollment broker's full-time, part-time or temporary employees and subcontractors.

m. Providing information before enrollment about the incentives that shall be offered to the enrollee as described in the plan’s contract in the Enrollee Services, Community Outreach and Marketing, and Incentive Programs sections. The plan may inform enrollees once they are actually enrolled in the plan about the specific incentives available.

n. Discussing, explaining, or speaking to a potential member about plan-specific information other than to refer all plan inquiries to the member services section of the plan or the state’s choice counselor/enrollment broker.

o. Distributing any community outreach materials without prior written notice to the state except as otherwise allowed under Permitted Activities and Provider Compliance subsections.

p. Distributing any marketing materials not expressly allowed by the state.

q. Subcontracting with any brokerage firm or independent agent as defined in Chapters 624-651, F.S., for purposes of marketing or community outreach.

r. Paying commission compensation to community outreach representatives for new enrollees. The payment of a bonus to a community outreach representative shall not be considered a commission if such bonus is not related to enrollment or membership growth.

s. All activities included in section 641.3903, F.S.

The MCOs and PIHPs are permitted by contract to engage in the following activities under the supervision and with the written approval of the state:

a. The plan may attend health fairs/public events upon request by the sponsor and after written notification to the state.

b. The plan may leave state community outreach materials at health fairs/public events at which the plan participates.

c. The plan may provide state-approved community outreach materials. Such materials may include Medicaid enrollment and eligibility information and information related to other health care projects and health, welfare and social services provided by the state or local communities. The plan staff, including community outreach representatives, shall refer all plan inquiries to the member services section of the plan or the state's choice counselor/enrollment broker. State approval of the script used by the plan's member services section must be obtained before usage.

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

Table 26 **Enrollment & Disenrollment** 42 CFR 438.56, 438.6, 42 CFR 438.10, 42 CFR 422.208, 42 CFR 422.210, 42 CFR 431.230, 42 CFR 438.400 through 42 CFR 438.424	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Sections I-V, VII-IX, XIV, XV, XVI
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Sections 2.1.1
PMHP Area 1	Attachment I, Sections 2.12, 2.13
PMHP Areas 2, 3, 4, 8, 9, and Child Welfare Specialty PMHP	Attachment I, Sections D.30 and D.31
PMHP Areas 5 and 7	Attachment D, Section D.31, D.32
PMHP Area 6	Attachment I, Sections 2.13, B. and 2.14
PMHP Area 11	Attachment I, Sections B.31 and B.32
Statewide Inpateint Psychiatric Program	Attachment II, Sections D.12, VV., YY. And D.24

5. Grievance System

The state requires the MCOs and PIHPs to develop, implement, and maintain a grievance system that complies with federal laws and regulations, including 42 CFR 431.200 and 438, Subpart F, Grievance System. The state requires the plan's member service handbook to include information on the plan's grievance system components.

The state requires the MCOs' and capitated PIHPs' grievance systems to include an external grievance resolution process as created in section 408.7056, Florida Statutes. The state's fee-for-service provider service networks do not have access to the external grievance resolution process established in section 408.7056, Florida Statutes. For those provider service networks only, the state requires the grievance system to include an external grievance resolution process referred to as the Beneficiary Assistance Program, which is operated by Florida Medicaid and modeled after the external grievance resolution process pursuant to section 408.7056, Florida Statutes.

The state requires all of the MCOs' and PIHPs' grievance systems to include written policies and procedures that are approved, in writing, by the state. Other state requirements include the following:

1. The plans must give enrollees reasonable assistance in completing forms and other procedural steps, including, but not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.
2. The plans must acknowledge receipt of each grievance and appeal.
3. The plans must ensure that decision makers about grievances and appeals were not involved in previous levels of review or decision making and are health care professionals with appropriate clinical expertise in treating the enrollee's condition or disease when deciding any of the following:
   - An appeal of a denial based on lack of medical necessity;
   - A grievance regarding denial of expedited resolution of an appeal; or
   - A grievance or appeal involving clinical issues.
4. The plans must provide information regarding the grievance system to enrollees as described in the plan's contract. The information shall include, but not be limited to:
   a. Enrollee rights to file grievances and appeals and requirements and time frames for filing.
   b. The availability of assistance in the filing process.
   c. The address, toll-free telephone number, and the office hours of the grievance coordinator.
   d. The method for obtaining a Medicaid fair hearing, the rules that govern representation at the hearing, and the DCF address for pursuing a fair hearing, which is:

      Office of Public Assistance Appeals Hearings
      1317 Winewood Boulevard, Building 5, Room 203
      Tallahassee, Florida 32399-0700

   e. A description of the external grievance resolution process, the types of grievances and appeals that can be submitted and directions for doing so.
   f. A statement assuring enrollees that the plan, its providers or the state will not retaliate against an enrollee for submitting a grievance, an appeal or a request for a Medicaid fair hearing.
   g. Enrollee rights to request continuation of benefits during an appeal or Medicaid fair hearing process and, if the plan's action is upheld in a hearing, the fact that the enrollee may be liable for the cost of said benefits.
   h. Notice that the MCO or PIHP must continue enrollee benefits if:
      (1) The appeal is filed timely, meaning on or before the later of the following:
         i. Within ten (10) calendar days of the date on the notice of action (Fifteen (15) calendar days if the notice is sent via surface mail), and
         ii. The intended effective date of the MCO or PIHP proposed action.
      (2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
      (3) The services were ordered by an authorized provider.
      (4) The authorization period has not expired.

(5) The enrollee requests extension of benefits.

i. The plan must provide information about the grievance system and its respective policies, procedures, and timeframes, to all providers and subcontractors at the time they enter into a subcontract/provider contract. The plan must clearly specify all procedural steps in the provider manual, including the address, telephone number, and office hours of the Grievance coordinator.

5. The plan must maintain records of grievances and appeals for tracking and trending for QI and to fulfill reporting requirements as described in the plan's contract.

6. Grievance Process.

The state requires the MCOs and PIHPs to comply by contract with the following grievance process requirements.

1. *Filing a Grievance*

   a. A grievance is any expression of dissatisfaction by an enrollee, about any matter other than an Action. A provider, acting on behalf of the enrollee and with the enrollee's written consent, may also file a grievance.

   b. A grievance may be filed orally.

2. *Grievance Resolution*

   a. The plan must resolve each grievance and provide the enrollee with a notice of the grievance disposition within ninety (90) days of its receipt.

   b. The grievance must be resolved more expeditiously, within twenty four (24) hours, if the enrollee's health condition requires, as found in s. 409.91211(3)(q), F.S.

   c. The notice of disposition must be in writing and include the results and the date of grievance resolution.

   d. The plan must provide the Agency with a copy of the notice of disposition upon request.

   e. The plan must ensure that punitive action is not taken against a provider who files a grievance on an enrollee's behalf or supports an enrollee's grievance as required in s. 409.9122(12), F.S.

3. *Submission to the Beneficiary Assistance Program (BAP) for FFS PSN or the Statewide Subscriber Program (SAP) for prepaid health plans.*

   a. The original grievance must be filed with the plan in writing.

   b. The submission of the grievance to the BAP must be done within one (1) year of the date of the occurrence which initiated the grievance.

   c. The grievance may be filed if it concerns:

      (1) The quality of health care services; or

      (2) Matters pertaining to the contractual relationship between an enrollee and the plan.

The state requires the MCOs and PIHPs to comply by contract with the following appeals process requirements.

1. *Filing an Appeal*

a. An enrollee may request a review of a health plan action by filing an appeal.

b. An enrollee may file an appeal, and a provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. The appeal procedure must be the same for all enrollees.

c. The appeal must be filed within thirty (30) days of the date of the notice of action. If the plan fails to issue a written notice of action, the enrollee or provider may file an appeal within one (1) year of the action.

d. The enrollee or provider may file an appeal either orally or in writing and must follow an oral filing with a written, signed appeal. For oral filings, time frames for resolution begin on the date the plan receives the oral filing.

