Agency for Health Care Administration

Comprehensive Quality Strategy

February 2024

Contents

Section I. Introduction

Pursuant to the Medicaid and CHIP Managed Care Final Rule (42 CFR 438.340), the Agency for Health Care Administration (Agency) prepared the following Comprehensive Quality Strategy (CQS). Consistent with the Agency's mission to provide "Better Health Care for All Floridians," this Comprehensive Quality Strategy (CQS) documents the delivery of Medicaid services in Florida by describing:

- Goals, quality improvement initiatives, and activities.
- Performance measurement, including methods and metrics for assessing program performance.
- Monitoring activities for assessing program performance and plan compliance.
- Evaluation design of Quality Strategy and Statewide Medicaid Managed Care (SMMC) program.

This report contains contributions by several units within the Agency's Division of Medicaid Policy, Quality, and Operations, including updates on current quality initiatives, as well as the addition of new programs and activities. Per the Final Rule, the quality strategy will be submitted to the Centers for Medicare and Medicaid Services (CMS) no less than every three years or whenever significant changes are made including:

- Adding new populations to managed care programs.
- Expanding managed care programs to new parts of the state.
- Carving new services into the managed care programs.

Section II of this report contains a brief program overview. Section III describes program goals, initiatives and activities that support those specific goals, as well as additional initiatives and activities that support multiple goals and health care improvement more broadly. Section IV describes the use of performance measures to assess program performance for health and dental plans. Section V details the Agency's monitoring of the operational performance of the health and dental plans, as well as the way in which the Agency uses quality improvement contracts to monitor and improve Medicaid covered services. Section VI describes the Agency's evaluation of the SMMC program and the CQS, with Section VII addressing the future of the SMMC program.

Section II. Statewide Medicaid Managed Care (SMMC) Program Overview

The State of Florida Agency for Health Care Administration operates a section 1115(a) research and demonstration waiver and an LTC 1915(b)(c) waiver. These waiver authorities allowed the Agency's Medicaid program to transition to Statewide Medicaid Managed Care (SMMC) in SFY 2013-2014. The Statewide Medicaid Managed Care program is designed to ensure improved coordination and quality of medical, behavioral health, dental, and long-term care for all enrollees. As of October 2023, the SMMC program provided managed medical assistance (MMA), long-term care (LTC), and dental services to more than 5 million Floridians[1].

The managed medical assistance program provides primary and acute medical care, behavioral health, therapeutic, pharmacy, and transportation services for enrollees. Most of Florida's Medicaid recipients receive their care from a health plan that covers MMA services.

The long-term care program provides services to adults with disabilities and elders who meet nursing home level of care requirements. These LTC services include care in a nursing facility or home and

[1] A table of the current SMMC health and dental plans and the regions they operate in can be found in Appendix I.

community-based services(e.g. home delivered meals and help with activities of daily living such as eating, bathing, and dressing) for those who can safely reside in a community setting.

The dental program provides preventive and therapeutic dental services to all recipients in managed care, as well as individuals in fee-for-service with dental benefits. For children under the age of 21, these services include, at minimum, exams, screening, x-rays, sealants, fluoride, fillings and crowns, root canals, periodontics, orthodontics, extractions, sedation, and ambulatory surgical center or hospital-based dental services. For adults aged 21 and up, services include exams, x-rays, dentures, extractions, sedation, and pain management.

Expanded Benefits

In addition to the standard benefits offered by Medicaid, health plans and dental plans also offer many expanded benefits to their enrollees. Expanded benefits are benefits provided by plans at no additional cost to the state and cover a variety of service areas[2].

SMMC Program Goals

The Agency has identified four key program goals for the current SMMC contracts (2018-2024), aimed at achieving sustained improvement in managed care plan performance.

1. Reducing Potentially Preventable Hospital Events (PPEs)
2. Improving birth outcomes
3. Improving access to dental care
4. Increasing the percentage of enrollees receiving long-term care services in their own home or the community instead of in a nursing facility

These program goals and supporting initiatives and activities are described in Section III.

Section III. Florida Medicaid Quality Initiatives and Activities

The accompanying table on page three lists the Agency's program goals, the initiatives, and activities that align with those goals. For ease of understanding, the table aligns specific initiatives and activities with individual SMMC program goals. However, several of the initiatives and activities support and impact multiple SMMC goals. The first part of Section III describes goal-specific initiatives and activities while the second part describes initiatives and activities associated with multiple goals.

[2] A full listing of the expanded benefits that health and dental plans provide as part of the SMMC program can be found in Appendix I.

Florida Medicaid
2023 Comprehensive Quality Strategy

Agency for Health Care Administration
Division of Medicaid Policy, Quality, and Operations
Bureau of Medicaid Quality

SMMC PROGRAM GOALS

Reduce Potentially Preventable Hospital Events (PPEs):	**Improve Birth Outcomes:**	**Improve Access to Dental Care:**	**Long-term Care Transitions to Home and Community-Based Settings**
• Admissions • Readmissions • Emergency Department (ED) Visits	• Reduce Primary C-Section Rate • Reduce Pre-term Birth Rate • Reduce the Rate of Neonatal Abstinence Syndrome (NAS)	• Increase the percentage of children receiving preventive dental services • Reduce potentially preventable dental-related Emergency Department visits	• Increase the percentage of enrollees receiving long-term care services in their own home or the community instead of a nursing facility

INITIATIVES AND ACTIVITIES

• Enhanced data sharing* • Health Information Exchange* • Health Plan Performance Dashboard* • Health Plan Resource Guides for Providers* • Improving follow-up after mental illness or substance abuse hospitalization* • Managed Medical Assistance Physician Incentive Program (MPIP)* • PPEs Stakeholder Workgroup • Value-based purchasing initiatives* • Housing Assistance Pilot* • Ensuring access to services • Directed payments to specified providers to maintain and improve access to services*	• Universal Medical Pregnancy Notification Form • Award for Excellence in Maternity Care for Reducing Unnecessary C-Sections • Doulas • Family Planning • Increase participation in Healthy Behavior programs* • Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) Health Plan Points of Contact • Adoption of SAMHSA's screening, Brief Intervention, and Referral to Treatment (SBIRT) codes • Free SBIRT Continuing Medical Education (CME) opportunity for eligible providers • Twelve-month postpartum eligibility extension	• Improve dental access for adults and children in Medicaid • Increase member access to preventive dental services • Increase outreach and follow-up with enrollees after dental-related ED visits • Reduce potentially preventable dental-related ED visits • Reduce transportation barriers to dental services • Dental Provider Incentive Program (DPIP)	• Caregiver assessments • Ensure person-centered care planning for long-term care enrollees and their caregivers • Home and Community-Based Settings Reviews • Increase performance on MLTSS performance measures. • Increase response rate for Medicaid Home and Community-Based Services (CAHPS) surveys. • Independent consumer support program • Quarterly case file reviews

* These initiatives and activities support multiple goals but are only listed once to reduce duplication.

SMMC Goal: Reduce Potentially Preventable Hospital Events (PPEs)

The Agency strives to ensure access to health care amid growing costs in the United States and is continually seeking efficiencies and savings while improving the quality of care. One such opportunity lies in identifying and reducing Potentially Preventable Hospital Events (PPEs). PPEs are health care events that might have been prevented with better access to primary or urgent care, improved medication management, or better coordination of care. The Agency and its health plans are committed to reducing potentially preventable hospital events to improve the patient experience while reducing the cost of crisis level care.

Goal Objectives

The 2018-2024 contract requires health plans to develop and implement quality improvement initiatives aimed at reducing PPEs. The health plans have committed to specific target reductions in all three PPE metrics. The following percentages are the average target reductions that MMA plans have committed to achieving by 2024:

- 4% reduction in Admission rates
- 3.7% reduction in Readmission rates
- 3.4% reduction in Emergency Department rates

Admissions (Potentially Preventable Admissions) – These admissions typically involve ambulatory-sensitive conditions such as asthma, diabetes, and chronic obstructive pulmonary disease (COPD). These hospital admissions can be prevented with adequate patient monitoring, medication management, and follow-up care according to accepted standards of care.

Readmissions (Potentially Preventable Readmissions, within 30 days) – Return admissions may result from deficiencies in care or treatment during a previous admission or reflect poor coordination of services at the time of discharge and inadequate post-discharge follow-up.

Emergency Visits (Potentially Preventable Emergency Department Visits) – Emergency department visits can occur for conditions that can be treated in a non-emergency setting such as primary or urgent care. These conditions may include an asthma patient experiencing shortness of breath. High rates of emergency department visits may indicate a lack of member education, adequate access, monitoring, or coordination of ambulatory care.

Quality Improvement Initiatives and Activities

The Health Information Exchange (HIE) facilitates the secure statewide exchange of health information and data between health care providers, hospital systems, and payers. The HIE supports the Encounter Notification Service (ENS), which provides real-time notice of health care encounters and closes the gap between inpatient and outpatient providers, reducing potential preventable hospital events.

All statewide Medicaid dental plans and SMMC plans subscribe to ENS and receive appropriate notification of encounters at emergency departments (ED). Plans are able to reach out to patients promptly to provide education and/or coordinate follow-up care. The Agency also provides health plans

with smart alerts on certain medical conditions of members such as diabetes, key lab results and other important health care information. This allows health plans to quickly coordinate care for their members and potentially reduce emergency department utilization.

Health Plan Provider Resource Guides[3] contain plan-specific direct service contacts, escalation contacts, and after-hours instructions. These guides help to improve communication and coordination between plans and providers, reduce readmissions, and improve member access to timely and appropriate services post-discharge.

Ensuring Access to Services is an important tool in reducing PPEs. Comprehensive case management, care coordination, effective telehealth, text messaging education campaigns and using the LACE index (length of stay, acuity of admission, comorbidity index and recent ED visit) are examples of health plan initiatives that facilitate increased engagement with recipients and reduce crisis level events.

SMMC Goal: Improve Birth Outcomes for Mothers and Infants

The Agency's birth outcomes initiatives aim to ensure quality care and safety for mothers and babies, with the long-term goal of lowering maternal/infant morbidity and mortality rates. In alignment with the federal Centers for Medicare and Medicaid Services (CMS) Maternal and Infant Health Initiative, the Agency and its contracted health plans are implementing evidence-based strategies and promising best practices to improve perinatal and infant health for the members we serve.

Goal Objectives

The following percentages are the average target reductions for MMA plans by 2024.

Primary C-section Rate - Caesarean rates rose more than 60% between 1996 and 2007 and continue to remain well above the pre-1996 levels.[4] The target is a 2% reduction in C-section rates.

Pre-term Birth Rate – Development of brain, lungs and liver are critical in the final weeks of pregnancy, indicating the importance of full-term births. The target is a 1.7% reduction in pre-term delivery rates.

Neonatal Abstinence Syndrome (NAS) – NAS is a condition in which infants exhibit a variety of withdrawal symptoms, typically due to chronic exposure to opioids while in utero. The target is a 2% reduction in NAS rates.

Quality Improvement Initiatives and Activities

Non-emergent C-section deliveries may increase the risk of major birth complications for women, as well as consequences for infants, including longer hospital stays in neonatal intensive care units and possibly increased risk of secondary conditions such as respiratory infection and decreased cognitive functioning. Perinatal care and access to treatment for perinatal conditions has proven effective in reducing rates of unnecessary C-sections, maternal morbidities, and incidence of low birthweight and preterm births.

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[3] "Florida Medicaid's Health Plan Resources", Agency for Health Care Administration, https://ahca.myflorida.com/Medicaid/Policy_and_Quality/Policy/health_plan_resources.shtml

[4] Boyle A, Reddy UM, Landy HJ, Huang CC, Driggers RW, Laughon SK. Primary cesarean delivery in the United States. Obstet Gynecol. 2013 Jul; 122(1): 33-40. Doi: 10.1097/AOG.0b013e3182952242. PMID: 23743454; PMCID: PMC3713634.

The Agency has committed to reducing the rate of primary C-sections and pre-term deliveries and worked with the health plans to implement the following initiatives and activities. Through partnerships with the Florida Perinatal Quality Collaborative (FPQC), the Florida Hospital Association (FHA), and Florida Department of Health (DOH), the Agency continues to work with its contracted health plans and other stakeholders to monitor and improve maternal health outcomes.

Timely Notification of Pregnancy – The Agency, in collaboration with the Chief Medical Officers from each Medicaid health plan, developed the standardized Florida Medicaid Pregnancy Notification Form[5] to ensure that pregnant members receive timely access to comprehensive prenatal care within the first trimester. The pregnancy notification form is brief, easily accessible for providers, and can be sent directly to the member's health plan through their provider portals. With the implementation of this universal form, the Agency aims to improve the rate of prenatal care visits occurring within the first trimester and improve birth outcomes for members by providing them with access to high-quality health care at the start of their pregnancies.

Award for Excellence in Maternity Care – In an effort to reduce unnecessary primary C-sections, the Agency in partnership with DOH, established the Award for Excellence in Maternity Care for Reducing Unnecessary C-Sections, to hospitals that achieved the Healthy People 2030 target goal of reducing Nulliparous, Term, Singleton, Vertex (NTSV) C-section deliveries for first-time mothers with low-risk pregnancies to a rate at or below 23.6 percent.

Doula Services – Doula support during and after pregnancy has proven to be effective in improving maternal health outcomes. Doula services are currently available across all Medicaid health plans as an expanded benefit.

Family Planning – Effective health and family planning services for post-partum women can help improve overall maternal health, reduce maternal morbidity, improve birth spacing and reduce premature and low weight births. The Agency provides multiple services to post-partum women that support improved family health outcomes.

Substance Abuse and Mental Health Services Administration Procedure Codes – The Agency adopted the SAMHSA recommended reimbursement codes for alcohol/substance use screening methods such as Screening, Brief Intervention, and Referral to Treatment (SBIRT), allowing Medicaid providers to receive additional reimbursements outside of traditional Evaluation and Management (E&M) visits.

Continuing Education – The Agency developed SBIRT Continuing Medical Education (CME)[6] opportunity at no cost to physicians and physician extenders.

Substance Abuse / Opioid Use Disorders – Streamlined the coordination of behavioral health services for members with SUD/OUD by establishing individual MMA plan contacts through standardized resource guides, eliminated prior authorization requirements for certain populations and collaborated with FPQC on their Maternal Opioid Recovery Effort (MORE).

Postpartum Continuum of Care Extension – To support the optimization of health care for women and children, the Agency has focused on improving the post-partum continuum of care. The Agency has

[5] "Florida Medicaid Pregnancy Notification Form", SMMC 2018-24: Agency-Approved Contract Materials, Agency for Health Care Administration, October 2022, https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/2018-23_Contract_Mats/Florida_Medicaid_Pregnancy_Notification_Form.pdf

[6] "Screening, Brief Intervention and Referral to Treatment (SBIRT) for Pregnant Women and Other Adult Patients", University of Florida College of Medicine Continuing Medical Education, https://cme.ufl.edu/screening-brief-intervention-and-referral-to-treatment-sbirt-for-pregnant-women-and-other-adult-patients/

encouraged providers to shift their focus from a "postpartum visit" to a "postpartum continuum of care", beginning with a visit with their obstetric provider within the first 3 weeks of giving birth.

In 2021, the Florida Legislature extended post-partum eligibility for mothers eligible for Medicaid to a period of 12 months, with the Centers for Medicare and Medicaid Services approving Florida's request to amend its 1115 demonstration waiver to extend post-partum coverage to 12 months in May 2022. The Agency will evaluate the impact of the extension on maternal preventive and primary care, maternal and infant morbidity and mortality rates, and health outcomes for mothers and infants.

The Florida Perinatal Quality Collaborative launched their new Postpartum Access and Continuity of Care (PACC) Initiative[7] to improve maternal health through a facilitated continuum of postpartum care. The Agency is encouraging health plans and Medicaid providers to adopt evidence-based practices in support of FPQC's PACC Initiative.

SMMC Goal: Improve Access to Dental Care

The Agency is committed to improving access to dental care. The 2018-2024 contract requires dental plans to develop and implement quality improvement initiatives to increase participation in preventive dental care.

Goal Objectives

Preventive Dental Services – Research continues to support the assertion that oral health is a significant factor in overall health. Increasing the percentage of children receiving preventive dental services is critically important to support overall health in children.

Emergency Department Visits – Better coordination between dental plans and health plans for transportation to regular dental visits should result in fewer ED visits for dental related issues.

Quality Improvement Initiatives and Activities

Dental plans are engaged in a variety of initiatives and activities to meet the goal of improving access to dental care.

Improve Dental Access – Dental plans encourage preventive dental services by offering members rewards for receiving recommended dental exams and visits. Dental plans also cover expanded benefits for adults that are not traditionally covered by the Medicaid state plan, including preventive, restorative, and periodontic services for adults, oral and maxillofacial surgery, diabetic testing, practice acclimation for adults with intellectual disabilities, and additional services for pregnant women.

Increase Outreach – The dental plans partner with community partners to promote the importance of oral health and to provide education on available Medicaid dental benefits. This includes working with school-based dental programs and other organizations to provide easier access to dental screenings and services.

[7] "Postpartum Access and Continuity of Care (PACC) Initiative", USF Health, College of Public Health, Florida Perinatal Quality Collaborative, 2022 https://health.usf.edu/publichealth/chiles/fpqc/pacc

Encounter Notification Service (ENS) – The dental plans subscribe to ENS to receive notifications of any dental-related ED visits by their enrollees, facilitating timely follow-up and appointment scheduling with these enrollees.

Provider Incentives – The plans support and recognize high-performing dental providers in various ways, including Gold Card programs that reduce or eliminate authorization review requirements for high performing providers.

SMMC Goal: Long-Term Care Transitions to Home and Community-Based Settings

To ensure continued improvements in the delivery of the highest quality care to Florida Medicaid recipients, the Agency seeks to increase the percentage of enrollees receiving long-term care (LTC) services in the home and community as opposed to in a nursing facility. Florida statute requires that base reimbursement rates provide an incentive to transition enrollees from nursing facilities to the community. The current SMMC contracts require a transition incentive until no more than 25% of the LTC Medicaid population receives LTC services in a nursing facility.

Goal Objectives

Home and Community Based Settings – Transition enrollees to the least restrictive setting, also known as Home and Community-Based Settings. The managed care plans are required to start services for all in-home home and community-based services within seven days of the initial face-to-face visit for at least 85% of the applicable population.

Ensure Person-Centered Care Planning – Increase and improve coordination and utilization of person-centered care planning to ensure that enrollees and their caregivers are involved in their care planning, including development of transition and care plans.

Initiatives and Activities Supporting Multiple Goals

As previously noted, many initiatives and activities support multiple SMMC program goals. Several examples of these initiatives and activities are described below.

Florida Health Information Exchange – The Florida HIE and enhanced data sharing support all four goals in the table on page six. The Agency is directed by statute to develop and implement a strategy for the adoption and use of electronic health records, including the development of an electronic health information network for sharing of electronic health records among health care facilities, health care providers, and health insurers. This statutory authority has allowed the Agency to develop a statewide health information network, known as the Florida Health Information Exchange (HIE), and to promote enhanced data sharing through a variety of health information technology and exchange initiatives among Florida's providers.

Since inception in 2011, the Florida HIE has expanded to offer the Encounter Notification Service (ENS). Utilizing data feeds from hospitals and skilled nursing facilities, information about a patient's health care

encounter (including demographic information, information on the source facility, and primary complaint) is securely sent to subscribers enabling them to immediately know when their patients have been admitted or discharged from any one of these connected facilities.

As of August 2023, over 800 acute care and rehabilitation hospitals provide encounter data to the ENS, covering 96% of Florida's acute care beds and 85% of Florida's rehab beds. 245 health organizations, including 26 health plans (which include all Medicaid Managed Care health plans in Florida), 29 accountable care organizations, and all 67 county health departments, subscribe to ENS. Over 10 million ENS alerts are sent each month.

