

Florida Medicaid

Draft Comprehensive Quality Strategy

2014 Update

Florida Medicaid's Comprehensive Quality Strategy reflects the state's three-part aim for continuous quality improvement through planning, designing, assessing, measuring, and monitoring the health care delivery system for all Medicaid managed care organizations, prepaid inpatient health plans, long-term care services and supports, and fee-for-service populations.



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I. Introduction and Overview

A. Introduction

This draft Comprehensive Quality Strategy (CQS) is an update including activities through State Fiscal Year (SFY) 2013-2014. It provides an overview of the Florida Medicaid program and its objectives, the state's methods of assessing program performance, improvement activities and results, and achievements and opportunities. The CQS describes quality improvement strategies and initiatives throughout the Florida Medicaid program, including managed care organizations, prepaid inpatient health plans, long-term care and fee-for-service programs, and Attachment II, which contains the Long-term Care Program Quality Strategy. While the state has continuously engaged in quality improvement initiatives for different components of the Medicaid program, the state is in the process of transitioning to a more comprehensive quality strategy.

On June 14, 2013, the Centers for Medicare and Medicaid Services (CMS) approved an amendment to the State of Florida Agency for Health Care Administration's Managed Medical Assistance Program section 1115(a) demonstration. During SFY 2013-2014, Florida Medicaid transitioned to Statewide Medicaid Managed Care (SMMC) from a variety of health care delivery systems, including MediPass (a Primary Care Case Management program); Health Maintenance Organizations (HMOs); both capitated and fee-for-service Provider Service Networks (PSNs); a capitated Nursing Home Diversion program and other fee-for-service home and community-based services waivers; Statewide Inpatient Psychiatric Program (SIPP); and carve-out programs for mental and behavioral health, children's dental care, and disease management. SMMC is aimed at ensuring better coordination and quality of services for all enrollees, including dental, medical, behavioral health, and long-term care. For those enrollees who are dually eligible for both Medicare and Medicaid, managed care plans are required to coordinate with Medicare providers to ensure improved communication, provision of appropriate services, and continuity of care.

There are two components to SMMC: the Long-term Care (LTC) program and the Managed Medical Assistance (MMA) program. The LTC program, which consolidated five home and community-based services programs into a single managed LTC and home and community-based services waiver, began operations in one region of the state on August 1, 2013, and was rolled out in all 11 regions of the state by March 1, 2014. At the beginning of February 2014, the Agency executed 17 contracts for the MMA program. Eight of the plans are providing only MMA services, while six of the plans are Comprehensive LTC plans that are providing MMA services and LTC services. One of the Comprehensive LTC plans is also a Specialty Plan for recipients in the Child Welfare system. Two plans are Specialty Plans for recipients with HIV/AIDS and there is one Specialty Plan for recipients with Serious Mental Illness. Two additional MMA Specialty Plan contracts have been executed since February—one for children with chronic conditions and one for recipients who are dually eligible for both Medicare and Medicaid and have particular chronic conditions. The MMA program began operations on May 1, 2014 and was rolled out in all 11 regions of the state by August 1, 2014. The managed care plans the Agency contracted with were selected through competitive procurement to ensure that enrollees receive care from the highest quality managed care plans, delivering the best value and service packages.

The MMA program is aimed at increasing consumer protections as well as improving quality of care and access for recipients in many ways, including:

- Increasing recipient participation on Florida's Medical Care Advisory Committee and forming smaller advisory committees to focus on key special needs populations and key service areas;
- Ensuring the continuation of services until the MMA plan's primary care or behavioral health provider reviews the enrollee's treatment plan;
- Ensuring recipient complaints, grievances, and appeals are reviewed immediately for resolution as part of the rapid cycle response system;
- Establishing healthy behaviors programs to encourage and reward health behaviors and, at a minimum, requiring plans to offer a medically approved smoking cessation program, a medically directed weight loss program, and a medically approved alcohol or substance abuse recovery program;
- Requiring Florida Medicaid's External Quality Review Organization to validate each plan's encounter data on an annual basis;
- Enhancing consumer report cards to ensure recipients have access to understandable summaries of each managed care plan's performance regarding quality, access, and timeliness of care;
- Enhancing the plans' performance improvement projects by focusing on several key areas, including preventive dental care for children, prenatal care, and well-child visits in the first 15 months of life; and
- Enhancing metrics on plan quality and access to care to improve plan accountability.

The shift from previous service delivery structures to SMMC is accompanied by a shift to a greater emphasis on quality improvement and quality measurement, and an opportunity to achieve the goals of CMS' Three-Part Aim: improving population health; improving enrollee experiences with care; and reducing per-capita costs. The shift from multiple delivery systems to SMMC is allowing the state to consolidate and better focus its quality efforts. Under the previous system, there were many different quality improvement activities for managed care, fee-for-service programs, and long-term care. The SMMC program, which is aimed at better coordination and quality of services, will allow a more coordinated, comprehensive quality strategy for the state. As part of the transition to managing and monitoring the SMMC program, the Agency is establishing a new Bureau of Medicaid Quality, which will provide data-driven, focused, and systematic feedback to managed care plan contract managers and policy staff, and recommend measureable ways to improve managed care plans' quality of service delivery and outcomes for Medicaid recipients. This bureau will also have oversight of the fee-for-service program, allowing more opportunities for a cohesive quality strategy across managed care and fee-for-service programs.

The state has historically used performance measures reported by its managed care plans (HMOs, PSNs, prepaid mental health and dental health plans), and as part of the state's Children's Health Insurance Program Reauthorization Act (CHIPRA) Grant, to identify areas in need of improvement throughout the Florida Medicaid program. These performance measures include NCQA Healthcare Effectiveness Data and Information Set (HEDIS) measures, CHIPRA Child Core Set measures, CMS Medicaid Adult Core Set measures, and state-defined measures. In addition to performance measures previously reported by managed care plans, the state has added several of the CMS Medicaid Adult Core Set measures to the reporting requirements for MMA plans, including Annual Monitoring for Patients on Persistent Medications, Plan All-Cause Readmissions, Antenatal Steroids, and Initiation and Engagement

of Alcohol and Other Drug Dependence Treatment. Florida uses plan-reported measures verified by independent audit, such as enrollee satisfaction, claims and encounter data, and expenditures to identify areas of quality improvement and to determine appropriate interventions. The state is continuing to work with its External Quality Review Organization (EQRO) and various stakeholders to identify areas in need of improvement.

While the state has historically looked at performance measure and survey data at a statewide program level and at the health plan level, under SMMC the state will work with CMS to determine metrics for evaluating direct service providers. LTC and MMA plans are contractually required to monitor the quality and performance of providers participating in their plan networks, so the state will assess which metrics the plans are using to monitor participating providers. For HEDIS measures with national Medicaid means and percentiles, the state has set the 75th percentile as the goal for its current and SMMC managed care plans. A performance improvement strategy including sanctions, liquidated damages, and incentives is described in the body of this CQS update. For measures without national benchmark data, the state will determine a methodology for establishing performance targets. The state is using managed care plan level data to develop consumer report cards, which will be available to Medicaid enrollees for use in selecting a plan. These consumer report cards will include performance measure and survey data, as well as EQRO findings that may be useful to consumers in selecting a plan.

As noted in the body of the CQS, the state has required each type of managed care plan to report performance measures that are relevant to the services it provides. For SMMC, the state has selected particular plan performance measures for the LTC plans and the MMA plans. Specialty plans are reporting on additional measures that are relevant to the populations they serve. For example, the Child Welfare Specialty Plan and the plan for children with chronic conditions will not be reporting on the adult-only performance measures, but will be reporting on several additional performance measures related to children's health care. On an annual basis, the state reviews and will continue to review the performance measures reported by the managed care plans, considering whether any measures should be removed and whether there are additional measures from the Child and Adult Core Sets that should be added to reporting requirements. As national, standardized measures are developed that can replace state-defined measures in particular areas (e.g., a Mental Health Readmission Rate measure), the state will adopt those measures in order to collect data that are more easily compared to other states and national benchmarks. As measures are added and removed from the Child and Adult Core Sets, and as technical specifications for these measures become available, the state will work to include these measures in required reporting.

In addition to monitoring its managed care plans, and external quality reviews of managed care plans, the state has historically contracted with several state universities to evaluate research various components of the Florida Medicaid program. With the shift to SMMC, the state is planning a rigorous evaluation of the LTC program as well as the MMA program. During SFY 2013-2014, Agency staff solicited proposals from state universities to conduct an evaluation of the LTC program, and worked closely with the selected university to develop the scope of work for the contract. The Agency also updated the evaluation design for the MMA waiver, and has been working with federal CMS to finalize the design prior to soliciting proposals for conducting the evaluation. While some elements of the evaluation will be similar to those for the Medicaid Reform 1115(a) demonstration, there will be new evaluation domains as well. To the extent that specialty plans are contracted under the MMA program, they will be included as a focus of the evaluation as well.

B. History

The Florida Medicaid program was created in 1970, and currently covers approximately 3.5 million Floridians. Although initially crafted as a medical care extension for persons who received federally funded cash assistance, over the 44 years the program has operated, the state has exercised options as they became available under federal law to expand Medicaid coverage to categorically related groups in addition to mandatory categorically needy eligibility groups. Further, the state also receives federal matching funds to provide certain optional services, and has sought and received federal waivers to provide services through home and community-based programs for individuals who otherwise might be institutionalized.

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

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

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

In 2006, in two geographic areas of the state, Florida embarked on a demonstration project with authority from an 1115 research and demonstration waiver. This project encouraged individual choice of health plan networks, emphasized personal responsibility for health, and rewarded healthy behaviors. The initial waiver period was July 1, 2006 through June 30, 2011. In December 2011, the Centers for Medicare and Medicaid Services approved Florida's three-year waiver extension request, extending the demonstration through June 30, 2014.

During its 2011 legislative session, the Florida legislature passed legislation to expand Medicaid managed care. This legislation created the Statewide Medicaid Managed Care (SMMC) program with two components: the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) program. The MMA program provides primary and acute medical assistance and related services, and the LTC program provides long-term care services including nursing facility and home and community-based services using a managed care

model. In June 2013, CMS approved an amendment to the 1115 waiver, which changed the waiver from the Medicaid Reform waiver to the Medicaid Managed Medical Assistance waiver. On July 31, 2014, CMS approved a three-year waiver extension request, to extend the MMA demonstration through June 30, 2017.

The Agency was directed by the Florida legislature to competitively procure managed care plans (managed care organizations and prepaid inpatient health plans) to provide MMA and LTC services in each of the 11 regions through an Invitation to Negotiate (ITN). The legislation established criteria for preference in reviewing ITN respondents, including plan accreditation by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body; experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations; availability and accessibility of primary care and specialty physicians in the provider network; establishment of community partnerships with providers that create opportunities for reinvestment in community-based services; commitment to quality improvement; provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes; and documentation of policies for preventing fraud and abuse. An ITN and model contract for the LTC program was issued by the Agency on June 29, 2012. Seven managed care plans were selected to provide LTC services to eligible recipients beginning in August 2013. On December 28, 2012, the ITN and model contract for the MMA program were issued by the Agency. Twenty managed care plans were selected to provide managed medical assistance to Medicaid recipients. The MMA program began its phase-in by region in May 2014 and was operational in all regions of the state by August 2014.

C. Overview

Florida Medicaid is making significant changes to its programs as the state implements its Statewide Medicaid Managed Care program. The state views this as an exciting opportunity to focus on the three-part aim to provide better care for individuals, including safety, effectiveness, patient centeredness, timeliness, efficiency and equity; better health for populations by addressing areas such as poor nutrition, physical inactivity, and substance abuse; and reducing per capita costs.

With the continued expansion of managed care in Florida, it is important to build appropriate quality management and improvement practices into managed care contracts and the state's oversight responsibilities. This document is a Comprehensive Quality Strategy update and contains details regarding the significant steps the state has taken, along with its managed care plan partners and External Quality Review Organization, to improve the quality of health care delivered to Medicaid managed care enrollees by MCOs and PIHPs. The document also outlines future plans to continue this improvement process.

Attachment I of this Comprehensive Quality Strategy identifies and summarizes Florida Medicaid's managed care contract provisions that are being monitored closely to ensure that quality services are provided by qualified providers, under the state's contracts with its current managed care plans.

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Table A below provides a list of the current MCO and PIHP contracts operated under the Florida Medicaid program as of August 2014.

Table A Florida's MCOs & PIHPs August 2014			
Plan Type	Waiver Authority	Number of Contractors	Type of Contract
<i>Managed Care Organizations</i>			
Managed Medical Assistance Plans	1115 Research and Demonstration Waiver	20 Contractors	Model Contract
<i>Prepaid Inpatient Health Plans</i>			
Long-term Care Plans	1915(b)(c) Managed Care and Home & Community Based Services Waivers	7 Contractors	Model Contract

D. Process for Obtaining Enrollee & Stakeholder Input

Formal Process and Methods

The process and method used for gathering input from enrollees and stakeholders on quality assessment and improvement standards in managed care included: public meetings and workshops, focus groups, conference calls, and advisory panel meetings. The primary focus of past public meetings and workshops was to provide information and obtain input on managed care as provided under the 1115 research and demonstration waiver. However, many issues raised and improvements suggested were applicable to Florida's entire Medicaid managed care program. The state used the input gathered during these public meetings, relevant to quality assessment and improvement standards, to strengthen the MCO and PIHP quality contract provisions for all MCO and PIHP contracts held by the state. The state also used the public input to strengthen its internal quality assessment and improvement processes with the development of the Quality and Performance Standards Team and the Continuous Improvement Team. The public process used to gather stakeholder input was:

1. The Agency conducted monthly Technical and Operational Issues conference calls with managed care plans and providers on various managed care issues.
2. As part of its contract with the state, Florida's EQRO, Health Services Advisory Group, Inc. met quarterly with health plans to discuss on-going EQRO activities and provide technical assistance as needed in areas of health care quality.
3. The Comprehensive Quality Strategy is posted on the Florida Medicaid website with an email link inviting comments from interested parties:

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

4. To assist recipients and providers with the transition to Statewide Medicaid Managed Care, the Agency implemented a comprehensive outreach approach with many different opportunities for the public and interested parties to provide input and to also submit complaints about the Statewide Medicaid Managed Care program. These opportunities include:
 - public meetings;
 - creation of a Statewide Medicaid Managed Care (SMMC) inbox and comprehensive list of Frequently Asked Questions (FAQs);
 - outreach to multiple advocacy groups;
 - social media;
 - a robust outreach plan; and
 - creation of a complaint hub to expeditiously handle complaints and issues from recipients and providers.

To assist recipients and providers with the transition to SMMC, the Agency implemented a comprehensive outreach approach including a series of webinars for interested parties. A calendar of scheduled outreach events and webinars, as well as links to provider webinars can be accessed through following link:

http://ahca.myflorida.com/medicaid/statewide_mc/news.shtml.

In addition, the Agency's choice counseling vendor conducted outreach to local community partners, including facilities, to provide them with information about the SMMC program.