2. *Resolution of Appeals*

The plan must:

a. Ensure that oral inquiries seeking to appeal an action are treated as appeals and acknowledge receipt of those inquiries, as well as written appeals, in writing, unless the enrollee or the provider requests expedited resolution.

b. Provide a reasonable opportunity for the enrollee/provider to present evidence, and allegations of fact or law, in person as well as in writing.

c. Allow the enrollee and their representative the opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records and any other documents and records.

d. Consider the enrollee representative or estate representative of a deceased enrollee as parties to the appeal.

e. Resolve each appeal and provide notice within forty-five (45) days from the day the plan receives the appeal.

f. Resolve the appeal more expeditiously if the enrollee's health condition requires.

g. The plan may extend the resolution time frames by up to fourteen (14) calendar days if the enrollee requests the extension or the plan documents that there is need for additional information and that the delay is in the enrollee's interest. If the extension is not requested by the enrollee, the plan must give the enrollee written notice of the reason for the delay.

h. Continue the Enrollee's Benefits if:

   (1) The appeal is filed timely, meaning on or before the later of the following:

      i. Within ten (10) calendar days of the date on the notice of action or fifteen (15) calendar days if sent by surface mail, or

      ii. The intended effective date of the plan's proposed action.

   (2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

   (3) The services were ordered by an authorized provider.

(4) The authorization period has not expired.

(5) The enrollee requests extension of benefits.

i. If the plan continues or reinstates enrollee benefits while the appeal is pending, the benefits must be continued until one of following occurs:

(1) The enrollee withdraws the appeal.

(2) Ten (10) calendar days (Fifteen (15) calendar days if the notice is sent via surface mail) pass from the date of the plan's adverse decision, and the enrollee has not requested a Medicaid fair hearing with continuation of benefits.

(3) A Medicaid fair hearing decision adverse to the enrollee is made.

(4) The authorization expires or authorized service limits are met.

j. Provide written notice of disposition that includes the results and date of appeal resolution, and for decisions not wholly in the enrollee's favor, also includes:

(1) Notice of the enrollee's right to request a Medicaid fair hearing.

(2) Information about how to request a Medicaid fair hearing, including the Florida Department of Children and Families address for pursuing a Medicaid fair hearing, which is:

Office of Public Assistance Appeals Hearings
1317 Winewood Boulevard, Building 5, Room 203
Tallahassee, Florida 32399

(3) Notice of the right to continue to receive Benefits pending a Medicaid fair hearing.

(4) Information about how to request the continuation of benefits.

(5) Notice that if the plan's action is upheld in a Medicaid fair hearing, the enrollee may be liable for the cost of any continued benefits.

k. Provide the Agency with a copy of the written notice of disposition upon request.

l. Ensure that punitive action is not taken against a provider who files an appeal on an enrollee's behalf or supports an enrollee's appeal.

3. *Post Appeal Resolution*

a. If the final resolution of the appeal in a fair hearing is adverse to the enrollee, the Agency may recover the cost of the services furnished while the appeal was pending, to the extent that they were furnished solely because of the requirements of this section.

b. The plan must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires, if the services were not furnished while the appeal was pending and the disposition reverses a decision to deny, limit, or delay services.

c. The plan must pay for disputed services, in accordance with state policy and regulations, if the services were furnished while the appeal was pending and the disposition reverses a decision to deny, limit, or delay services.

4. *Expedited Process*

a. The plan must establish and maintain an expedited review process for grievances and appeals when the plan determines (if requested by the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

b. The enrollee or provider may file an expedited appeal either orally or in writing. No additional enrollee follow-up is required.

The plan must:

(1) Inform the enrollee of the limited time available for the enrollee to present evidence and allegations of fact or law, in person and/or in writing.

(2) Resolve each expedited appeal and provide notice, as expeditiously as the enrollee's health condition requires, not to exceed seventy-two (72) hours after the plan receives the appeal.

(3) Provide written notice of disposition that includes the results and date of expedited appeal resolution, and for decisions not wholly in the enrollee's favor, that includes:

i. Notice of the enrollee's right to request a Medicaid fair hearing.

ii. Information about how to request a Medicaid fair hearing, including the Florida Department of Children and Families address for pursuing a fair hearing, which is:

Office of Public Assistance Appeals Hearings
1317 Winewood Boulevard, Building 5, Room 203
Tallahassee, Florida 32399-0700

iii. Notice of the right to continue to receive benefits pending a hearing.

iv. Information about how to request the continuation of benefits.

v. Notice that if the plan's action is upheld in a hearing, the enrollee may be liable for the cost of any continued benefits.

c. If the plan denies a request for expedited resolution of an appeal, the plan must:

(1) Transfer the appeal to the standard time frame of no longer than forty-five (45) days from the day the plan receives the appeal with a possible fourteen (14) day extension.

(2) Make reasonable efforts to provide prompt oral notice of the denial.

(3) Provide written notice of the denial within two (2) calendar days.

(4) Fulfill all general plan duties listed above.

5. *Submission to the BAP for FFS PSN and the SAP for Prepaid Health Plans.*

a. The submission of the appeal to the BAP or the SAP must be done within one (1) year of the date of the occurrence that initiated the appeal.

b. An enrollee may submit an appeal to the BAP or SAP if it concerns:

(1) The availability of health care services or the coverage of benefits, or an adverse determination about benefits made pursuant to UM; or

(2) Claims payment, handling, or reimbursement for benefits.

c. If the enrollee has taken the appeal to a Medicaid fair hearing, the enrollee cannot submit the appeal to the BAP or SAP.

7. Medicaid Fair Hearing System.

1. Request for a Medicaid Fair Hearing

a. An enrollee may request a Medicaid fair hearing either upon receipt of a notice of action from the plan or upon receiving an adverse decision from the plan, after filing an appeal with the plan.

b. A provider, acting on behalf of the enrollee and with the enrollee's written consent, may request a Medicaid fair hearing under the same circumstances as the Enrollee.

c. Parties to the Medicaid fair hearing include the plan, as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

d. The enrollee or provider may request a Medicaid fair hearing within ninety (90) calendar days of the date of the notice of action from the plan regarding an enrollee appeal.

e. The enrollee or provider may request a Medicaid fair hearing by contacting Florida Department of Children and Families at:

The Office of Public Assistance Appeals Hearings
1317 Winewood Boulevard, Building 5, Room 203
Tallahassee, Florida 32399-0700

2. The Plan Responsibilities

The plan must:

a. Continue the enrollee's benefits while the Medicaid fair hearing is pending if:

(1) The Medicaid fair hearing is filed timely, meaning on or before the later of the following:

i. Within ten (10) calendar days of the date on the notice of action (Fifteen (15) calendar days if the notice is sent via surface mail); or

ii. The intended effective date of the plan's proposed action.

(2) The Medicaid fair hearing involves the termination, suspension, or reduction of a previously authorized course of treatment.

(3) The services were ordered by an authorized provider.

(4) The authorization period has not expired.

(5) The enrollee requests extension of benefits.

b. Ensure that punitive action is not taken against a provider who requests a Medicaid fair hearing on the enrollee's behalf or supports an enrollee's request for a Medicaid fair hearing.

c. If the plan continues or reinstates enrollee benefits while the Medicaid fair hearing is pending, the benefits must be continued until one of following occurs:

   (1) The enrollee withdraws the request for a Medicaid fair hearing.

   (2) Ten (10) calendar days pass from the date of the plan's adverse decision and the enrollee has not requested a Medicaid fair hearing with continuation of benefits until a Medicaid fair hearing decision is reached. (Fifteen (15) calendar days if the notice is sent via surface mail)

   (3) A Medicaid fair hearing decision adverse to the enrollee is made.

   (4) The authorization expires or authorized service limits are met.

3. Post Medicaid Fair Hearing Decision

a. If the final resolution of the Medicaid fair hearing is adverse to the enrollee, the plan may recover the cost of the services furnished while the Medicaid fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

b. The plan must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires, if the services were not furnished while the Medicaid fair hearing was pending and the Medicaid fair hearing officer reverses a decision to deny, limit, or delay services.

c. The plan must pay for disputed services, in accordance with state policy and regulations, if the services were furnished while the Medicaid fair hearing was pending and the Medicaid fair hearing officer reverses a decision to deny, limit, or delay services.