The Florida HIE's Encounter Notification Service supports the Agency's Quality Strategy in multiple ways including:

- Timely notification of hospital encounters to reduce potentially preventable events.
- Timely notification of post-acute care encounters which can enable providers to better manage transitions of care.
- Supporting positive birth outcomes by alerting health plan care managers of obstetrical hospital admissions.
- Care coordination for Medically Complex Children though real-time notification of encounters to health plans and providers caring for children with special needs.
- Patient Record Exchange Solutions – The Florida HIE supports the exchange of patient records through connectivity to one of the three national networks (eHealth Exchange, Carequality, or Commonwell) or through Florida regional networks.
- Patient Record Retrieval Solution – The Automated Retrieval of Clinical Health eRecords (ARCHER) uses pre-defined ENS event triggers to launch automated queries to relevant health care facilities via national networks to deliver more robust clinical documentation to participants.
- Closing the gap in post-acute care coordination –Care managers are sometimes unaware of patient encounters at post-acute facilities, which can increase the potential for hospital readmission. To address this issue, the Florida HIE has worked diligently over the past year to onboard post-acute facilities. To date, the Florida HIE has onboarded 240 skilled nursing facilities and 286 hospitals as data sources to the ENS. Closing this gap in the post-acute care space has added tremendous value to ENS subscribers, their patients, and the Florida HIE as it continues to expand its reach into the post-acute care space during SFY 23/24.

The Agency is also responsible for the implementation of the Florida Medicaid Electronic Health Record (EHR) Incentive Program (also known as the Promoting Interoperability Program), as established by Section 4201 of the American Recovery and Reinvestment Act of 2009. The program provided funding to support incentive payments to Eligible Professionals and Hospitals for adopting, and the subsequent meaningful use of, certified electronic health records (EHRs) to promote the widespread adoption and use of EHRs. Participants in the program met the CMS meaningful use benchmarks, which include reporting on electronic Clinical Quality Measures (eCQMs).

The Medicaid version of the Promoting Interoperability Program ended in 2021. Final rounds of payments have been made and post-payments audits are in progress at this time. The audits are being completed in 2023. In the final round of payment, Eligible Professionals received a total of $268,638,530, while Eligible Hospitals received $323,081,915. A total of 9,060 unique Eligible Professionals and 182 unique Eligible Hospitals received these payments.

Value-Based Purchasing and Directed Payment Initiatives – Under the current contract, plans committed to achieving performance targets related to the percentage of their members assigned to

primary care providers with value-based purchasing (pay-for-performance) arrangements. While health plans may establish their own provider incentive programs and risk-based agreements with providers, all SMMC health plans are required to operate a Managed Medical Assistance Physician Incentive Program (MPIP), which is designed to pay the equivalent Medicare rate to physicians who meet certain qualifying criteria. The Agency has identified Pediatric Primary Care Physicians (PCPs), Obstetrician-Gynecologists (OB/GYNs) and Specialty Physicians as the provider types eligible for the MPIP payments.

The Agency continues to use the directed payment arrangement option as described in the §438.6(c) preprint to increase payment rates by managed care plans for specific providers, aimed at improving access to care and ensuring that members are receiving high quality, cost-effective health care. The measures considered for inclusion in directed payment arrangements are based on stakeholder input and are intended to advance the Agency's quality goals from page six of this report.

Housing Assistance Pilot Program – In April 2019, the federal Centers for Medicare and Medicaid Services (CMS) approved an amendment to the 1115 MMA waiver for the Agency to create a Housing Assistance Pilot Program as part of the Florida Medicaid program. The goal of the program is to facilitate housing stability and improve health outcomes for up to 4,000 individuals with serious mental illness and/or substance use disorder who are homeless or at risk of homelessness. In February 2020, an amendment was approved to increase the behavioral health and supportive housing assistance services annual enrollment limit.

The program aims to improve health outcomes by helping individuals obtain stable and permanent housing through services traditionally not covered by Medicaid, such as transitional housing services; individual housing and tenancy sustaining services; mobile crisis management; and self-help/peer support services. As of October 2023, the housing assistance program has 567 enrollees. Plans are required to submit quarterly performance metrics for monitoring effectiveness.

Healthy Behaviors Programs – SMMC health and dental plans incorporate evidence-based practices to encourage and incentivize healthy behaviors. Health plans must establish Health Behaviors programs that include tobacco cessation, weight loss and alcohol or substance abuse recovery programs. as a minimum.

Many health plans have additional Healthy Behaviors programs, including diabetes management, healthy pregnancy, and well child visit rewards. Dental plans promote the utilization of preventive dental services, including incentives for members for completing an initial and timely six-month recall dental visit.

All Healthy Behaviors programs are voluntary and require written consent from the participant prior to enrollment. Retail gift cards or points that can be converted into a monetary value are common incentives across health and dental plans. Incentives are limited to a value of twenty dollars ($20) for completing a single activity and up to fifty dollars ($50) for completing a series of activities within a Healthy Behaviors program.

Section IV. Performance Measurement and Satisfaction Surveys

Section IV describes the ways in which the Agency measures plan performance and quality through performance measures and surveys.

Health Plan Performance Measures

All SMMC health plans providing MMA services are required to report specified performance measures to the Agency each year. Performance measures include:

- The Healthcare Effectiveness Data and Information Set (HEDIS) measures developed by the National Committee for Quality Assurance (NCQA)[8] (e.g., the percentage of women who received their yearly breast cancer screening and the percentage of deliveries that received a prenatal care visit)
- Children's Health Insurance Program Reauthorization Act (CHIPRA) Child Core Set measures[9] (e.g., Child and Adolescent Well-Care Visits)
- CMS Medicaid Adult Core Set measures (e.g., the percentage of adults that were readmitted to the hospital within 30 days)
- State-defined measures (used for areas of focus for which no national standardized measures are available – (e.g., Prescription of HIV Antiretroviral Therapy)

Plans report specific performance measures that align with the Agency's goals and are relevant to the services they provide. Appendix II provides a detailed list of the annually reported performance measures. The state continues to work with its External Quality Review Organization (EQRO) and various stakeholders to identify additional areas for improvement and corresponding performance metrics and standards.

The state reviews the performance measures to determine whether measures should be removed or added to the plan reporting requirements. To promote accountability and transparency, as national standardized measures and technical specifications are developed, those measures are added in lieu of the state-defined versions so that data may be directly compared to other states and national benchmarks.

Since 2019, the SMMC comprehensive plans and the LTC Plus plan have reported on all eight of the Medicaid Managed Long-Term Services and Supports (MLTSS) quality measures developed for CMS by Mathematica Policy Research and its partner NCQA. These measures provide information about assessment and care planning processes among MLTSS health plan members that can be used by states, health plans, and other stakeholders for quality improvement purposes.

Annual Comparison of Health Plans' Quality Performance

Health plan contract requirements are designed to move the entire system of care toward higher quality through comparison of and accountability for each health plan's performance. Annual comparison of the health plans' results to specific thresholds and national benchmarks (when available) document the performance of Florida Medicaid's health plans relative to each other, and to national means and percentiles for other Medicaid programs.

[8] HEDIS measures for which NCQA calculates national Medicaid means and percentiles, the Agency has established the 75th percentile as the goal for its SMMC health plans.
[9] The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included provisions to strengthen the quality of care provided and health outcomes of children in Medicaid and CHIP. CHIPRA required HHS to identify and publish a core measure set of children's health care quality measures for voluntary use by State Medicaid and CHIP programs.

Florida Medicaid's goal is for SMMC health plans to achieve the 75th percentile for all HEDIS measures, as listed in the NCQA's National Means and Percentiles for Medicaid plans. Each year, the Agency analyzes and publishes the plans' performance measures, enabling health plans to compare their performance, consumers to select high performing plans, a basis for the Agency to assess liquidated damages, and stakeholders to compare Florida's plans against national metrics. Appendix II provides a detailed description of the methodology for comparing health plans' quality metrics to specified benchmarks. In addition to the contractual requirements, to assess important facets of the new SMMC program goals, the Agency has placed an immediate focus on:

Behavioral and Mental Health Services – Monitor performance measures such as Follow-up After Hospitalization for Mental Illness to assess the percentage of discharges for 7-day and 30-day follow-up.

Improve Access to Dental Care – Meet specific targets related to potentially preventable dental-related ED visits and preventive dental services for children. Monitor plans' progress by reviewing their performance on these metrics each year compared to the targets set by the plans and requiring the dental plans to collect and report other quality metrics annually.

Improve Birth Outcomes – The Agency uses measures to assess Timeliness of Prenatal Care and Postpartum Care as both components are instrumental in preventing poor birth outcomes.

Medicaid Health Plan Report Card – The Florida Medicaid program has historically evaluated and compared performance measure and survey data both at the statewide program level and at the individual health plan level. The state uses health plan level data for its Medicaid Health Plan Report Card[10], which is available to Medicaid enrollees for use in selecting a plan. The current consumer report card includes audited[11] HEDIS performance measure results, which are posted online for consumers to view. In addition, Medicaid staff solicit input from health plans regarding relevant metrics the plans are using to monitor their participating providers.

Dental Plan Performance Measures

Dental plans collected and reported data on 11 performance measures for calendar year 2022 services including HEDIS, Child Core Set, Dental Quality Alliance, and Agency-Defined Measures. These measures focused on improving oral health outcomes by measuring those that had at least one dental visit during the year, use of preventive services, use of sealants, and others. Dental performance measures are used to assess plan performance and quality of care compared to national benchmarks (when available) as well as plan-specific targets. These measures include:

- HEDIS measures (Annual Dental Visits);
- Children's Health Insurance Program Reauthorization Act (CHIPRA) Child Core Set measures (e.g., Oral Evaluation, Topical Fluoride for Children); and
- Dental Quality Alliance measures (e.g., Ambulatory Care Sensitive ED Visits for Dental Caries in Children, Caries Risk Documentation).

[10] "Florida Medicaid Health PlanInformation", Agency for Health Care Administration, http://www.floridahealthfinder.gov/HealthPlans/Default.aspx.

[11] The National Committee for Quality Assurance (NCQA) licenses organizations and certifies selected employees of licensed organizations to conduct audits of HEDIS data using NCQA's standardized audit methodology. The audit includes two parts: an overall information systems capabilities assessment, followed by an evaluation of the managed care plan's ability to comply with HEDIS specifications. Additional details about this process are included in Appendix II of the Quality Strategy.

Enrollee Experience and Provider Satisfaction Surveys

Florida Medicaid also measures plan performance through enrollee and provider satisfaction and experience surveys. These include Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys[12] for MMA and MMA Specialty Plans, Dental Plan CAHPS surveys for Dental Plans, and Home and Community Based Services (HCBS) CAHPS surveys for Long-term Care Plans. Additionally, Provider Satisfaction surveys measure providers' overall satisfaction with the managed care plans.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey

The CAHPS Health Plan Survey collects standardized information on enrollees' experiences with health plans and their services. The Health Plan Survey 5.1H includes standardized instruments and optional supplemental items that are administered to adults and children enrolled in Medicaid and asks about experiences in the previous six (6) months. The CAHPS survey results are due to the Agency by July 1 of each year.

Managed care plans submit an annual written proposal for survey administration and reporting to the Agency for review and approval prior to fielding the survey. The proposal includes the plan's CAHPS survey vendor's NCQA certification, survey administration protocol, sampling methodology, analysis plan, reporting description, copy of the survey tool, and cover letters and/or postcards. The Agency compiles survey results and calculates the statewide rates. Individual plan rates and statewide rates are compared to previous years to assess performance and track trends. Results are posted on Florida Health Finder, providing consumers with additional information when selecting a Medicaid health plan.

Home and Community-Based Services CAHPS Survey

In 2018, the Agency adopted the Home and Community-Based Services Consumer Assessment of Healthcare Providers and Systems (HCBS CAHPS) survey, which is conducted by the Florida Medicaid Long-term Care (LTC) plans. The HCBS CAHPS survey measures the experiences of adult Medicaid recipients receiving these services. It consists of 69 core items (103 total items) that ask LTC recipients to report on their experiences with the following:

- Reliability of providers.
- Communication with providers.
- Case managers.
- Choice of services.
- Medical transportation.
- Personal safety.
- Community inclusion and empowerment.

[12] CAHPS surveys ask consumers to report on and evaluate their experiences with their health care and their health plan. CAHPS surveys are developed and maintained by the Agency for Healthcare Research and Quality (AHRQ) and included in HEDIS by NCQA. The Agency requires MMA plans to contract with NCQA-certified CAHPS survey vendors to conduct their surveys each year. Additional details about this survey are included in Appendix II of the Quality Strategy.

The HCBS CAHPS survey was developed by CMS for voluntary use by state Medicaid programs to assess the experiences of adult Medicaid enrollees who receive long-term services and supports. The HCBS CAHPS survey results are due to the Agency by September 1 of each year.

Survey administration guidelines require plans to contract with an Agency-approved survey vendor certified by NCQA for CAHPS survey administration. The survey must be administered telephonically or in-person. The survey sample includes only those enrollees who have been enrolled in the LTC plan and receiving home and community-based services for at least three consecutive months. From 2018 through 2022, the Agency required a minimum sample size of 2,000, with a target of 411 completed surveys. Beginning with the 2023 survey, the Agency increased the minimum sample size to 5000. The LTC plan is required to have its sample validated by an NCQA-certified HEDIS Auditor.

The Agency compiles all results and calculates the statewide rates. Individual plan rates and statewide rates are compared to previous years to assess performance and track trends.

Dental Plan CAHPS Survey

Dental plans are also required to measure plan performance through surveys of enrollee experience using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Dental Plan Survey. The Dental Plan CAHPS tool surveys parents about their experiences with their child's dentist, dental care, and dental plan. In addition, the plans survey their providers on their experiences with service, communication, and overall plan satisfaction. Results from both surveys are submitted to the Agency for review on an annual basis.

The Agency monitors and publishes performance measure results annually for dental measures on the Agency's Quality in Managed Care page[13]. Child Core Set metrics are also reported to the Centers for Medicare and Medicaid Services (CMS) and are used for their annual Medicaid Scorecard, which provides increased transparency about the program's administration and outcomes.

Provider Satisfaction Survey

Since 2019, the Agency has deployed a standardized provider satisfaction survey tool for managed care plans to assess the satisfaction of providers in the plans' networks. The survey provides the Agency and health plans with valuable feedback on the physicians' and office managers' experience with plans' provider relations and communications; authorization processes, including denials and appeals; timeliness of claims payment and assistance with claims processing; complaint resolution process; and care coordination/case management support. The Agency requires plans to submit their provider satisfaction survey results annually for review.

Federal and Other Reporting of Performance Measure and Survey Results

Besides the aforementioned submissions to the Agency, the plans also submit HEDIS results and CAHPS results to NCQA for inclusion in their National Medicaid Means and Percentiles. The plans also submit their Health Plan CAHPS and HCBS CAHPS results to the Agency for Healthcare Research and Quality's (AHRQ) CAHPS Survey Database, so that they are included in their national Medicaid benchmarks.

[13] "Performance Measure Data Submissions for Medicaid", Agency for Health Care Administration, https://ahca.myflorida.com/medicaid/medicaid-quality-activities-and-projects/performance-measure-data-submissions-for-medicaid.

The Agency compiles and analyzes plan performance measures for assessing the plans' performance compared to prior years and to national benchmarks and other targets, as well as to report the Adult and Child Core Set measures to the Centers for Medicare and Medicaid (CMS). The Agency reports Adult and Child Core Set measures to CMS on an annual basis and has been preparing for 2024, when reporting becomes mandatory for states for the full Child Core Set and the behavioral health measures in the Adult Core Set.

Section V. Monitoring Activities within the SMMC Program

In addition to collecting and analyzing plan performance and survey data, the Agency also monitors managed care plan performance and provides oversight of all aspects of managed care plan operations. The Agency imposes liquidated damages for failure to meet the responsibilities of the SMMC contract and imposes sanctions and/or requires corrective actions for contract violations or noncompliance.

The Agency reviews routine reports and submissions and conducts ad hoc targeted monitoring studies to ensure that the managed care plans are providing high quality, medically necessary health care.

The SMMC contract requires health plans to submit specified reports on a periodic basis. Many of the required reports focus on aspects of the provision of high-quality health care to Medicaid enrollees. These reports are reviewed for quality and clinical compliance. Reports reflecting suboptimal performance by a health or dental plan may result in compliance actions, including corrective action plans or assessment of liquidated damages[14].

Reports fall into one of three categories as listed below.

1. Provision of Primary Care – Reports in this category (e.g., PCP Appointments, and ER Visits without PCP Appointments) allow the Agency to monitor, track, and trend the health plans' focus on the promotion of primary care, preventive care, and chronic disease management. These reports are key drivers in achieving the Agency's goal of reducing potentially preventable hospitalizations.
2. Provision of Medically Necessary Cost-Efficient Services – Reports such as the Service Authorization Performance Outcome Report and the Inter-rater Reliability Report allow the Agency to monitor and track and trend the health plans' provision of all medically necessary services to Medicaid enrollees in a cost-effective manner, while assuring that service authorization decisions are made in a timely manner by qualified, trained staff.
3. Protection of Vulnerable Populations – Reports such as the Residential Psychiatric Report, Enhanced Care Coordination, and Housing Assistance Rosters allow the Agency to monitor that highly vulnerable Medicaid populations, such as medically complex children, frail elderly, and HIV patients receive appropriate case management to navigate the healthcare system and to receive appropriate medical services.

Long-Term Care Focus Monitoring

The Agency continuously monitors, tracks, and trends LTC service quality through desk reviews of several required report submissions by LTC managed care plans. The Agency focuses on LTC monitoring to track

[14] A detailed list of routine monitoring reports, their primary purpose, and reporting frequency can be found in Appendix III.

and trend the care of LTC enrollees and ensure the sustainability of quality care within the home and community setting. Agency staff review plan performance over time to assure contractual compliance. The main areas of focus for monitoring compliance of the managed care plans are centered around the following:

1. Ensure case managers are meeting all contractual requirements in connecting LTC enrollees with high quality care providers and services, are not over-burdened by caseload, that enrollees receive all appropriate services in a timely manner, and that the services are of the highest quality of care.
2. Identify all incidents that occur in the home or community setting that negatively affect the enrollee's health or safety while in the care of home and community-based providers, ensure these incidents are reported to the Agency, and that the health plan followed up properly to mitigate any future occurrences.
3. Monitor missed, denied, reduced, terminated, or suspended LTC services to make certain they are not done so arbitrarily and are within the contractual requirements.
4. Ensure the physical location of all enrollees receiving LTC services is tracked for emergency and disaster planning, and all transitions into and out of the community are tracked and used for trending.

The Agency conducts an in-depth review of a sample of case files quarterly from each LTC plan. This review ensures that enrollees receive the highest quality of care from their health plans. Additionally, the Agency reviews case files to ensure case managers are consistently meeting all requirements for enrollee services and minimizing gaps in care. The case file reviews focus on quality compliance in the areas of:

- Timely completion of initial/annual comprehensive assessments.
- Timely and accurate Case Management and Care Coordination standards (e.g., timely communication and service initiation).
- Case Record requirements.
- Ensuring that the enrollee is directing their care and is able to enact freedom of choice of where services are received through a person-centered care planning approach.

To ensure compliance with the 1915(c) federal waiver requirements, the Agency assesses all contracted Home and Community-Based Settings (HCBS) that serve Medicaid recipients for home-like environments. This requirement is delegated to the managed care plans, who conduct the assessments using the Agency-approved tool. The Agency validates the assessments using a combination of desk reviews and on-site visits. If an HCBS is not in compliance, a remediation plan must be completed and submitted to meet compliance standards, or an evidentiary package explaining how the federal standards have been met under unique circumstances must be submitted.