Public Meetings

The first opportunity for public input into the Statewide Medicaid Managed Care program was a series of statutorily required public meetings held in each region throughout the state in June 2011. In follow up to the statutorily required public meetings, the Agency held two additional meetings in September 2011 in Miami-Dade County. Finally, the Agency held three additional public meetings in October 2013 to receive input and feedback prior to seeking federal authority to extend Florida's Managed Medical Assistance (MMA) Waiver for the period July 1, 2014 to June 30, 2017. During these meetings, the Agency received feedback from the public and various stakeholders which was reviewed, considered, and incorporated into developing the SMMC program.

Creation of a SMMC Email Inbox and Comprehensive list of FAQs and White Papers

The Agency created an email inbox with the primary purpose of responding to SMMC-related questions. This inbox has helped the Agency to identify areas where the public needs additional clarification and information are needed for the public. These areas have been addressed through more than 120 webinars, creating a comprehensive FAQ document, and posting a series of white papers on a number of important MMA topics.

- The webinars have covered a number of important topics. For example, several webinars have been held to explain the impact on specific provider types including Assisted Living Facilities and Hospices as well as a webinar on enrolling as a Medicaid provider and changes in the process. The webinars also covered topics such as recipient eligibility verification, prescription drug benefits and specialty plan benefits. During most of these webinars questions were submitted that were responded to verbally during webinars and then in writing through the above referenced FAQs.

- The FAQ document became an extremely valuable resource and currently has more than 500 responses to questions relating to long-term care and more than 290 responses related to the Managed Medical Assistance (MMA) program. The Agency anticipates this number will grow for the MMA program as additional questions arise during implementation. The FAQ document can be accessed through the following link: http://ahca.myflorida.com/medicaid/statewide_mc/mmahome.shtml
- The Agency has posted a series of white papers on its Statewide Medicaid Managed Care website to provide information and clarification on a number of important topics related to the MMA program. These documents include topics such as Continuity of Care Requirements, Transportation Service Requirements, Coordinating Dual Eligibles' Medicare and Medicaid Managed Medical Assistance Benefits, Services New to the MMA Program, and the Complaint Process in the SMMC Program. The white paper documents can be accessed through the following link: http://ahca.myflorida.com/medicaid/statewide_mc/mmahome.shtml

Robust Outreach Plan

The Agency recognizes the importance of outreach to its stakeholders and has developed an aggressive strategic plan to maintain their involvement. The Agency continues to hold weekly internal meetings to discuss outreach opportunities and has created a prospective and retrospective tracking system for outreach events. The retrospective tracking sheet includes all outreach efforts since the beginning of the program. While the Agency does not have exact participant counts for all of the outreach activities, the Agency has provided outreach to almost 57,000 unduplicated individuals. This includes webinars, the Agency's vendor, Automated Health System's outreach efforts, Agency legislative presentations, and other outreach efforts.

In addition to these outreach activities, guidance statements and other program information are available on the following page:

http://ahca.myflorida.com/medicaid/statewide_mc/mmahome.shtml

Outreach to Multiple Advocacy Groups

The Agency has reached out directly to multiple advocacy groups, including Florida Legal Services, the Foundation for LTC Solutions, and Florida CHAIN to meet to discuss LTC and MMA implementation. The Agency also had direct correspondence with many other associations on a variety of topics including dental services and the Low-Income Pool. The Agency will continue to work with advocacy groups on any issues that arise. Their feedback has been very valuable to the state during implementation of the Statewide Medicaid Managed Care program.

Social Media

The Agency for Health Care Administration uses profiles on Facebook, Twitter, YouTube and SlideShare to engage with stakeholders at all levels. Hosting these sites allows the Agency to share news and events with legislators, state and federal agencies and healthcare providers as well as respond to questions and concerns from both providers and recipients. These platforms have resulted in over 193,000 views of Agency slideshow presentations, nearly 14,000 views of the Agency's instructional videos, and dozens of direct interactions with Medicaid providers and recipients. The Agency will continue to foster relationships using social media as part of its ongoing pursuit of its mission, "Better Health Care for All Floridians."

Addressing Complaints and the Complaint Hub

The Agency also created the centralized complaint/issues hub as a way to streamline and better track and respond to all complaints and issues related to Florida's Statewide Medicaid Managed Care program. The hub handles issues related to both the Long-term Care program and the Managed Medical Assistance program. The centralized hub has been in operation since the roll-out of the Long-term Care program (August 1, 2013). Anyone encountering difficulty interacting with the managed care plans (e.g., delayed authorization or payment, etc.), is encouraged to inform the Agency immediately so the issue can be handled in an expedited manner. Individuals can submit a complaint through the Agency's Web site at:

<http://ahca.myflorida.com/SMMC>. Select the blue "Report a Complaint" button and complete the online form. Complaints are reviewed, responded to, and tracked throughout the day by Agency staff. The Agency is closely monitoring all complaints from providers and other stakeholders and is holding plans accountable to their contract with the state.

E. Strategy Objectives

Florida's priority is to ensure access to quality health care for all Medicaid recipients and to utilize partnerships between the Agency, and other state agencies (e.g., the Department of Elder Affairs, the Department of Health, the Agency for Persons with Disabilities, and the Department of Children and Families), enrollees, the state's External Quality Review Organization (EQRO), and managed care plans to improve access, quality, and continuity of care. Florida Medicaid supports these partnerships for quality improvement through regular meetings with stakeholders, including managed care plans, advocacy groups, and enrollees.

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

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

The Agency for Health Care Administration has contracted with Health Services Advisory Group, Inc. (HSAG) as its EQRO vendor since 2006. In 2013, the Agency again selected HSAG as its EQRO vendor, through a competitive procurement process, for a new contract that began on July 1, 2013 and will continue through June 30, 2018. The state's MCO and PIHP contracts require these entities to be subject to annual, external independent review of quality outcomes, timeliness of, and access to the services covered in accordance with 42 CFR 438.204. The state's EQRO, in compliance with section 1932(c)(2) of the Social Security Act and 42 CFR 438 Subpart E, conducts an annual, independent, external quality review of the outcomes and timeliness of, and access to the services delivered under each MCO and PIHP contract in Florida.

The 2013 – 2018 EQRO contract includes the following eight categories of activities:

1. Validation of Performance Improvement Projects;
2. Validation of Performance Measures;
3. Review of Compliance with Access, Structural and Operational Standards;
4. Validation of Encounter Data;
5. Focused Studies;
6. Dissemination and Education;
7. Annual Technical Report; and
8. Technical Assistance and Other Activities

All of the eight activities listed above will be performed on an annual basis, with the exception of the Focused Studies and Technical Assistance Activities, which will be performed as deemed necessary by the Agency.

Each year, HSAG produces an External Quality Review Technical Report for the Agency covering the previous state fiscal year (SFY). The report includes: a description of the scope of the EQRO's activities during the state fiscal year; MCO and PIHP specific findings regarding the quality and timeliness of, and access to, care and services; and recommendations to the Agency to improve MCO and PIHP compliance with BBA requirements and to improve the quality and timeliness of, and access to, services provided to Florida Medicaid managed care enrollees. The Annual Technical Report for state fiscal year 2012-2013, prepared by Health Services Advisory Group, Inc., was submitted to the Centers for Medicare and Medicaid Services by the Agency on April 9, 2014, and is the most recent report available.

F. Measurable Goals to Allow an Annual Evaluation

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

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

The performance measure sanction strategy in the 2012-2015 HMO and PSN contracts was applied to the managed care plans' performance measure submissions for calendar year 2012, which were submitted to the Agency in July 2013. The key provisions of the sanction strategy are as follows:

- Each performance measure (PM) is assessed a score based on its ranking relative to the national percentiles. A seven point scoring system is used (0-6).
- The PMs are placed into PM groups comprised of similar PMs. The PM groups will receive an average PM group score. The PM groups are: Mental Health and Substance Abuse; Well-Child; Prenatal/Postpartum; Chronic Care; Diabetes; and Other Preventive Care.

- Managed care plans are required to develop and submit Performance Measure Action Plans (PMAPs) for any HEDIS measures where the plan's score falls below the 50th national percentile. PMs are included in determinations of sanctions after the health plan has developed and implemented a PMAP. As the 2012-2015 contracts are ending during 2014 and being replaced with the Managed Medical Assistance (MMA) contracts, HMOs and PSNs were asked to compile lessons learned through their PMAPs over the past several years, rather than to develop and submit new PMAPs.
- For the 2013 performance measure submission, PM group sanctions were assessed for PM group scores that fell below the equivalent of the 50th national percentile. Managed care plans were sanctioned up to \$10,000 per PM group score that fell below the threshold national percentile.
- Individual measure sanctions for measures in the Mental Health and Substance Abuse, Chronic Care, and Diabetes groups may be applied if the health plan's rate fell below the equivalent of the 10th national percentile.

Thus far, the performance improvement and sanction strategies for performance measures have been limited to HEDIS measures. The Agency is reviewing the Agency-defined performance measure data that have been submitted to the Agency in order to determine an appropriate performance improvement strategy and sanction strategy for measures for which there are no comparable national benchmarks. As non-HEDIS measures from the Child and Adult Core Sets are reported moving forward, the Agency will look to Federal CMS' reporting on these measures at the national level to determine what benchmarks may be available and appropriate.

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

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II. Assessment

During SFY 2013-2014, the state assessed the performance of MCOs and PIHPs based on reviews of contract compliance, performance improvement projects, and performance measures. As the Agency's validation of and analyses using encounter data evolve, quality metrics related to and generated from encounter data will be included as well.

A. Quality and Appropriateness of Care and Services

Procedures related to Race, Ethnicity, and Primary Language

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

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

As the Affordable Care Act's single streamlined application has gone into effect, there have been enhancements and changes to how race, ethnicity, and primary language are captured in the state's systems. The Department of Children and Families (DCF), the state agency that determines Medicaid eligibility, worked with its vendor to develop a Modified Adjusted Gross Income (MAGI) rules engine to implement the eligibility systems changes required to implement the provisions under the Affordable Care Act. Florida Healthy Kids Corporation, which operates a portion of the CHIP program, accesses the DCF MAGI rules engine to apply MAGI rules to the CHIP population. These changes and new data collection requirements being developed at the federal level have impacted how race, ethnicity, and primary language are captured in the Medicaid and CHIP enrollment application and eligibility and payment systems.

External Quality Review Activities

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

HSAG's findings are provided in the Improvement section of the Comprehensive Quality Strategy.

Encounter Data

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

The Agency is actively working toward using encounter data to assess the quality and appropriateness of care and services. The Agency is also evolving the processes for using health plan encounter data to assess quality of care with Agency for Healthcare Research and Quality's Prevention Quality Indicator measures.

Encounter data is used to evaluate managed care plans' performance in particular areas. Reports were presented to the legislature, legislative staff and the health plan association demonstrating four specific examples of measures being calculated through analysis of the data. Analyses measured Emergency Department Utilization, Ambulatory Care Sensitive Conditions, Primary Care Provider Utilization, and History and Physical Within 180 Days. The Agency used potentially preventable hospital readmission models to evaluate the availability of data on hospital transactions and in the data warehouse. This process improvement project resulted in improvements to the system as well as identification of opportunities for gleaning data from other sources, e.g., birth weights. The Agency will continuously refine performance measure reports to focus on cost containment and health plan accountability. Results are used to communicate deficiencies to the managed care plans and to identify issues needing focused analyses by compliance, fraud or program integrity units.

A method for analyzing access to specialists was developed and results reported to the managed care plans in compliance reports. The methodology uses encounter data to analyze specialty care and to produce baselines for three types of specialty care. The reviews focused on the following three specialties in calendar year 2013: neurology, dermatology, and orthopedics. Dental services were added to the focus in 2014, and other specialties are under consideration. The Agency used the analyses to initiate an encounter data performance improvement project focusing on specialty access. The project measured managed care plans' specialty care access and common encounter data transaction errors. The analyses and reports to the plans aim to improve access to care and data quality.

Managed care plans are required to submit encounter data to the Agency using national standard transaction formats. Agency efforts to improve encounter data systems by refining the Florida Medicaid Management Information System (FMMIS) claims system coding and rules have changed the rates of accuracy over the past two years. Managed care plans' encounter data submissions previously generated no claims error responses. This has evolved generate of detailed response files that include errors requiring correction and resubmission. One of the system changes requires the managed care plans' providers to be known in FMMIS because the billing and rendering providers are required elements on the encounter transactions. This requirement has generated changes at the Agency and at the managed care plans. This is one refinement that has improved the quality of the encounter data but has resulted in a high percentage of errors. The errors related to providers at one time approached seventy percent across managed care plans, but has significantly improved through conscientious efforts by the

plans and the Agency. New managed care plans must synchronize provider data with the National Provider Identification data in the FMMIS.

Issues with new plan encounter data can vary based on the plan's prior experience with submitting encounter data. Typically, new plans initially submit encounters with higher than expected errors and lower than expected volumes. However, the Agency is proactive in monitoring encounter data submissions to identify problem areas. If there are any problems noted, the plan is referred to the appropriate office for technical assistance.

B. The Level of Contract Compliance of MCOs and PIHPs

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

1. Availability and accessibility of services, including emergency and post stabilization of services;
2. Coordination and continuity of care;
3. Provider selection, credentialing, and re-credentialing;
4. Enrollee information;
5. Enrollee rights and protections;
6. Confidentiality and accuracy of enrollee information;
7. Enrollment and disenrollment;
8. Grievance systems;
9. Subcontracting relationships and delegation;
10. Practice guidelines;
11. Health information systems;
12. Mechanisms to detect both under and over utilization of services;
13. Quality assessment and improvement;
14. Utilization management;
15. Member services;
16. Provider services;
17. Record keeping;
18. Access standards; and
19. Data availability, accuracy, and reporting.

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

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

Health Services Advisory Group, Inc., the state's contracted EQRO, has developed a compliance database and contract review tool for Agency staff to use to assess MCO and PIHP compliance with state and federal standards. The tool has been used in on-site surveys since 2010. The new EQRO contract that was effective July 1, 2013 included the provision for HSAG to develop a web-based compliance database and contract review tool for Agency and Department of Elder Affairs (DOEA) staff to use in monitoring the Statewide Medicaid Managed Care plans. The Agency, DOEA, and HSAG established a workgroup tasked with designing the web-based compliance database and contract review tool. The workgroup met during July and August of 2013 to develop the new compliance tool. The new compliance tool will be an important component in helping to streamline the compliance review and reporting process for SMMC.

Compliance Reviews

According to 42 CFR 438.358, the Agency for Health Care Administration or its contracted EQRO must use information from a review conducted within a three-year period to determine a Medicaid managed care plan's compliance with federal requirements and standards established by the state for access to care, structure and operations, and quality measurement and improvements. The Agency met this requirement by completing its third year of a three year standard review cycle in 2011 – 2012. A new three-year review cycle began in 2012 – 2013, coinciding with the implementation of the Statewide Medicaid Managed Care program. The Agency and DOEA conducted readiness reviews for each of the SMMC plans prior to implementation of the new program, which involved desk review and on-site compliance reviews of requirements related access to care and structure and operations. The readiness reviews also included desk reviews of requirements related to the plans' quality improvement programs, accreditation status and results, and experience with and abilities regarding performance measure reporting.