The plan's grievance system is monitored by the state through on-site surveys, desk reviews and reports to the state. The annual on-site survey conducted by the state looks at a sample of the plan's grievance files. The annual desk review monitors the plan's policies and procedures and member materials for compliance with all state and Federal regulations. The state requires the plans to submit a quarterly report on new and outstanding grievances to the state.

The reference to the contract provisions which incorporate the grievance system requirements can be found by contract in Table 27.

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Table 27 Grievance System 42 CFR 431.200 and 438, Subpart F	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section IV, A.6.a(12)-(14), Section VII, I.2.a(6), Section IX
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.5
PMHP Area 1	Attachment I, Sections 1.1, TT., UU. and 2.15.1
PMHP Areas 2, 3, 4, 8, 9, and Child Welfare Specialty PMHP	Attachment I, Section D.33
PMHP Areas 5 and 7	Attachment D, Section D.34
PMHP Area 6	Attachment I, Sections 1.1, TT., UU. And 2.16.1
PMHP Area 11	Attachment I, Section D.35, B.
Statewide Inpatient Psychiatric Program	Attachment II, Section D.18

8. Subcontractual Relationship & Delegation

The state requires the plans to oversee and holds the plans accountable for any functions and responsibilities that it delegates to any subcontractor pursuant to 42 CFR 438.6(l), 42 CFR 438.230(a), 42 CFR 438.230(b)(1),(2),(3), SMM 2087.4, including:

- All plan subcontracts are required to fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract.
- The plans' contracts require that the plan evaluate the prospective subcontractor's ability to perform the activities to be delegated.
- The plans' contracts require a written agreement between the plan and the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
- The plans' contracts require that each plan monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the state, consistent with industry standards or the applicable laws and regulations.
- The plans' contracts require that if the plan identifies deficiencies or areas for improvement, the plan and the subcontractor must take corrective action.

During the initial MCO and PIHP contract application process, the state ensures the plans' subcontractual relationships and delegations comply with 42 CFR 438.6(l), 42 CFR 438.230(a), 42 CFR 438.230(b)(1),(2),(3), SMM 2087.4. The state conducts annual on-site surveys and desk reviews of the plans to ensure each plan's subcontractual relationships and delegations remain in compliance with 42 CFR 438.6(l), 42 CFR 438.230(a), 42 CFR 438.230(b)(1),(2),(3), SMM 2087.4.

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

Table 28 Subcontracted Relationships & Delegation 42 CFR 438.6(l), 42 CFR 438.230(a), 42 CFR 438.230(b)(1),(2),(3), SMM 2087.4	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section XVI, O.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.12.4
PMHP Area 1	Attachment I, Section 2.23
PMHP Areas 2, 3,4, 8, and 9	State Standard Contract, Item H
PMHP Areas 5 and 7	Attachment C, Section C.22
PMHP Area 6	Attachment I, Section 2.24
PMHP Area 11	Attachment I, Section B.18
Child Welfare Specialty PMHP	State Standard Contract, Section I.H
Statewide Inpatient Psychiatric Program	Attachment II, Section CC.

D. Detailed information related to Florida's Structure and Operation Standards

The state requires the plans to have a grievance system for enrollees that include a grievance process, an appeal process, and access to the Medicaid fair hearing system in compliance with 42 CFR 431.200 and 438, Subpart F. The plan's grievance system is monitored by the state through annual on-site surveys, desk reviews and reports submitted quarterly to the state. The references to the contract provision which incorporates the grievance requirements can be found by contract in Table 27.

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

- Administration and Management Policy and Procedures
- Staffing
- Disaster Plan
- Minority Retention and Recruitment Plan
- Insurance documents
- Member Identification Care
- Credentialing and Recredentialing Policy and Procedures
- Credentialing files
- Medical Record Requirements Policy and Procedures
- Member Handbook
- Provider Directories
- Board Meeting and Committee Meeting Minutes
- Quality Improvement Policy and Procedures
- Member Services and Enrollment Policy and Procedures
- Utilization Management Policy and Procedures

- Case Management/Continuity of Care Policy and Procedures
- Community Outreach Policy and Procedures
- Community Outreach Staff Qualifications and Credentials
- Community Outreach Plan
- Behavioral Health Policy and Procedures
- Provider Networks
- Provider Site Visit Form
- Grievance and Appeals Policy and Procedures
- Grievance and Appeals Letters
- Quality Benefit Enhancements
- Organization Chart
- Information Systems
- Model Subcontracts (Primary Care Provider, Specialty Care Provider, Ancillary Care Agreement)
- Hospital Service Agreement

Standards for Quality Measurement and Improvement and Contract Provisions

1. Practice Guidelines.

Pursuant to 42 CFR 438.236(b), the state requires the MCOs and PIHPs to adopt practice guidelines that meet the following requirements:

- Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.
- Consider the needs of the enrollees.
- Are adopted in consultation with contracting health care professionals.
- Are reviewed and updated periodically as appropriate.

The state requires that the MCOs and PIHPs disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. This section specifies that decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply shall be consistent with the guidelines.

The reference to the contract provision which incorporates the practice guidelines requirements can be found by contract in Table 29.

Table 29 Practice Guidelines 42 CFR 438.236(b)(c)(d)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section VIII, B.3
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Sections 2.12.2 (11) a through d, 2.12.2 (12)
PMHP Area 1	Attachment I, Section 2.16
PMHP Areas 2 and 3	Attachment I, Section D.34
PMHP Areas 4, 8, 9, and Child Welfare Specialty PMHP	Attachment I, Section D.34
PMHP Areas 5 and 7	Attachment D, Section D.22
PMHP Area 6	Attachment I, Sections 2.1, 2.3
PMHP Area 11	Attachment I, Section B.35
Statewide Inpatient Psychiatric Program	State Standard Contract, Section I

2. Quality Assessment & Performance Improvement Program.

The state requires the MCOs and PIHPs to have an ongoing quality improvement (QI) program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes in service performance to its Medicaid population. The plans' written policies and procedures are required to address components of effective health care management including, but not limited to, anticipation, identification, monitoring, measurement, and evaluation of enrollee's health care needs, and effective action to promote quality of care. The plans are required to define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success. Each plan and the plan's quality improvement program is required to demonstrate in each plan's care management how specific interventions better manage care and impact healthier patient outcomes to achieve the goal of providing comprehensive, high quality, accessible, cost effective, and efficient health care to Medicaid enrollees. Pursuant to 42 CFR 438.208(c)(1), the state requires the plans to implement mechanisms to identify persons with special health care needs, as those persons are defined by the state.

The state requires the plans to provide a written descriptive QI program that identifies FTE staff specifically trained to handle the Medicaid business and delineates how staffing is organized to interact and resolve problems, define measures and expectations, and demonstrate the process for decision making (i.e. project selection, interventions) and reevaluation.

The references to the contract provision which incorporates this requirement can be found by contract in Table 30.

Table 30 Quality Assessment & Performance Program 42 CFR 438.240(a)(1)(a)(2)(b)(3)(4)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section VIII, A.1., B.1.a.(1), B.2.a., e., and j.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.4
PMHP Area 1	Attachment I, Section 2.16
PMHP Areas 2, 3, 4, 8, 9, and Child Welfare Specialty PMHP	Attachment I, Section D.34
PMHP Areas 5 and 7	Attachment D, Section D.35
PMHP Area 6	Attachment I, Sections 2.17 and 2.30
PMHP Area 11	Attachment I, Section B.35
Statewide Inpatient Psychiatric Program	Attachment II, Section D.22

The state requires the plans to cooperate with the state and the External Quality Review Organization (EQRO) vendor. The state sets methodology and standards for QI performance improvement with advice from the EQRO. Prior to implementation, the state reviews each plan's QI program. Each plan's quality improvement program must be approved, in writing, by the state no later than three months following the effective date of the contract. If a plan has submitted and received approval for the present calendar year, an extension may be granted for the submission of new projects.

The state requires that the MCOs' and PIHPs' quality improvement programs be based on the minimum requirements listed below.