These required report submissions allow the Agency to identify areas of improvement for the LTC program and LTC managed care plans. Data from these reports help to inform policy changes needed to ensure quality care for LTC enrollees.

Targeted Monitoring Projects and Focused Reviews

The Agency's monitoring techniques have evolved over time into a comprehensive and robust monitoring strategy. This strategy efficiently focuses on identified issues, so that corrective action can be employed to prevent or eradicate noncompliance,

The Agency continues to make improvements to its quality initiatives and strategies through ongoing stakeholder engagement, robust monitoring strategies of managed care plans, and constant improvements to policies within the SMMC contract based on monitored findings. Developing and participating in various stakeholder engagement activities such as behavioral health roundtable discussions, quarterly calls with stakeholder groups on specific topics to improve the quality of care for Medicaid enrollees and working with managed care plans to adjust as needed have proven to be successful in the overall quality monitoring of SMMC programs.

The targeted review process allows the Agency to be responsive to emerging trends, so the focus and priority areas of concern evolve over time as circumstances change. As an example, as telemedicine service utilization and accessibility surged over the last several years, comprehensive monitoring became a priority. In 2020, the Agency also completed a targeted monitoring project related to prior authorization of children's physical, speech, and occupational therapies resulting from an increase in provider and enrollee complaints. A random sample of prior authorizations for children's therapies was reviewed to ensure that all health plans were compliant with medical necessity and EPSDT requirements.

Each targeted monitoring project incorporates a series of steps and processes to successfully implement and execute project designs and timelines. This monitoring process is composed of the following phases:

- Information collection
- Project design
- Monitoring instruments development
- Intra-Agency coordination and collaboration
- Sample selection
- Health plan communication
- Data collection
- Data analysis
- Management reporting
- Feedback to health plans
- Potential remediation actions
- Contract/policy changes (if applicable)

Targeted monitoring projects undertaken during calendar year 2022 include:

- Completion of Health Risk Assessments/Oral Health Risk Assessments
- Pharmacy Preferred Drug List Compliance
- High Utilizers of Pediatric Crisis Stabilization Unit Services/Children with Multiple Baker Act Admissions
- Managed Care Rule Compliance Monitoring

The Clinical Compliance Monitoring Unit (CCMU) is currently administrating two targeted monitoring projects.

- Missed long-term care services
- Compliance with Notice of Adverse Benefit Determination Requirements and Service Authorization Performance Outcomes timelines.

These projects are set to conclude by the end of 2024 with feedback provided to the plans.

Performance Improvement Projects (PIPs)

The Agency requires SMMC plans to implement Performance Improvement Projects (PIPs) aimed at achieving sustained improvements in the quality of care, access to services, and overall health outcomes of members. For the 2018-2024 contracts, the Agency has required plans to implement the following PIP topics:

Health Plans

- A combined focus on improving primary Cesarean section (C-section) rates, pre-term delivery rates, and neonatal abstinence syndrome (NAS) rates.
- Reduce potentially preventable events including hospital admissions, readmissions, and emergency department visits.
- Improve 7-day follow-up after hospitalizations for people with mental health conditions and emergency department visits for people with mental health conditions and/or alcohol and other drug abuse or dependence.
- An administrative PIP focusing on the administration of the non-emergency transportation benefit, specifically focusing on the rate of trips resulting in the enrollee arriving to their scheduled appointment on time.

Dental Plans

- Increase the rate of enrollees under age 21 accessing preventive dental services.
- Reduce potentially preventable dental-related emergency department visits in collaboration with the SMMC plans.
- An administrative PIP focused on coordination of non-emergency transportation services with the SMMC plans.

Plan performance rates (including process and outcome measures) and intervention activities are submitted to the Agency for review as part of their annual PIP submissions. PIPs are reviewed and evaluated to ensure that plan activities and interventions are effectively improving performance. PIPs are revised when an intervention is not achieving the intended effect.

Throughout the year, progress is closely monitored by the Agency through internal performance dashboards and ongoing quality initiative activities. The Agency also monitors plan performance on any related Healthcare Effectiveness Data and Information Set (HEDIS) and Medicaid Child and Adult Core Set measures defined in Appendix II of this document to support the quality initiatives and interventions implemented by the managed care plans.

Quality Improvement Contracts

External Quality Review Organization (EQRO)

States with managed care Medicaid plans are federally required to contract with a qualified EQRO to perform an annual audit review (an "external quality review" (EQR)) of the contracted managed care plans. The Agency contracts with Health Services Advisory Group, Inc. (HSAG) as its EQRO vendor. Consistent with federal requirements[15], the Agency's contract with HSAG includes the following categories of activities[16]:

- Validation of health plans' Performance Improvement Projects.
- Validation of Performance Measures.
- Review of health plan compliance with Access, Structural and Operational Standards.
- Validation of Encounter Data.
- Dissemination and Meetings.
- Annual Technical Report of compliance.
- Technical Assistance on Other Activities, if requested by the Agency.
- Administration of Provider Satisfaction Surveys, if requested by the Agency.
- Quality Initiatives, if requested by the Agency.
- Managed Medical Assistance Program Waiver Evaluation.
- Long-term Care Evaluation.

Quality Assurance Reviews for the Individual Budgeting Waiver

The Agency contracts with Qlarant to administer a Florida State Quality Assurance Program (FSQAP) for the Developmental Disabilities Individual Budgeting (iBudget) Home and Community-Based Services Waiver and the Consumer Directed Care Plus (CDC+) Program. Through an interagency agreement, the Agency for Persons with Disabilities (APD) is the state agency responsible for the operation of the iBudget Waiver and the CDC+ program. The iBudget Waiver provides home and community-based supports and services to eligible persons with developmental disabilities living at home or in a home-like setting. This waiver utilizes an individual budgeting model. The flexibility of the model allows recipients more opportunities to participate in determining service choices.

Qlarant's quality assurance program assesses the efficiency and quality of home and community-based supports, services, planning, and service delivery from the individual's perspective, as well as evaluating provider performance in delivering appropriate services and supports. Provider compliance with requirements in the Medicaid Waiver Services Agreement is also evaluated. In addition, the program provides training on the use of Qlarant's information technology system(s) and review tools to providers, the Agency and APD staff, and APD providers through a web-based resource center.

The Agency works collaboratively with APD to implement a Quality Management Strategy (QMS) based on a close variant of the HCBS Quality Measure Set developed by CMS. This strategy provides an approach that is highly suited for Florida while assuring future compliance with emerging federal

[15] External quality review is required by 42 CFR 438.350. External quality review activities are described in 42 CFR 438.358. The Centers for Medicare and Medicaid Services (CMS) have established external quality review protocols for each activity which are available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html

[16] A more detailed description of EQRO activities is provided in Appendix II.

requirements. This strategy is deployed by APD and assigns roles and responsibilities to all parties associated with the process.

The three quality management functions featured by QMS are discovery, remediation, and improvement. Although there is interactivity and connectivity between the three functions, it has been determined that the discovery activity is best suited for a contracted vendor (Qlarant), while the remediation function fits well with the APD regional office structure, and the improvement function is best performed at the APD headquarters level.

Discovery activities conducted by Qlarant's quality assurance program include the following two main components:

- Person Centered Reviews (PCRs) –interviews with the individual receiving services to determine whether supports and services are adequate to achieve personally defined outcomes and whether the planning and coordination of services were delivered as the recipient had expected.
- Provider Discovery Reviews (PDRs) – evaluate provider performance in delivering appropriate services and supports to assist the recipient in achieving personal goals and meeting identified needs.

In addition, Qlarant provides the Agency and APD with a quarterly analysis of overall quality assurance program findings, The analysis includes significant review findings, identification of patterns and trends, and a summary of findings related to identified risks involving recipient health, healthcare, medical record reviews, safety, incident reports, and facilities.

Qlarant convenes Quality Council meetings three times a year that include recipients who receive developmental disability services, family members, Medicaid Waiver Providers, Waiver Support Coordinators, and other stakeholders. The Quality Council provides oversight of quality assurance activities conducted by Qlarant, to ensure compliance with contractual obligations, and to contribute feedback to the Agency and APD. The meetings provide a forum for discussion and development of recommendations that result in practical, useful information for stakeholders and meaningful quality improvement activities. The meetings also raise awareness of available community resources and community partnerships, which in turn expands resources for persons with developmental disabilities.

Electronic Visit Verification – Home Health Services

The State of Florida has implemented Electronic Visit Verification (EVV) for Home Health (HH) services. The EVV Program verifies the delivery of services using technology that is effective for electronically verifying service performance, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends.

For fee-for-service (FFS) home health providers who render private duty nursing (PDN), home health visits, and personal care services, the Agency has adopted an "open vendor" approach. This model allows providers the option to use the State's contracted Vendor EVV system at no cost. Providers may use their own third-party EVV system in lieu of the Agency system, if approved by the Agency. Third-party systems must be interoperable with the Agency's EVV claims system for billing purposes as a condition of approval. The Agency chose this approach to allow flexibility and reduce the administrative burden on providers.

The Agency has also implemented EVV compliance requirements for managed care plans to ensure validation and monitoring of the delivery of HH services through the managed care plans' EVV systems, effective January 1, 2020. The Agency requires managed care plans to report on EVV compliance through Agency prescribed monthly reporting on their validation, monitoring, and complaint logs.

Fee-For-Service Utilization Management Activities

The Agency has contracted with a certified Quality Improvement Organization (QIO), eQHealth Solutions, LLC, to provide prior authorizations for several services paid for through the fee-for-service delivery system, including inpatient hospital services, home health, therapy services, durable medical equipment and supplies, and behavior analysis services. The QIO contract safeguards against the provision of unnecessary medical services or inappropriate use of Medicaid services and ensures appropriate care.

eQHealth Solutions, LLC provides enhanced care coordination services for recipients under the age of twenty-one years who are enrolled in the fee-for-service delivery system and are receiving private duty nursing (PDN) or personal care services in their family home or other community-based setting, receiving services in a nursing facility, or receiving Florida Model Waiver services. Enhanced care coordination is also provided to recipients receiving Prescribed Pediatric Extended Care (PPEC) services, regardless of plan enrollment. The care coordinator caseloads currently do not exceed forty recipients to one care coordinator for recipients receiving PDN services and fifteen recipients to one care coordination for recipients receiving services in a nursing facility.

Section VI. SMMC Program Evaluation Design

In addition to monitoring health and dental plan report submissions, performance measures, and general program activities, the following reports, dashboards, and contracts are utilized to evaluate the effectiveness of the Agency's quality strategy and to determine the achievement of improvement in the quality of services provided to recipients and providers.

- Annual Health Plan Performance Measure Data[17] – The Agency monitors and evaluates the health plans' performance through a combination of HEDIS, Adult and Child Core Set, and Agency-defined performance measures.
- External Quality Review Organization (EQRO) Annual Technical Reports[18] – The Agency utilizes EQRO's recommendations for improvement from the annual technical reports to continually improve quality of care, timeliness, and access to healthcare services provided by the SMMC health and dental plans.
- Health Plan Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys[19] – The Agency monitors plan performance by comparing individual plan rates and statewide rates to previous years, along with tracking trends regarding different measures. Plan rates are shared publicly to help Floridians make more informed choices when choosing a health plan and to stimulate the plans' quality improvement processes.
- MMA Waiver Monitoring[20] – The annual monitoring report documents accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative issues in the operation of the 1115 MMA Waiver for each year of the demonstration.

[17] "Performance Measure Data Submissions for Medicaid", Agency for Health Care Administration, https://ahca.myflorida.com/Medicaid/quality_mc/submission.shtml
[18] "Annual Technical Report of External Quality Review Results", Agency for Health Care Administration, https://ahca.myflorida.com/Medicaid/quality_mc/mgd_care_atr.shtml
[19] "Health Plan Information", Agency for Health Care Administration, https://www.floridahealthfinder.gov/HealthPlans/Default.aspx
[20] "MMA Annual Reports", Agency for Health Care Administration, https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/annual.shtml

- Quality Initiatives Dashboard[21] – The Agency developed a publicly available dashboard related to Agency goals for reducing Potentially Preventable Hospital Events and improving birth outcomes. This dashboard allows users to look at statewide rates as well as by region, health plan, and hospital.
- SMMC Research and Evaluation Contracts[22] – The Agency contracts with universities and other entities to conduct independent and unbiased research and evaluation projects which describe and analyze recipient, service, and program characteristics. Reports produced from the research and evaluation projects ensure Agency compliance with waiver requirements and enable the Agency to further develop clinically appropriate, fiscally responsible, and effective health care policy.

Florida Medicaid also contracts with several state universities and the EQRO to perform independent evaluations of various components of the program. At present, Florida's EQRO, HSAG, conducts the independent evaluation of the MMA waiver program.

MMA Evaluation

HSAG conducts a program evaluation of the MMA 1115(a) Demonstration Waiver as required in the Waiver's Special Terms and Conditions and in accordance with an evaluation design plan approved by CMS. The goal of the evaluation is to provide the Agency with an unbiased program evaluation that describes and analyzes recipient, service, and program characteristics.

The MMA program evaluation consists of ten (10) components, each with associated research questions. These components are:

- The effect of managed care on access to care, quality and efficiency of care, and the cost of care.
- The effect of customized benefit plans on beneficiaries' choice of plans, access to care, or quality of care.
- Participation in the Healthy Behaviors programs and its effect on participant behavior or health status.
- The impact of Low-Income Pool (LIP) funding on hospital charity care programs.
- The effect of having separate managed care programs for acute care and LTC services on access to care, care coordination, quality, efficiency of care, and the cost of care (This component was sunset after DY12).
- The impact of efforts to align with Medicare and improve beneficiary experiences and outcomes for dual eligible individuals.
- The effectiveness of enrolling individuals into a managed care plan upon eligibility determination in connecting beneficiaries with care in a timely manner.
- The effect the Statewide Medicaid Prepaid Dental Health Program has on accessibility, quality, utilization, and cost of dental health care services.
- The impact of the waiver of retroactive eligibility on beneficiaries and providers; and
- The impact of the behavioral health and supportive housing assistance pilot on beneficiaries who are 21 and older with serious mental illness (SMI), substance use disorder (SUD) or SMI with co-occurring SUD and are homeless or at risk of homelessness due to their disability.

[21] "Quality Initiatives", Agency for Healthcare Administration, https://ahca.myflorida.com/Medicaid/Policy_and_Quality/Quality/QI-initiatives/index.shtml
[22] "Medicaid Research and Evaluations", Agency for Health Care Administration, https://ahca.myflorida.com/medicaid/Policy_and_Quality/Quality/performance_evaluation/MER/index.shtml

In addition, the state must investigate cost outcomes for the demonstration as a whole, including administrative costs of implementation and operation, Medicaid health service expenditures, and uncompensated provider costs. Finally, the state must use results of hypothesis tests and cost analyses to assess demonstration effects on Medicaid program sustainability.

LTC Evaluation

An independent assessment was required for the first two renewal periods of the State's 1915(b)(c) LTC Waiver Program, and the state submitted the independent assessment for the second renewal period in December 2021. Florida State University was contracted by the state to conduct the assessment. The focus of the evaluation projects for the independent assessment were as follows:

1. Project 1 – Access to Care: Provide a comparison of the LTC waiver programs and nursing facility services that were in place prior to the implementation of the LTC program to the LTC services available after the LTC program. The assessment also compares changes in accessibility over time.

2. Project 2 – Quality of Care: Provide a comparison of the quality of LTC waiver programs and nursing facility services that were in place prior to the implementation of the LTC program to the quality of LTC services available after the LTC program was implemented. The assessment also compares changes in quality of care over time.

3. Project 3 – Cost-effectiveness: Provide a comparison of the LTC waiver programs and nursing facility services that were in place prior to the implementation of the LTC program to the LTC services available after the LTC program was implemented. The assessment also compares cost-effectiveness of LTC services over time.

An independent assessment is no longer required. The Agency continues to assess the program through regular monitoring activities, as described above.

Section VII. Future of the SMMC Program

The Agency remains committed to achieving improved health outcomes for members by pursuing innovative opportunities to increase access to high quality, cost-effective care for Florida's most vulnerable populations. The Agency remains committed to the goals articulated in this document, as well as diligent monitoring for emerging needs and exploring activities and initiatives to support those goals. Several potential activities and initiatives have been identified that would support the goals and the mission of the Agency, including improved integration of behavioral health services and strengthening of community partnerships. The Agency is in the midst of the procurement process for the next phase of the SMMC program, the goals, activities, and initiatives of which will be detailed in the next update of the Comprehensive Quality Strategy.

Appendix I. SMMC Health and Dental Plan Tables

STATEWIDE MEDICAID MANAGED CARE (SMMC) HEALTH PLANS (2018-2024)									
REGION	AETNA BETTER HEALTH (COV)	AMERIHEALTH (PRS)	COMMUNITY CARE PLAN (CCP)	FLORIDA COMMUNITY CARE (FCC)	HUMANA MEDICAL PLAN (HUM)	MOLINA HEALTHCARE (MOL)	SIMPLY HEALTHCARE (SHP)	SUNSHINE HEALTH (SUN)	UNITED HEALTHCARE (URA)
1				FCC LTC+	HUM COMP		SHP MMA	SUN COMP	
2				FCC LTC+	HUM COMP		SHP MMA	SUN COMP	
3				FCC LTC+	HUM COMP			SUN COMP	URA COMP
4				FCC LTC+	HUM COMP			SUN COMP	URA COMP
5				FCC LTC+	HUM COMP		SHP COMP	SUN COMP	
6	COV COMP			FCC LTC+	HUM COMP		SHP COMP	SUN COMP	URA COMP
7	COV COMP			FCC LTC+	HUM COMP		SHP COMP	SUN COMP	
8				FCC LTC+	HUM COMP	MOL COMP	SHP MMA	SUN COMP	
9		PRS MMA		FCC LTC+	HUM COMP		SHP MMA	SUN COMP	
10			CCP MMA	FCC LTC+	HUM COMP		SHP COMP	SUN COMP	
11	COV COMP	PRS MMA		FCC LTC+	HUM COMP	MOL COMP	SHP COMP	SUN COMP	URA COMP

COMP = Comprehensive Plan MMA = Managed Medical Assistance Plan LTC+ = Long-Term Care Plus Plan As of 12-15-2022