Performance Improvement Projects

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

focus more on managed care plans achieving and sustaining statistically significant improvement over baseline rates.

With the implementation of the Statewide Medicaid Managed Care program, the Managed Medical Assistance plans will continue to be required to perform four Agency-approved performance improvement projects. The proposals for these PIPs were due to the Agency and the EQRO on August 1, 2014. Two PIP topics are state-mandated: one PIP combines a focus on improving prenatal care and well-child visits in the first fifteen months, while the other PIP focuses on preventive dental care for children. One of the PIPs is an administrative/non-clinical PIP focusing on a topic prior approved by the Agency. One of the PIPs includes a choice of one of the following topic areas: population health issues (such as diabetes, hypertension and asthma) within a specific geographic area that is identified as in need of improvement; integrating primary care and behavioral health; and reducing preventable readmissions. The long-term care plans are required to perform two Agency-approved statewide performance improvement projects, which will include one clinical PIP and one non-clinical PIP. The current state-mandated PIP topic for the LTC plans is Medication Review, which is a clinical PIP.

Each study/project conducted by a plan must include a statistically significant sample of Medicaid lives. Prior to implementation of PIPs, plans are required to provide notification to the state, including the general description, justification, and methodology for each project and documenting the potential for meaningful improvement. Plans are required to report to the state annually on their PIPs. The reports must include the current status of the project including goals, anticipated outcomes, and ongoing interventions. For more details on contractual requirements for PIPs, please see Attachment I.

Through June 30, 2014, HSAG was contracted to perform the validation of two Agency-approved performance improvement projects for each medical assistance plan and two Agency-approved performance improvement projects for each long-term care plan. Beginning in SFY 2014 – 2015, HSAG will increase the number of the PIPs it validates for each medical assistance plan to four PIPs.

HSAG's findings regarding PIPs for SFY 2013 - 2014 are included in the Improvement section of the Comprehensive Quality Strategy (see Section III).

Performance Measures

The state made widespread, significant changes to its performance measure process in 2008 and 2009. Beginning in 2008, Medicaid MCOs were required to submit an expanded set of performance measures to Medicaid, with measures being phased in over three years. This was a new process for the PSNs, which had not previously submitted performance measures. Over the past few years, the state has added several of the Children's Health Insurance Program Reauthorization Act core set measures that were not previously captured for Medicaid MCOs. The state has reviewed the CMS Adult Medicaid Quality Measures and is including a number of these measures in performance measure reporting for the SMMC MMA plans. Table B includes the performance measures that were submitted by MCOs in July 2014 for calendar year 2013.

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**Table B
Medicaid Managed Care Performance Measures –
HMOs and PSNs**

Performance Measure	Measure Type
Adolescent Well Care	HEDIS
Adults' Access to Preventive/Ambulatory Health Services	HEDIS
Ambulatory Care	HEDIS
Annual Dental Visits	HEDIS
Antidepressant Medication Management	HEDIS
BMI Assessment	HEDIS
Breast Cancer Screening	HEDIS
Call Abandonment [previously HEDIS]	Agency-Defined
Call Answer Timeliness	HEDIS
Cervical Cancer Screening	HEDIS
Childhood Immunization Status (Combo 2 and 3)	HEDIS
Children and Adolescents' Access to Primary Care	HEDIS
Chlamydia Screening for Women	HEDIS
Comprehensive Diabetes Care <ul style="list-style-type: none"> • Hemoglobin A1c (HbA1c) testing • HbA1c poor control • HbA1c control (<8%) • Eye exam (retinal) performed • LDL-C screening • LDL-C control (<100 mg/dL) • Medical attention for nephropathy 	HEDIS
Controlling Blood Pressure	HEDIS
Follow-up Care for Children Prescribed ADHD Medication	HEDIS
Follow-Up after Hospitalization for Mental Illness	Agency-Defined
Frequency of HIV Disease Monitoring Lab Tests (CD4 and VL)	Agency-Defined
Highly Active Anti-Retroviral Treatment	Agency-Defined
HIV-Related Medical Visits	Agency-Defined
Immunizations for Adolescents	HEDIS
Lead Screening in Children	HEDIS
Lipid Profile Annually	Agency-Defined
Mental Health Readmission Rate	Agency-Defined
Prenatal Care Frequency	Agency-Defined
Prenatal and Postpartum Care	HEDIS
Pharyngitis – Appropriate Testing related to Antibiotic Dispensing	HEDIS
Transportation Timeliness	Agency-Defined
Transportation Availability	Agency-Defined
Use of Appropriate Medications for People with Asthma	HEDIS
Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	Agency-Defined
Well-Child Visits in the First 15 Months of Life	HEDIS
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	HEDIS

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

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

HMOs and PSNs are contractually required to report performance measures annually, to submit an attestation that the performance measures report is accurate, and to undergo an NCQA HEDIS Compliance Audit conducted by an independent, licensed audit organization. HSAG validates the HMOs' and PSNs' performance measures annually using methods that comply with the CMS validation of performance measures protocol. To complete its validation, HSAG combines the findings from the independent audit with additional information collected from the plans.

Prepaid Mental Health Plans (PMHPs) and the Child Welfare PMHP reported three performance measures in SFY 2012 - 2013 and SFY 2013 - 14 (see Table C). All three of the measures were Agency-defined. HSAG conducted the validation audits.

Table C Medicaid Managed Care Performance Measures – PMHPs and Child Welfare PMHP	
Performance Measure	Measure Type
Follow-up within 7 Days after Acute Care Discharge for a Mental Health Diagnosis	Agency-Defined
Follow-up within 30 Days after Acute Care Discharge for a Mental Health Diagnosis	Agency-Defined
30-day Readmission Rate	Agency-Defined

HSAG's findings regarding performance measure validation and the MCOs' and PIHPs' performance measure results that were reported in SFY 2012 - 2013 are discussed in the Improvement section of the Comprehensive Quality Strategy (see Section III).

C. Evolution of Health Information Technology

FMMIS and Encounter Data

In 2008, the state implemented a new Florida Medicaid Management Information System (system), under contract with a new fiscal agent vendor, which was then acquired by Hewlett Packard. The Agency based the general requirements on the Medicaid Information Technology Architecture (MITA) concept and requirements available at that time. Features of the new system include encounter data processing for managed care encounter data and the ability to generate data for pre-programmed quality measures and utilization metrics. The new system also provided the ability to capture race, ethnicity, and primary spoken language of MCO and PIHP enrollees.

Using the MITA 3.0 framework, the state has developed goals and objectives to guide both business development and technical infrastructure implementation needed to meet the ever-changing Medicaid Enterprise, service delivery and accountability to our recipients. These goals align with the overall goals of MITA. Planned information technology projects are aligned to these goals and MITA goals are used during the Advanced Planning Document Process.

The state has made significant progress in collecting and reporting managed care encounter data. Analytical measures designed to measure the accuracy and timeliness of encounter data submissions have been developed, are periodically refined, and accommodate changes accompanying implementation of 5010 X12 standards and the NCPDP D.0 format.

EQRO Encounter Data Validation

The new EQRO contract with HSAG, which was implemented on July 1, 2013, includes provisions for annual encounter-type focused validation studies. The primary goal of the encounter data validation (EDV) study is to examine the extent to which encounters submitted to the Agency by its contracted managed care plans are complete and accurate.

During SFY 2013 - 2014, HSAG assessed 33 percent of the managed care plans that were operational as of January 2013. Beginning in SFY 2014 – 2015, HSAG will review 100% of all capitated Statewide Medicaid Managed Care plans each year going forward. The reviews will include a comparative analysis between the state's encounter data and the managed care plans' administrative data to evaluate the extent to which encounters submitted by the plans and maintained in Florida's MMIS are accurate and complete when compared to data stored in the managed care plans' data systems. A minimum of 50 medical records per plan will be reviewed. It is expected that the results of the annual encounter data validation study will be available no later than August 1st of each year.

The EDV study for SFY 2013 – 2014 was originally designed to include several analytic activities consistent with the CMS Protocol for Encounter Data Validation, including:

- An information systems assessment designed to ascertain the managed care plans' abilities to submit encounter data according to the encounter data submission requirements established by the Agency;
- A comparative data analysis between the state's encounter data and the plans' administrative data, to evaluate the extent to which encounters submitted by the plans and maintained in the state's Medicaid Management Information System are accurate and complete when compared to data stored in the plans' data systems; and
- An assessment of the completeness and accuracy of Agency encounters using medical record reviews.

Due to delays associated with the acquisition of encounter data, the comparative analysis component was modified to focus instead on an Agency encounter data file review, and the number of medical record reviews was reduced.

Based on analyses of the key encounter data fields, HSAG found that most encounters submitted to the state's encounter data system contained reasonable and accurate values.

State Medicaid Health Information Technology Plan

The Agency submitted a State Medicaid Health Information Technology Plan (SMHP), in accordance with implementation activities authorized by the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5). CMS provided the Agency with approval of the initial SMHP on February 9, 2011.

Florida's SMHP describes the current and future Medicaid and statewide health information technology (HIT) activities in support of statewide health information exchange (HIE) and electronic health record (EHR) adoption, and describes how Florida administers and oversees the program. This plan has been updated as needed with the most recent update approved on March 18, 2013.

In the original submission of the SMHP, the Agency developed high-level goals related to the implementation of the statewide HIE and the use of HIT within the Agency. The goals were developed through visioning sessions with Medicaid subject matter experts and further refined through sessions conducted with Agency leadership. The following are a sample of the high-level goals identified:

- Increase provider adoption and meaningful use of EHRs through the implementation of the incentive program and outreach to eligible professionals and hospitals;
- Improve quality of care and patient safety by providing timely access to patient data at the point-of-care. This will further be accomplished through the use of personal health records, electronic record adoption, and utilization of the state HIE services;
- Improve health care outcomes through the use of clinical data for outcome-based decision-making. The ability to access and exchange a rich set of health care information through the HIE will expand opportunities for improved health care outcomes;
- Improve program administrative efficiencies within the Medicaid program and in the other payer programs by using HIE to streamline public health reporting as well as health plan quality reporting; and
- Enhance cost containment through the reduced duplication of tests and related costs. It is expected that this will be achieved through improved access to existing laboratory reports through the HIE.

Florida's EHR Incentive Program and technical solution for program registration and attestation establishes and validates program eligibility; issues, monitors, audits, and tracks incentive payments; identifies suspected fraud and abuse; allows for provider appeals; and validates and monitors compliance with Meaningful Use requirements as defined by CMS. The program provides outreach to eligible professionals and hospitals, and collaboration with Regional Extension Centers and the Florida Department of Health (Florida's public health agency), partners in our mission of provider adoption and Meaningful Use of EHRs.

The Agency collaborates with the Florida Department of Health to facilitate meaningful use by assuring connection through the HIE for county health department providers and by facilitating the electronic submission of data to the immunization registry, syndromic surveillance data, and other public health registries according to applicable law and practice.

Florida Health Information Exchange Overview

In 2009, the Office of the National Coordinator for Health Information Technology (ONC) announced a program of State Cooperative Agreements to Promote Health Information Technology. The Agency submitted an application for funding, including a Strategic and Operations Plan, to the ONC in October of 2009. In March 2010, the Agency was awarded \$20.7 million to complete planning and implement a statewide health information exchange infrastructure during a four-year funding period. In February 2011, the Agency contracted with Harris Corporation, an international communications and information technology company, to implement a statewide HIE infrastructure, the Florida HIE. Under the contract, Harris Corporation has implemented the following HIE services:

- Patient Look-Up (PLU) enables the search and retrieval of a patient's health information made available by other participating health care organizations and data sources. There is no central database of patient records. Providers, with patient permission, search for

records using patient demographic information. Harris Corporation uses an open-source, standards-based software solution, Express, to connect the established HIEs of participating organizations.

- Hybrid PLU Access services are offered by organizations participating in PLU and enables physicians authorized to write prescriptions in Florida the ability to access PLU with patient permission. This is an option for health care providers not currently sharing data in a HIE connected to the Florida HIE.
- Direct Messaging is a service that encrypts electronic messages and allows for the secure transmission of emails including attachments. It enables providers to “push” clinical documents and other patient information related to treatment, payment, and health care operations to other providers and managed care plans. As of July 1, 2014, the Florida HIE will be transitioning to a new Direct Messaging service. The new service will retain much of the current functionality while providing several new features including Direct Trust accreditation. Participation in the Direct Trust community will expand the number of connections available to users.
- The Event Notification Service (ENS) provides notification of hospital admissions, discharges, or emergency department visits by a health plan's member to managed care plans enrolled in the service. Hospitals provide a data feed which is matched to the managed care plan member with the notification issued to the health plan using Direct Messaging. ENS offers options for frequency of delivery.

The Florida HIE will participate in the Nationwide Health Information Network (now called the eHealth Exchange) for PLU with partner organizations that accept the privacy and security policies of the Florida HIE.

Effective October 1, 2013, CMS approved a request in a Health Information Technology Implementation Advance Planning Document Appendix D for Federal Financial Participation to accelerate the meaningful use of electronic health records by connecting hospitals to the Florida HIE. The funding pays Florida HIE costs for a limited time to enable additional hospitals, Medicaid eligible group practices, clinics, and other entities to participate in the Florida HIE PLU service.

Telemedicine

The Agency has been expanding coverage of telemedicine as a means to provide broader access to care. The following describes the coverage of telemedicine in Florida Medicaid.

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

Florida allows video conferencing between dental hygienists and supervising dentists to deliver oral prophylaxis, topical fluoride application, and oral hygiene instruction. In addition, the

Agency has developed a policy to cover telemedicine as a delivery mechanism for certain Medicaid community behavioral health services. A contract amendment was implemented for Medicaid managed care plans to allow for telemedicine for certain behavioral health services, specifically individual and family therapy and medication management. The Agency revised the Medicaid Community Behavioral Health Services Coverage and Limitations Handbook this year to allow for additional services to be provided via telemedicine. The Agency has also revised the Practitioner Services Coverage and Limitations Handbook to include telemedicine policy related to physician consultation services.

In implementing the Managed Medical Assistance portion of the Statewide Medicaid Managed Care program, the Agency issued a reminder to Managed Medical Assistance plans that they may contract directly with providers who render services using telemedicine for medical services and dental services. Services must be provided in accordance with the contractual requirements and any state and federal regulations for services rendered using telemedicine.

Information on eligible practitioners for telemedicine services may be found in Attachment 3.1-B, page 11, of the Florida Medicaid State Plan at the following website:

http://ahca.myflorida.com/Medicaid/stateplanpdf/florida_medicaid_state_plan_part_II.pdf

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III. Improvement

A. Provider Network Verification/Validation

The Agency has developed an automated network verification tool using network adequacy standards derived from Medicare. The automated verification system will provide valuable information to ensure that managed care network reviews are complete and thorough. The Agency will have the ability to perform more regular and specific monitoring and oversight of the adequacy, accuracy and quality of provider networks going forward. This system has the ability to match files with the Florida Medicaid Management Information System, the state's licensing database, the Medicaid prescription database, excluded provider lists, and other criminal databases. The plans began submitting weekly provider network files upon signature of the SMMC contract in February 2014. The Agency is finalizing monitoring tools and capabilities to measure network adequacy and accuracy moving forward.