(a) The plan's QI governing body shall monitor, evaluate, and oversee results to improve care. The governing body shall have written guidelines and standards defining their responsibilities for:

- Supervision and maintenance of an active QI committee;
- Ensuring ongoing QI activity coordination with other management activity, demonstrated through written, retrievable documentation from meetings or activities;
- Planning, decisions, interventions, and assessment of results to demonstrate coordination of QI processes;
- Oversight of QI program activities; and
- A written diagram that demonstrates the QI system process.

(b) Each plan is required to have a quality improvement review authority which shall:

- Direct and review quality improvement activities;
- Assure that quality improvement activities take place throughout the plan;
- Review and suggest new or improved quality improvement activities;
- Direct task forces/committees in the review of focused concern;
- Designate evaluation and study design procedures;
- Publicize findings to appropriate staff and departments within the plan;

- Report findings and recommendations to the appropriate executive authority; and
- Direct and analyze periodic reviews of members' service utilization patterns.

(c) Each plan is required to provide for quality improvement staff specifically trained to handle the Medicaid business which have the responsibility for: identifying their Medicaid enrollees' needs and problems related to quality of care for covered health care and professional services, measuring how well these needs are met, and improving processes to meet these needs. Each plan is required to evaluate ways in which care is provided, identify outliers to specific indicators, determine what shall be accomplished, ascertain how to determine if a change is an improvement, and initiate interventions that will result in an improved quality of care for covered health care and professional services. Each plan is required to prioritize problem areas for resolution and design strategies for change, implement improvement activities and measure success.

(d) The systematic process of quality assessment and improvement shall be objective in systematically monitoring and evaluating the quality and appropriateness of care and service delivery (or the failure of delivery) to the Medicaid population through quality of care projects and related activities. Opportunities for improvement shall be identified on an ongoing basis. The plans are required to assess, evaluate, decrease inappropriate care, decrease inappropriate service denials, and increase coordination of care. The plans are required to document in their QI programs that they are monitoring the range of quality of care across services and all treatment modalities. This review of the range of care shall be carried out over multiple review periods and not only on a concurrent basis.

(e) At least four state-approved Performance Improvement Projects (PIPs) must be performed by each HMO and PSN and at least two PIPs must be performed by each NHDP, PMHP, and SIPP. Each study/project conducted by a plan must include a statistically significant sample of Medicaid lives. One of the four projects must focus on Clinical Health Care Disparities or Culturally and Linguistically Appropriate Services. The plans are required to provide notification to the state prior to implementation. The notification shall include the general description, justification, and methodology for each project and document the potential for meaningful improvement. The plans are required to report annually to the state. The report shall include the current status of the project including, but not limited to, goals, anticipated outcomes, and ongoing interventions. Each project shall have been through the plan's quality process, including reporting and assessments by the quality committee and reporting to the board of directors.

Pursuant to 42 CFR 438.240, the state requires the projects to focus on clinical care and non-clinical areas (i.e. health services delivery). These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year. CMS, in consultation with states and other stakeholders, may specify performance measures and topics for performance improvement projects. If CMS specifies performance improvement projects, the plan will participate and this will count towards the State-approved quality-of-care projects. Each individual CMS project can be counted as one of the State-approved quality of care projects. The quality-of-care projects used to measure performance improvement projects shall include diagrams (e.g., algorithms and/or flow charts) for monitoring and shall:

1. Target specific conditions and specific health service delivery issues for focused individual practitioner and system-wide monitoring and evaluation.
2. Use clinical care standards or practice guidelines to objectively evaluate the care the entity delivers or fails to deliver for the targeted clinical conditions.
3. Use appropriate quality indicators derived from the clinical care standards or practice guidelines to screen and monitor care and services delivered.
4. Implement system interventions to achieve improvement in quality.
5. Evaluate the effectiveness of the interventions.
6. Provide sufficient information to plan and initiate activities for increasing or sustaining improvement.
7. Monitor the quality and appropriateness of care furnished to enrollees with special health care needs.
8. Reflect the population served in terms of age groups, disease categories, and special risk status.
9. Ensure that appropriate health professionals analyze data.
10. Ensure that multi-disciplinary teams will address system issues.
11. Include objectives and quantifiable measures based on current scientific knowledge and clinical experience and have an established goal or benchmark.
12. Identify and use quality indicators that are measurable and objective.
13. Validate the design to assure that the data to be abstracted during the QI project is accurate, reliable and developed according to generally accepted principles of scientific research and statistical analysis.
14. Maintain a system for tracking issues over time to ensure that actions for improvement are effective.

The state requires the plan's quality improvement information to be used in such processes as recredentialing, recontracting, and annual performance ratings. The state requires the plans to coordinate with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of member grievances. The state requires the plans to establish a link between other management activities such as network changes, benefits redesign, medical management systems (e.g., precertification), practice feedback to physicians, patient education, and member services.

The state requires the plans' quality improvement programs to have a peer review component with the authority to review practice methods and patterns of individual physicians and other health care professionals, morbidity/mortality, and all grievances related to medical treatment; evaluate the appropriateness of care rendered by professionals; implement corrective action when deemed necessary; develop policy recommendations to maintain or enhance the quality of care provided to Medicaid enrollees; conduct a review process which includes the appropriateness of diagnosis and subsequent treatment, maintenance of medical records requirements, adherence to standards generally accepted by professional group peers, and the process and outcome of care; maintain written minutes of the meetings; receive all written and oral allegations of inappropriate or aberrant service; and educate recipients and staff on the role of the peer review authority and the process to advise the authority of situations or problems.

(f) The state requires the plans to collect data on patient outcome performance measures, as defined by the Healthcare Effectiveness Data and Information Set (HEDIS) or otherwise defined by the state and to report the results of the measures to the state annually. The state may add or remove reporting requirements with 30-days advance notice.

The state requires the plans to submit their performance measure data and a certification by a state-approved, NCQA-certified independent auditor that the performance measure data reported for the previous calendar year have been fairly and accurately presented.

Further discussion of performance measures can be found in section III, Improvement.

(g) For HMOs and PSNs, the state conducts an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The plans use the results of the annual member satisfaction survey to develop and implement plan-wide activities designed to improve member satisfaction. The state reviews the CAHPS survey results and if there are any deficiencies, a corrective action plan is required within two (2) months of the request from the state. Activities conducted by the plan pertaining to improving member satisfaction resulting from the annual member satisfaction survey must be reported to the agency on a quarterly basis.

Prepaid Mental Health Plans, Nursing Home Diversion Plans, and Statewide Inpatient Psychiatric Programs are required to conduct state-approved enrollee satisfaction surveys.

The references to the contract provision which incorporates this requirement can be found by contract in Table 31.

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

Plan Type	Contract Provision
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section VIII, A.3.a.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.4.3.a.
PMHP Area 1	Attachment I, Section 2.16
PMHP Areas 2, 3, 8, and 9	Attachment I, Sections D.34 and D.55
PMHP Areas 4 and Child Welfare Specialty PMHP	Attachment I, Section D.34
PMHP Areas 5 and 7	Attachment D, Section D.35
PMHP Area 6	Attachment I, Section 2.30
PMHP Area 11	Attachment I, Section B.35
Statewide Inpatient Psychiatric Program	Attachment II, Section D.22, A.3

3. Health Information Systems.

The state requires the plans to comply with all the reporting requirements established by the state and specified in the plan's contract. The plans are responsible for assuring the accuracy, completeness, and timely submission of each report. Deadlines for report submission referred to in the plan's contract specify the actual time of receipt at the state, not the date the file was postmarked or transmitted. Before October 1 of each contract year, the plans are required to deliver to the state certifications by a State of Florida approved independent auditor that the

Child Health Check Up screening rate reports have been fairly and accurately presented. In addition, by July 1, the plans are required to deliver to the state a certification by a State of Florida approved independent auditor that the quality indicator data reported for the previous calendar year have been fairly and accurately presented. The state furnishes the plans with the appropriate reporting formats, instructions, submission timetables and technical assistance as required.

The state requires certification of data as provided in 42 CFR 438.606. The data that must be certified include, but are not limited to, enrollment information, encounter data, and other information required by the state. The state reserves the right to modify the reporting requirements to which the plans must adhere but will allow the plans 90 calendar days to complete the implementation, unless otherwise required by law. The state provides the plans written notification of modified reporting requirements. Failure of the plan to submit required reports accurately and within the time frames specified in the plan's contract may result in sanctions being levied.