	SMMC SPECIALTY PLANS (2018-2024)					SMMC DENTAL PLANS (2018-2024)		
REGION	CHILDREN'S MEDICAL SERVICES PLAN – CHILDREN WITH CHRONIC CONDITIONS	CLEAR HEALTH ALLIANCE (HIV/AIDS)	MOLINA HEALTHCARE SERIOUS MENTAL ILLNESS (SMI)	SUNSHINE SERIOUS MENTAL ILLNESS (SMI)	SUNSHINE HEALTH CHILD WELFARE (CW)	DENTAQUEST	LIBERTY	MCNA DENTAL
1	CHILDREN'S MEDICAL SERVICES PLAN	CLEAR HEALTH ALLIANCE		SUNSHINE HEALTH	SUNSHINE HEALTH	DENTAQUEST	LIBERTY	MCNA
2	CHILDREN'S MEDICAL SERVICES PLAN	CLEAR HEALTH ALLIANCE		SUNSHINE HEALTH	SUNSHINE HEALTH	DENTAQUEST	LIBERTY	MCNA
3	CHILDREN'S MEDICAL SERVICES PLAN	CLEAR HEALTH ALLIANCE		SUNSHINE HEALTH	SUNSHINE HEALTH	DENTAQUEST	LIBERTY	MCNA
4	CHILDREN'S MEDICAL SERVICES PLAN	CLEAR HEALTH ALLIANCE	MOLINA HEALTHCARE	SUNSHINE HEALTH	SUNSHINE HEALTH	DENTAQUEST	LIBERTY	MCNA
5	CHILDREN'S MEDICAL SERVICES PLAN	CLEAR HEALTH ALLIANCE	MOLINA HEALTHCARE	SUNSHINE HEALTH	SUNSHINE HEALTH	DENTAQUEST	LIBERTY	MCNA
6	CHILDREN'S MEDICAL SERVICES PLAN	CLEAR HEALTH ALLIANCE		SUNSHINE HEALTH	SUNSHINE HEALTH	DENTAQUEST	LIBERTY	MCNA
7	CHILDREN'S MEDICAL SERVICES PLAN	CLEAR HEALTH ALLIANCE	MOLINA HEALTHCARE	SUNSHINE HEALTH	SUNSHINE HEALTH	DENTAQUEST	LIBERTY	MCNA
8	CHILDREN'S MEDICAL SERVICES PLAN	CLEAR HEALTH ALLIANCE		SUNSHINE HEALTH	SUNSHINE HEALTH	DENTAQUEST	LIBERTY	MCNA
9	CHILDREN'S MEDICAL SERVICES PLAN	CLEAR HEALTH ALLIANCE		SUNSHINE HEALTH	SUNSHINE HEALTH	DENTAQUEST	LIBERTY	MCNA
10	CHILDREN'S MEDICAL SERVICES PLAN	CLEAR HEALTH ALLIANCE		SUNSHINE HEALTH	SUNSHINE HEALTH	DENTAQUEST	LIBERTY	MCNA
11	CHILDREN'S MEDICAL SERVICES PLAN	CLEAR HEALTH ALLIANCE		SUNSHINE HEALTH	SUNSHINE HEALTH	DENTAQUEST	LIBERTY	MCNA

Expanded Benefits (Services covered in addition to your current benefits) Contact the plan for benefit limits ***Benefits that exceed State Plan covered services**	Humana Healthy Horizons in Florida	UnitedHealthcare	Aetna Better Health	Simply Healthcare	Sunshine Health	Molina Healthcare	Florida Community Care	Community Care Plan	AmeriHealth Caritas Florida	Children's Medical Services Network (CMSN)	Health Alliance HIV/AIDS	Sunshine (Serious Mental Illness)	Sunshine (Child Welfare)	CMS Health Plan Children with Special Health Care Needs)	Molina (Serious Mental Illness)
General Expanded Benefits - *Available for children and/or adults*															
Cellular Services (minutes and/or data)	✓	✓		✓	✓		✓	✓	✓	✓	✓	✓		✓	
Circumcision (newborns only)	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
Doula Services (birth coach who helps pregnant women)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Go365 Wellness for Pediatrics	✓														
Home Delivered Meals	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Housing Assistance (rent, utilities, and/or grocery assistance)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	
Meal Stipend (available for long distance medical appointment day-trips)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
*Over-the-Counter Benefit	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Swimming Lessons (children only)	✓	✓		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	
Transportation Services to Non-Medical Appointments/Activities	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	
Tutoring K-12	✓			✓			✓	✓	✓	✓					
Adult Expanded Benefits - *These services are only available for adults because they are already covered for children on Medicaid when medically necessary*															
Acupuncture Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				
Art Therapy			✓	✓	✓			✓	✓	✓	✓				
*Behavioral Health Assessment/Evaluation Services	✓	✓	✓	✓	✓			✓	✓	✓	✓				✓
*Behavioral Health Day Services/Day Treatment	✓	✓	✓	✓	✓			✓	✓	✓	✓				✓

Behavioral Health Intensive Outpatient Treatment	✓		✓	✓		✓		✓	✓	✓				✓
*Behavioral Health Medical Services (e.g., medication management, drug screening, etc.)	✓	✓	✓	✓	✓			✓	✓	✓	✓			✓
*Behavioral Health Psychosocial Rehabilitation	✓	✓	✓	✓	✓			✓		✓	✓			✓
*Behavioral Health Screening Services	✓	✓	✓	✓	✓			✓	✓	✓	✓			✓
Biometric Equipment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
*Chiropractic Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓
Computerized Cognitive Behavioral Therapy	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓			
*Durable Medical Equipment/Supplies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Equine Therapy			✓	✓	✓			✓	✓		✓			
Financial Literacy	✓	✓					✓	✓						
Flu/Pandemic Prevention Kit	✓	✓			✓	✓	✓		✓	✓	✓	✓	✓	✓
*Group Therapy (Behavioral Health)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓
*Hearing Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓
*Home Health Nursing/Aide Services		✓	✓	✓	✓	✓	✓		✓	✓	✓			
Homemaker Services (e.g., hypoallergenic carpet cleanings)		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		
Home Visit by a Social Worker	✓		✓	✓	✓		✓	✓	✓	✓	✓			
Legal Guardianship	✓				✓	✓	✓				✓	✓	✓	✓
*Individual/Family Therapy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓
Massage Therapy	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓			✓
*Medication Assisted Treatment Services	✓	✓	✓	✓	✓		✓	✓	✓		✓			✓
*Mental Health Targeted Case Management	✓	✓	✓		✓			✓	✓		✓			✓
Nutritional Counseling	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓
*Occupational Therapy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓

Appendix II. Measuring Plans' Performance

I. Statewide Medicaid Managed Care (SMMC)

SMMC plans are required to collect and report MMA and LTC performance measures, as applicable, and Dental plans are required to collect and report dental performance measures using statewide data to the Agency by July 1 of each year, covering services that their enrollees received in the previous calendar year. The Agency compares plan-specific and aggregate program HEDIS and other performance measure data to national benchmarks, as available, to assess the performance of the SMMC program. The Agency compares plan-specific HEDIS performance measure data to national benchmarks to calculate performance measure liquidated damages and ratings for the Florida Medicaid Health Plan Report Card, which is available online at: http://www.floridahealthfinder.gov . The Agency also posts a full report of Agency performance measures, by MMA and LTC plan, to the Agency's website: http://ahca.myflorida.com/Medicaid/quality_mc/submission.shtml .

II. Managed Medical Assistance

A. Required Performance Measures

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool developed and maintained by the National Committee for Quality Assurance (NCQA), that is used by more than 90 percent of America's health plans to measure performance on important dimensions of health care and service. Widespread use of HEDIS performance measures allows for an "apples-to-apples" comparison of Florida Medicaid health plans' performance to each other and to plans around the nation.

The Agency requires MMA plans to collect and report annually a specified list of performance measures, certified by a qualified auditor. NCQA licenses organizations and certifies selected employees of licensed organizations to conduct audits using NCQA's standardized audit methodology. The HEDIS compliance audit indicates whether a plan has adequate and sound capabilities for processing medical, member, and provider information as a foundation for accurate and automated performance measurement. The audit is composed of two parts: an overall information systems capabilities assessment and an evaluation of the plan's ability to comply with conventional reporting practices and HEDIS specifications for the various HEDIS domains. While many of the performance measures the Agency requires health plans to report are HEDIS measures, the Agency requires that plans have the non-HEDIS measures audited and certified as well.

The Agency requires health plans to contract with software vendors that are certified through NCQA's Measure Certification program. The Measure Certification program validates the integrity of the software and demonstrates that the performance measures meet current NCQA standards, which helps ensure the accuracy of reporting measures, and produces more reliable and comparable results.

Over the past four years, the Agency has made several changes to the list of performance measures that the health plans are required to report, due to modifications to HEDIS by the NCQA and due to changes to the Child Core Set and Adult Core Set by Federal CMS. Several HEDIS measures have been retired by NCQA and thus have been removed from the Agency's list of required performance measures (e.g.,

Adolescent Well Care Visits, Comprehensive Diabetes Care – Medical Attention for Nephropathy, and Adult BMI Assessment).

Beginning with the performance measure report submissions for calendar year 2020 services, MMA plans have been required to report on the following measures:

Table 1
MMA Required Performance Measures
2018-2023 Contract

HEDIS		Children's and/or Adult Core Set Measure
1	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	Yes
2	Adults' Access to Preventive/Ambulatory Health Services (AAP)	No
3	Ambulatory Care (AMB)	Yes
4	Antidepressant Medication Management (AMM)	Yes
5	Breast Cancer Screening (BCS)	Yes
6	Cervical Cancer Screening (CCS)	Yes
7	Childhood Immunization Status (CIS) – Combinations 2 and 3	Yes
8	Chlamydia Screening in Women (CHL)	Yes
9	Comprehensive Diabetes Care (CDC) • Hemoglobin A1c (HbA1c) testing • HbA1c poor control. • HbA1c good control (<8%). • Eye exam (retinal) performed.	Yes
10	Controlling High Blood Pressure (CBP)	Yes
11	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Yes
12	Immunizations for Adolescents (IMA)	Yes
13	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Yes
14	Lead Screening in Children (LSC)	No
15	Asthma Medication Ratio (AMR)	Yes
16	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Yes
17	Prenatal and Postpartum Care (PPC)	Yes
18	Child and Adolescent Well-Care Visits (WCV)	No
19	Well-Child Visits in the First 30 Months of Life (W30)	No
20	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Yes
21	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence Treatment (FUA)	Yes
22	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Yes
23	Plan All-Cause Readmissions	Yes

24	Use of Opioids at High Dosage (HDO)	No
25	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: • Body Mass Index Assessment for Children/Adolescents. • Counseling for Nutrition. • Counseling for Physical Activity.	Yes
26	Follow-Up After Hospitalization for Mental Illness (FUH)	Yes
27	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	Yes
Agency-Defined		
28	Prescription of HIV Antiretroviral Therapy (HAART)	No
29	HIV Medical Visit Frequency (HIVV)	No
30	Gap in HIV Medical Visits (HIVG)	No
Child Core Set		
31	Contraceptive Care – Postpartum Women Ages 15-20 (CCP-CH)	Yes
32	Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CW)	Yes
33	Cesarean Birth (PC-02)	Yes
34	Contraceptive Care – All Women Ages 15-20 (CCW-CH)	Yes
35	Developmental Screening in the First Three Years of Life (DEV-CH)	Yes
Adult Core Set		
36	Contraceptive Care – Postpartum Women Ages 21–44 (CCP-AD)	Yes
37	Contraceptive Care - All Women Ages 21 – 44 (CCW-AD)	Yes
38	Concurrent Use of Opioids and Benzodiazepines (COB)	Yes
39	HIV Viral Load Suppression (VLS)	Yes
40	Screening for Depression and Follow-Up Plan: Ages 18 and older (CDF-AD)	Yes
41	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)	Yes
42	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	Yes
43	Elective Delivery (PC-01)	Yes
44	Bipolar Disorder and Major Depression: Appraisal for Alcohol or Chemical Substance Use (BMD)	No

1. Performance Measure Sanctions

The Agency may sanction MMA plans for failure to achieve minimum scores on HEDIS performance measures after the first year of poor performance. Each of the performance measures listed below is assigned a point value that correlates to the NCQA HEDIS National Means and Percentiles for Medicaid plans. The scores are assigned according to the table below. Individual performance measures are grouped and scores are averaged within each performance measure group.

PM Ranking	Score
>= 90th percentile	6
75th – 89th percentile	5
60th – 74th percentile	4
50th – 59th percentile	3
25th – 49th percentile	2
10th – 24th percentile	1
< 10th percentile	0

MMA plans may receive a monetary sanction of up to $10,000 for each performance measure group where the group score is below three (3). Performance measure groups are as follows:

i. Mental Health and Substance Abuse
   - Antidepressant Medication Management – Effective Acute Phase Treatment.
   - Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase.
   - Follow-up after Hospitalization for Mental Illness – 7 day.
   - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation – Total.
   - Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence – 7 day – Total.

ii. Well-Child
   - Childhood Immunization Status – Combination 3.
   - Immunizations for Adolescents – Combination 1.
   - Lead Screening in Children.

iii. Other Preventive Care
   - Adults' Access to Preventive/Ambulatory Health Services – Total.
   - Breast Cancer Screening.
   - Cervical Cancer Screening.
   - Chlamydia Screening for Women – Total.

iv. Prenatal/Perinatal
   - Prenatal and Postpartum Care (includes two measures).

v. Diabetes – Comprehensive Diabetes Care measure components
   - HbA1c Testing.
   - HbA1c Control (< 8%).
   - Eye Exam.

vi. Other Chronic and Acute Care
   - Controlling High Blood Pressure.

- Asthma Medication Ratio – 75% Compliance – Total.

The Agency will review the Specialty plan's performance on Specialty plan-specific measure data to determine acceptable performance levels and may establish sanctions for these measures based on those levels after the first year of reporting.

In addition to sanctions, the Agency may require MMA plans to complete a Performance Measure Action Plan (PMAP) after the first year of poor performance.

2. Performance Measure Liquidated Damages

The Agency may impose liquidated damages on plans for failure to achieve minimum scores on HEDIS performance measures.

The Agency compares the MMA plans' performance measure rates to the NCQA HEDIS National Means and Percentiles for Medicaid plans. Beginning with the performance measures report that was due to the Agency by July 1, 2020, the Agency has used the following methodology when calculating performance measure liquidated damages.

For each eligible HEDIS measure where the MMA plan's rate falls below the 50th percentile, the MMA plan may receive liquidated damages. Liquidated damages are calculated based on the number of members eligible for the measure who did not receive the service being measured up to the 50th percentile rate. For measures calculated using a sample, liquidated damages are calculated based on the number of eligible members who did not receive the service being measured, not just those in the sample, up to the 50th percentile rate.

Performance measure liquidated damage amounts per eligible member vary by performance measure tier:

- **Tier 1**: $150 per eligible member not receiving the service being measured up to the 50th percentile rate for the measure.
- **Tier 2**: $100 per eligible member not receiving the service being measured up to the 50th percentile rate for the measure.
- **Tier 3**: $80 per eligible member not receiving the service being measured up to the 50th percentile rate for the measure.

The Agency may reduce the liquidated damage amount per eligible enrollee when a plan's rate for a performance measure has improved three percentage points or more compared to the previous reporting period and that rate is between the 40th and 50th percentiles.

Liquidated damages are not imposed for measures being reported by plans for the first time or for measures for which NCQA has not calculated means and percentiles. For measures with multiple components, liquidated damages are often assessed for one component (e.g., Antidepressant Medication Management has two components, an acute phase and a continuation phase, but liquidated damages are only assessed for the acute phase component).

Due to calendar year 2018 being a transition year across contracts, the Agency collected and reported performance measures publicly, labeling the performance measures as "transition year" measures. The Agency did not assess liquidated damages or sanctions related to where performance measure results fall relative to the NCQA HEDIS National Means and Percentiles for Medicaid plans, but assessed liquidated damages and sanctions due to incomplete, late, and/or inaccurate reporting.

The Agency may assess liquidated damages for each of the following measures:

i. Tier 1:
- Antidepressant Medication Management – Effective Acute Phase Treatment.
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Comprehensive Diabetes Care – HbA1c Control (<8%)
- Controlling High Blood Pressure
- Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence – 7 day – Total
- Follow-up after Emergency Department Visit for Mental Illness – 7 day.
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation – Total
- Asthma Medication Ratio – 75% Compliance – Total

ii. Tier 2:
- Child and Adolescent Well-Care Visits
- Adults' Access to Preventive/Ambulatory Health Services – Total
- Childhood Immunization Status – Combination 3
- Immunizations for Adolescents – Combination 1
- Timeliness of Prenatal Care

iii. Tier 3:
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening in Women – Total
- Comprehensive Diabetes Care – HbA1c Testing
- Comprehensive Diabetes Care – Eye Exam
- Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase
- Lead Screening in Children
- Postpartum Care

B. Medicaid Health Plan Report Card

The Special Terms and Conditions of the MMA program 1115 waiver require that Florida create a health plan report card that must be posted on the State's website and present an easily understandable summary of quality, access, and timeliness of care based on performance data for each MMA plan. Recipients can use this information to compare plans and help them to decide which plan to choose.

Individual performance measures are used to compare plans and are rolled up into five performance measure categories:

i. Pregnancy-related Care
ii. Keeping Kids Healthy
iii. Keeping Adults Healthy
iv. Living With Illness
v. Behavioral Health Care.

Plans are compared against national Medicaid benchmarks published by NCQA, using a 5-star rating scale. Only those who have been enrolled in plans for a specified amount of time are included in measure calculations.

The report card displays ratings by plan for each of the five performance measure categories. There are also options to see the plans' 1–5 star ratings per individual performance measure in the categories, and to see the plans' actual scores for each measure (e.g., the percentage of plan enrollees who received breast cancer screening).

The Agency has published four report cards. The currently posted Medicaid Health Plan Report Card, published in December 2021, is based on HEDIS 2020 data (i.e., CY 2020 data reported in 2021) and includes plan performance data for services provided under the MMA plan contracts.

The Agency will continue to make improvements to the report card to make it more useful to consumers.

C. Achieved Savings Rebate

In order to ensure that capitated payments made to plans participating in the SMMC program are appropriate, the Agency has implemented a statutorily defined program called the Achieved Savings Rebate program. This program includes enhanced financial monitoring of plans and plan expenditures through submission of detailed financial reporting by plans and an annual audit of that documentation conducted by an independent certified public accountant in accordance with generally accepted auditing standards.

Audits must include an annual premium revenue, medical and administrative costs, and income or losses reported by each prepaid plan, in order to determine and validate the achieved savings rebate. Plans are required to make available to the Agency and the Agency's contracted certified public accountant all books, accounts, documents, files, and information that relate to the prepaid plan's Medicaid transactions.

The independent auditor will determine the achieved savings of each plan. Plans who have achieved savings are also eligible to retain an additional 1% of revenue by meeting or exceeding certain quality standards. In order to retain the 1% incentive, plans must achieve performance measure rates at or above the 75th percentile for five of the nine performance measures listed below, with none of the rates below the 50th percentile. The performance measures are as follows:

- Antidepressant Medication Management – Effective Acute Phase Treatment.
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia.
- Comprehensive Diabetes Care – HbA1c Control (<8%).
- Controlling High Blood Pressure.

- Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence – 7 day – Total.
- Follow-up after Emergency Department Visit for Mental Illness – 7 day.
- Follow-up after Hospitalization for Mental Illness – 7 day.
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation – Total.
- Asthma Medication Ratio – 75% Compliance – Total.

D. Well-Child Visit Performance Measures

The Federal CMS-416 report, which reports on children's utilization of services, is due to Federal CMS on April 1 of each year. To increase the accuracy of the report and avoid duplication, the Agency worked with Federal CMS to refine the Agency's data collection process to eliminate potential duplication of eligible recipients in the reported data by comparing FFS claims and encounter data. Each spring, the Agency calculates statewide CMS-416 results based on claims and encounter data. The Agency also requires MMA plans to collect and report their plan-specific CMS-416 and well-child visit screening results by July 1 of each year, representing services received during the previous federal fiscal year.

MMA plans, by Agency contract and state law, must achieve a well-child visit rate of at least 80% for those members who are continuously enrolled in the plan for at least eight months during the federal fiscal year (October 1 – September 30). The well-child visit rate indicates the percentage of children that receive the number of initial and periodic screening services required by Florida's periodicity schedule, and is based on the data reported by the MMA plan in its audited Well-Child Visit (CMS-416) and FL 80% Screening Report that is due annually to the Agency. For each federal fiscal year that the plan does not achieve the 80% well-child visit rate, the Agency may require a corrective action plan (CAP) to be submitted and may assess liquidated damages.

In addition, the Agency contract and Centers for Medicare & Medicaid Services require that plans must achieve at least an 80% well-child visit participation rate. The well-child visit participation rate indicates the percentage of children that receive any initial and periodic screening service during the federal fiscal year and will be based on the data reported by the MMA plan in its audited Well-Child Visit (CMS-416) and FL 80% Screening Report that is due annually to the Agency. For each federal fiscal year that the plan does not meet the 80% well-child visit participation rate, the Agency may require a CAP to be submitted and may assess liquidated damages.

E. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys

CAHPS surveys ask enrollees to report on and evaluate their experiences with health care and their health plan. CAHPS surveys are developed and maintained by the Agency for Healthcare Research and Quality (AHRQ). These surveys are confidential, standardized, cover topics that are important to consumers, and focus on aspects of quality that consumers are best qualified to assess, such as customer service and ease of access to health care services.

MMA plans are contractually required to contract with an NCQA-certified CAHPS Survey Vendor to conduct the CAHPS Health Plan Survey each year. The surveys must be conducted according to NCQA's mixed mode protocol (mail with telephone follow-up) and plans must field an adult survey (for enrollees 18 years of age and older) and a child survey (for parents to report on the experience of a child 17 years of age or younger). In order to ensure that the CAHPS surveys reflect the

experience of a diverse population, all surveys must be available in English and Spanish. The survey vendors are required to pull a systematic sample of enrollees to whom the surveys will be mailed, which only includes those enrollees who have been continuously enrolled in the plan for six months prior to the start of the survey. In 2019, the required Adult Medicaid sample size was 1,350 and the Child Medicaid sample size was 1,650. Beginning in 2021, the Medicaid health plans are required to conduct the Child with Chronic Conditions (CCC) CAHPS survey, for which the sample size is 3,490.

Plans are required to report their certified results to the Agency on an annual basis. Beginning with the 2016 survey, plans were also required to report their results to NCQA so they may be included in the National Medicaid Means and Percentiles. The results of these surveys are posted on the Agency's Florida Health Finder website so that Medicaid enrollees may use the survey results to compare plans when making enrollment decisions.

III. Long-term Care

A. Required Performance Measures

The 2018-2023 SMMC contract requires the plans providing long-term care (LTC) services to report on the measures in the table below. Plans that operated under the prior SMMC contracts were required to collect and report on the first four measures by November 1, 2019, for services provided in calendar year 2018. All plans providing LTC services under the 2018-2023 SMMC contracts were required to collect and report on the following measures by July 1, 2020 for services provided in calendar year 2019; and in subsequent years.

Table 2 **LTC Required Performance Measures** **2018-2023 Contract**	
Centers for Medicare and Medicaid Services and Mathematica Managed Long-Term Services and Supports (MLTSS) Measures	
1	Comprehensive LTSS Assessment and Update
2	Comprehensive LTSS Care Plan
3	Shared Care Plan
4	Reassessment and Care Plan Update after Discharge
5	Falls: Screening, Risk Assessment, and Plan of Care to Prevent Future Falls
6	Admission to an Institution from the Community Among LTSS Beneficiaries
7	Successful Transition after Short-Term Institutional Stay Among LTSS Enrollees
8	Successful Transition after Long-Term Institutional Stay Among LTSS Enrollees

1. Performance Measure Sanctions

The Agency may sanction LTC plans for failure to achieve minimum scores on the below performance measures specified by the Agency after the first year of poor performance.

Table 3 **LTC Performance Measure Sanctions**	
Centers for Medicare and Medicaid Services and Mathematica MLTSS Measures	**Rate and applicable sanction**

Comprehensive LTSS Assessment and Update	Rate < 85%, $10,000 monetary sanction
Comprehensive LTSS Care Plan	Rate < 85%, $10,000 monetary sanction
Shared Care Plan	Rate < 85%, $10,000 monetary sanction
Reassessment and Care Plan Update after Discharge	Rate < 85%, $10,000 monetary sanction

2. Performance Measure Liquidated Damages

The Agency compares the LTC plans' performance measure rates to the established thresholds. The liquidated damages thresholds and amounts are outlined in Table 4.

Table 4 **LTC Performance Measure Liquidated Damages Amounts**	
Comprehensive LTSS Assessment and Update	Failure to achieve a rate of 85% or higher for this measure will result in liquidated damages of $100 per each case in the denominator not present in the numerator for the measure up to the 85% rate.
Comprehensive LTSS Care Plan	Failure to achieve a rate of 85% or higher for this measure will result in liquidated damages of $100 per each case in the denominator not present in the numerator for the measure up to the 85% rate.
Shared Care Plan	Failure to achieve a rate of 85% or higher for this measure will result in liquidated damages of $100 per each case in the denominator not present in the numerator for the measure up to the 85% rate.
Reassessment and Care Plan Update after Discharge	Failure to achieve a rate of 85% or higher for this measure will result in liquidated damages of $100 per each case in the denominator not present in the numerator for the measure up to the 85% rate.

Due to calendar year 2018 being a transition year across contracts, the Agency collected and may report performance measures publicly, labeling such performance measures as "transition year" measures. The Agency did not assess liquidated damages or sanctions related to where performance measure results fall relative to established targets, but could assess liquidated damages and sanctions due to incomplete, late, and/or inaccurate reporting.

During negotiations, LTC plans agreed to achieve at least a 2% improvement in their performance measure rates each year of the Contract until the LTC plan achieves the performance standards established by the Agency. One plan committed to at least a 5% improvement each year. If LTC plans fail to comply with these commitments, they may receive liquidated damages as determined by the Agency.

B. Achieved Savings Rebate

In order to be eligible to retain up to an additional 1% of revenue in the first year, LTC plans must exceed a specified threshold for each of the performance measures listed below:

- Comprehensive LTSS Assessment and Update.
- Comprehensive LTSS Care Plan.
- Shared Care Plan.

- Re-Assessment and Care Plan Update after Discharge.

C. LTC - Home and Community-Based Services (HCBS) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys

The LTC plans are required to conduct an annual enrollee experience survey using the Home and Community-Based Services (HCBS) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey and following the Technical Assistance Guide created by the Centers for Medicare & Medicaid Services (CMS). This confidential survey assesses experience with care for LTC enrollees receiving home and community-based services. The first HCBS CAHPS survey was fielded in spring 2018. The 2019 HCBS CAHPS survey results were due to the Agency by November 1, 2019. Subsequent submissions are due to the Agency by September 1st of every year, although the surveys were suspended in 2020.

LTC plans are required to contract with an NCQA-certified CAHPS Survey Vendor to conduct the surveys with a minimum sample size of 5000 and a target of 411 completed surveys. The survey must be administered telephonically or in person. LTC plans are required to use the core HCBS CAHPS 1.0 Survey. If they would like to add questions to the survey, those questions may be added to the end of the core survey. Additional questions must be submitted to the Agency for review and approval prior to being included in the survey.

To be included in the survey sample, enrollees must have been enrolled in the plan and receiving home and community-based services for at least three consecutive months. Enrollees can have someone help them with the survey if needed.

IV. Dental Health Plans

A. Required Performance Measures

The initial list of required performance measures for the dental plans has been updated each year. Beginning with the performance measures report that was due to the Agency by July 1, 2023 (for calendar year 2022 services), dental plans were required to collect and report on the following measures:

Table 5 Dental Plan Required Performance Measures 2018-2023 Contract	
HEDIS	
1	Annual Dental Visit
Child Core Set	
2	Oral Evaluation
3	Topical Fluoride for Children
4	Sealant Receipt on Permanent First Molars
Dental Quality Alliance	
5	Ambulatory Care Sensitive Emergency Department (ED) Visits for Dental Caries in Children
6	Follow-up after ED Visits for Dental Caries in Children
7	Ambulatory Care Sensitive ED Visits for Non-Traumatic Dental Conditions in Adults
8	Caries Risk Documentation
9	Treatment Services (Pediatric Measure)
Agency-Defined – based on Dental Quality Alliance specifications for children's measure	
10	Follow-up with Dentist after Dental-Related ED Visits
11	Preventive Dental Services (based on CMS-416)

1. Performance Measure Sanctions

The Agency may sanction Dental Health Plans for failure to maintain and/or improve scores on performance measures after the first year of poor performance. The Agency may impose monetary sanctions as described below in the event that the plan's performance is not consistent with the Agency's expected standards.

For each of the performance measures listed below where the Dental Health Plan's rate decreases more than two percentage points compared to the previous year, the plan may receive a monetary sanction of $10,000.

- Annual Dental Visit.
- Preventive Dental Services.
- Dental Treatment Services.
- Oral Evaluation.
- Topical Fluoride for Children.
- Follow-up after Emergency Department Visits for Dental Caries in Children.

2. Performance Measure Liquidated Damages

The Agency compares the dental plans' performance measure rates to the targets that each plan committed to for each contract year. If a dental plan does not meet its target for preventive dental services or dental treatment services, the liquidated damage amount is $50,000 per occurrence in addition to $10,000 for each percentage point less than the target. If a dental plan does not meet its target for the Annual Dental Visit measure, the liquidated damage amount is $25 per eligible enrollee not receiving the service up to the target. One additional performance measure liquidated damage is in the table below:

Table 6
Dental Performance Measure Liquidated Damages Amounts

Issue	Amount
Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children (ages 0 - <21 years)	$250 per occurrence

A. Achieved Savings Rebate

Dental Plans must achieve the below established target rates for a select list of dental performance measures in order to be eligible to retain up to an additional 1% of revenue.

- Federal Fiscal Year (FFY) 2018-19/Calendar Year (CY) 2019:
  - Annual Dental Visit: 60% or higher.
  - Preventive Dental Services: 50% or higher.
- FFY 2019-20/CY 2020:
  - Annual Dental Visit: 60% or higher.
  - Preventive Dental Services: 50% or higher.
- FFY 2020-21/CY 2021:
  - Annual Dental Visit: 62% or higher.
  - Preventive Dental Services: 52% or higher.
- FFY 2021-22/CY 2022:
  - Annual Dental Visit: 63% or higher.
  - Preventive Dental Services: 54% or higher.
- FFY 2022-23/CY 2023:
  - Annual Dental Visit: 65% or higher.
  - Preventive Dental Services: 56% or higher.

B. Well-Child Visit Performance Measures

Each dental plan committed to achieving particular targets for preventive dental services and dental treatment services in each contract year. Failure to meet or exceed the targets may result in a corrective action plan (CAP) in addition to liquidated damages.

Appendix III. Quality Compliance Monitoring Reports

Adverse and Critical Incident Report: The purpose of this monthly report is to monitor all managed care plans' adverse and critical incident reporting and management systems for adverse and critical incidents that negatively impact the health, safety or welfare of enrollees. This includes all service delivery settings applicable to enrollees.

Child Staffing Attendance Report: The purpose of this monthly report is for managed care plans to report to the Agency whether they were in attendance on the local medical neglect or behavioral health related child staffing calls. Each monthly report should only include enrollees who the health plan received notification for a child staffing from the Agency for Health Care Administration, other state agencies, or community-based organizations. The Agency internally tracks the health plans' attendance, and this report is reviewed to ensure accuracy and compliance with requirements of attendance for child staffings.

Enhanced Care Coordination Report: The purpose of this monthly report is for managed care plans to report on enhanced care coordination for enrollees under the age of twenty-one (21) years receiving skilled nursing facility (NF) or private duty nursing (PDN) services. The Agency monitors this report to ensure compliance and ensure additional services are not needed for an enrollee; if there are, the Agency works with the managed care plans to ensure enrollees receive the services needed.

ER Visits for Enrollees without a PCP/PDP Appointment Report: The purpose of this annual report is to provide the Agency with information regarding the number of emergency room visits by enrollees with MMA or Dental Plan benefits who have not had at least one appointment with their primary care provider (PCP) or primary dental provider (PDP) during the reporting year. The Agency is working to enhance this report for more timely identification of these enrollees to ensure managed care plans work with these enrollees to set them up with a PCP and/or PDP home in helping to prevent potentially preventable hospital events.

Health Risk Assessment Report: The purpose of this quarterly report is to monitor completion of health risk assessments (HRAs) within the specified timeframe of completion (within 60 days of enrollment), specifically for pregnant enrollees and enrollees with serious mental illness (SMI), diabetes, and/or asthma. This report allows the Agency to identify managed care plans' compliance with targets they set for themselves in terms of completed HRAs for each high-risk population noted above.

Hernandez Settlement Agreement Survey: The purpose of this annual report is to provide the Agency with annual settlement agreement surveys related to Hernandez et al. v. Medows, commonly referred to as the Hernandez Settlement Agreement (HSA), conducted by the Managed Care Plans on no less than 5% of all participating pharmacy locations in an effort to ensure compliance with the HSA, for enrollees receiving MMA benefits. The Agency reviews the surveys to ensure that participating pharmacies are trained on the requirements of the HSA and are providing enrollees with proper notices, including appeal rights.

Hernandez Settlement Ombudsman Log: The purpose of this quarterly report is to provide the Agency with details regarding any enrollee pharmacy issues related to the settlement agreement Hernandez et al. v. Medows, commonly referred to as the Hernandez Settlement Agreement, for enrollees receiving MMA benefits. The Agency ensures that pharmacy issues involving refills, medication access, and service authorizations are properly resolved.

Inter-Rater Reliability Report: The purpose of this quarterly report is to provide the Agency with information regarding the managed care plan's quality assurance and quality improvement program. The managed care plan conducts inter-rater reliability (IRR) audits of at least 1% of service authorization decisions per reviewer (nurses, therapists, physicians, etc.). Each reviewer must maintain an 85% accuracy rate. The Agency reviews and monitors IRR rates to ensure compliance and imposes compliance actions if managed care plans do not meet the 85% accuracy rate.

Medical Foster Care Report: The purpose of this quarterly report is to provide the Agency with information regarding enrollees under the age of twenty-one (21) years, who are receiving Medical Foster Care Services. The Agency reviews and monitors this report to ensure that the Medical Foster Care Children are receiving care coordination and wrap-around services according to the child's plan of care.

Oral Health Risk Assessment Report: The purpose of this quarterly report is to monitor completion of oral health risk assessments within the specified timeframe of completion (within 60 days of enrollment), specifically for pregnant members, enrollees under the age of 21, and enrollees with a developmental disability diagnosis. This report allows the Agency to identify dental plans' compliance with targets they set for themselves in terms of completed assessments for each population noted above.

PCP/PDP Appointment Report: The purpose of this annual report is to provide the Agency with information regarding the number of enrollees with MMA benefits who have not had an appointment with their primary care provider (PCP) or primary dental provider (PDP) within their first year of enrollment. The Agency is working to enhance this report for more timely identification of these enrollees to ensure managed care plans work with these enrollees to set them up with a PCP and/or PDP home in helping to prevent potentially preventable hospital events.

Residential Psychiatric Treatment Report: The purpose of this monthly report is to provide the Agency with information regarding enrollees under the age of twenty-one (21) years who are receiving residential psychiatric treatment in Statewide Inpatient Psychiatric Program (SIPP) or Therapeutic Group Care (TGC) placements. The Agency closely monitors this report to ensure enrollees are placed into a facility for treatment timely and coordinates closely with managed care plans on any enrollees that require further assistance.

Service Authorization Performance Outcome Report: The purpose of this monthly report is to provide the Agency with information regarding the managed care plans' service authorization process, including service authorization volumes, service authorization denial data, and timeframes for service authorization decisions. The Agency monitors this report to identify trends in service authorizations specific to covered service types.

Case Management File Audit Report: The purpose of this quarterly report is to ensure that the managed care plan has an internal monitoring system in place for its case management program, and that enrollees receiving LTC services are receiving quality care.

Case Manager and Provider Training Report: The purpose of this annual report is to gather data on performance measures for the Centers for Medicare and Medicaid Services (CMS) on the following: the most recent date direct hire and contracted LTC case managers received abuse, neglect, and exploitation training and Alzheimer's disease and dementia training; and whether Direct Service Providers that are mandated to report abuse, neglect, and exploitation have received appropriate training.

Case Manager Caseload Report: The purpose of this monthly report is to ensure that enrollees receiving LTC services are receiving quality case management services by monitoring the caseload requirements.

Critical Incident Report—Individual: The purpose of this report is to monitor LTC plans' critical incident reporting and management systems for critical incidents that negatively impact the health, safety or welfare of LTC enrollees. This includes critical incidents in all service delivery settings applicable to enrollees. This report is due immediately upon occurrence and no later than twenty-four (24) hours after detection or notification.

Denial, Reduction, Termination, or Suspension of Services Report: The purpose of this monthly report is to monitor for trends in the amount and frequency that the managed care plan denies, reduces, terminates or suspends services, including both home and community-based and nursing facility services, for enrollees receiving LTC services and reviewed to ensure managed care plans submit the Notice of Adverse Benefit Determination letters in compliance with the timeframe specified in the contract.

Enrollee Roster and Facility Residence Report: The purpose of this monthly report is to provide information on the current physical location of each enrollee receiving LTC services. The report is used to track and trend the number of LTC enrollees transitioning into the community from a nursing facility and vice versa and may be used for disaster recovery planning and relief.

Missed Services Report: The purpose of this monthly report is to monitor all missed facility and non-facility services covered by the managed care plan for enrollees receiving LTC services for the previous month, in accordance with the Long-term Care Contract/Exhibit. It is used to trend the most frequently missed Home and Community Based services. If any services were missed due to the provider (e.g., provider no-show, provider cancellation), the Agency will follow up with the managed care plans to mitigate any care coordination issues.

Participant Directed Option (PDO) Roster Report: The purpose of this monthly report is for the managed care plans to identify the Long-Term Care enrollees who are receiving PDO services, which services are provided, and if an enrollee is disenrolled from the PDO program, including a reason for disenrollment. The report is reviewed to track and trend the number of enrollees participating in the PDO program and as a data source for PDO targeted monitoring projects.

Appendix IV. Managed Care Contract Provisions

A. External Quality Review Requirements

The state's MCO and PAHP contracts require the entities to be subject to annual, external independent review of the quality outcomes, timeliness of, and access to the services covered under each contract.

The Agency's contracted External Quality Review Organization produces an Annual Technical Report that reports on its review activities.

The reference to the contract provisions incorporating this requirement can be found in Table 1.

Table 1

External Quality Review
42 CFR 438.350

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance (MMA) and Long Term care (LTC) Programs	Attachment II, Section IX. A. 1 and 3
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section IX. A. 1 and 5

B. Access standards

1. Availability of Services

The state's MCO and PAHP 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, regarding managed care. MCO and PAHP access to care requirements are in this section. The table following each standard provides the location where this requirement is in each of the state's MCO and PAHP contracts.

(a) Maintains and Monitors a Network of Appropriate Providers

The state's MCO and PAHP contracts require each entity to establish and maintain a network of appropriate providers 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. Written agreements must support each entity's network of appropriate providers.

The state requires the MCOs and PAHPs 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 PAHPs 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 handbooks and fee schedules and the plans' provider handbooks, which must be incorporated in all plan subcontracts by reference, for each service category covered by the plan. Exceptions exist where different standards are specified elsewhere in the contract or if the standard is waived in writing by the state on a case-by-case basis when the member's medical needs would be equally or better served in an alternative care setting or using alternative therapies or devices within the prevailing medical community.

The state requires MCOs and PAHPs to make emergency medical care available 24 hours a day, seven days a week. 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. This includes but is 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 incorporating these requirements can be found in Table 2.

Table 2 **Availability of Services** **42 CFR 438.206(b)(1)**	
Plan Type	**Contract Provision**
Managed Care Organizations	
MMA and LTC Programs	Attachment II, Section VI. A; Section VIII. A.1. and 2; Exhibit II-A., Section V.C.3; Section VIII. A.2.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section VI. A.; Section VIII. A.; Exhibit II-A., Section V.C.3; Section VIII. A.2..

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

The state requires MCOs and PAHPs 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 incorporating this requirement can be found 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	
MMA and LTC Program	Attachment II, Exhibit II-A, Section VIII.-A.4.a.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Exhibit II-A, Section VIII. A.4.a.

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

The state requires each MCO and PAHP 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 incorporating this requirement can be found in Table 4.

Table 4

Second Opinion Requirement

42 CFR 438.206(b)(3)

Plan Type	Contract Provision
Managed Care Organizations	
MMA and LTC Programs	Attachment II, Section VI. G.2.c.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section VI. H.2.d.