B. Performance Measure Improvement Strategy

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

The Agency has set the 75th national percentile as the goal for HMOs and PSNs on their HEDIS measures. Through the 2013 submission of performance measures (for calendar year 2012), there has been a steady upward trend for many of the performance measures, though additional progress will be needed to reach the 75th national percentile. There are several measures where the statewide average results for managed care plans are very close to or surpass the 75th percentile. For the Antidepressant Medication Management (continuation phase) and Chlamydia Screening for women 21-24 years measures, the Reform plans are above the 75th percentile rates. Both Reform and Non-Reform plans are above the 75th percentile rate for Call Answer Timeliness. The Reform plans are within three percentage points of the 75th percentile for Well-Child Visits in the 3rd, 4th, 5th, and 6th years of life, Antidepressant Medication Management (acute phase), Children and Adolescents' Access to Primary Care Practitioners (25 months – 6 years), and Follow-up Care for Children Prescribed ADHD Medication (initiation phase). Non-Reform plans are within three percentage points of the 75th percentile for Children and Adolescents' Access to Primary Care Practitioners (12 – 24 months). Both Reform and Non-Reform plans are within three percentage points of the 75th percentile for the LDL Screening and Medical Attention for Nephropathy components of the Comprehensive Diabetes Care measure, and for the Chlamydia Screening total and women 16-20 years measure components. The following table includes the weighted means for the Non-Reform and Reform HEDIS measures for calendar year 2012, as well as the National Medicaid Mean (as published by the National Committee for Quality Assurance) for comparison.

Calendar Year 2012 HEDIS Measures – Non-Reform and Reform Plan Weighted Means			
Performance Measure	Non-Reform	Reform	National Mean*
Adolescent Well-Care	50.1%	48.5%	49.6%
Adult BMI Assessment	73.8%	63.0%	67.6%
Adults' Access to Preventive/Ambulatory Health Services – total	70.9%	74.7%	82.5%
Annual Dental Visit	31.6%	40.4%	49.1%
Antidepressant Medication Mgmt – Acute	51.8%	55.1%	52.9%
Antidepressant Medication Mgmt -- Continuation	36.5%	41.7%	36.9%
Appropriate Medications for Asthma	81.0%	79.3%	83.8%
Breast Cancer Screening	50.0%	52.7%	51.7%
Call Answer Timeliness	93.5%	95.4%	83.9%
Childhood Immunization Combo 2	77.5%	77.8%	75.8%
Childhood Immunization Combo 3	71.9%	71.6%	72.1%
Children & Adolescents' Access to Primary Care – 12-24 months	95.3%	94.5%	96.0%
Children & Adolescents' Access to Primary Care -25 mos.-6 years	87.4%	88.3%	88.3%
Children & Adolescents' Access to Primary Care – 7-11 years	85.7%	86.2%	89.8%
Children & Adolescents' Access to Primary Care – 12-19 years	82.8%	82.3%	88.3%
Chlamydia Screening for Women – total	61.2%	62.9%	56.9%
Controlling Blood Pressure	52.9%	45.4%	56.1%
Cervical Cancer Screening	56.5%	58.2%	64.1%
Diabetes – HbA1c Testing	79.6%	79.5%	82.9%
Diabetes - HbA1c Poor Control (INVERSE)	44.0%	48.9%	44.8%
Diabetes – HbA1c Good Control (<8)	47.5%	43.6%	46.5%
Diabetes - Eye Exam	46.1%	48.7%	53.2%
Diabetes - LDL Screening	79.2%	80.1%	75.4%
Diabetes - LDL Control	35.0%	32.1%	33.9%
Diabetes – Nephropathy	79.8%	80.2%	78.4%
Follow-Up after Mental Health Hospitalization – 7 day	36.3%	23.5%	43.3%
Follow-Up after Mental Health Hospitalization – 30 day	53.5%	40.8%	63.1%
Follow-up Care for Children Prescribed ADHD Medication – Initiation	41.3%	45.0%	39.1%
Frequency of Prenatal Care	62.8%	53.7%	60.5%
Immunizations for Adolescents – combo 1	57.3%	54.6%	67.2%
Lead Screening in Children	57.4%	61.7%	67.4%
Prenatal Care	73.3%	67.2%	82.9%
Postpartum Care	52.1%	51.4%	63.1%
Well-Child First 15 Months – Zero Visits (INVERSE)	2.7%	1.6%	1.8%
Well-Child First 15 Months – Six Visits	56.3%	55.6%	63.6%
Well-Child 3-6 years	73.2%	75.6%	71.9%

*National Mean as published by NCQA, Medicaid product line. The National Mean presented is for Calendar Year 2012 (reported in 2013).

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

Performance measure results for the HMOs and PSNs may be viewed at the following website: http://ahca.myflorida.com/Medicaid/quality_mc/index.shtml

The state is continuing to examine trends for performance measures that do not have available national benchmarks, in order to develop an improvement strategy approach for these measures. This project will include Agency-defined measures as well as Adult and Child Core Set measures that do not yet have national benchmarks. The state will seek technical assistance from the EQRO with this process.

C. External Quality Review Findings Related to Performance Improvement Projects (PIPs) and Performance Measures

All Medicaid managed care plans are required to implement performance improvement projects (PIPs) and have their PIPs validated in accordance with the Code of Federal Regulations at 42 CFR 438.358. The purpose of a PIP is to assess and improve the managed care plan's processes for delivering services to enrollees and to assess and improve enrollee health outcomes. The Agency's contracted EQRO, Health Services Advisory Group, Inc. must validate performance improvement projects in accordance with the CMS publication, Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for Use in Conducting External Quality Reviews, Final Protocol, Version 2.0, September 1, 2012. The mandatory protocol is used to determine whether a managed care PIP was designed, conducted, and reported in a methodologically sound manner. If the EQRO determines that a PIP was properly designed and conducted, it receives a status of "Met".

During SFY 2013 - 2014, HSAG validated a total of 126 performance improvement projects across the MCO and PIHP types. Of the 126 PIPs that were validated, 60 were collaborative PIPs and 66 were non-collaborative PIPs. The HMOs, PSNs, and PMHPs submitted one collaborative PIP and one non-collaborative PIP for validation. The SIPPs submitted one collaborative PIP and the PDHPs submitted two non-collaborative PIPs. Due to the implementation of Statewide Medicaid Managed Care, the Nursing Home Diversion plans did not submit PIPs for validation in SFY 2013 – 2014.

Across all managed care plan types, 33 percent of the collaborative PIPs had a Met overall validation status versus 26 percent for the non-collaborative PIPs. Across all managed care plan types, the percentage of PIPs achieving a Met overall validation status was lower for the 2013 - 2014 validation year compared to the 2012 – 2013 validation year, when 84 percent of collaborative PIPs and 60 percent of non-collaborative PIPs had a Met overall validation status. HSAG indicated that this decline in performance may be due to the shift to using the outcomes-focused PIP scoring methodology, including a critical analysis of the quality improvement process used to develop improvement strategies for the 2013 – 2014 validation year.

The Balanced Budget Act of 1997 requires states to ensure that their contracted managed care organizations and prepaid inpatient health plans collect and report performance measure data annually in accordance with the Code of Federal Regulations at 42 CFR 438.358. HSAG's role in the validation of performance measures is to ensure that validation activities are conducted

as outlined in the CMS publication, Validating Performance Measures: A Mandatory Protocol for Use in Conducting External Quality Reviews, Final Protocol, Version 2.0, September 1, 2012. To determine if performance measure rates were collected, calculated and reported according to the specifications required by the state, HSAG performed audits on all Nursing Home Diversion plans and PMHPs during SFY 2012 – 2013 and on all HMOs and PSNs during SFY 2013 – 2014. HSAG's most recent Performance Measure Validation Findings Report dated February 2014 compiles all the audit findings and results from all plan types except for the SIPPs. The Performance Measure Validation Findings Report for the PDHPs was issued in a separate report, which was also completed in February 2014. Performance measures that were collected, calculated, and reported according to standards receive a status of "Met".

The following is a summary of findings for PIPs and performance measures provided to the Agency by its contracted External Quality Review Organization.

Health Maintenance Organizations

HSAG reviewed PIPs and performance measures to evaluate the services provided by the Health Maintenance Organizations to enrolled members based on quality, access, and timeliness. During SFY 2013 – 2014, HSAG determined that 52 percent of the collaborative PIPs and 27 percent of the non-collaborative PIPs received a Met validation status. During SFY 2012 - 2013, HSAG determined that 88 percent of the collaborative PIPs and 66 percent of the non-collaborative PIPs received a Met validation status.

All Reform and Non-Reform HMOs were required to report performance measures annually to the state. During SFY 2013 – 2014, the Agency required that each HMO undergo an NCQA HEDIS compliance audit on the performance measures selected for reporting. These audits were performed by NCQA-licensed organizations. Beginning in 2013, the Agency included sanctions and liquidated damages language in the managed care plans' contract for inconsistent or inaccurate data reporting. According to the Agency's data reporting and submission requirements, the managed care plans' auditors were required to validate the performance measure reports submitted to the Agency. Upon receiving these reports, the Agency carefully reviewed the plans' data files and identified any discrepancies and errors within the files. The Agency sent feedback to the plans for any errors. The plans with discrepancies in the rates and those with NR (Not Reported – The calculated rate was materially biased, the plan chose not to report the measure, or the plan was not required to report the measure) designations were required to resubmit corrected rates. The Agency required the resubmitted rates to be approved by the plans' auditors, along with a new attestation from the plans' chief executive officers, and a new Final Audit Report was required.

For calendar year 2012, there were 23 HMO submissions, with seven from Reform plans and 16 from Non-Reform plans. For the validation of SFY 2013 – 2014 performance measures, HSAG used the measure-specific audit designation from the final audit statements for this report instead of the IDSS (Interactive Data Submission System) files, although for most plans, both were submitted for validation. Based on the final audit statements submitted by the HMOs, all Reform plans followed the NCQA HEDIS 2013 and Agency-defined measure specifications to calculate their rates for the selected performance measures. None of the plans had any measures reporting NR or NB (No Benefit – the plan did not offer the benefit required by the measure) audit designation status.

Provider Service Networks

During SFY 2013 – 2014, HSAG determined that 27 percent of the collaborative PIPs received a Met validation status and 39 percent of the non-collaborative PIPs received a Met validation

status. During SFY 2012 - 2013, HSAG determined that 100 percent of the collaborative PIPs for the PSNs received a Met validation status and 75 percent of the non-collaborative PIPs received a Met validation status.

The Agency required all PSNs to report performance measures annually to the state. During SFY 2013 – 2014, the Agency required that each PSN undergo an NCQA HEDIS compliance audit on the performance measures selected for reporting. These audits were performed by NCQA-licensed organizations. For calendar year 2012, there were 11 PSN submissions, with five from Reform plans and six from Non-Reform plans. HSAG reviewed and validated the audit findings from each managed care plan's final audit report produced by the licensed auditing organization. All PSNs were fully compliant with all Information System standards and all of the PSNs' performance measures were Reportable (the organization followed the specifications and produced a reportable rate or result for the measure). The Information System standards included medical services data, enrollment data, practitioner data, medical record review processes, supplemental data, member call center data, and data integration.

Prepaid Mental Health Plans and Child Welfare Prepaid Mental Health Plans

During SFY 2013 – 2014, HSAG determined that 8 percent of the collaborative PIPs received a Met validation status and 17 percent of the non-collaborative PIPs received a Met validation status. During SFY 2012 - 2013, of the total PIPs assessed, Health Services Advisory Group, Inc. determined that 92 percent of the collaborative PIPs received a Met validation status and 83 percent of the non-collaborative PIPs received a Met validation status. HSAG indicated in their 2013-2014 Florida Annual Performance Improvement Project Validation Summary Report that this decline in performance may be due to the shift to using the outcomes-focused PIP scoring methodology, including a critical analysis of the quality improvement process used to develop improvement strategies for the 2013-2014 validation year.

The Agency required all PMHPs to undergo a performance measure validation process conducted by HSAG according to the CMS protocol. During SFY 2012 – 2013, HSAG conducted performance measure audits on five PMHPs and the Child Welfare PMHP for three Agency-defined performance measures. All measures were calculated by the plans based on Agency specifications. The PMHPs and Child Welfare PMHP all received Fully Compliant audit designations for the three required performance measures. HSAG did not have any issues or concerns with the processes in place to capture data and generate rates. All of the plans understood the measure reporting process, followed the measure specifications, and reported accurate and valid rates. It should be noted that the Prepaid Mental Health program was phased out with implementation of the Statewide Medicaid Managed Care program.

Statewide Inpatient Psychiatric Program

During SFY 2013 – 2014, HSAG determined that 25 percent of the PIPs assessed received a Met validation status. During SFY 2012 - 2013, of the total PIPs assessed, 77 percent of the collaborative PIPs received a Met validation status and 39 percent of the non-collaborative PIPs received a Met validation status. It should be noted that with the implementation of SMMC, the SIPPs were phased out as a managed care plan type, although it continues to be a service provided by Florida Medicaid.

Prepaid Dental Health Plans

The PDHPs participated in PIP validation for the first time during the SFY 2013 – 2014 validation cycle. Only one of the two PDHPs progressed to the point of reporting remeasurement results for one PIP.

This was the first year that the PDHPs participated in the performance measure validation audit process. Due to an incomplete understanding of the Agency's contract requirement, one of the PDHPs conducted the audit within a short timeframe and could not complete the required documentation for the audit. HSAG also found that neither PDHP followed the reporting guidelines provided by the Agency. Although HSAG did not find any major issues associated with the PDHPs' data systems and processes, the PDHPs' measure interpretation, calculation, and reporting processes were not very clear. While all four performance measures were assessed as "Reportable" by the PDHPs' auditors, HSAG could not ascertain measure calculation and reporting consistency for the three Agency-defined measures due to insufficient information available. As such, HSAG could only validate the *Annual Dental Visit* measure as "Reportable." HSAG recommends that both PDHPs keep the state informed of progress throughout the audit season to ensure the plans are fully prepared for the audit in 2014. HSAG also recommended the following for both PDHPs:

- Both PDHPs should request technical assistance from an NCQA licensed organization regarding the audit process and performance measure validation;
- Prior to the annual compliance audit, the PDHPs should clarify the measure specifications with the State in order to calculate the rates accurately;
- PDHPs should contract with a licensed organization early so they have adequate time to prepare for the upcoming audit. This would include sufficient time to complete the Roadmap and compile any supporting documentation;
- Both PDHPs should review and follow the Health Plan Report Guide provided by the Agency when submitting their rates to the State. PDHPs should also ensure that their auditors are familiar with the required reporting format laid out by the Agency; and
- For the medical record review abstraction and process, the PDHPs should provide documented policies and procedures to ensure the reliability and validity of the collected data.