Health information systems requirements specified in the MCO and PIHP contracts are outlined below.

(a) General Provisions

1. *Systems Functions*. The plans are required to have Information management processes and Information Systems (hereafter referred to as Systems) that enable the plan to meet state and federal reporting requirements and other contract requirements and that are in compliance with the contract and all applicable state and federal laws, rules and regulations including HIPAA.
2. *Systems Capacity*. The plans' Systems are required to possess capacity sufficient to handle the workload projected for the begin date of operations and that will be scalable and flexible so they can be adapted as needed, within negotiated timeframes, in response to changes in contract requirements, increases in enrollment estimates, etc.
3. *E-Mail System*. The plans are required to provide a continuously available electronic mail communication link (E-mail system) with the state. This system shall be available from the workstations of the designated plan contacts and capable of attaching and sending documents created using software products other than the plan's systems, including the state's currently installed version of Microsoft Office and any subsequent upgrades as adopted.
4. *Participation in Information Systems Work Groups/Committees*. The state requires the plans to meet, as requested by the state, to coordinate activities and develop cohesive systems strategies across vendors and agencies that actively participate in the Reform initiative.
5. *Connectivity to the Agency/State Network and Systems*. The plans are responsible for establishing connectivity to the state's wide area data communications network, and the relevant information systems attached to this network, in accordance with all applicable state policies, standards and guidelines.

(b) Data and Document Management Requirements

1. *Adherence to Data and Document Management Standards.*

a. The state requires the plans' Systems to conform to the standard transaction code sets specified in the contract.

b. The state requires the plans' Systems to conform to HIPAA standards for data and document management that are currently under development within one hundred twenty (120) Calendar Days of the standards' effective date or, if earlier, the date stipulated by CMS or the state.

c. The state requires the plans to partner with the state in the management of standard transaction code sets specific to the state. Furthermore, the plans are required to partner with the state in the development and implementation planning of future standard code sets not specific to HIPAA or other federal efforts and shall conform to these standards as stipulated in the plan to implement the standards.

2. *Data Model and Accessibility*. The state requires the plans' Systems to be Structured Query Language (SQL) and/or Open Database Connectivity (ODBC) compliant; alternatively, Health Plan Systems shall employ a relational data model in the architecture of their databases in addition to a relational database management system (RDBMS) to operate and maintain them.

3. *Data and Document Relationships*. The state requires the plans' Systems to house indexed images of documents used by Enrollees and providers to transact with the plan in the appropriate database(s) and document management systems so as to maintain the logical relationships between certain documents and certain data.

4. *Information Retention*. The state requires the information in plans' Systems to be maintained in electronic form for three years in live Systems and, for audit and reporting purposes, for seven years in live and/or archival Systems.

5. *Information Ownership*. All Information, whether data or documents, and reports that contain or make references to said Information, involving or arising out of the contract, is owned by the state. The plans are expressly prohibited from sharing or publishing the state information and reports without the prior written consent of the state. In the event of a dispute regarding the sharing or publishing of information and reports, the state's decision on this matter shall be final and not subject to change.

(c) System and Data Integration Requirements

1. Adherence to Standards for Data Exchange.

a. The plan's Systems are required to be able to transmit, receive and process data in HIPAA-compliant formats that are in use as of the plan's contract execution date; these formats are detailed in plan's contract.

b. The plan's Systems are required to be capable of transmitting, receiving and processing data in the state-specific formats and/or methods that are in use on the plan's contract execution date, as specified in plan's contract.

c. The plan's Systems are required to conform to future federal and/or state specific standards for data exchange within one hundred twenty (120) calendar days of the standard's effective date or, if earlier, the date stipulated by CMS or the state. The plans are required to partner with the state in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other Federal effort. The plans

are required to conform to these standards as stipulated in the plan to implement such standards.

2. HIPAA Compliance Checker.

All HIPAA-conforming exchanges of data between the state and the plans are subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker application.

3. Data and Report Validity and Completeness.

The plans are required to institute processes to ensure the validity and completeness of the data, including reports, the plan submits to the state. At the state's discretion, the state will conduct general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include but are not limited to: Enrollee ID, date of service, assigned Medicaid Provider ID, category and sub category (if applicable) of service, diagnosis codes, procedure codes, revenue codes, date of claim processing, and (if and when applicable) date of claim payment. Control totals shall also be reviewed and verified.

4. State/Agency Website/Portal Integration.

Where deemed that the plan's Web presence will be incorporated to any degree in the state's or the state's Web presence (also known as Portal), the plans are required to conform to any applicable state standard for Website structure, coding and presentation.

5. Connectivity to and Compatibility/Interoperability with Agency Systems and IT Infrastructure.

The state requires the plans to be responsible for establishing connectivity to the state's wide area data communications network, and the relevant information systems attached to this network, in accordance with all applicable state policies, standards and guidelines.

6. Functional Redundancy with FMMIS.

The state requires the plans to be able to transmit and receive transaction data to and from FMMIS as required for the appropriate processing of claims and any other transaction that could be performed by either System.

7. Data Exchange in Support of the Agency's Program Integrity and Compliance Functions.

The state requires the plans' System(s) to be capable of generating files in the prescribed formats for upload into Agency Systems used specifically for program integrity and compliance purposes.

8. Address Standardization.

The state requires the plan's system(s) to possess mailing address standardization functionality in accordance with US Postal Service conventions.

9. Eligibility and Enrollment Data Exchange Requirements

a. The state requires the plans to receive, process, and update enrollment files sent daily by the Agency or its Agent.
b. The state requires the plans to update their eligibility/Enrollment databases within twenty-four (24) hours of receipt of said files.
c. The state requires the plans to transmit to the state or its agent, in a periodicity schedule, format and data exchange method to be determined by the state, specific data it may garner from a plan's enrollee including third party liability data.
d. The state requires the plans to be capable of uniquely identifying a distinct Medicaid Recipient across multiple Systems within its Span of Control.

(d) Systems Availability, Performance and Problem Management Requirements

1. Availability of Critical Systems Functions.

The state requires the plans to ensure that critical systems functions available to plan enrollees and providers – functions that if unavailable would have an immediate detrimental impact on enrollees and providers – are available twenty-four (24) hours a day, seven (7) days a week, except during periods of scheduled System unavailability agreed upon by the state and the plan. Unavailability caused by events outside of a plan's span of control is outside of the scope of this requirement.

2. Availability of Data Exchange Functions.

The state requires the plans to ensure that the systems and processes within its Span of Control associated with its data exchanges with the state and/or its Agent(s) are available and operational according to specifications and the data exchange schedule.

3. Availability of Other Systems Functions.

The state requires the plans to ensure that at a minimum, all other System functions and Information are available to the applicable System users between the hours of 7:00 a.m. and 7:00 p.m., EST or EDT as appropriate, Monday through Friday.

4. Problem Notification.

a. Upon discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of all Systems functions and the availability of information in said Systems, including any problems impacting scheduled exchanges of data between the plan and the state and/or its Agent(s), the plan must notify the applicable state staff via phone, fax and/or electronic mail within fifteen (15) minutes of such discovery. In their notification, the plans are required to explain in detail the impact to critical path processes such as enrollment management and claims submission processes.
b. The state requires the plans to provide to appropriate state staff information on System unavailability events, as well as status updates on problem resolution. At a minimum these updates shall be provided on an hourly basis and made available via electronic mail and/or telephone.

5. Recovery from Unscheduled System Unavailability.

Unscheduled System unavailability caused by the failure of systems and telecommunications technologies within the plan's span of control will be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of System unavailability.

6. Exceptions to System Availability Requirement.

The plans are not responsible for the availability and performance of systems and information technology infrastructure technologies outside of the plan's span of control.

7. Corrective Action Plan.

Full written documentation that includes a corrective action plan, that describes how problems with critical Systems functions will be prevented from occurring again, are required to be delivered within five (5) business days of the problem's occurrence.