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

The state requires MCOs or PAHPs 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 PAHP is unable to provide them in compliance with 42 CFR 438.206(b)(4).

The reference to the contract provision incorporating this requirement can be found in Table 5.

Table 5

Outside the Network

42 CFR 438.206(b)(4)

Plan Type	Contract Provision
Managed Care Organizations	
MMA and LTC Programs	Attachment II, Section VIII. A.1.d.(1) and (2)
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section VIII. A.1.d. (1) and (2)

(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 incorporating this requirement can be found in Table 6.

Table 6

Coordination with Outside the Network Providers

42 CFR 438.206(b)(5)

Plan Type	Contract Provision
Managed Care Organizations	
MMA and LTC Programs	Attachment II, Section VIII. A.1.i.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section VIII. A.1.i.

(f) Demonstration of Providers' Credentialing.

The state requires the MCOs and PAHPs to establish and verify credentialing and recredentialing criteria for all professional providers and that, at a minimum, the plan providers meet the state's Medicaid participation standards. Pursuant to 641.512(1)(a) F.S., the managed care plans must be accredited by a nationally recognized accrediting body, or have initiated the accreditation process within one (1) year after contract execution. If a managed care plan is not accredited within eighteen (18) months after contract execution, the Agency may terminate the contract and will suspend all assignments until a nationally recognized body accredits the managed care plan. The following are some of the provisions in chapter 641, Florida Statutes, related to licensed capitated plan's provider credentialing:

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

    a) A written statement of goals and objectives which stress health outcomes as the principal criteria for the evaluation of the quality of care rendered to subscribers;
    b) A written statement describing how state-of-the-art methodology has been incorporated into an ongoing system for monitoring of care which is individual case oriented and, when implemented, can provide interpretation and analysis of patterns of care rendered to individual patients by individual providers;
    c) Written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided; and (d) A written plan for providing review of physicians and other licensed medical providers which includes ongoing review within the organization.

Prior to contracting, the state reviewed the MCOs' and PAHPs' written policies and procedures for credentialing of providers to ensure compliance with all applicable federal and state regulations.

The reference to the contract provision incorporating this requirement can be found in Table 7.

Table 7 ***Provider Credentialing*** **42 CFR 438.206(b)(6)**	
Plan Type	**Contract Provision**
Managed Care Organizations	
MMA and LTC Programs	Attachment II, Section VIII. C. 1 and 2; Section IX. A. 2.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section VIII, C. 1 and 2; Section IX, A. 4.

(g) Timely Access to Care.

The state requires the MCOs and PAHPs to:

1. Meet the state's timely access to care and services, taking into account the urgency of the need for services;
2. Ensure that the network of providers offers hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service. If the provider serves only Medicaid enrollees;
3. Make services included in the contract available 24 hours a day, seven days a week, when medically necessary;
4. Establish mechanisms to ensure compliance by providers;
5. Monitor providers regularly to determine compliance; and
6. Take corrective action if there is a failure to comply.

Prior to contracting with an MCO or PAHP, the state assures the plan's ability to comply with federal and state timely access requirements. The state conducts annual reviews of the plans to ensure on-going compliance with the timely access requirements of chapter 409 and 641, F.S., and 42 CFR 438.206(c).

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

1. *Emergency* – immediately upon presentation or notification; the plans are required to maintain sufficient medical staff available 24 hours per day to handle emergency care inquiries;
2. *Urgent Care* – within one day;
3. *Routine Sick Patient Care* – within one week;
4. *Well Care* – within one month;
5. *Pregnancy Related Care* – Within 30 calendar days of enrollment, the plans are required to advise members of and ensure the availability of, a screening for all members known to be pregnant or

who advise the plan that they may be pregnant. The plan shall refer pregnant members and members reporting they may be pregnant for appropriate prenatal care; and

6. *Health Risk Assessment* – the plans are required to contact each new member at least two times, if necessary, within 90 calendar days of enrollment, to urge scheduling of an initial appointment with the primary care provider for the purpose of a health risk assessment.

The reference to the contract provisions incorporating these requirements can be found in Table 8.

Table 8

Timely Access to Care

42 CFR 438.206(c)(1)

Plan Type	Contract Provision
Managed Care Organizations	
MMA and LTC Programs	Attachment II, Section VIII, A.4.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section VIII, A.7.

(h) Cultural Considerations.

The state requires the MCOs and PAHPs to participate in Florida's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The plans are required to assure that appropriate foreign language versions of all materials are developed and available to members and potential members. For enrollees whose primary language is a foreign language, the plans are required to provide interpreter services in person where practical or by telephone. 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.

The plan shall ensure that appropriate foreign language versions of all materials are developed and available to members and potential members.

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). Materials must be available in alternative communication methods (such as large print, video or audio recordings, or Braille) appropriate for persons with disabilities.

The reference to the contract provision incorporating this requirement can be found in Table 9.

Table 9 *Cultural Considerations* **42 CFR 438.206(c)(2)**	
Plan Type	**Contract Provision**
Managed Care Organizations	
MMA and LTC Program	Attachment II, Section IV, G; Section V, B.2 and C. 2.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section IV, G.4 and 9. Section V, B.2 and C. 2.

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 PAHPs are required to submit documentation that demonstrates the plan: (1) offers an appropriate range of preventive, primary care, and specialty services and (2) maintains a network of appropriate providers 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 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 incorporating this requirement can be found in Table 10.

Table 10 *Documentation of Adequate Capacity & Services* **42 CFR 438.207(b)**	
Plan Type	**Contract Provision**
Managed Care Organizations	
MMA and LTC Program	Attachment II, Section VIII. A.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section VIII. A.

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

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

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

2) At any time there has been a significant change in the plan's operations that would affect adequate capacity and services, including but not limited to:
   a) Changes in plan services, benefits, geographic service area, or payments.
   b) Enrollment of a new population in the plan.

At least sixty (60) days before the termination effective date, the plan must provide written notification to all enrollees. The notification must include the following information: the date on which the managed care plan will no longer participate in the state's Medicaid program and instructions on contacting the Agency's enrollment broker help line to obtain information on enrollment options and to request a change in managed care plans.

The state conducts at least annual reviews of the plan's network of providers to ensure compliance with federal and state access to care standards.

The reference to the contract provision incorporating this requirement can be found in Table 11.

Table 11

Sufficient Network of Providers

42 CFR 438.207(c)

Plan Type	Contract Provision
Managed Care Organizations	
MMA and LTC Program	Attachment II, Section VIII. B.3 and C.7.c; Section XV. G.4.h.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section VIII. B.3 and C.7.c; Section XV. G.4.g.

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 PAHPs 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 PAHPs are required to offer each enrollee a choice of primary care physicians. After making a choice, each member shall have a single or group primary care physician. The plan shall inform enrollee of the following: (1) their primary care physician assignment, (2) their ability to choose a different primary care provider, (3) a list of providers from which to make a choice, and (4) the procedures for making a change.

The reference to the contract provision incorporating this requirement can be found in Table 12.

Table 12 *Coordination and Continuity of Care* **42 CFR 438.208(b) (1)**	
Plan Type	**Contract Provision**
Managed Care Organizations	
MMA and LTC Program	Attachment II, Exhibit II-A, VI. D.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section VI. E.

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

Pursuant to 42 CFR 428.208(b), the state requires the MCOs and PAHPs 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 incorporating this requirement can be found in Table 13.

Table 13 *Coordination of Services* **42 CFR 438.208(b)**	
Plan Type	**Contract Provision**
Managed Care Organizations	
MMA and LTC Program	Attachment II, Section VI, E; Exhibit II-A, Section VI, E.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section VI. F.

(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 PAHPs 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 incorporating this requirement can be found in Table 14.

Table 14 *Duplicative Services for Individuals with Special Health Care Needs* **42 CFR 438.208(c)**	
Plan Type	**Contract Provision**
Managed Care Organizations	
MMA and LTC Program	Attachment II, Section VI. E.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section VI. F.4.

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

Pursuant to 42 CFR 428.208(b)(6), 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. 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 reference to the contract provisions incorporating this requirement can be found in Table 15.

Table 15 *Privacy Protection* **42 CFR 438.224 and 42 CFR 431 Subpart F**	
Plan Type	**Contract Provision**
Managed Care Organizations	
MMA and LTC Program	Attachment II, Section VIII. C.5.c.(25); Section X, D.1.d.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section VIII. C.5.c.(23); Section X D.1.d.

(e) Additional services for persons with special health care needs, including Identification, Assessment, Treatment Plans, and Direct Access to Specialists.

The state requires the MCOs and PAHPs to implement mechanisms for identifying, assessing and ensuring the existence of a treatment plan for individuals with special health care needs.
Mechanisms include evaluation of health risk assessments, claims data, and, if available, CPT/ICD-10 codes. The plans are required to implement a process for receiving and considering provider and enrollee

input. The treatment plan for an enrollee must be developed by the enrollee's primary care provider with enrollee participation; 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. For enrollees with special health care needs, each plan must have a mechanism in place to allow enrollees to access a specialist (i.e. through a standing referral or an approved number of visits) directly as appropriate for the enrollee's condition and identified needs.

The reference to the contract provision incorporating this requirement can be found 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	
MMA and LTC Program	Attachment II, Section VI. E. 1 and 5.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section VI. F. 2 and 4.

4. Coverage and authorization of services

(a) The amount, duration and scope of each service that Florida MCOs and PAHPs are required to offer.

The state requires the MCOs and PAHPs 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 PAHPs 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 coverage policies 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 coverage policies. Pursuant to 42 CFR 438.210(a), the plan must furnish services up to the limits specified by the Medicaid program. The plan may exceed these limits. Service limitations shall not be more restrictive than the Florida fee-for-service program, pursuant to 42 CFR 438.210(a), except as approved by the state and authorized in Florida's 1115 Medicaid waiver or other applicable waivers.

The state allows the plans to offer services to enrolled Medicaid recipients in addition to those covered services specified in the contract. Additional covered services must be well defined in regard 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. If quality improvement and performance indicators based on HEDIS and other outcome measures are not met, the state may restrict the plan's enrollment activities. Such restrictions may include the termination of mandatory assignments.

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

The state requires the MCOs and PAHPs to have a quality improvement and quality utilization program, which includes, among other 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 incorporating these requirements can be found in Table 17.

Table 17

Coverage of Services

42 CFR 438.210(a)(1)(2)(3)

Plan Type	Contract Provision
Managed Care Organizations	
MMA and LTC Program	Attachment II, Section II. A.3; Section VI. C.1.b and G-; Section IX. A.1 and 3; Exhibit II-A,
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section II, A.3.; Section VI. E and H.

(b) Medically Necessary Services in Florida MCOs and PAHPs

The state requires that the MCO and PAHP 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 59G1.010(166), Florida Administrative Code, to include that medical or allied care, goods, or services furnished or ordered must meet the following conditions:

a) Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

b) Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

c) Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

d) Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide; and

e) Be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee's caretaker, or the provider.

"Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed, recommended, or approved medical or allied goods, or services does not, in itself, make such care, goods or services medically necessary, a medical necessity, or a covered service."

The reference to the contract provisions incorporating this requirement can be found in Table 18.

Table 18

Medically Necessary Services

42 CFR 438.210(a)(4)

Plan Type	Contract Provision
Managed Care Organizations	
MMA and LTC Program	Attachment II, Section I, A.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section I, A.

(c) Written Policies and Procedures for Authorization of Services

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

- Pursuant to 42 CFR 431.51 (b), the plan shall allow each member to obtain family planning services from any participating Medicaid provider and require no prior authorization for such services. If the member receives services from a non-plan Medicaid provider, then the plan must reimburse at the Medicaid reimbursement rate, unless another payment rate is negotiated.

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

- The managed care plans will honor any written documentation of prior authorization of ongoing covered services for a period of sixty (60) days after the effective date of enrollment, or until the enrollee's PCP or behavioral health provider (as applicable to

medical care or behavioral health care services, respectively) reviews the enrollee's treatment plan, whichever comes first.

For all enrollees, written documentation of prior authorization of ongoing medical and behavioral health services includes the following, if the services were prearranged prior to enrollment with the managed care plan:

(1) Prior existing orders;

(2) Provider appointments, e.g., dental appointments, surgeries, etc.;

(3) Prescriptions (including prescriptions at non-participating pharmacies); and

The plans are required to comply with the following prior authorization requirements as they relate to behavioral health services:

- The plans cannot delay service authorization if written documentation is not available in a timely manner; however, the plan is not required to pay claims for which it has received no written documentation.
- The plans shall not deny claims submitted by a noncontracting 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:

- 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 PAHPs are responsible for ensuring the consistent application of review criteria for authorization decisions and consulting with the requesting provider when appropriate.

    1. The managed care plan must have written approval from the Agency for its service authorization protocols and for any changes to the original protocols.

    2. The plan's service authorization systems shall provide the authorization number and effective dates for authorization to participating providers and non-participating providers.

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

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

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

            (b) Obstetrical care (at first visit);

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

            (d) Transplants.

        ii. The plan shall ensure that all decisions to deny a service authorization request, or limit a service in amount, duration, or scope that is less than requested, are made by health care professionals who have the appropriate clinical expertise in treating the enrollee's condition or disease. (See 42 C.F.R. 438.210(b)(3))

    4. Only a licensed psychiatrist may authorize a denial for an initial or concurrent authorization of any request for behavioral health services. The psychiatrist's review shall be part of the UM process and not part of the clinical review. The provider or the enrollee may request a reconsideration after the issuance of a denial.

The plan shall provide post authorization to County Health Departments for the provision of emergency shelter medical screenings provided for clients of the Department of Children and Families (DCF).

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

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

- The managed care plan shall provide a physical screening within seventy-two (72) hours, or immediately if required, for all enrolled children/adolescents taken into protective custody, emergency shelter or the foster care program by DCF. (See 65C-29.008, F.A.C.) The managed care plan shall provide these required examinations without requiring prior authorization, or, if a non-participating provider is utilized by DCF, approve and process the out of-network claim.

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

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

The contract provisions incorporating the prior authorization requirements can be found in Table 19.

Table 19

Service Authorization Policies & Procedures

42 CFR 438.210(b)(d)(1)

Plan Type	Contract Provision
Managed Care Organizations	
MMA and LTC Program	Attachment II, Section VI. G.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section Vl. H.

(d) Decisions to Deny Services

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 incorporating this requirement can be found in Table 20.

Table 20 *Denial of Authorized Services Request* **42 CFR 438.210(b)(3)**	
Plan Type	**Contract Provision**
Managed Care Organizations	
MMA and LTC Program	Attachment II, Section VI. G. 5.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section Vl. H. 5.

C. Detailed Information Related to Access to Care Standards

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

The Statewide Medicaid Managed Care Core Contract (Section I. Definitions and Acronyms) defines Enrollees with Special Health Care Needs as "Enrollees who face physical, behavioral or environmental challenges daily that place at risk their health and ability to fully function in society."

Special health care needs include:

- Intellectual disabilities or related conditions, serious chronic illnesses, such as human immunodeficiency virus (HIV);
- Schizophrenia or degenerative neurological disorders;
- Disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes;
- Certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care; and
- All enrollees in LTC Managed Care Plans.

The state requires the MCOs and PAHPs to implement mechanisms for identifying and ensuring the existence of a treatment plan for individuals with special health care needs. Mechanisms shall include evaluation of health risk assessments, claims data, and, if available CPT/ICD-10 codes. The plans are required to implement a process for receiving and considering provider and enrollee input. In accordance 42 CFR 438.208(c)(3), a treatment plan for an enrollee determined to need a course of treatment or regular care monitoring must be developed by the enrollee's care provider with enrollee participation and in consultation with any specialists caring for the enrollee; approved by the plan in a timely manner if this approval is required; and developed in accordance with any applicable state quality assurance and utilization review standards.

Pursuant to 42 CFR 438.208(c)(4), for enrollees with special health care needs determined through an assessment by appropriate health care professionals (consistent with 42 CFR 438.208(c)(2)) and who need a course of treatment or regular care monitoring, the state

requires each plan to have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

The state requires the MCOs and PAHPs to assess new enrollees using a health risk assessment tool to identify persons with special health care needs. The MCO and PAHP contracts provide the following definition for Individuals with Special Health Care Needs - November 6, 2000 Report to Congress - Individuals with special health care needs are adults and children who daily face physical, mental, or environmental challenges that place at risk their health and ability to fully function in society. They include, for example, individuals with developmental disabilities; individuals with serious chronic illnesses such as Human Immunodeficiency Virus (HIV), schizophrenia, or degenerative neurological disorders; individuals with disabilities from many years of chronic illness such as arthritis, emphysema, or diabetes; and children and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care. The state requires the MCOs and PAHPs 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 affect healthier patient outcomes. The goal shall be to provide comprehensive, high quality accessible, cost effective, and efficient health care to Medicaid enrollees.

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

The reference to the contract provision incorporating this requirement can be found 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	
MMA and LTC Program	Attachment II, Section IX. A.3.; Exhibit II-A, Section VI.E.7 and G.2.b.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section IX. A.3.

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

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

The managed care plans will honor any written documentation of prior authorization of ongoing covered services for a period of sixty (60) days after the effective date of enrollment, or until the enrollee's PCP or behavioral health provider (as applicable to medical care or behavioral health care services, respectively) reviews the enrollee's treatment plan, whichever comes first.

For all enrollees, written documentation of prior authorization of ongoing medical and behavioral health services includes the following, provided that the services were prearranged prior to enrollment with the managed care plan:

(1) Prior existing orders;

(2) Provider appointments (e.g., dental appointments, surgeries);

(3) Prescriptions (including prescriptions at non-participating pharmacies); and

(4) Behavioral health services.

The reference to the contract provisions incorporating this requirement can be found in Table 22.

Table 22 ***Treatment Plan Standard*** **42 CFR 438.208(c)(3)**	
Plan Type	**Contract Provision**
Managed Care Organizations	
MMA and LTC Program	Attachment II, Section VI. E. 2.d and 7.b.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section VI. F.2.b; Section IX. A. 3, H. 2 and 3.

D. Standards for Structure and Operations and Contract Provisions

1. Provider Selection

The state requires the MCOs and PAHPs 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 PAHPs provider selection policies and procedures not discriminate against 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 incorporating this requirement can be found in Table 23.

Table 23 ***Provider Selection and Retention, Credentialing and Recredentialing, Nondiscrimination, and Excluded Providers*** **42 CFR 438.12(a)(2), 42 CFR 438.214(a)-(d), 42 CFR 438.206(b)(6)**	
Plan Type	**Contract Provision**
Managed Care Organizations	
MMA and LTC Program	Attachment II, Section VIII. C. 2, 3, 4, and 5.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section VIII. C. 2, 3, 4, and 5.

2. Enrollee Information

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

- A detailed description of the plan's authorization and referral process for health care services which shall include reasons for denial of services based on moral or religious grounds as required by section 1932(b)(3), Social Security Act (enacted in section 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;
- A description of the plan's quality improvement program;
- Policies and procedures relating to the plan's prescription drug benefits program;
- Policies and procedures relating to the confidentiality and disclosure of the member's medical records; and
- A detailed description of the plan's credentialing process.

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

The managed care plans will ensure that enrollees are notified of their rights and responsibilities; the role of primary care physicians; how to obtain care; what to do in an emergency or urgent medical situation; how to pursue a complaint, a grievance, appeal or Medicaid Fair Hearing; how to report suspected fraud and abuse; how to report abuse, neglect and exploitation; and all other requirements and benefits of the managed care plan.

The managed care plans will provide enrollee information in accordance with 42 CFR 438.10, which addresses information requirements related to written and oral information provided to enrollees, including: languages; format; managed care plan features, such as benefits, cost sharing, provider network and physician incentive plans; enrollment and disenrollment rights and responsibilities; grievance system; and advance directives. The managed care plans will notify enrollees, on at least an annual basis, of their right to request and obtain information in accordance with the above requirements.