It should be noted that with the implementation of SMMC, the PDHPs were phased out as a managed care plan type.

Nursing Home Diversion Plans

During SFY 2012 -2013, HSAG conducted performance measure validation audits on 15 NHDP plans for four Agency-defined performance measures. HSAG found that all plans had adequate review and validation processes to ensure accurate data for performance measure reporting. All plans' performance measure rates were determined to be valid and reportable. HSAG offered the following recommendation related to the NHDP performance measures:

- Statewide performance demonstrated a slight improvement on the *Disenrollment Rate* measure. Although there was a decline in the *Retention Rate* and *Voluntary Disenrollment Rate*, as well as a decrease in the *Average Length of Enrollment* among enrollees who voluntarily disenrolled from the NHDP plan, the decline appeared to be associated with one plan that had a merger in April 2012. In general, the trends for these measures have been very stable over the past three years. Under normal circumstances, HSAG would recommend that DOEA consider retiring these measures and develop new sets of performance measures for these plans.

It should be noted that the Nursing Home Diversion program was phased out with implementation of the Statewide Medicaid Managed Care program.

EQRO Recommendations Regarding PIPs

In June 2014, HSAG submitted the *2013 - 2014 Florida Annual Performance Improvement Project Validation Summary Report* to the Agency. HSAG made the following recommendations regarding PIPs, which they disseminated to the MCOs and PIHPs. Note that in the recommendations, “MCOs” refers to both MCOs and PIHPs.

- The Agency, with HSAG’s assistance, should identify statewide goals or expected levels of performance for the study indicators in all new state-mandated PIPs.
- The Agency should provide opportunities for MCOs that achieve statistically significant improvement in remeasurement periods to discuss lessons learned and successful improvement strategies with all MCOs.
- The MCOs should verify that all information and results documented in the PIP Summary Form are accurate.
- The MCOs should contact HSAG for technical assistance on how to conduct statistical testing, if needed.
- The MCOs should conduct an annual causal/barrier and drill-down analysis in addition to periodic analyses of their most recent data.
- The MCOs should integrate proven quality improvement processes, such as the Plan-Do-Study-Act (PDSA) cycle, into their PIPs in order to ensure a robust causal/barrier analysis, identifying the root causes affecting outcomes improvement.
- The MCOs should conduct barrier analyses more often than once per year to support an ongoing and cyclical quality improvement process. Analysis should be performed as an MCO evaluates the effectiveness of interventions to determine if adjustments are needed to better support outcomes improvement.
- The MCOs should prioritize their identified barriers and ensure there is a direct link between each intervention and its associated barrier.
- The MCOs should have a process in place to evaluate efficacy of each intervention and determine if the desired effect is being achieved. The results of each intervention’s evaluation should be included in the PIP documentation.
- The MCOs should use and document problem-solving techniques to revise or replace ongoing interventions that are deemed ineffective, to achieve the desired improvement in the study indicator(s).
- The MCOs should incorporate successful interventions into standard practices and processes.

The Agency for Health Care Administration requires that all EQRO recommendations regarding performance improvement projects be implemented by the managed care plans, and is working closely with the plans to ensure compliance with these recommendations.

Accomplishments and Improved Outcomes

Going forward, Florida's EQR reports will incorporate more detail on outcomes and specific innovative practices implemented by the managed care plans in their efforts to improve care in the areas targeted for improvement.

During SFY 2013 - 2014, the following notable interventions were successfully implemented by the managed care plans:

- One of the HMOs led a statewide initiative reminding providers of all the documentation requirements and supplied the providers with the Bright Futures forms in an effort to improve compliance with Well-Child Visits in the First 15 Months of Life – Six or More Visits (collaborative).
- Two HMOs utilized the HEDIS Care Gap program that identified enrollees due for services at the time of an inbound call from an enrollee and supported an interactive HEDIS Online Portal (iHOP) for providers to access and update enrollee care gap data, in their efforts to improve compliance with Well-Child Visits in the First 15 Months of Life – Six or More Visits (collaborative).

EQRO Recommendations Regarding Performance Measures

HSAG offered the following recommendations to both the HMOs and PSNs in their Performance Measure Validation Findings Report dated February 2014:

- Reviews of each plan's FARs showed that the auditors did not note any major issues associated with the plan's approach to accommodate NCQA's new medical record review validation policies and procedures for HEDIS 2013. Nonetheless, the auditors did recommend that their plans continue to ensure that adequate resources be available for next HEDIS reporting season, including development of a sound project plan with critical key dates for HEDIS 2014 reporting, starting the medical record abstraction as early as possible, the high level of inter-rater review, and the oversight of the medical record review abstraction process.
- Since NCQA has provided new guidelines for collecting and using supplemental data for HEDIS 2014, the HMOs/PSNs should ensure that all staff members involved in preparing the supplemental data for HEDIS 2014 reporting meet the required timeline and include appropriate proof-of-service documents for auditors' reviews.
- For both Non-Reform and Reform plans, although statewide averages reveal significant improvements in several performance measures, performance for a majority of the measures reflected minor changes from the prior year. HMOs/PSNs should focus their efforts to improve measures whose rates were at least 10 percentage points below the Agency's performance target. These measures include *Lead Screening in Children*, *Annual Dental Visits*, *Cervical Cancer Screening*, *Prenatal and Postpartum Care*, and *Comprehensive Diabetes Care—Eye Exam Performed*.
- The HMOs/PSNs should continue to ensure that their auditors are aware of the Agency's specific reporting requirements as listed in the Health Plan Report Guide and are responsible for validating the Performance Measure Report. HMOs/PSNs should consider including the penalty associated with failure to perform this task satisfactorily in their contracts with their licensed organizations.

The Agency for Health Care Administration is working closely with the managed care plans to comply with the EQRO recommendations regarding performance measures.

D. External Quality Review Findings Related to Compliance Reviews

According to 42 CFR 438.358, the Agency for Health Care Administration or its contracted EQRO must use information from a review conducted within a three-year period to determine a Medicaid managed care plan's compliance with federal requirements and standards established by the state for access to care, structure and operations, and quality measurement and improvements. The Agency met this requirement by completing its third year of a three year standard review cycle in 2011 – 2012. A new three-year review cycle began in 2012 – 2013, coinciding with the implementation of the Statewide Medicaid Managed Care program. The Agency and DOEA conducted readiness reviews for each of the SMMC plans prior to implementation of the new program, which involved desk review and on-site compliance reviews of requirements related access to care and structure and operations. The readiness reviews also included desk reviews of requirements related to the plans' quality improvement programs, accreditation status and results, and experience with and abilities regarding performance measure reporting.

In January 2013, HSAG completed its most recent analysis of the Agency's review of compliance for HMOs, PSNs, and PMHPs in SFY 2011-12. The following is a summary of findings for the compliance reviews related to quality, access, and timeliness.

HMOs and PSNs

SFY 2011 - 2012 was the third year of the three-year cycle of reviews for HMOs and PSNs. For the SFY 2011 - 2012 compliance reviews, Agency HMO and PSN managers chose three standards for review. These included: Eligibility, Enrollment, and Disenrollment; Enrollee Services and Enrollee Rights; and Community Outreach. Agency staff conducted file reviews to verify if the managed care plans accurately applied the procedures described in the policies and other documents submitted as evidence of compliance with the standards reviewed. The file reviews completed by Agency staff during SFY 2011 - 2012 included: Appeals; Denials; Grievances; Case Management; Child Health Check-up; Medical Record Review; Newborn; Pregnancy; Online Provider Directory; and Printed Provider Directory.

The majority of the HMOs scored 100 percent compliance for Eligibility, Enrollment, Disenrollment, and Community Outreach. The lowest average score generated from the HMO standards review was for Enrollee Services and Enrollee Rights, with a score of 94.2 percent. The Newborn and Pregnancy file reviews generated the lowest average rates of all the file review rates (36.5% and 41.2% respectively), and showed the greatest opportunities for improvement across the managed care plans. The Newborn and Pregnancy file reviews were based upon the contract provisions for pregnancy related requirements (prenatal and newborn). Some of the plan's provider medical records did not consistently maintain sufficient documentation to support contractual requirements for the following provisions: prenatal risk screening; documentation of Healthy Start risk screenings; contacts to enrollees who failed to keep prenatal appointments as soon as possible; documentation of the nutrition care plan; provision of safe and adequate nutrition for infants by promoting breast-feeding; or documentation that providers offered all pregnant women counseling and HIV testing at 32 weeks.

The review of compliance standards for PSNs showed strong results for all plans. The average score for all PSNs for all standards was 97.1 percent. The Newborn and Pregnancy file reviews generated the lowest average rates of all the file review rates (48.9% and 57.4% respectively), and showed the greatest opportunities for improvement. Grievances (81.9%), Case Management (81.3%), CHCUP (86.9%), and Medical Records file reviews (85.2%) also showed room for improvement. Going forward, the state will use the newly-designed web-based managed care survey tool developed by Florida's External Quality Review Organization, with input from the Agency and the Department of Elder Affairs, to monitor and track improvements in meeting compliance standards.

PMHPs and CWPMHPs

During SFY 2011 - 2012, Agency PMHP and CWPMHP staff completed the third year of a three-year review cycle for all access, structure, and operations standards. Seven standards were reviewed: Administrative Compliance; Utilization Management; Targeted Case Management; Provider Network/Credentialing/Access to Services; Quality Improvement Program; Grievances and Appeals; and Outreach. Quality Improvement Program and Grievances and Appeals were the highest scoring reviews at 100 percent. Although the plans demonstrated compliant policies and procedures, the review of their grievance files indicated that practices of five of the plans had room for improvement with administering their grievance procedures.

File reviews were completed for Appeals, Denials, Grievances, Case Management, Clinical, Claims, Non-Physician Credentialing, and Physician Credentialing. The plans demonstrated the highest level of compliance in the Appeals and Claims file reviews with 96.8 percent and 96.5 percent, respectively. The two lowest average rates of all the file reviews were the Grievance review (79.6 percent) and the Clinical review (85.7 percent). These two file review areas represent the greatest opportunities for improvements.

EQRO Recommendations Regarding Compliance Reviews

In January 2013, HSAG submitted the "Review of Compliance with Access, Structure, and Operations Standards Report" to the Agency. The report contained the following recommendations:

- Agency staff should continue to define necessary revisions to the database, checklists, and file review tools based on state and federal policy changes or changes in requirements;
- Agency staff should create policies and procedures to document the process used to perform compliance reviews;
- Agency staff should review and update the policies annually to ensure that they adequately capture the compliance review process; and
- Agency staff should carefully review the standards and elements to be included in the SFY 2012 - 2013 compliance audit to ensure that the monitoring tools align with the most current contract requirements prior to starting the on-site reviews.

E. External Quality Review Focused Study

The Agency's contract with Health Services Advisory Group, Inc. states that the contracted EQRO will conduct at least one focused study of health care quality each contract year (July – June) as deemed necessary by the Agency. The study design will be drafted during the first quarter of the contract year, data collection will occur during the second quarter, and reports will be submitted to the Agency before the end of the fourth quarter.

The Centers for Medicare and Medicaid Services, during their review of the Agency's draft Comprehensive Quality Strategy in February 2014, requested that Florida include more information on cultural considerations in future External Quality Review reports. The Agency's response to CMS stated that the Agency will explore, with its contracted External Quality Review Organization, the possibility of performing a statewide focused study related to cultural considerations to assist the Agency and its managed care plans in identifying areas and strategies for improvement.

The Agency's model agreement with its contracted Statewide Medicaid Managed Care plans contains provisions in its Core Contract that require all SMMC plans to have a comprehensive written cultural competency plan (CCP). The CCP must describe the managed care plan's program to ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency. The contract requires that the CCP be updated annually and submitted to the Agency by June 1st for approval.

The Agency began meeting internally in June 2014 to discuss proposals for a focused study on cultural competencies. These proposals were forwarded to HSAG, and conference calls began in July with the Agency, DOEA and HSAG to design and implement the focused study for July 1, 2014 through June 30, 2015.

F. Quality Improvement Initiatives for Florida's Long-Term Care and Fee-For-Service Programs

In addition to specific contract requirements and quality improvement activities implemented by the Agency for Health Care Administration related to its managed care programs, the Agency has implemented numerous quality strategies for its fee-for-service and long-term care programs.

Oral Health Quality Improvement Strategies

The Agency for Health Care Administration is committed to improving oral health outcomes for Medicaid recipients, with a particular emphasis on significantly increasing the number of children regularly accessing preventative dental services. CMS has set national oral health goals to increase the number of children in Medicaid accessing preventative services by ten percentage points by the end of federal fiscal year 2015 and those getting sealants on a permanent molar by ten percentage points (a target date has not yet been established).

The Agency is establishing an Oral Health Action Plan that maps out goals and strategies to achieve improved oral health outcomes for children. The first step in establishing the plan was to research strategies used by other states that have successfully improved oral health outcomes. The second step was to select strategies that would potentially work in Florida and to engage with stakeholders to receive their feedback on the viability of the strategies. This is underway, with senior Agency leaders actively engaged with the Oral Health Florida coalition,

researchers, and dental provider associations to determine which strategies would be most efficient and effective. One of the most successful strategies, a move to managed care for provision of dental services to children, is already in place. Data show that, compared to fee-for-service, children enrolled in the state's Prepaid Dental Health Plans receive the most preventative dental services. At the direction of the Florida Legislature, the Agency expanded Prepaid Dental Health Plans statewide in 2012 and in July 2013, ended an option to opt out into fee-for-service. With these changes, the Agency expects the percentage of children receiving preventative dental services to increase as the managed care dental contracts require connecting children to a dental home and outreach to families whose children have not received preventative care services.

Another improvement strategy currently being implemented by the state is to require Managed Medical Assistance plans under the 1115 MMA waiver to conduct a performance improvement project on preventive dental care for children. This is a requirement of the Special Terms and Conditions of approval for the waiver. The Agency is making the dental performance improvement project a statewide collaborative PIP, which gives managed care plans a forum for sharing challenges and best practices as they implement interventions. In addition to this PIP, the plans are required to report annually on the following dental performance measures: annual dental visits, preventive dental series, dental treatment services, and sealants.

The Agency does not yet have data available to demonstrate the effectiveness of the established oral health initiatives. However, the data is being collected to analyze the impact of all oral health efforts. It is anticipated that the data demonstrating quality outcomes will be available by April 2015 for the 2014 federal fiscal year.

The Agency required the Prepaid Dental Health Plans (PDHPs) to adhere to the following contract compliance and report submission requirements:

- Quality Improvement Program – The PDHP was required to describe its process for monitoring and evaluating the quality and appropriateness of dental care and services rendered, including a plan to demonstrate specific interventions to promote healthier outcomes;
- Child Health Check Up Corrective Action Plan – A corrective action plan was required if the PDHP did not achieve the state's target screening rate;
- Cultural Competency Plan and Evaluation – The PDHP was required to maintain a current plan describing the PDHP's program to ensure that services were provided in a culturally competent manner to all enrollees, including those with limited English proficiency. A description of the evaluation, its results, the analysis of the results, and interventions to be implemented were required by the Agency;
- Performance Improvement Projects – The PDHP was required to perform two Performance Improvement Projects (PIPs) that the plan identified, to improve quality of care and patient outcomes. The PDHP was required to complete at least one clinical PIP and one non-clinical PIP; and
- Dental Records Audits (Primary Dental Provider records, Plan's Care Management files) – The PDHP dental records were submitted for desk review as requested by the Agency in conjunction with the survey year.