8. Business Continuity-Disaster Recovery (BC-DR) Plan

   a. Regardless of the architecture of its Systems, the plans are required to develop and be continually ready to invoke a business continuity and disaster recovery (BC-DR) plan that is reviewed and prior-approved by the state.
   b. At a minimum the plan's BC-DR plan shall address the following scenarios: (1) the central computer installation and resident software are destroyed or damaged, (2) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage, (3) System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system, (4) System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the System, i.e., causes unscheduled System unavailability.

      The state requires the plans to periodically, but no less than annually, perform comprehensive tests of its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to the state that it can restore System functions per the standards outlined elsewhere in contract.

   c. In the event that the plan fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in the contract, the plans must submit to the state a corrective action plan in accordance with contract which describes how the failure will be resolved. The corrective action plan shall be delivered within ten (10) business days of the conclusion of the test.

(e) System Testing and Change Management Requirements

1. Notification and Discussion of Potential System Changes.

The state requires the plans to notify the applicable state staff person of the following changes to Systems within its span of control within at least ninety (90) Calendar Days of the projected date of the change; if so directed by the state, the plan is required to discuss the proposed

change with the applicable state staff: (1) software release updates of core transaction Systems: claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management; (2) conversions of core transaction management Systems.

2. Response to Agency Reports of Systems Problems not Resulting in System Unavailability.

The state requires the plans to respond to state reports of System problems not resulting in System unavailability according to the following timeframes:

   a. Within seven (7) calendar days of receipt, the Health Plan shall respond in writing to notices of system problems.
   b. Within twenty (20) calendar days, the correction will be made or a requirements analysis and specifications document will be due.
   c. The plan will correct the deficiency by an effective date to be determined by the state.

3. Valid Window for Certain System Changes.

Unless otherwise agreed to in advance by the state as part of the activities described in the contract, scheduled System unavailability to perform System maintenance, repair and/or upgrade activities shall not take place during hours that could compromise or prevent critical business operations.

4. Testing

   a. The state requires the plans to work with the state pertaining to any testing initiative as required by the state.
   b. The state requires the plans to provide sufficient system access to allow the state and/or independent testing of the plan's systems during and subsequent to readiness review.

(f) Information Systems Documentation Requirements

1. Types of Documentation.

The state requires the plans to develop, prepare, print, maintain, produce, and distribute distinct System Process and Procedure Manuals, User Manuals and Quick/Reference Guides, and any updates thereafter, for the state and other applicable state staff.

2. Content of System Process and Procedure Manuals.

The state requires the plans to ensure that written System process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems.

3. Content of System User Manuals.

The System user manuals shall contain information about, and instructions for, using applicable System functions and accessing applicable system data.

4. Changes to Manuals.

   a. When a System change is subject to state sign off, the plans are required to draft revisions to the appropriate manuals prior to state sign off of the change.
   b. Updates to the electronic version of these manuals shall occur in real time; updates to the printed version of these manuals shall occur within ten (10) business days of the update taking effect.

5. Availability of/Access to Documentation.

All of the aforementioned manuals and reference guides shall be available in printed form and/or on-line. If so prescribed, the manuals will be published in accordance with the appropriate state standard.

(g) Reporting Requirements - Specific to Information Management and Systems Functions and Capabilities and Technological Capabilities

1. Reporting Requirements.

The state requires the plans to submit a monthly Systems Availability and Performance Report to the state as described in contract.

2. Reporting Capabilities.

The state requires the plans to provide systems-based capabilities to authorized state personnel, on a secure and read-only basis, to access data that can be used in ad hoc reports.

(h) Other Requirements

Community Health Record/Electronic Medical Record and Related Efforts

   a. At such time that the state requires, the plans are required to participate and cooperate with the state to implement, within a reasonable timeframe, secure, Web-accessible Community Health Records for enrollees.
   b. The design of the vehicle(s) for accessing the Community Health Record, the health record format and design shall comply with all HIPAA and related regulations.
   c. The state requires the plans to also cooperate with the state in the continuing development of the state's health care data site (FloridaHealthFinder).

(i) Compliance with Standard Coding Schemes

1. Compliance with HIPAA-Based Code Sets.

A plan's System that is required to or otherwise contains the applicable data type shall conform to the following HIPAA-based standard code sets; the processes through which the data are generated should conform to the same standards as needed:

   a. Logical Observation Identifier Names and Codes (LOINC)
   b. Health Care Financing Administration Common Procedural Coding System (HCPCS)
   c. Home Infusion EDI Coalition (HEIC) Product Codes

d. National Drug Code (NDC)

e. National Council for Prescription Drug Programs (NCPDP)

f. International Classification of Diseases (ICD-9)

g. Diagnosis Related Group (DRG)

h. Claim Adjustment Reason Codes

i. Remittance Remarks Codes

2. Compliance with Other Code Sets.

A plan System that is required to or otherwise contains the applicable data type shall conform to the following non-HIPAA-based standard code sets:

a. As described in all AHCA Medicaid Reimbursement Handbooks, for all "Covered Entities", as defined under the HIPAA, and which submit transactions in paper format (non-electronic format).

b. As described in all AHCA Medicaid Reimbursement Handbooks for all "Non-covered Entities", as defined under the HIPAA.

(j) Data Exchange and Formats and Methods Applicable to Health Plans

1. HIPAA-Based Formatting Standards.

MCO and PIHP Systems are required to conform to the following HIPAA-compliant standards for information exchange effective the first day of operations in the applicable service region:

<u>Batch transaction types</u>

- ASC X12N 834 Enrollment and Audit Transaction
- ASC X12N 835 Claims Payment Remittance Advice Transaction
- ASC X12N 837I Institutional Claim/Encounter Transaction
- ASC X12N 837P Professional Claim/Encounter Transaction
- ASC X12N 837D Dental Claim/Encounter Transaction
- NCPDP 1.1 Pharmacy Claim/Encounter Transaction

<u>Online transaction types</u>

- ASC X12N 270/271 Eligibility/Benefit Inquiry/Response
- ASC X12N 276 Claims Status Inquiry
- ASC X12N 277 Claims Status Response
- ASC X12N 278/279 Utilization Review Inquiry/Response
- NCPDP 5.1 Pharmacy Claim/Encounter Transaction

2. Methods for Data Exchange.

The plan and the state and/or its agent(s) shall make predominant use of Secure File Transfer Protocol (SFTP) and Electronic Data Interchange (EDI) in their exchanges of data.

3. Agency-Based Formatting Standards and Methods.

Plan Systems are required to exchange the following data with the state and/or its agent(s) in a format to be jointly agreed upon by the plan and the state:

a. Provider network data
b. Case management fees
c. Administrative payments

The references to the contract provision which incorporates these requirements can be found by contract in Table 32.

Table 32 **Health Information Systems** 42 CFR 438.242(a)(b)(1)(2)(3)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section XI, Section XII, A.1. and Table 1.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.2, 3.2.2, Attachment IV
PMHP Area 1	Attachment I, Sections 2.24, 2.30
PMHP Areas 2 and 3	Attachment I, Sections D.54, Standard Contract C.2
PMHP Area 4, 8, 9, and 11	Attachment I, Section D.54
PMHP Areas 5 and 7	Attachment D, SectionD.55
PMHP Area 6	Attachment I, Section 2.25
Child Welfare Specialty PMHP	Attachment I, Section D.53
Statewide Inpatient Psychiatric Program	Attachment II, Section D.22, A.2 and Attachment II-A, Items 9.e (4) and 11.e (4)

Table 33 provides a summary list of the reports required by the state for contracts operated under the Florida 1915(b) Managed Care Waiver and the 1115 Demonstration Waiver.