- Procedures for filing a request for disenrollment for cause. As noted in the section, the state-approved for-cause reasons listed must be listed verbatim in the disenrollment section of the enrollee handbook. In addition, the managed care plan shall include the following language verbatim in the disenrollment section of the enrollee handbook:

  "Some Medicaid recipients may change managed care plans whenever they choose, for any reason. To find out if you may change plans, call the Enrollment Broker [INSERT APPROPRIATE TELEPHONE NUMBER]."

- Information regarding newborn enrollment, including the mother's responsibility to notify the Managed Care Plan and DCF of the pregnancy and the newborn's birth;
- Enrollee rights and responsibilities, including the extent to which and how enrollees may obtain services from non-participating providers and other provisions in accordance with 42 CFR 438.100;

- Description of services provided, including limitations and general restrictions on provider access, exclusions and out-of-network use, and any restrictions on enrollee freedom of choice among participating providers;
- Procedures for obtaining required services, including second opinions at no expense to the enrollee (in accordance with 42 CFR 438.206(3) and s. 641.51, F.S.), and authorization requirements, including any services available without prior authorization;
- The extent to which, and how, after hours and emergency coverage is provided, and that the enrollee has a right to use any hospital or other setting for emergency care;
- Cost sharing for the enrollee, if any;
- Information that interpretation services and alternative communication systems are available, free of charge, including for all foreign languages and vision and hearing impairment, and how to access these services;
- How and where to access any benefits that are available under the Medicaid State Plan but are not covered under this Contract, including any cost sharing;
- Procedures for reporting fraud, abuse and overpayment that includes the following language verbatim:

  To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at:

  https://apps.ahca.myflorida.com/mpi-complaintform/

  If you report suspected fraud and your report results in a fine, penalty or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (toll-free 1-866-966-7226 or 850-414-3990). The reward may be up to twenty-five percent (25%) of the amount recovered, or a maximum of $500,000 per case (Section 409.9203, Florida Statutes). You can talk to the Attorney General's Office about keeping your identity confidential and protected."

- Clear specifics on the required procedural steps in the grievance process, including the address, telephone number and office hours of the grievance staff. The managed care plan shall specify telephone numbers to call to present a complaint, grievance, or appeal. Each telephone number shall be toll-free within the caller's geographic area and provide reasonable access to the managed care plan without undue delays;
- Fair Hearing procedures;
- Information that services will continue upon appeal of a denied authorization and that the enrollee may have to pay in case of an adverse ruling;
- Information regarding HIPAA relative to the enrollee's personal health information (PHI);
- Information to help the enrollee assess a potential behavioral health problem;
- Procedures for reporting abuse, neglect, and exploitation, including the abuse hotline number: 1-800-96-ABUSE;
- Information regarding health care advance directives pursuant to ss. 765.302 through 765.309, F.S., 42 CFR 438.6(i)(1)-(4) and 42 CFR 422.128;

- The managed care plan's information shall include a description of state law and must reflect changes in state law as soon as possible, but no later than ninety (90) days after the effective change;
- The managed care plan shall provide these policies and procedures to all enrollees age 18 and older and shall advise enrollees of the enrollee's rights under state law, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

The managed care plan's written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience;

- The managed care plan's information shall inform enrollees that complaints about noncompliance with advanced directive laws and regulations may be filed with the state's complaint hotline;
- The managed care plan shall educate enrollees about their ability to direct their care using this mechanism and shall specifically designate which staff and/or participating providers are responsible for providing this education;
- How to get information about the structure and operation of the managed care plan and any physician incentive plans, as set forth in 42 CFR 438.10(g)(3);
- Instructions explaining how enrollees may obtain information from the managed care plan about how it rates on performance measures in specific areas of service;
- How to obtain information from the managed care plan about quality enhancements (QEs) as specified in Section V.F.; and
- Toll-free telephone number of the appropriate Medicaid ~~Area~~ Office and Aging and Disability Resource Centers.

The state requires the plans to provide enrollee information in accordance with 42 CFR

438.10(f), including notification to enrollees at least on an annual basis of their right to request and obtain information.

The reference to the contract provisions incorporating this requirement can be found 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	
MMA and LTC Program	Attachment II, Section V. A, B, and C; Section VI; Section VII; Exhibit II-A, Section VII.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section V; Section VI; Section VII

3. Confidentiality

During the initial MCO and PAHP contract application process, the state ensures the plans establish and implement procedures consistent with Federal and state regulations including confidentiality requirements in 45 CFR parts 160 and 164, and 42 CFR 438.224. The managed care plan shall have a policy to ensure the confidentiality of medical records in accordance with

42 CFR, Part 431, Subpart F. This policy shall also include confidentiality of a minor's consultation, examination, and treatment for a sexually transmissible disease in accordance with s. 384.30(2), F.S.

The state conducts annual on-site surveys and desk reviews to ensure the plans maintain procedures consistent with state and Federal regulations.

The reference to the contract provisions incorporating this requirement can be found in Table 25.

Table 25 *Confidentiality* **45 CFR parts 160 and 164, 42 CFR 438.224**	
Plan Type	**Contract Provision**
Managed Care Organizations	
MMA and LTC Program	Attachment II, Section XV. T.
Prepaid Health Plans	
Dental Program	Attachment II, Section XV, T.

4. Enrollment & Disenrollment

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

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

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

b. Notification that enrollees can change their plan selection, subject to Medicaid limitations;

c. Enrollment materials regarding PCP choice as described in the plan contract; and

d. New enrollee materials as described in the managed care plan contract.

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

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

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

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

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

   (1) Moving out of the service area;

   (2) Loss of Medicaid eligibility; and

   (3) Enrollee death.

e. An enrollee may submit to the state or its agent a request to disenroll from the plan without cause during the 90-calendar day change period following the date of the enrollee's initial enrollment with the plan, or the date the state or its agent sends the enrollee notice of the

enrollment, whichever is later. An enrollee may request disenrollment without cause every 12 months thereafter.

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

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

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

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

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

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

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

a. With proper written documentation, the managed care plans may submit involuntary disenrollment requests to the Agency or its enrollment broker in a manner prescribed by the Agency. The following are acceptable reasons for which the managed care plans may submit involuntary disenrollment requests:

(1) Fraudulent use of the enrollee identification (ID) card. In such cases the managed care plan shall notify MPI of the event.

(2) Falsification of prescriptions by an enrollee. In such cases the managed care plan shall notify MPI of the event.

(3) The enrollee's behavior is disruptive, unruly, abusive or uncooperative to the extent that enrollment in the managed care plan seriously impairs the organization's ability to furnish services to either the enrollee or other enrollees.

a) This provision does not apply to enrollees with medical or mental health diagnoses if the enrollee's behavior is attributable to the diagnoses.

b) An involuntary disenrollment request related to enrollee behavior must include documentation that the managed care plan:

(i) Provided the enrollee at least one (1) oral warning and at least one (1) written warning of the full implications of the enrollee's actions;

(ii) Attempted to educate the enrollee regarding rights and responsibilities;

(iii) Offered assistance through care coordination/case management that would enable the enrollee to comply; and

(iv) Determined that the enrollee's behavior is not related to the enrollee's medical or mental health condition.

(4) The enrollee will not relocate from an assisted living facility or adult family care home that does not and will not conform to HCB characteristics required under the managed care plan's contract.

b. The plan shall promptly submit such disenrollment requests to the state. In no event shall the plan submit the disenrollment request at such a date as would cause the disenrollment to be effective later than 45 calendar days after the plan's receipt 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 months of enrollment; and

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

g. The plan may submit an involuntary disenrollment request to the state or its agent after providing to the enrollee at least one verbal warning and at least one written 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 consecutive appointments within a continuous six-month period. Such requests must be submitted at least 60 calendar days prior to the requested effective date.

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

h. The state may approve such requests provided that the plan documents that attempts were made to educate the enrollee regarding his/her rights and responsibilities, assistance which would enable the enrollee to comply was offered through case management, and it has been determined that the enrollee's behavior is not related to the enrollee's medical or behavioral condition. All requests will be reviewed on a case-by-case basis and subject to the sole discretion of the state. Any request not approved is final and not subject to dispute or appeal.

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

1) Health diagnosis;
2) Adverse changes in an enrollee's health status;
3) Utilization of medical services;
4) Diminished mental capacity;
5) Pre-existing medical condition;
6) Uncooperative or disruptive behavior resulting from the enrollee's special needs (with the exception of g.2 above);
7) Attempt to exercise rights under the plan's grievance system; or
8) Request of one (1) primary care provider to have an enrollee assigned to a different provider out of the plan.

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

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

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

c. The managed care plan shall not market nor distribute any marketing materials without first obtaining Agency approval. The managed care plan shall ensure compliance with its contract and all state and federal marketing requirements, including monitoring and overseeing the activities of its subcontractors and all persons acting for, or on behalf of, the managed care plan.

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

a. Prohibited marketing, enrollment and disenrollment activities and practices;

b. Permitted activities under the supervision of the Agency for Health Care Administration regarding marketing, enrollment and disenrollment;

c. Requirements for the community outreach notification process;

d. Requirements for provider compliance;

e. Requirements for community outreach representatives;

f. Pre-enrollment activities and requirements;

g. Enrollment activities and requirements;

h. Behavioral health enrollment activities and requirements;

i. Newborn enrollment activities and requirements;

j. Enrollment levels;

k. Disenrollment requirements;

l. Voluntary disenrollment requirements; and

m. Involuntary disenrollment requirements.

The managed care plans shall ensure compliance with their contract and all state and federal marketing requirements, including monitoring and overseeing the activities of its subcontractors and all persons acting for, or on behalf of, the managed care plan (see 42 CFR 438.104; s. 409.912, F.S.; s. 641.3901, F.S.; s. 641.3903, F.S.; s. 641.386, F.S., s. 626.112, F.S.; s. 626.342, F.S.; s. 626.451, F.S.; s. 626.471, F.S.; s. 626.511, F.S.; and s. 626.611, F.S.). If the Agency finds that a managed care plan failed to comply with applicable contract, federal or state marketing requirements, the Agency may take compliance action, including sanctions.

The MCOs and PAHPs 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. Choice counselor/enrollment broker. State approval of the script used by the plan's member services section must be obtained before usage.

c. The reference to the contract provisions incorporating these requirements can be found 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	
MMA and LTC Program	Attachment II, Section III. C and D; Section IV; Section V
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section III. C and D.; Section IV; Section V

1. Grievance System

The state requires the MCOs and PAHPs 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 PAHPs' grievance systems to include:

a. The plan may leave state community outreach materials at health fairs/public events at which the plan participates.
b. 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 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 PAHPs' grievance systems to include written policies and procedures that are approved, in writing, by the state. Other state requirements include the following:

a. The plans must give enrollees reasonable assistance in completing forms and other procedural steps, including, but not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

b. The plans must acknowledge receipt of each grievance and appeal.

c. The plans must ensure that decision makers about grievances and appeals were not involved in previous levels of review or decision making and are health care professionals with appropriate clinical expertise in treating the enrollee's condition or disease when deciding any of the following:

- An appeal of a denial based on lack of medical necessity;
- A grievance regarding denial of expedited resolution of an appeal; or
- A grievance or appeal involving clinical issues.

d. The plans must provide information regarding the grievance system to enrollees as described in the plan's contract. The information shall include, but not be limited to:

1) Enrollee rights to file grievances and appeals and requirements and time frames for filing.

2) The availability of assistance in the filing process.

3) The address, toll-free telephone number, and the office hours of the grievance coordinator.

4) The method for obtaining a Medicaid fair hearing, the rules that govern representation at the hearing, and the address for pursuing a fair hearing, which is:

Agency for Health Care Administration

Office of Fair Hearings

P.O. Box 60127

Ft. Myers, Florida 33906

Phone: 1-877-254-1055

Fax: 239-338-2642

Email: MedicaidHearingUnit@ahca.myflorida.com

5) A description of the external grievance resolution process, the types of grievances and appeals that can be submitted and directions for doing so.

6) A statement assuring enrollees that the plan, its providers or the state will not retaliate against an enrollee for submitting a grievance, an appeal or a request for a Medicaid fair hearing.

7) Enrollee rights to request continuation of benefits during an appeal or Medicaid fair hearing process and, if the plan's action is upheld in a hearing, the fact that the enrollee may be liable for the cost of said benefits.

8) Notice that the MCO or PAHP must continue enrollee benefits if:

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

i. Within ten calendar days of the date on the notice of action (15 calendar days if the notice is sent via surface mail), and

ii. The intended effective date of the MCO or PAHP proposed action.

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

c) The services were ordered by an authorized provider.
d) The authorization period has not expired.
e) The enrollee requests extension of benefits.

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

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

2. Grievance Process

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

a. Filing a Grievance
   1) A grievance is any expression of dissatisfaction by an enrollee, about any matter other than an Action. A provider, acting on behalf of the enrollee and with the enrollee's written consent, may also file a grievance.
   2) A grievance can be filed orally.

b. Grievance Resolution
   1) The plan must resolve each grievance and provide the enrollee with a notice of the grievance disposition within 90 days of its receipt.
   2) The grievance must be resolved more expeditiously, within 24 hours, if the enrollee's health condition requires, as found in s. 409.91211(3)(q), F.S.
   3) The notice of disposition must be in writing and include the results and the date of grievance resolution.
   4) The plan must provide the Agency with a copy of the notice of disposition upon request.
   5) The plan must ensure that punitive action is not taken against a provider who files a grievance on an enrollee's behalf or supports an enrollee's grievance as required in s. 409.9122(12), F.S.

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

a. Filing an Appeal:
   1) An enrollee may request a review of a health plan action by filing an appeal.
   2) An enrollee may file an appeal, and a provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. The appeal procedure must be the same for all enrollees.
   3) The appeal must be filed within 30 days of the date of the notice of action. If the plan fails to issue a written notice of action, the enrollee or provider may file an appeal within one (1) year of the action.
   4) The enrollee or provider may file an appeal either orally or in writing and may follow an oral filing with a written, signed appeal. For oral filings, time frames for resolution begin on the date the plan receives the oral filing.

b. Resolution of Appeals

The plan must:

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

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

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

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

5) Resolve each appeal and provide notice within 45 days from the day the plan receives the appeal.

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

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

8) Continue the enrollee's benefits if:

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

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

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

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

   c) The services were ordered by an authorized provider.

   d) The authorization period has not expired.

   e) The enrollee requests extension of benefits.

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

   a) The enrollee withdraws the appeal;
   b) Ten calendar days (15 calendar days if the notice is sent via surface mail) pass from the date of the plan's adverse decision, and the enrollee has not requested a Medicaid fair hearing with continuation of benefits;
   b) A Medicaid fair hearing decision adverse to the enrollee is made; or
   c) The authorization expires or authorized service limits are met.

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

a) Notice of the enrollee's right to request a Medicaid fair hearing;
b) Information about how to request a Medicaid fair hearing, including the address for pursuing a Medicaid fair hearing, which is:

Agency for Health Care Administration

Office of Fair Appeal Hearings

P.O. Box 60127

Ft. Myers, Florida 33906

Phone: 1-877-254-1055

Fax: 239-338-2642

Email: MedicaidHearingUnit@ahca.myflorida.com

b) Notice of the right to continue to receive benefits pending a Medicaid fair hearing;

c) Information about how to request the continuation of benefits; and

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

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

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

c. Post Appeal Resolution:

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

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

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

a. Expedited Process

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

2) The enrollee or provider may file an expedited appeal either orally or in writing. No additional enrollee follow-up is required. The plan must inform the enrollee of the limited time available for the enrollee to present evidence and allegations of fact or law, in person and/or in writing.

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

4) The plan must provide written notice of disposition that includes the results and date of expedited appeal resolution, and for decisions not wholly in the enrollee's favor, that includes:

a) Notice of the enrollee's right to request a Medicaid fair hearing;

b) Information about how to request a Medicaid fair hearing, including the address for pursuing a fair hearing, which is:

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Office of Fair Appeal Hearings
P.O. Box 60127
Ft. Myers, Florida 33906
Phone: 1-877-254-1055
Fax: 239-338-2642
Email: MedicaidHearingUnit@ahca.myflorida.com

c) Notice of the right to continue to receive benefits pending a hearing;

d) Information about how to request the continuation of benefits; and

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

5) If the plan denies a request for expedited resolution of an appeal, the plan must:

a) Transfer the appeal to the standard time frame of no longer than 45 days from the day the plan receives the appeal with a possible 14-day extension;
b) Make reasonable efforts to provide prompt oral notice of the denial;

c) Provide written notice of the denial within two calendar days; and

d) Fulfill all general plan duties listed above.

7. Medicaid Fair Hearing System

a. Request for Medicaid Fair Hearing

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

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

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

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

5) The enrollee or provider may request a Medicaid fair hearing by contacting the Agency for Health Care Administration at:

Office of Fair Hearings

P.O. Box 60127

Ft. Myers, Florida 33906

Phone: 1-877-254-1055

Fax: 239-338-2642

Email: MedicaidHearingUnit@ahca.myflorida.com

b. The Plan Responsibilities

The plan must:

1) Continue the enrollee's benefits while the Medicaid fair hearing is pending if:

a) The Medicaid fair hearing is filed timely, meaning on or before the later of the following:
   i. Within ten calendar days of the date on the notice of action (15 calendar days if the notice is sent via surface mail); or
   ii. The intended effective date of the plan's proposed action.

b) The Medicaid fair hearing involves the termination, suspension, or reduction of a previously authorized course of treatment;

c) The services were ordered by an authorized provider;

d) The authorization period has not expired; or

e) The enrollee requests extension of benefits.

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

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

a) The enrollee withdraws the request for a Medicaid fair hearing;

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

c) A Medicaid fair hearing decision adverse to the enrollee is made; or

d) The authorization expires or authorized service limits are met.

B. Post Medicaid Fair Hearing Decision

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

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

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

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

The reference to the contract provisions incorporating these requirements can be found in Table 27.

Table 27
Grievance System
42 CFR 431.200 and 438, Subpart F

Plan Type	Contract Provision
Managed Care Organizations	
MMA and LTC Program	Attachment II, Section VII.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section VII.

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 and 42 CFR 438.230 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 PAHP contracting process, the state ensures the plans' subcontractual relationships and delegations comply with 42 CFR 438.6 and 42 CFR 438.230. 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 and 438.230.

The references to the contract provision incorporating this requirement can be found in Table 28.

Table 28

Subcontracted Relationships & Delegation

42 CFR 438.6 and 42 CFR 438.230

Plan Type	Contract Provision
Managed Care Organizations	
MMA and LTC	Attachment II, Section X. C.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section X. C.

E. Detailed Information Related to Florida's Structure and Operation Standards

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

Other components of the MCO and PAHP contracts that are reviewed by the state during the onsite survey include:

- Administration and Management Policy and Procedures
- Staffing
- Disaster Plan
- Minority Retention and Recruitment Plan
- Insurance documents
- Member Identification Care

- Credentialing and Recredentialing Policy and Procedures
- Credentialing files
- Medical Record Requirements Policy and Procedures
- Member Handbook
- Provider Directories
- Board Meeting and Committee Meeting Minutes
- Quality Improvement Policy and Procedures
- Member Services and Enrollment Policy and Procedures
- Utilization Management Policy and Procedures
- Case Management/Continuity of Care Policy and Procedures
- Community Outreach Policy and Procedures
- Community Outreach Staff Qualifications and Credentials
- Community Outreach Plan
- Behavioral Health Policy and Procedures
- Provider Networks
- Provider Site Visit Form
- Grievance and Appeals Policy and Procedures
- Grievance and Appeals Letters
- Quality Benefit Enhancements
- Organization Chart
- Information Systems
- Model Subcontracts (Primary Care Provider, Specialty Care Provider, Ancillary Care Agreement)
- Hospital Service Agreement

F. Standards for Quality Measurement and Improvement and Contract Provisions

1. Practice Guidelines

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

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

The state requires that the MCOs and PAHPs 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 incorporating these requirements can be found in Table 29.