The Prepaid Dental Health Plans will cease operating as Medicaid managed care plans on September 30, 2014. Dental services will be assumed by the Managed Medical Assistance plans as they are implemented in each region. The MMA plans are required to cover full dental

services to enrollees under the age of 21. Some plans have elected to offer dental services to enrollees age 21 and older as an expanded benefit. The MMA plans have the same contract compliance and report submission requirements as the PDHPs related to the Quality Improvement Program, Child Health Check Up Corrective Action Plan, Cultural Competency Plan and Evaluation, Performance Improvement Projects, and Dental Records Audits.

MEDS AD / Medicaid Drug Therapy Management Program

The Agency for Health Care Administration, through an agreement with the University of Florida, provides Medicaid Drug Therapy Management Program services to Medicaid recipients assigned to the Medicaid for the Aged and Disabled (MEDS AD) waiver program. This program involves a collaboration between physicians and pharmacists to determine appropriate practice patterns and clinical guidelines to improve the prescribing, dispensing, and use of applicable drugs in the Medicaid program as required by section 409.912(39)(a)11.a., Florida Statutes. The goals of the program are to improve the quality of care and prescribing practices based on best-practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending for certain Medicaid prescription drugs.

The program uses high-intensity pharmacy case management services in conjunction with access to appropriate medical care for select aged and disabled individuals as a way to maintain care in the community and prevent premature institutionalization.

The Medicaid Drug Therapy Management Program's (MTM program) final evaluation report integrates findings across all quantitative and qualitative evaluation questions for MTM participants, MTM eligible non-participants, and a matched group (on age, gender, health status, etc.) of the MTM eligible non-participants using the latest available data for inpatient, outpatient, long-term care, medical, and pharmacy claim types (for a period extending from January 2010 to May 2013).

A thorough examination of many health, utilization, and financial outcomes potentially influenced by the MTM intervention produced the following substantive findings:

- From the participants' perspectives, the MTM program clearly increased their medication adherence; the encouragement of pharmacists was credited as instrumental in that adherence;
- For Cohort 1, substantial pharmacy cost savings were realized between the pre-intervention and intervention periods in the MTM participant group compared to the MTM eligible non-participants. The range of average pharmacy cost savings per MTM participant ranged from \$2,456 to \$2,612 per recipient per year; and
- For Cohort 2, the total number of hospitalizations, as well as the likelihood of future hospitalizations, declined in the MTM participant group compared to the MTM eligible non-participant population between the pre-intervention and intervention periods.

Medicaid Drug Therapy Management Program for Behavioral Health

In 2005, the Florida legislature authorized the implementation of the Medicaid Drug Therapy Management Program for Behavioral Health (MDTMP), a program that works collaboratively with prescribers in the Medicaid program to improve the quality and efficiency of the prescribing of mental health drugs, and to improve the health outcomes of Medicaid recipients with a mental illness. Additional information about the MDTMP can be accessed at the following link:

<http://medicaidmentalhealth.org/>

Designed to be an extension of the former Behavioral Pharmacy Management Program, MDTMP is being implemented by the Louis de la Parte Florida Mental Health Institute of the University of South Florida (USF), through agreements with the Agency for Health Care Administration and the Department of Children and Families and its subcontractors.

Components of the program include:

- Development of Florida-specific best practice psychotherapeutic medication guidelines for children and adults that represent a consensus of the prescriber community and reflect the most recent scientific information available;
- A communications strategy for dissemination of the guidelines through a variety of methods, including print and electronic media;
- Collaboration with Florida medical societies, community mental health centers, clinicians, consumer organizations, and other stakeholders throughout Florida involved in the care of individuals with mental illness;
- Development of a website designed to reach the prescribing community;
- Identification of complex care indicators;
- Analysis of claims for mental health medications;
- Peer-to-peer interventions with clinicians;
- Ongoing surveillance, follow-up and re-measurement;
- Promoting integration of medical and mental health care;
- Implementation of a state-wide Child Psychiatry Access Call Line;
- Development of a registry to track the use of antipsychotics in children;
- Project to promote the appropriate use of Clozapine;
- Implementation of a clinical trial designed to assess the risks and benefits of switching patients with schizophrenia from two to one antipsychotic medication;
- Development of a peer-to-peer project to improve adherence to medication;
- Educational outreach to ARNPs who are increasingly prescribing psychotherapeutic medications; and
- Special studies as requested by the Agency.

The Medicaid Drug Therapy Management Program for Behavioral Health uses several strategies to improve the quality of behavioral drug prescribing, reduce clinical risk and lower the rate of inappropriate spending for psychotherapeutic drugs.

From SFY 2007 - 2008 through SFY 2013 -2014, the program reported the following progress:

- The average number of adult antipsychotic prescriptions written by 26,026 unique Medicaid prescribers has declined by 4.6% while the adult Medicaid population has increased by 18.05%.
- The average number of antipsychotic (AP) prescriptions written for children by 8,336 unique prescribers decreased by 4.82%, and the number of children prescribed AP medication declined by 41%.

The prior authorization (PA) program for children under the age of six years old, administered collaboratively with the Agency, the MDTMP and USF's Psychiatry and Neurodevelopmental program, has contributed greatly to the decline of inappropriate prescribing of antipsychotics for children. All initial requests for an antipsychotic medication are reviewed by board-certified child psychiatrists at the USF Department of Psychiatry and the All Children's Hospital Department of Neurodevelopmental Psychiatry. The volume of PA requests has dramatically declined from a high of 500 per quarter (Quarter 2, 2008) to less than 100 requests as of Quarter 1, 2014. In SFY 2013 - 2014, 937 unique children had a request for a PA review, which represents a significant decline in the number of requests received.

Additionally, antipsychotic safety monitoring practices have significantly improved. Prescribers are now documenting essential monitoring information such as body mass index (BMI), increasing from limited compliance of 11% at the onset of the PA program, to 98% as of Quarter 1, 2014. Metabolic monitoring and tardive dyskinesia screens were added in 2010, and are now at 98% and 72% compliance respectively.

The program collects, analyzes and reports to the Agency on the trends of antipsychotic prescribing. As a result of the PA program, the MDTMP has developed a registry of more than 3,600 children under the age of six who have been prescribed an antipsychotic. The registry collects both behavioral and medical information longitudinally, providing a rich database which can be mined to observe the effects of antipsychotic prescribing and any side effects that may develop as the children grow up and remain on antipsychotic medication. The numbers of children diagnosed with weight gain, diabetes, tremors, high blood pressure and sleep disorders increased by a statistically significant amount from the pre-antipsychotic year to the post-antipsychotic years, hence the need to closely monitor for side effects of psychotherapeutic medications. In addition to antipsychotic prescribing, safety issues were identified by the panel of experts on child and adolescent psychiatry, including prescribing paroxetine for children under the age of 13 and concurrent use of different classes of psychotropic medications. In SFY 2013 - 2014, 13 prescribers were identified with these issues. All were contacted through a peer-to-peer intervention.

The MDTMP has developed and implemented activities designed to facilitate the adoption of the Florida Psychotherapeutic Medication Guidelines for children and adults and identified high volume prescribers (for children and adults) of behavioral health drugs. Through quarterly retrospective analysis of pharmacy claims, the MDTMP has focused on those providers with both a high volume of psychotherapeutic medications prescribed and patients with large numbers of complex care indicators. Eighty-one high volume prescribers have been identified, subsequently visited by peers, and monitored over time. Resulting actions ranged from termination from the Medicaid program by the Agency to active surveillance on the part of the program. As the program continues to engage prescribers and other stakeholders in guidelines development, it has also documented a decrease in inappropriate prescribing.

The MDTMP continues to monitor the performance of all Florida Medicaid prescribers of psychotherapeutic medications and implements quality improvement projects where the Agency has identified areas of concern. As managed care implementation proceeds, the program will monitor the experience of Medicaid recipients enrolled in the Statewide Medicaid Managed Care program and will be working collaboratively with the Agency and managed care plans to continue to ensure the quality of care individuals with mental health care needs receive.

CHIPRA Demonstration Grant

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

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

Florida, as the lead state, with Illinois, received a grant award for work in Categories A, B, C, and E totaling nearly \$11.3 million for the states to split as needed. The grant was awarded in February 2010 and ends in February 2015. Both states have workgroups comprised of state staff, subject matter experts, private professionals, advocates, stakeholders, and project management.

- For Category A, Florida is working to collect, aggregate, and report measures of children's health care quality using multiple existing data sources from various children's programs across state agencies. Several of the children's core set measures have been added to the list of required measures for HMOs and PSNs. In federal fiscal year (FFY) 2012, Florida reported 22 of 23 CHIPRA measures. This represents an improvement over FFY 2011, when Florida reported 20 core measures and FFY 2010 when Florida reported 12 core measures. In addition to supporting state activities, Florida's child quality data is reported to CMS and is issued in a national report on child health care quality.
- For Category B, the state is ensuring that ongoing statewide health information exchange and health information technology efforts support the goal of improving child health care quality and enhance provider-based systems of care. The Agency has identified Direct Secure Messaging (DSM) as a tool that can help pediatricians provide specialists with better information in making a referral. The Agency has recently used CHIPRA funds to support the South Florida Regional Extension Center in enrolling pediatricians in the DSM service that is part of the state's information exchange. Additional strategies to promote secure electronic health information are under development.

- For Category C, Florida provided training and technical assistance to 34 child-serving practice sites (i.e., private pediatric practices, hospital-based outpatient clinics, and free-standing health centers) to improve the way they deliver care to children by strengthening their medical home through care coordination, use of evidence-based practices, and enhanced access to needed services, particularly for children with special health care needs. A CHIPRA grant-funded evaluation will assess changes in quality resulting from this medical home work.
- Category E activities are being conducted through an existing public-private partnership, the Florida Perinatal Quality Collaborative, which is focused on population-based, data-driven perinatal quality improvement. Numerous stakeholders working on perinatal care in Florida have created a forum for sharing data, experiences from past initiatives, and new ideas to address problems in birth outcomes and infant health. Florida completed its first project to reduce elective pre-term births that lead to short and long-term health care problems and costs. The success on reducing pre-term births was substantial. Six pilot hospitals in Florida participated by putting in place restrictions on elective preterm births, educating patients and providers about the risk of an elective preterm delivery, and establishing consistent policies and procedures for scheduling, collecting, and entering data for tracking improvements in practice and outcomes. In a two-year period, the early-term cesarean rate in the six pilot hospitals dropped from approximately 50 percent to below 10 percent. Experts on baby-friendly hospitals, ante-natal steroids, blood stream infections, and breast feeding have presented evidence on current quality and room for improvement in Florida hospitals and are developing similar quality improvement projects for the Collaborative to consider.

The next quality improvement project for the Collaborative relates to newborn resuscitation during the “golden hour” after birth when short and long-term outcomes could be improved the most. The first phase of this quality improvement initiative will focus on the effects of delivery room management practices, including teamwork, thermoregulation, oxygen administration and delayed cord clamping. In addition to the content area, much attention was paid to the cost and challenges of conducting data collection, and problems of complete coding of the hospital experience. Finally, the group focused on how to integrate improved practices into the hospitals’ culture so that improvements would be sustained.

In a separate but related project to improve child health care quality, Florida is participating in the CMS Quality Improvement Action Learning Series. The two primary objectives are:

1. To ask for expert help in areas where the medical home demonstration practices were experiencing challenges reaching the milestones; and
2. To ask for expert advice on how to expand the pediatric medical home model in Florida once the CHIPRA grant ends.

To meet objective one, a call was held on December 24, 2013 with all three practice facilitators, project staff and the quality improvement (QI) expert. One topic discussed during the call was how best to assist practice teams in prioritizing and testing the changes they want to make. The QI expert suggested the following strategies be suggested to practice teams:

- Analyze chart review and other practice level data to determine focus areas;

- Focus on changes that will impact families the most; and
- Connect with fellow practice teams both within the current Round 2 and mentor teams from Round 1 or meet together in between Learning Sessions.

Efforts were made to hold a joint practice facilitation visit with two practices within the same health system, but it was not possible for practice staff to travel. The call participants discussed additional strategies to connect Round 1 and Round 2 teams, such as holding a joint call or webinar.

To meet objective two, Florida has formed an advisory group to identify opportunities to spread the pediatric medical home concept. State experts in pediatric care have spent a significant amount of time and effort focusing on the QI Action Learning Series in preparation for expanding the model. Although this team was originally scheduled to meet in early 2014 to start to plan a strategy for expanding the medical home model to the pediatric community, due to a change in key staff at the Florida Chapter of the American Academy of Pediatrics, this meeting has been postponed indefinitely.

Prior Authorization and Quality Improvement Contracts

The purpose of the utilization review program is to safeguard against unnecessary and inappropriate medical care rendered to Medicaid recipients. Recipient medical services and/or records are reviewed for medical necessity, quality of care, appropriateness of place of service and length of stay (inpatient hospital). Florida Medicaid manages a number of quality improvement and prior authorization contracts to ensure that Medicaid recipients receive medically necessary, quality services in the most cost-effective manner.

The following Medicaid services are subject to review for quality improvement or prior authorization:

- Care Coordination
- Community Behavioral Health
- Dental
- Durable Medical Equipment
- Inpatient Medical and Surgical
- Hearing
- Home and Community Based Waiver Services for the Developmentally Disabled
- Home Health
- Outpatient Diagnostic Imaging
- Prescribed Pediatric Extended Care
- Targeted Case Management
- Therapy
- Vision

The organizations that are contracted with the Agency to provide quality improvement or prior authorization services are Delmarva Foundation, eQHealth Solutions, Magellan Medicaid Administration, MedSolutions, and Sandata Technologies.

Delmarva Foundation, Inc., a federally-designated Quality Improvement Organization (QIO), provides quality assurance for Florida's Developmental Disabilities Services system. Delmarva works in partnership with the state's Agency for Persons with Disabilities at the state and regional offices to improve the quality of supports for Medicaid recipients with developmental disabilities. The developmental services system, called iBudget Florida, gives APD customers

more control and flexibility to choose services that are important to them. This program measures the success of services and supports from the blended perspectives of both the individual receiving services as well as program measures and requirements. The goal of this program is to support people to live their everyday lives through quality improvement strategies designed to promote a person-directed service delivery system.

eQHealth Solutions, Inc., a federally-designated Quality Improvement Organization (QIO), provides utilization management of Florida Medicaid services, including prior authorization of inpatient medical and surgical, prescribed pediatric extended care therapies, durable medical equipment (DME), dental, hearing, vision, and home health services. Reviews for home health services have recently expanded to include care coordination services for individuals under 21 years of age in skilled nursing facilities, receiving prescribed pediatric extended care, or receiving private duty nursing services. Care coordination includes home visits, monthly phone calls, and bi-annual multi-disciplinary team meetings that include the recipient's health care team to determine the most appropriate services for the recipient.