Table 33 **Medicaid Managed Care Required Reports**		
Contract Section	**Report Name**	**Frequency**
Section II	**Benefit Maximum Report**	**Monthly,** fifteen (15) days after end of reporting month **once $450,000 in enrollee costs is reached**
Section III	**Newborn Enrollment Report**	**Weekly,** on Wednesday
Section III	**Involuntary Disenrollment Report**	**Monthly,** first Thursday of month
Section IV	**Medicaid Redetermination Notice Summary Report**	**Quarterly,** forty-five (45) days after end of reporting quarter

Table 33 Medicaid Managed Care Required Reports		
Contract Section	**Report Name**	**Frequency**
Section IV	**Community Outreach Health Fairs/Public Events Notification**	**Monthly,** no later than the 20th day of the month before event month; amendments two weeks before event
Section IV	**Community Outreach Representative Report**	Two (2) weeks before activity **Quarterly,** forty-five (45) days after end of reporting quarter
Section V	**Customized Benefit Notifications Report**	**Monthly,** fifteen (15) days after end of reporting month
Section V	**CHCUP (CMS-416) & FL 60% Screening (Child Health Check Up report)**	**Annually,** unaudited by January 15th for prior federal fiscal year; **Annually,** audited report by October 1st
Section V	**Inpatient Discharge Report**	**Quarterly, within** thirty (30) calendar days after end of reporting quarter
Section V	**Hernandez Settlement Ombudsman Log**	**Quarterly,** fifteen (15) days after end of reporting quarter
Section V	**Hernandez Settlement Agreement Survey**	**Annually,** on August 1st
Section V	**Quarterly Pharmacy (RX Quarterly) Encounter Data Submissions**	**Quarterly,** 30 calendar days after end of reporting quarter
Section V	**Behavioral Health – Pharmacy Encounter Data Report**	**Quarterly,** forty-five (45) days after end of reporting quarter
Section V	**Pharmacy Navigator Report**	**Annually,** by December 1st
Section V and Exhibit 4	**Enhanced Benefits Report**	**Monthly,** ten (10) days after end of reporting month
Section VI, Exhibit 6	**Behavioral Health Annual 80/20 Expenditure Report**	**Annually,** by April 1st

Table 33 Medicaid Managed Care Required Reports		
Contract Section	**Report Name**	**Frequency**
Section VI, Exhibit 6	**Behavioral Health Critical Incident Report - Individual**	**Immediately, no later than twenty-four (24) hours after occurrence or knowledge of incident**
Section VI, Exhibit 6	**Behavioral Health Critical Incident Report - Summary**	**Monthly,** on the 15th
Section VI, Exhibit 6	**Behavioral Health - Required Staff/Providers Report**	**Quarterly,** forty-five (45) days after end of reporting quarter for Health Plans operating less than one (1) year; **Annually,** by August 15th, for all other Health Plans
Section VI, Exhibit 6	**Behavioral Health - FARS/CFARS**	**Semi-Annually,** August 15th and February 15th
Section VI, Exhibit 6	**Behavioral Health - Enrollee Satisfaction Survey Summary**	**Annually,** by March 1st
Section VI, Exhibit 6	**Behavioral Health - Stakeholders' Satisfaction Survey - Summary**	**Annually,** by March 1st
Section VI, Exhibit 6	**Behavioral Health - Encounter Data Report**	**Quarterly,** forty-five (45) days after end of reporting quarter
Section VII	**Provider Network File**	**Monthly,** first Thursday of month (optional weekly submissions each Thursday for remainder of month)
Section VII	**Provider Termination and New Provider Notification Report**	**Monthly,** by (15th) calendar day of the month following the reporting month
Section VII	**PCP Wait Times Report**	**Annually,** by February 1st
Section VIII	**Cultural Competency Plan (and Annual Evaluation)**	**Annually,** June 1st
Section IX	**Complaints, Grievance, and Appeals Report**	**Quarterly,** fifteen (15) calendar days after end of quarter
Section X	**Performance Measures**	**Annually,** on July 1st
Section X	**MPI – Quarterly Fraud & Abuse Activity Report**	**Quarterly,** fifteen (15) days after the end of reporting quarter
Section X	**MPI - Suspected/ Confirmed Fraud & Abuse Reporting**	**Within** fifteen (15) days of detection

Table 33 Medicaid Managed Care Required Reports		
Contract Section	**Report Name**	**Frequency**
Section XI	**Claims Aging Report & Supplemental Filing Report**	**Quarterly,** forty-five (45) days after end of reporting quarter; **Capitated Plans,** optional supplemental filing – one-hundred and five (105) calendar days after end of reporting quarter
Section XIII	**Medicaid Reform Supplemental HIV/AIDS Report**	**Monthly,** by second Thursday of month
Section XIII	**Catastrophic Component Threshold Report**	**Monthly,** fifteen (15) days after end of reporting month
Section XV	**Insolvency Protection Multiple Signatures Agreement Form**	**Annually,** by April 1st **Thirty (30) calendar** days after any change
Section XV	**Audited Annual and Unaudited Quarterly Financial Reports**	**Audited - Annually** on or before April 1 following the end of reported calendar year; **Unaudited** – **Quarterly**, forty-five (45) calendar days after end of reporting quarter
Section XVI	**Minority Participation Report**	**Monthly,** fifteen (15) days after month being reported

D. Detailed information related to the Quality Measurement and Improvement Standards

1. A Description of the Methods and Timeframes to Assess the Quality and Appropriateness of Care and Services to all Medicaid Enrollees.

The state requires the plans to implement mechanisms for identifying, assessing and ensuring the existence of a treatment plan for individuals with special health care needs. The plans are required to have mechanisms for all enrollees that include evaluation of health risk assessments, claims data, and, if available CPT/ICD-9 codes. The plans are required to implement a process for receiving and considering provider and enrollee input. In addition, the state requires the plans to contact each new member at least two times, if necessary, within 90 calendar days of enrollment, to urge scheduling of an initial appointment with the primary care provider for the purpose of a health risk assessment.

The references to the contract provision which incorporates this requirement can be found by contract in Table 34.

Table 34 Assessment of the Quality & Appropriateness of Care and Services 42 CFR 438.208(c)(2)(3)	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section IV, A.8.a.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.1.1.11, 2.1.1.15
PMHP Area 1	Attachment I, Section 2.4.K.
PMHP Areas 2, 3, 4, 8, and 9	Attachment I, Section D.22,J.
PMHP Areas 5 and 7	Attachment D, Section D.23,J.
PMHP Area 6	Attachment I, Section 2.4
PMHP Area 11	Attachment I, Section B.23, J.
Child Welfare Specialty PMHP	Attachment I, Section D.22 (7)
Statewide Inpatient Psychiatric Program	Attachment II, Sections D.10, F.8, D.11, D., and D.12, RR.

2. An Identification of the Populations Florida Considers when Determining Individuals with Special Health Care Needs.

The state uses the following population groups that were identified in the "Report to Congress – Safeguards for Individuals with Special Health Care Needs Enrolled in Medicaid Managed Care" dated November 6, 2000.

- Children with special health care needs;
- Children in foster care;
- Individuals with serious and persistent mental illness and/or substance abuse;
- Individuals who are homeless;
- Older adults with disabilities; and
- Non-elderly adults who are disabled or chronically ill with physical or mental disabilities.

To further define children with special health care needs, the state uses the CMS functional definition of children with special health care needs as stated in the January 19, 2001, State Medicaid Director letter, SMDL #01-012:

- Blind/Disabled Children and Related Populations (eligible for SSI under Title XVI);
- Eligible under section 1902(e)(3) of the Social Security Act and are an optional Medicaid eligibility group (also known as "Katie Beckett" children) who require a level of care provided in institutions but reside in the community;
- In foster care or other out-of-home placement;
- Receiving foster care or adoption assistance; and
- Receiving services through a family-centered, community-based coordinated care system that receives grant funds under Section 501 (a)(1)(D) of Title V, as defined by the State in terms of either program participant or special health care needs.

*Note - Children with special health care needs are exempt from Florida's Medicaid managed care mandatory assignment process as specified in s. 409.9126, F.S. Medicaid eligible recipients under age 21 who have special health care needs and are in the Florida Medicaid primary care case management program (referred to as MediPass) eligibility category may elect to enroll in Florida's Children's Medical Services Network. The Florida Legislature has defined children with special health care needs as "those children whose serious or chronic physical or developmental conditions require extensive preventive and maintenance care beyond that required by typically healthy children".

3. Florida standards for the identification and assessment of individuals with special health care needs.

The plans must have mechanisms that include evaluation of health risk assessments, claims data, and, if available CPT/ICD-9 codes for identifying, assessing and ensuring the existence of a treatment plan for individuals with special health care needs. Additionally, the plans are required to implement a process for receiving and considering provider and enrollee input.