Table 29 ***Practice Guidelines*** **42 CFR 438.236(b)(c)(d)**	
Plan Type	**Contract Provision**
Managed Care Organizations	
MMA and LTC Program	Attachment II, Section VI. G. 4.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section VI. H. 4.

2. Quality Assessment & Performance Improvement Program

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

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

The references to the contract provision incorporating this requirement can be found in Table 30.

Table 30 Quality Assessment & Performance Program **42 CFR 438.330 (b)(c) and (e)**	
Plan Type	**Contract Provision**
Managed Care Organizations	
MMA and LTC Program	Attachment II, Section IX
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section IX.

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 PAHPs' quality improvement programs be based on the minimum requirements listed below.

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

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

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

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

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

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

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

(e) At least four state-approved Performance Improvement Projects (PIPs) must be performed by each Managed Medical Assistance (MMA) plan and at least two PIPs must be performed by each Long-term care (LTC) plan. Each study/project conducted by a plan must include a statistically significant sample of Medicaid lives. For MMA plans, one project must focus on each of the following topics:

- Improving prenatal care and well child visits in the first 15 months;
- Preventative dental care for children;
- An administrative PIP approved by the Agency; and
- Population health issues within a specific geographic area.

For the LTC plans, the projects must focus on:

- Medication Review; and
- A non-clinical PIP proposed by the plan and approved by the Agency.

The plans are required to provide notification to the state prior to implementation. The notification shall include the general description, justification, and methodology for each project and document the potential for meaningful improvement. The plans are required to report annually to the state. The report shall include the current status of the project including, but not limited to, goals, anticipated outcomes, and ongoing interventions. Each project shall have been through the plan's quality process, including reporting and assessments by the quality committee and reporting to the board of directors.

Pursuant to 42 CFR 438.330, 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 ensure that the data to be abstracted during the QI project is accurate, reliable and developed according to generally accepted principles of scientific research and statistical analysis; and
14. Maintain a system for tracking issues over time to ensure that actions for improvement are effective.

The state requires the plan's quality improvement information to be used in such processes as recredentialing, recontracting, and annual performance ratings. The state requires the plans to coordinate with other performance monitoring activities, including utilization

management, risk management, and resolution and monitoring of member grievances. The state requires the plans to establish a link between other management activities such as network changes, benefits redesign, medical management systems (e.g., precertification), practice feedback to physicians, patient education, and member services.

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

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

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

(g) The managed care plans conduct an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The plans use the results of the annual member satisfaction survey to develop and implement plan-wide activities designed to improve member satisfaction. The state reviews the CAHPS survey results and if there are any deficiencies, a corrective action plan is required within two months of the request from the state. The managed care plans report CAHPS survey results to the Agency by July 1 of each contract year.

The references to the contract provision incorporating this requirement can be found in Table 31.

Table 31 ***Performance Improvement Projects*** **42 CFR 438.330(d)**	
Plan Type	**Contract Provision**
Managed Care Organizations	
MMA and LTC Program	Attachment II, Section IX, C.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section IX, C.

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 PAHP 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 in compliance with the contract and all applicable state and federal laws, rules and regulations including HIPAA.

2. *Systems Capacity*. The plans' Systems are required to possess capacity sufficient to handle the workload projected for the begin date of operations and that will be scalable and flexible so they can be adapted as needed, within negotiated timeframes, in response to changes in contract requirements, increases in enrollment estimates, etc.

3. *E-Mail System*. The plans are required to provide a continuously available electronic mail communication link (E-mail system) with the state. This system shall be available from the workstations of the designated plan contacts and capable of attaching and sending documents created using software products other than the plan's systems, including the state's currently installed version of Microsoft Office and any subsequent upgrades as adopted.

4. *Participation in Information Systems Work Groups/Committees*. The state requires the plans to meet, as requested by the state, to coordinate activities and develop cohesive systems strategies across vendors and agencies.

5. *Connectivity to the Agency/State Network and Systems*. The plans are responsible for establishing connectivity to the state's wide area data communications network, and the relevant information systems attached to this network, in accordance with all applicable state policies, standards and guidelines.

(b) Data and Document Management Requirements

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

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

   b. The state requires the plans' systems to conform to HIPAA standards for data and document management that are currently under development within 120 calendar days of the standards' effective date or, if earlier, the date stipulated by CMS or the state.

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

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

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

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

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

(c) System and Data Integration Requirements

1. Adherence to Standards for Data Exchange.

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

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

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

2. HIPAA Compliance Checker.

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

3. Data and Report Validity and Completeness.

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

4. State/Agency Website/Portal Integration.

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

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

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

6. Functional Redundancy with FMMIS.

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

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

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

8. Address Standardization.

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

9. Eligibility and Enrollment Data Exchange Requirements:

   a. The state requires the plans to receive, process, and update enrollment files sent daily by the Agency or its Agent;

   b. The state requires the plans to update their eligibility/enrollment databases within twenty-four (24) hours of receipt of said files;

   c. The state requires the plans to transmit to the state or its agent, in a periodicity schedule, format and data exchange method to be determined by the state, specific data it may garner from a plan's enrollee including third party liability data; and

   d. The state requires the plans to be capable of uniquely identifying a distinct Medicaid recipient across multiple systems within its span of control.

(d) Systems Availability, Performance and Problem Management Requirements

1. Availability of Critical Systems Functions.

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

2. Availability of Data Exchange Functions.

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

3. Availability of Other Systems Functions.

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

4. Problem Notification.

   a. Upon discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of all systems functions and the availability of information in the systems, including any problems impacting scheduled exchanges of data between the plan and the state and/or its Agent(s), the plan must notify the applicable state staff via phone, fax and/or electronic mail within 15 minutes of such discovery. In their notification, the plans are required to explain in detail the impact to critical path processes such as enrollment management and claims submission processes.

   b. The state requires the plans to provide to appropriate state staff information on system unavailability events, as well as status updates on problem resolution. At a minimum these updates shall be provided on an hourly basis and made available via electronic mail and/or telephone.

5. Recovery from Unscheduled System Unavailability.

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

6. Exceptions to System Availability Requirement.

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

7. Corrective Action Plan.

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

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

   a. Regardless of the architecture of its systems, the plans are required to develop and be continually ready to invoke a business continuity and disaster recovery (BC-DR) plan that is reviewed and prior-approved by the state.

   b. At a minimum the plan's BC-DR plan shall address the following scenarios: (1) the central computer installation and resident software are destroyed or damaged, (2) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromises the integrity of transactions that are active in

a live system at the time of the outage, (3) System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system, (4) System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the system, i.e., causes unscheduled system unavailability.

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

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

(e) System Testing and Change Management Requirements

1. Notification and Discussion of Potential System Changes.

The state requires the plans to notify the applicable state staff person of the following changes to Systems within its span of control within at least 90 calendar days of the projected date of the change; if so directed by the state, the plan is required to discuss the proposed change with the applicable state staff: (1) software release updates of core transaction Systems: claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management; (2) conversions of core transaction management Systems.

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

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

a. Within seven calendar days of receipt, the Health Plan shall respond in writing to notices of system problems.

b. Within 20 calendar days, the correction will be made or a requirements analysis and specifications document will be due.

c. The plan will correct the deficiency by an effective date to be determined by the state.

3. Valid Window for Certain System Changes.

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

4. Testing

d. The state requires the plans to work with the state pertaining to any testing initiative as required by the state.

e. The state requires the plans to provide sufficient system access to allow the state and/or independent testing of the plan's systems during and subsequent to readiness review.

(f) Information Systems Documentation Requirements

1. Types of Documentation.

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

2. Content of System Process and Procedure Manuals.

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

3. Content of System User Manuals.

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

4. Changes to Manuals.

a. When a system change is subject to state sign off, the plans are required to draft revisions to the appropriate manuals prior to state sign off of the change.

b. Updates to the electronic version of these manuals shall occur in real time; updates to the printed version of these manuals shall occur within ten business days of the update taking effect.

5. Availability of/Access to Documentation.

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

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

1. Reporting Requirements.

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

2. Reporting Capabilities.

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

(h) Other Requirements

Community Health Record/Electronic Medical Record and Related Efforts

a. At such time that the state requires, the plans are required to participate and cooperate with the state to implement, within a reasonable timeframe, secure, Web-accessible Community Health Records for enrollees.

b. The design of the vehicle(s) for accessing the Community Health Record, the health record format and design shall comply with all HIPAA and related regulations.

c. The state requires the plans to also cooperate with the state in the continuing development of the state's health care data site: www.FloridaHealthFinder.gov

(i) Compliance with Standard Coding Schemes

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

   a. Logical Observation Identifier Names and Codes (LOINC)

   b. Health Care Financing Administration Common Procedural Coding System (HCPCS)

   c. Home Infusion EDI Coalition (HIEC) Product Codes

   d. National Drug Code (NDC)

   e. National Council for Prescription Drug Programs (NCPDP)

   f. International Classification of Diseases (ICD-9)

   g. Diagnosis Related Group (DRG)

   h. Claim Adjustment Reason Codes

   i. Remittance Remarks Codes

2. Compliance with Other Code Sets.

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

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

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

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

1. HIPAA-Based Formatting Standards.

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

Batch transaction types

- ASC X12N 834 Enrollment and Audit Transaction

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

Online transaction types

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

2. Methods for Data Exchange.

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

3. Agency-Based Formatting Standards and Methods.

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

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

The references to the contract provision incorporating these requirements can be found in Table 32.

Table 32
Health Information Systems
42 CFR 438.242(a)(b)(1)(2)(3)

Plan Type	Contract Provision
Managed Care Organizations	
MMA and LTC Program	Attachment II, Section X; Exhibit II-A; Exhibit II-B
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section X

4. Table 33 provides a summary list of the reports required by the state for contracts operated under the 1115 Demonstration Waiver.

5. The SMMC Report Guide containing detailed instructions for these reports can be accessed at:
6. https://ahca.myflorida.com/medicaid/statewide_mc/report_guide_2019-09-01.shtml

Table 33
Medicaid Managed Care Required Reports

Contract Section	Report Name	Frequency
Attachment II-Section XI	**Achieved Savings Rebate Claim Lags Template**	**Annually** **Quarterly**
Attachment II-Section XII	**Achieved Savings Rebate Dental Claim Lags Template**	**Annually** **Quarterly**
Attachment II-Section XII	**Achieved Savings Rebate Dental Financial Report**	**Annually** **Quarterly**
Attachment II-Section XII and XVI	**Achieved Savings Rebate Financial Reports**	**Annually** **Quarterly**
Exhibit II-A, Section XVI	**Actual Value Enhanced Payment MPIP Report**	**Semi-Annual**
Attachment II-Section XII and XVI	**Administrative Subcontractors and Affiliates Report**	**Quarterly,** within fifteen (15) calendar days after the end of the reporting quarter.
Attachment II-Section XII and XVI	**Adverse and Critical Incident Summary Report**	**Monthly**
Attachment II-Section VIII and XVI	**Annual Fraud and Abuse Activity Report**	**Annually,** by September 1st.
Exhibit II-A, Section XVI	**Appointment Wait Times Report**	**Quarterly**

Table 33
Medicaid Managed Care Required Reports

Contract Section	Report Name	Frequency
Exhibit II-B, Section V and XVI	**Case Management File Audit Report**	**Quarterly,** within 30 calendar days after the end of the reporting quarter.
Exhibit II-B, Section V and XVI	**Case Manager Caseload Report**	**Monthly,** within fifteen (15) calendar days after the end of the reporting month.
Exhibit II-B, Section V and XVI	**Case Manager and Provider Training Report**	**Annually**
Exhibit II-A, Section XVI	**Child Staffing Attendance Report**	**Monthly**
Attachment II-Section VIII and XVI	**Claims Aging Report & Supplemental Filing Report**	**Monthly** **Capitated Managed Care Plans,** optional Supplemental Filing Report is due within one hundred-five (105) calendar days after the end of each reporting quarter.
Exhibit II-B, Section VII and XVI	**Critical Incident Report**	**Variable,** immediately upon occurrence and **no later than** twenty-four (24) hours after detection of notification.
Attachment II-Section XII	**Custody Arrangement Multiple Signature Verification Agreement Form**	**Variable,** within thirty (30) calendar days of account execution and resubmitted within thirty (30) calendar days after a change in authorized Dental Plan personnel occurs
Exhibit II-B, Section V and XVI	**Denial, Reduction, Suspension or Termination of Services Report**	**Monthly,** within fifteen (15) calendar days after the end of the reporting month.

Attachment II-Section VII and XVI	**Denied/Suspended/Terminated Provider Report**	**Quarterly**
Attachment II-Section VII and XVI	**Enhanced Care Coordination Report**	**Monthly**
Attachment II-Section VII and XVI	**Enrollee Complaints, Grievances, and Appeals Report**	**Monthly,** within fifteen (15) calendar days after the end of the reporting month.
Exhibit II-B, Section V and XVI	**Enrollee Roster and Facility Residence Report**	**Monthly,** within fifteen (15) calendar days after the beginning of the reporting month.
Exhibit II-A, Section V and XVI	**ER Visits for Enrollees without PCP Appointment Report**	**Annually**
Exhibit II-A, Section V and XVI	**Estimated Value of Enhanced Reimbursement MPIP Report**	**Annually**
Exhibit II-A, Section V and XVI	**Health Risk Assessment Report**	**Quarterly**
Exhibit II-A, Section V and XVI	**Healthy Behaviors Report**	**Quarterly**
Exhibit II-A, Section V and XVI	**Hernandez Settlement Ombudsman Log**	**Quarterly,** fifteen (15) calendar days after the end of the reporting quarter.
Exhibit II-A, Section V and XVI	**Hernandez Settlement Agreement Survey**	**Annually,** on or before August 1 of each year.
Exhibit II-A, Section VIII	**Hernandez Settlement Survey Requirements**	**Annually**

Exhibit II-C, Section III	**HIV/AIDS DM Algorithm**	**Annually**
Exhibit II-C, Section IX and Attachment II-Section XVI	**HIV/AIDS Performance Measures Attachment**	**Annually**
Exhibit II-A, Section XVI	**IMD Reimbursement Report**	**Semi-Annual**
Attachment II-Section XII	**Insolvency Protection Multiple Signature Verification Agreement Form**	**Annually, on April 1st of each contract year.**
Attachment II-Section XVI	**Inter-Rate Reliability Report**	**Quarterly**

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

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

The state requires the plans to implement mechanisms for identifying, assessing and ensuring the existence of a treatment plan for individuals with special health care needs. The plans are required to have mechanisms for all enrollees that include evaluation of health risk assessments, claims data, and, if available CPT/ICD-10 codes. The plans are required to implement a process for receiving and considering provider and enrollee input. In addition, the state requires the plans to contact each new member at least two times, if necessary, within 90 calendar days of enrollment, to urge scheduling of an initial appointment with the primary care provider for the purpose of a health risk assessment.

The references to the contract provision incorporating this requirement can be found in Table 34.

Table 34 ***Assessment of the Quality & Appropriateness of Care and Services for Enrollees with Special Health Care Needs*** **42 CFR 438.208(c)(2)(3)**	
Plan Type	**Contract Provision**
Managed Care Organizations	
MMA and LTC Program	Attachment II, Section IX, A. 3.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section IX, A. 3.

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

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

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

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

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

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

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

The references to the contract provision, which incorporates these requirements, is below 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	
MMA and LTC Program	Attachment II, Section IX. A.3; Exhibit II-A, Section VI. E.7. c. and G.2.b
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section IX. A.3; Exhibit II-A, Section VI. E.7. c. and G.2.b

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

Prior to contracting with MCOs and PAHPs, 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 PAHPs, 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/PAHP Contractual Compliance

The state conducts desk reviews and on-site surveys to document the plan's capacity to comply with the state-established standards for access to care, structure and operations, and quality measurement and improvement. The state conducts quality of care surveys to ensure the MCOs and PAHPs maintain compliance with the plan's contract including all applicable federal

and state access to care, structure and operations, and quality measurement and improvement requirements. The state regularly monitors the MCOs and PAHPs through desk reviews.

The references to the contract provision, which incorporates these requirements, is below in Table 36.

Table 36
Monitoring and Evaluation
42 CFR 438.330

Plan Type	Contract Provision
Managed Care Organizations	
MMA and LTC Assistance Program	Attachment II, Section IX, A. and F; Exhibit II-A. Section IX. A.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section IX, A, and F.

Intermediate Sanctions

The MCO and PAHP 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 PAHP:

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 non-willful 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 non-willful 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—
      i 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
      ii There is substantial risk to enrollees' health; or
   b. 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.
3. 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.
4. The state may not delay imposition of temporary management to provide a hearing before imposing this sanction.
5. The state may not terminate temporary management until it determines that the plan can ensure that the sanctioned behavior will not recur.
6. Granting enrollees the right to terminate enrollment without cause and notifying affected enrollees of their right to disenroll.
7. Suspension or limitation of all new enrollment, including default enrollment, after the effective date of the sanction.
8. 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.
9. 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.
10. 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 incorporating this requirement can be found in Table 37.

Table 37
MCO Intermediate Sanctions
42 CFR 438 Subpart I

Plan Type	Contract Provision
Managed Care Organizations	
MMA and LTC Program	Attachment II, Section XIII, A. and B.
Prepaid Ambulatory Health Plans	
Dental Program	Attachment II, Section XIII, A. and B.

Appendix V. Non-Duplication of Mandatory Activities – Methodology for Determining Comparability

42 CFR §438.360 (referred to as "Final Rule" hereafter) addresses the non-duplication of mandatory activities with Medicare or accreditation reviews. The Final Rule allows states to use information obtained from a Medicare or national accreditation review for the mandatory EQR activities when the state requires the MCOs to be accredited by a private accrediting organization recognized by CMS, when the accreditation standards are at least as stringent as those required by CMS (§422.158); are comparable to standards established through the EQR protocols (§438.352 and §438.358); and the MCOs provide the state with all reports, findings and results of the private accreditation review activities.

The Agency requires all the Florida Medicaid plans to be accredited. As such, the Agency deems certain EQR-related activities that crosswalk to CMS requirements. There is some overlap between the private accrediting organization's survey quality standards the plans must meet to maintain accreditation and the three CMS-mandated quality activities performed by the Agency's contracted EQRO.

The Agency deems some of the duplicative CMS-EQR requirements as being met (hereafter referred to as "deeming") as long as the plan meets the private accreditation standards. The criteria for deeming is supported in 42 CFR §438.360 (non-duplication of mandatory activities).

Using Private Accreditation Results

42 CFR §438.360

CMS determines the CFR requirements that can be considered for deeming. HSAG uses the most current CFRs and compares the requirements to the most current private accreditation Medicaid Managed Care Crosswalk to determine comparability. For de-duplication (deeming) purposes, HSAG assesses whether each accreditation standard met the relevant regulation in the CFR in its entirety.

HSAG reviews accreditation standards that are fully comparable with the federal standards pertaining to a plan's operations. If the State's plan contract requirements are more stringent or include additional requirements than the Final Rule, HSAG compares the private accreditation standard to the State-specific requirements.

Rationale for Determining Comparability to EQR Activities

The Agency determined that all standards found to be 100 percent comparable with the Final Rule are eligible for deeming with the following caveats:

- The Agency requires the plans to receive full (100 percent) compliance with the applicable accreditation element, standard, and/or CFR requirement.
- A private accreditation survey standard was not eligible for deeming unless the standard was 100 percent compliant with the Medicaid CFR requirement.