Magellan Medicaid Administration, Inc. is the Quality Improvement Organization-like vendor for Florida Medicaid behavioral health programs. They are contracted to perform utilization management functions for fee-for-service community behavioral health and targeted case management providers. Magellan is required to certify and enroll Medicaid providers, to ensure quality of services, and to assist in the prevention and detection of Medicaid program fraud and abuse. Magellan monitors compliance with service eligibility determination procedures, service authorization, policy, staffing requirements, and service documentation requirements in accordance with s.409.913, Florida Statutes.

MedSolutions performs prior authorization utilization management for outpatient diagnostic imaging services and utilizes real-time predictive modeling and evidence-based criteria in the decision-making process. This prior authorization utilization management process facilitates increased efficiency and cost effectiveness; and ensures that Medicaid recipients receive the most clinically appropriate advanced imaging services according to approved clinical guidelines.

Sandata Technologies, LLC, verifies the utilization and delivery of home health services and provides an electronic billing interface for home health services. The Telephonic Home Health Services Delivery Monitoring and Verification Program requires providers to submit claims for home health visits electronically through the vendor's system. Home health visits are verified by telephone using a technology called voice biometrics. Sandata maintains databases for each home health agency in the program. The databases contain information on home health agency staff, recipients, service authorizations, visit schedules, visit verification, and billing activity.

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IV. Review of Comprehensive Quality Strategy

A. Periodic Reviews of Quality Strategies by the State

The Agency for Health Care Administration conducts an annual review of the effectiveness of its Comprehensive Quality Strategy each calendar year following receipt and review of the EQRO Technical Report and the annual managed care program reporting. The Agency solicits input of the Medical Care Advisory Committee and other stakeholders annually through public meetings and posting the updated Comprehensive Quality Strategy document on its website for public review and comment each year. The feedback provided by stakeholders, including Medicaid recipients and their representatives, is taken into consideration and incorporated into the Comprehensive Quality Strategy updates.

B. Definition of Significant Change to Quality Strategies

The factors requiring a review of the Comprehensive Quality Strategy that includes gathering stakeholder input are the following:

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

The information contained in this update to the CQS was developed to reflect a comprehensive strategy based on changes made to the Florida Medicaid program as the Agency for Health Care Administration fully implemented Statewide Medicaid Managed Care in 2013 - 2014.

C. Timeframes for Updating Quality Strategies

The Agency for Health Care Administration will review and update the Comprehensive Quality Strategy annually. Each time the CQS is updated, it will be posted on the Agency's website and presented to the Medical Care Advisory Committee and other stakeholders for review and public comment. The Agency will work with the Centers for Medicare and Medicaid Services to ensure that the CQS and the state's submission process are compliant with Section 508 of the Rehabilitation Act. The Agency will continue to submit quarterly and annual reports to CMS on the implementation and effectiveness of the Florida Managed Medical Assistance program, as required by the 1115 waiver.

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V. Achievements and Opportunities

A. Achievements

Florida continues to make significant progress in improving the quality processes of its managed care, long-term care and fee-for-service systems of care.

Infrastructure is now in place to implement and measure the quality of care delivered to Medicaid managed care enrollees. Achievements since the initial quality strategy was developed include:

- Implementation and engagement of the External Quality Review Organization;
- Selection and reporting of HEDIS, child core set, and adult core set measures by MCOs and PIHPs;
- Development and reporting of performance measure specifications for MCOs and PIHPs;
- Selection of performance goals and implementation of a performance improvement strategy;
- Maturation of the PIPs with technical assistance from the EQRO;
- Statewide Collaborative PIPs for each MCO and PIHP plan type;
- Implementation of a new fiscal agent system; and
- Collection of encounter data.

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

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

With implementation of the Statewide Medicaid Managed Care Program, the Agency has established enhanced accountability and performance standards. Some of the new standards were implemented in the HMO and PSN contracts for the September 2012 – August 2015 period as well. The enhanced accountability and performance standards in the 2012-2015 managed care contracts and that are statutory requirements for the MMA program are provided below.

General/Transition Requirements

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

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

Preferred Drug List Requirements

- Requires that preferred drug list changes are reviewed and approved by the plan's Pharmacy and Therapeutics committee. [July 2012 contract general amendment]
- During the first year of SMMC implementation, the Agency is requiring that MMA plans cover prescription drugs listed in the Agency's Medicaid Preferred Drug List (PDL).
- After the first year of operation, capitated managed care plans may develop a plan-specific PDL for the Agency's consideration, if requested by the Agency at that time.
- Requires posting of the managed care plan's PDL on the managed care plan's website and ensuring the PDL is updated within 24 hours of any change. [Statutorily required 2014 SMMC contract requirement]

Provider Network Requirements

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

- Adds cardiovascular surgery, orthopedics and orthopedic surgery, rheumatology, and physical, respiratory, and speech therapies as pediatric specialist requirements for the provider network. [September 2012-15 contract requirement]
- Requires termination of providers (that were terminated from the Agency) within five calendar days of notice from the Agency (new timeframe specification). [September 2012-15 contract requirement]
- Adds additional provider contract specifications: acknowledgement by the provider of its duty to supervise and be responsible for the service provided and for claims preparation and submission, and to ensure such services were actually furnished and were medically necessary; specifying that failure to cooperate in reviews and audits may result in immediate termination of the contract and requiring providers to comply with the terms of the health plan's provider handbook. [September 2012-15 contract requirement]
- Requires physician compensation to equal or exceed Medicare rates for similar services and requires sanctions for failure to meet this performance requirement after two years of continuous operation. [Statutorily required 2014 SMMC contract requirement]
- Specifies additional handbook requirements regarding procedures for reporting of suspected fraud and abuse. [September 2012-15 contract requirement]

Quality Requirements

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

In addition, the Managed Medical Assistance plans are required to address the following focus areas through performance improvement projects, to improve patient care, population health, and reduce per capita Medicaid expenditures:

- A PIP that focuses on improving prenatal care and well-child visits in the first 15 months;
- A PIP focused on preventive dental care for children;
- An administrative PIP, the topic of which must be approved by the state;
- A choice of PIP in one of the following topic areas:
 1. Population health issues (such as diabetes, hypertension and asthma) within a specific geographic area that have been identified as in need of improvement;
 2. Integrating primary care and behavioral health; and
 3. Reducing preventable readmissions.

Administration and Management Requirements

- Specifies adequate staffing and information system capability to ensure the ability to manage financial transactions, recordkeeping, data collection and other administrative functions. [September 2012-15 contract requirement]
- Requires compliance with the Agency's reporting requirements for Medicaid encounter data. In addition, the Agency will fine plans \$5,000 per day for each day of noncompliance beginning on the 31st day. The Agency is required to notify the plan on the 31st day that the Agency will initiate contract termination procedures on the 90th day unless the plan comes into compliance. [Statutorily required 2014 SMMC contract requirement]
- Participation in an achieved savings rebate program. [Statutorily required 2014 SMMC contract requirement]
- Specifies that the fraud and abuse compliance plan include a description of the methods for verifying with members whether services billed by providers were received. [September 2012-15 contract requirement]
- Specifies liquidated damages for failure to meet certain contract requirements. [September 2012-15 contract requirement]
- Establishes of a five-year contract. [Statutorily required 2014 SMMC contract requirement]
- Specifies that, upon receipt of a plan's request for termination or withdrawal, the Agency will remove the plan from receipt of new voluntary enrollments, assignments and reinstatements. [September 2012-15 contract requirement]
- Requires financial penalties for plans that leave a region or reduce enrollment levels, including reimbursing the Agency for the cost of enrollment changes and other transition activities. Requires for departing provider service networks, a per-enrollee penalty of up to three months' payment and requires continuation of services for up to 90 days; requires all other plans to pay a penalty of 25 percent of their minimum surplus requirement pursuant to s. 641.225(1), F.S. See s. 409.967(2)(h)1., F.S. [Statutorily required 2014 SMMC contract requirement]
- Requires plans to provide at least 180 days notice before withdrawing from a region. See s. 409.967(2)(h)1., F.S. [Statutorily required 2014 SMMC contract requirement]
- Requires the Agency to terminate a plan's contracts in all regions if a plan leaves a region before the end of the contract term. See s. 409.967(2)(h)1., F.S. [Statutorily required 2014 SMMC contract requirement]

Statewide Medicaid Managed Care Program Improvements

As mentioned previously in this document, the Statewide Medicaid Managed Care (SMMC) program has two key components: the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) program. The following improvements will be implemented with the SMMC program:

Plan Accreditation

As a condition of participation in the Statewide Medicaid Managed Care program, all managed care plans are required to be accredited by the National Committee for Quality Assurance (NCQA), the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), or another nationally recognized accrediting body, or have initiated the accreditation process within one year after their contract with the Agency is executed. For any health plan not accredited within 18 months after contract execution, the Agency will suspend automatic assignment of recipients to those managed care plans.

As of July 2014, sixteen managed care plans participating in the SMMC program are accredited and two are pursuing accreditation status. The two plans pursuing accreditation status have informed the Agency that they anticipate receiving accreditation during the Fall of 2014.

HEALTH PLAN NAME	ACCREDITED?	ACCREDITING BODY	NOTES
AHF/Positive	a	AAAHC	
Amerigroup	a	AAAHC	
Better Health	a	AAAHC	
Children's Medical Services Network			Pursuing AAAHC
Clear Health Alliance	a	AAAHC	
Coventry	a	NCQA	
First Coast Advantage			Pursuing NCQA
Humana	a	NCQA	
Integral	a	AAAHC	
Magellan Complete Care	a	NCQA	
Molina	a	NCQA	
Preferred	a	AAAHC	
Prestige	a	AAAHC	
SFCCN	a	AAAHC	
Simply Healthcare	a	AAAHC	
Staywell	a	NCQA	
Sunshine	a	NCQA	
United	a	NCQA	

Stability Among Plans

In order to ensure that enrollees have continuous access to high quality plans without need for plan transition, other than those transitions made based on an individual's choice, Florida statute and the SMMC procurement included significant financial surplus requirements and substantial penalties for plans that choose to withdraw from regions after contract award. These measures were designed to ensure that contracts were awarded to plans with sufficient financial stability up front to ensure their continued presence in the region in which they won an award, and to provide a clear and substantial disincentive to plan withdrawal.

Specifically, language in the statute, the procurement document, and the resulting contract provide penalties for withdrawal or reduction. Managed care plans that reduce enrollment levels or leave a region before the end of the contract term must reimburse the Agency for the cost of enrollment changes and other transition activities. If more than one plan leaves a region at the

same time, costs must be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing provider services networks must pay a per-enrollee penalty of up to three months' payment and continue to provide services to the enrollee for 90 days or until the individual is enrolled in another plan, whichever occurs first. In addition to payment of costs, all other departing plans must pay a penalty of 25 percent of that portion of the minimum surplus maintained pursuant to s. [641.225\(1\)](#), Florida Statutes, which is attributable to the provision of coverage to Medicaid enrollees. Plans must provide at least 180 days' notice to the Agency before withdrawing from a region. If a managed care plan leaves a region before the end of the contract term, the Agency will terminate all contracts with that plan in other regions.

As part of the evaluation of responses to the competitive procurement, the Agency asked potential vendors to provide documentation as to whether, in the past seven years, they had voluntarily terminated all or part of a contract (other than a provider contract) to provide services; had such a contract partially or fully terminated before the contract end date (with or without cause); had withdrawn from a contracted service area; or had requested a reduction of enrollment levels. If so, vendors were asked to describe the contract; the month and year of the contract action; the reason(s) for the termination, withdrawal, or enrollment level reduction; the parties involved; and to provide the address and telephone number of the client/other party. If the contract was terminated based on the respondent's performance, the plans were required to describe any corrective action taken to prevent any future occurrence of the problem leading to the termination. Plans were directed to include information for the respondent as well as the respondent's affiliates and subsidiaries and its parent organization and that organization's affiliates and subsidiaries. Potential vendors received the most points for this evaluation criterion if they had no voluntary or involuntary terminations to report.

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. Records not in the prepaid plan's immediate possession must be made available to the Agency or the certified public accountant in this state within three days after a request is made by the Agency or certified public accountant engaged by the Agency. A prepaid plan has an obligation to cooperate in good faith with the Agency and the certified public accountant and failure to comply with records requests made by the Agency will be deemed a breach of contract.

The independent auditor will determine the achieved savings of each plan. This program includes the incentive that a plan which exceeds Agency-defined quality measure benchmarks in the reporting period may retain an additional one percent of revenue. In order to retain the one percent incentive, plans must achieve a group score of four or higher for each of the six performance measure groups in the first year of reporting performance measures. To be eligible to retain an additional one percent of revenue based on the second year and

subsequent years of reporting performance measures, the managed care plan shall achieve a group score of five or higher for each of the six performance measure groups.

The Agency will assign performance measures a point value that correlates to the National Committee for Quality Assurance HEDIS National Means and Percentiles for Medicaid. The scores will be assigned according to the table below. Individual performance measures will be grouped and the scores averaged within each group.

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

Performance measure groups are as follows:

- a. Mental Health and Substance Abuse
 - (1) Antidepressant Medication Management
 - (2) Follow-up Care for Children Prescribed ADHD Medication
 - (3) Follow-up after Hospitalization for Mental Illness (7 day)
 - (4) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

- b. Well-Child
 - (1) Adolescent Well Care Visits
 - (2) Childhood Immunization Status – Combo 3
 - (3) Immunizations for Adolescents
 - (4) Well-Child Visits in the First 15 Months of Life (6 or more)
 - (5) Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
 - (6) Lead Screening in Children

- c. Other Preventive Care
 - (1) Adults' Access to Preventive/Ambulatory Health Services
 - (2) Annual Dental Visits
 - (3) BMI Assessment
 - (4) Breast Cancer Screening
 - (5) Cervical Cancer Screening
 - (6) Children and Adolescents' Access to Primary Care
 - (7) Chlamydia Screening for Women

- d. Prenatal/Perinatal
 - (1) Prenatal and Postpartum Care (includes two measures)
 - (2) Prenatal Care Frequency

e. Diabetes – Comprehensive Diabetes Care measure components

- (1) HbA1c Testing
- (2) HbA1c Control (< 8%)
- (3) Eye Exam
- (4) LDL-C Screening
- (5) LDL-C Control
- (6) Medical Attention for Nephropathy

f. Other Chronic and Acute Care

- (1) Controlling High Blood Pressure
- (2) Pharyngitis – Appropriate Testing related to Antibiotic Dispensing
- (3) Use of Appropriate Medications for People with Asthma
- (4) Annual Monitoring for Patients on Persistent Medications

Consumer Report Cards

Florida is developing a consumer report card for the plans that will be participating in the Statewide Medicaid Managed Care program. This new initiative will provide valuable feedback to the plans and the public on the performance of all Medicaid managed care plans. During SFY 2012-2013, Agency staff reviewed other state Medicaid report cards and displays of health plan information and identified a variety of data that could be included in the report cards. These data include:

- Accreditation and certification information (e.g., recognitions for Patient-Centered Medical Homes; Disease Management programs for particular conditions)
- Plan results/scores for performance measures including (but not limited to) HEDIS, Child Health Check-up, Agency-defined measures, Adult and Child Core Set measures
- CAHPS/Enrollee Experiences with Care Survey results
- Disenrollment rates/reasons
- Expanded Benefits offered
- Health Behavior programs offered
- Average length of enrollment
- Complaint/Grievance information/rates

During the spring of 2014, Agency staff mocked up draft consumer report cards, showing different ways that performance measures could be grouped and managed care plans could be rated on their performance for those groupings (e.g., Pregnancy-related Care, Keeping Kids Healthy, Keeping Adults Healthy). In June 2014, Agency staff met with an advocacy group to gather feedback and comments on the draft consumer report cards. In the fall of 2014, the Agency will be sharing these draft report cards with the Medical Care Advisory Committee and additional stakeholders. The Agency will be requesting feedback and suggestions from these stakeholders in order to make the report cards as consumer-friendly and useful as possible. Based on this feedback, the Agency will finalize the format and policy related to the consumer report card. The Agency anticipates posting the first consumer report cards in early 2015.