The references to the contract provision which incorporates these requirements can be found by contract in Table 35.

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

Plan Type	Contract Provision
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section IV, A.8.a.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.1.1.14 (2) b and d.
PMHP Area 1	Attachment I, Section 2.4.K.
PMHP Areas 2, 3, 4, 8, and 9	Attachment I, Section D.22,J.
PMHP Areas 5 and 7	Attachment D, Section D.23,J.
PMHP Area 6	Attachment I, Section 2.4
PMHP Area 11	Attachment I, Section B.23, J.
Child Welfare Specialty PMHP	Attachment I, Section D.22 (7)
Statewide Inpatient Psychiatric Program	Attachment II, Sections D.10, F.8 and D.12, RR.

4. Florida's Procedures to Separately Assess the Quality and Appropriateness of Care and Services Furnished to all Medicaid Managed Care Enrollees and to Individuals with Special Health Care Needs.

Prior to contracting with MCOs and PIHPs, the state conducts on-site surveys to document the plan's capacity to assess the quality and appropriateness of care and services to Medicaid enrollees and individuals with special health care needs. The state conducts annual on-site quality of care surveys and desk reviews to ensure the plan maintains compliance with the plan's contract including all applicable Federal and state quality measurement and improvement regulations. The state quarterly monitors MCOs and PIHPs, which have been approved to provide services to Medicaid-eligible children with special health care needs as specified in s. 409.9126, Florida Statutes, each plan based on the plan's provider network capacity to serve children with special health care needs. The state also utilizes the required health information

system reports specified in each plan's contract to monitor and assess the quality and appropriateness of care and services furnished by the plans to Medicaid enrollees and to individuals with special health care needs.

MCO/PIHP Contractual Compliance

During the MCO and PIHP contract application process, the state conducts on-site surveys to document the plan's capacity to comply with the State-established standards for access to care, structure and operations, and quality measurement and improvement. The state conducts annual on-site quality of care surveys to ensure the MCOs and PIHPs maintain compliance with the plan's contract including all applicable Federal and state access to care, structure and operations, and quality measurement and improvement requirements. The state quarterly monitors the MCOs and PIHPs through desk reviews.

The state conducts an exit interview with the plan to address immediate findings after each annual on-site quality of care compliance survey. If on-site survey findings warrant formal correction, the state will send the plan a summary of corrective actions along with relevant supporting documentation and request a corrective action plan to be submitted to the state within 10 business days. The state reviews all corrective action plans. The state monitors the plans through follow-up on-site surveys until the plan has demonstrated full compliance.

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

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

Plan Type	Contract Provision
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section II, C.1. and 16.
Prepaid Inpatient Health Plans	
Nursing Home Diversion Plans	Attachment I, Section 2.12.5
PMHP Area 1	Attachment I, Sections D.56, D.81, and Core Contract Section I., E.2.
PMHP Areas 2, 3, 4, 8, and 9	Attachment I, Section D.55
PMHP Areas 5 and 7	Attachment D, SectionD.56 and Core Contract, E.2.
PMHP Area 6	Attachment I, Section 2.42, Core Contract, E.2.
PMHP Area 11	Attachment I, Section B.56
Child Welfare Specialty PMHP	Attachment I, Sections D.22 and D.54
Statewide Inpatient Psychiatric Program	Attachment II, Section D.22

Intermediate Sanctions

The MCO and PIHP intermediate sanctions are designed to address identified quality of care problems in support of the state's quality strategy and these sanctions meet, at a minimum, the requirements specified in 42 CFR 438 Subpart I. In accordance with section 4707 of the Balanced Budget Act of 1997, and section 409.912, F.S., the state may impose any of the

following sanctions against the plan if the state determines that the plan has violated any provision of its contract, or the applicable statutes or rules governing the MCO or PIHP:

a. Suspension of the plan's voluntary enrollments and participation in the assignment process for Medicaid enrollment;

b. Suspension or revocation of payments to the plan for Medicaid enrollees enrolled during the sanction period. If the plan has violated the contract, the state may order the plan to reimburse the complainant for out-of-pocket medically necessary expenses incurred or order the plan to pay non-network plan providers who provide medically necessary services;

c. Suspension of all marketing activities to Medicaid enrollees;

d. Imposition of a fine for violation of the contract with the state, pursuant to section 409.912, F.S. With respect to any nonwillful violation, such fine shall not exceed $2,500 per violation. In no event shall such fine exceed an aggregate amount of $10,000 for all nonwillful violations arising out of the same action. With respect to any knowing and willful violation of section 409.912, F.S., or the contract with the state, the state may impose a fine upon the entity in an amount not to exceed $20,000 for each such violation. In no event shall such fine exceed an aggregate amount of $100,000 for all knowing and willful violations arising out of the same action.

e. Termination pursuant to paragraph III.B. (3) of the state's core contract and the section on termination procedures, if the plan fails to carry out substantive terms of its contract or fails to meet applicable requirements in sections 1932, 1903(m) and 1905(t) of the Social Security Act. After the state notifies the plan that it intends to terminate the contract, the state may give the plan's enrollees written notice of the state's intent to terminate the contract and allow the enrollees to disenroll immediately without cause.

f. The state may impose intermediate sanctions in accordance with 42 CFR 438.702, including:

    1. Civil monetary penalties in the amounts specified in section 409.912, F.S.

    2. Appointment of temporary management for the plan. Rules for temporary management pursuant to 42 CFR 438.706 are as follows:

        (a) The state may impose temporary management only if it finds (through onsite survey, enrollee complaints, financial audits, or any other means) that—

            (1) There is continued egregious behavior by the plan, including but not limited to behavior that is described in 42 CFR 438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Social Security Act; or

            (2) There is substantial risk to enrollees' health; or

            (3) The sanction is necessary to ensure the health of the plan's enrollees—

                (i) While improvements are made to remedy violations under 42 CFR 438.700; or

                (ii) Until there is an orderly termination or reorganization of the plan.

        (b) The state must impose temporary management (regardless of any other sanction that may be imposed) if it finds that a plan has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act or 42 CFR 438.706. The state must also grant enrollees the right to terminate enrollment without

cause, as described in 42 CFR 438.702(a)(3), and must notify the affected enrollees of their right to terminate enrollment.

(c) The state may not delay imposition of temporary management to provide a hearing before imposing this sanction.

(d) The state may not terminate temporary management until it determines that the plan can ensure that the sanctioned behavior will not recur.

3. Granting enrollees the right to terminate enrollment without cause and notifying affected enrollees of their right to disenroll.
4. Suspension or limitation of all new enrollment, including default enrollment, after the effective date of the sanction.
5. Suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS or the state is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
6. Denial of payments provided for under the contract for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with 42 CFR 438.730.

   Before imposing any intermediate sanctions, the state must give the plan timely notice according to 42 CFR 438.710.

g. In accordance with section 409.912, F.S., if the plan's Child Health Check-Up screening compliance rate is below 60 percent, it must submit to the state, and implement, a state accepted corrective action plan. If the plan does not meet the standard established in the corrective action plan during the time period indicated in the corrective action plan, the state has the authority to impose sanctions in accordance with this section.

   Unless the duration of a sanction is specified, a sanction shall remain in effect until the state is satisfied that the basis for imposing the sanction has been corrected and is not likely to recur.

The references to the contract provision which incorporates this requirement can be found by contract in Table 37.

Table 37 **MCO Intermediate Sanctions** 42 CFR 438 Subpart I	
Plan Type	**Contract Provision**
Managed Care Organizations	
Reform and Non-Reform HMOs and PSNs	Attachment II, Section XIV
Nursing Home Diversion Plans	Attachment I, Section 2.12.13
Prepaid Inpatient Health Plans	
PMHP Areas 1 and 6	Attachment I, Section D.3
PMHP Areas 2, 3, 4, 8, and 9	Attachment I, Section D.58
PMHP Areas 5 and 7	Attachment D, Section D.59
PMHP Area 11	Attachment I, Section B.59
Children Welfare Specialty PMHP	Amendment No. 2. 7. 6) D.
Statewide Inpatient Psychiatric Program	Attachment II, section D.26

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