Florida Medical Schools Quality Network

The Statewide Medicaid Managed Care statute required that the Florida Medicaid program contract with a single organization representing medical schools and graduate medical education programs in the state for the purpose of establishing an active and ongoing program to improve clinical outcomes in all managed care plans. Contracted activities must support greater clinical integration for Medicaid enrollees through interdependent and cooperative efforts of all providers participating in managed care plans. The Agency is required to support these activities with certified public expenditures and any earned federal matching funds and shall seek any plan amendments or waivers necessary to comply with this subsection. To be eligible to participate in the quality network, a medical school must contract with each managed care plan in its region. Specific Appropriation 190, of the 2014 General Appropriations Act, authorized the Agency to utilize \$3,000,000 from the Grants and Donations Trust Fund and \$3,000,000 from the Medical Care Trust Fund to contract with the Florida Medical Schools Quality Network.

The Agency has been working with this group, which is headed by the deans of the state's medical schools, to define projects that could help improve quality of care for Medicaid recipients. The first project being developed will focus on children's oral health. The goals of the project include identifying dental issues in young children in primary care settings, increasing referrals for dental services and increasing utilization of dental services. Interventions will be developed for both the primary care provider as well as parents of children at risk of dental caries.

Emphasis on Comprehensive, Coordinated Care

Implementation of the Statewide Medicaid Managed Care program is offering an excellent opportunity for Florida Medicaid and its contracted managed care plans to ensure better coordination of services for all enrollees, including dental, medical, behavioral health, and long-term care. For those enrollees who are dually eligible and have both Medicare and Medicaid, plans are required to coordinate with Medicare providers to ensure improved communication, provision of appropriate services, and continuity of care. The Agency has achieved its goal of establishing contracts with comprehensive plans with the capacity to cover all medical and long-term care services and provide better alignment with Medicare. SMMC plans are able to offer flexible services with a greater focus on community-based care. The state will continue to gain increased efficiencies through administrative simplification. These improvements to the Medicaid program are expected to effectively lower costs, while increasing system efficiencies and service quality going forward.

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Attachment I

Managed Care Contract Provisions

A. External Quality Review Requirements

As noted in the Introduction, the state’s MCO and PIHP contracts require the entities to be subject to annual, external independent review of the quality outcomes, timelines of, and access to, the services covered in accordance with 42 CFR 438.204.

In January 2013, the Agency’s contracted External Quality Review Organization released its annual report on Compliance with Access, Structure, and Operations Standards. This report indicated that the HMOs and PSNs met more than 90 percent of the elements for all standards reviewed during SFY 2011-2012. These standards included eligibility, enrollment, and disenrollment; enrollee services and enrollee rights; and community outreach. During SFY 2011-2012, the Prepaid Mental Health Plans achieved an overall rate of 96.2% compliance with their standards, which included administrative compliance; utilization management; targeted case management; provider network/credentialing/access to services; quality improvement program; grievances and appeals; and outreach standards. The Agency is continuing to enhance its compliance monitoring process and its efforts to align with CMS-approved protocol. During this past year, the Agency and the Department of Elder Affairs (DOEA) provided input into the design of a new web-based managed care survey tool, developed by Health Services Advisory Group, which will allow the state to more easily record, compile, and track information on plan compliance going forward.

The reference to the contract provisions which incorporate this requirement can be found by contract in Table 1.

Table 1	
External Quality Review	
42 CFR 438 Subpart E	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VII, A.1.b.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VII, A.1.b.

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

MCO/PIHP Requirements

1. Availability of Services

The state’s MCO and PIHP contracts require the entities to comply with all applicable federal and state laws, rules, and regulations including but not limited to: all access to care standards

in Title 42 Code of Federal Regulations (CFR) chapter IV, subchapter C; Title 45 CFR 95, General Grants Administration Requirements; chapter 409 and as applicable part I and III of chapter 641, Florida Statutes, in regard to managed care. MCO and PIHP access to care contract requirements are summarized in this section. The table following each standard provides the location where this requirement can be found in each of the state's MCO and PIHP contracts.

(a) Maintains and Monitors a Network of Appropriate Providers

The state's MCO and PIHP contracts require each entity to establish and maintain a network of appropriate providers that is sufficient to provide adequate access to all services covered under each entity's contract for the enrolled population in accordance with section 1932(b)(7) of the Social Security Act (as enacted by section 4704(a) of the Balanced Budget Act of 1997). The entities are required to make available and accessible facilities, service locations, service sites, and personnel sufficient to provide the covered services. The entities are required to provide adequate assurances, with respect to a service area, and demonstrate the capacity to serve the expected enrollment in such service area, including assurances that the entity: offers an appropriate range of services; offers access to preventive and primary care services for the populations expected to be enrolled in such service area; and maintains a sufficient number, mix, and geographic distribution of providers of services. Each entity's network of appropriate providers must be supported by written agreements.

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

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

The state requires MCOs and PIHPs to make emergency medical care available on a 24 hours a day, seven days a week basis. The entities are required to assure that primary care physician services and referrals to specialty physicians are available on a timely basis, to comply with the following standards: urgent care - within one day; routine sick patient care - within one week; and well care - within one month. The plans are required to have telephone call policies and procedures that shall include requirements for call response times, maximum hold times, and maximum abandonment rates. The primary care physicians and hospital services provided by

the plans are available within 30 minutes typical travel time, and specialty physicians and ancillary services must be within 60 minutes typical travel time from the member's residence. For rural areas, if the plan is unable to contract with specialty or ancillary providers who are within the typical travel time requirements, the state may waive, in writing, these requirements. The plans are required to allow each enrollee to choose his or her health care professional, to the extent possible and appropriate. Each plan is required to provide the state with documentation of compliance with access requirements no less frequently than the following: (a) at the time it enters into a contract with the state; and (b) at any time there has been a significant change in the plan's operations that would affect adequate capacity and services, including but not limited to: (1) changes in plan services, benefits, geographic service area, or payments; and (2) enrollment of a new population in the plan.

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

Table 2	
Delivery Network Requirements	
42 CFR 438.206(b)(1)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, A.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, A.

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

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

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The reference to the contract provision which incorporates this requirement can be found by contract in Table 3.

Table 3 Direct Access to Women’s Health Specialist 42 CFR 438.206(b)(2)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Exhibit A, Section VI, A.4.a.(2)
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Exhibit A, Section VI, A.4.a.(2)

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

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

Table 4 Second Opinion Requirement 42 CFR 438.206(b)(3)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section IV, A.7.a.(8)
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section IV, A.7.a.(8)

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

The state requires MCOs or PIHPs that are unable to provide medically necessary services covered under the contract to a particular enrollee to adequately and timely cover these services outside of the network for the enrollee for as long as the MCO or PIHP is unable to provide them in compliance with 42 CFR 438.206(b)(4).

The reference to the contract provision which incorporates this requirement can be found by contract in Table 5.

Table 5 Outside the Network 42 CFR 438.206(b)(4)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Care Program	Attachment II, Exhibit A, Section V, A.1.a.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Exhibit A, Section V, A.1.a.

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

The state requires the plans to coordinate with out-of-network providers with respect to payment and to ensure that cost to the enrollee is no greater than it would be if the covered services were furnished within the network.

The reference to the contract provision which incorporates this requirement can be found by contract in Table 6.

Table 6 Coordination with Outside the Network Providers 42 CFR 438.206(b)(5)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Exhibit A, Section V, A.10-.h.-i p.22-23 and A.11.m.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Exhibit A, Section V, A.10-.h.-i p.22-23 and A.11.m.

(f) Demonstration of Providers' Credentialing.

The state requires the MCOs and PIHPs to establish and verify credentialing and recredentialing criteria for all professional providers and that, at a minimum, the plan providers meet the state's Medicaid participation standards. Pursuant to s. 409.967(2)(e)3., 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 the managed care plan is accredited by a nationally recognized body. 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 PIHPs' written policies and procedures for credentialing of providers to ensure compliance with all applicable federal and state regulations.

The reference to the contract provision which incorporates this requirement can be found by contract in Table 7.

Table 7 Provider Credentialing 42 CFR 438.206(b)(6)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, C.2.a. (4)
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, C.2.a. (4)

(g) Timely Access to Care.

The state requires the MCOs and PIHPs to: (1) meet the state’s timely access to care and services, taking into account the urgency of the need for services; (2) ensure that the network of providers offers hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees; (3) make services included in the contract available 24 hours a day, 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 PIHP, the state assures the plan’s ability to comply with federal and state timely access requirements. The state conducts annual reviews of the plans to ensure on-going compliance with the timely access requirements of chapter 409 and 641, F.S., and 42 CFR 438.206(c).

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

- 1) *Emergency* – immediately upon presentation or notification; in addition the plans are required to maintain sufficient medical staff available 24 hours per day to handle emergency care inquiries;
- 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 which incorporate these requirements can be found by contract in Table 8.

Table 8 Timely Access to Care 42 CFR 438.206(c)(1)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, A.8, C.6.c.(6) and A.4
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, A.8, C.6.c.(6) and A.4

(h) Cultural Considerations.

The state requires the MCOs and PIHPs 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. The plans are required to provide interpreter services in person where practical, but otherwise by telephone, for applicants or members whose primary language is a foreign language. Foreign language versions of materials are required if, as provided annually by the state, the population speaking a particular foreign (non-English) language in a county is greater than five percent.

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

- a. All materials developed for the Medicaid population must be at or near the fourth-grade comprehension level so that the materials are understandable (in accordance with section 1932(a)(5) of the Social Security Act as enacted by section 4701 of the Balanced Budget Act of 1997), and be available in alternative communication methods (such as large print, video or audio recordings, or Braille) appropriate for persons with disabilities; and
- b. The plan shall assure that appropriate foreign language versions of all materials are developed and available to members and potential members. The plan shall provide interpreter services in person where practical, but otherwise by telephone, for applicants or members whose primary language is a foreign language. Foreign language versions of materials are required if, as provided annually by the Agency, the population speaking a particular foreign (non-English) language in a county is greater than five percent.

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

Table 9 Cultural Considerations 42 CFR 438.206(c)(2)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section IV, B.4.a.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section IV, B.4.a.

2. Assurances of Adequate Capacity and Services

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

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

The reference to the contract provision which incorporates this requirement can be found by contract in Table 10.

Table 10	
Documentation of Adequate Capacity & Services	
42 CFR 438.207(b)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, A.1.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, A.1.

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

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

- 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.

If a plan intends to terminate services, at least sixty (60) days before the termination effective date, the plan must provide written notification to all enrollees of 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 which incorporates this requirement can be found by contract in Table 11.

Table 11 Sufficient Network of Providers 42 CFR 438.207(c)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, A.3.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, A.3.

3. Coordination and Continuity of Care

(a) Ongoing Source of Primary Care

Pursuant to 42 CFR 428.208(b), the state requires the MCOs and PIHPs to implement procedures to ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and whom the plan has formally designated as primarily responsible for coordinating the health care services furnished to the enrollee. The MCOs and PIHPs are required to offer each enrollee a choice of primary care physicians. After making a choice, each member shall have a single 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 which incorporates this requirement can be found by contract in Table 12.

Table 12 On-going Source of Primary Care 42 CFR 438.208(b)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, B.2.b
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, B.2.b

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

Pursuant to 42 CFR 428.208(b), the state requires the MCOs and PIHPs to implement procedures to coordinate the services the plan furnishes to the enrollee with the services the enrollee receives from any other managed care entity during the same period of enrollment.

The reference to the contract provision which incorporates this requirement can be found by contract in Table 13.

Table 13 Coordination of Services 42 CFR 438.208(b)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Exhibit A, Section V. E.2.b
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Exhibit A, Section V. E.2.b

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

Pursuant to 42 CFR 428.208(b), the state requires the MCOs and PIHPs to implement procedures to share with other managed care entities serving the enrollee with special health care needs the results of its identification and assessment of the enrollee's needs to prevent duplication of those activities.

The reference to the contract provision which incorporates this requirement can be found by contract in Table 14.

Table 14 Duplicative Services for Individuals with Special Health Care Needs 42 CFR 438.208(b)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section V. E.2.a.(7)
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section V. E.2.a.(7)

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

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

The references to the contract provisions which incorporate these requirements can be found by contract in Table 15.

Table 15	
Privacy Protection	
42 CFR 438.224 and 42 CFR 431 subpart F	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section V, E.2.a.(7) and Section I, A
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section V, E.2.a.(7) and Section I, A

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

The state requires the MCOs and PIHPs to implement mechanisms for identifying, assessing and ensuring the existence of a treatment plan for individuals with special health care needs. Mechanisms include evaluation of health risk assessments, claims data, and, if available, CPT/ICD-10 codes. The plans are required to implement a process for receiving and considering provider and enrollee input. The plan’s treatment plan for an enrollee determined to need a course of treatment or regular care monitoring must be developed by the enrollee’s primary care provider with enrollee participation and in consultation with any specialists caring for the enrollee; approved by the plan in a timely manner if this approval is required; and developed in accordance with any applicable state quality assurance and utilization review standards. Pursuant to 42 CFR 438.208(c)(4), for enrollees with special health care needs determined through an assessment by appropriate health care professionals (consistent with 42 CFR 438.208(c)(2)) to need a course of treatment or regular care monitoring, each plan must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee’s condition and identified needs. The reference to the contract provision which incorporates this requirement can be found by contract in Table 16.

The reference to the contract provision which incorporates this requirement can be found by contract in Table 16.

Table 16	
Additional Services for Individuals with Special Health Care Needs	
42 CFR 438.208(c)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, B.2.b; Exhibit A, Section V, E.2.b and E.4.c.(8)(11)
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, B.2.b; Exhibit A, Section V, E.2.b and E.4.c.(8)(11)

4. Coverage and authorization of services

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

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

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

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

The state requires the plans to have a quality improvement program that ensures enhancement of quality of care and emphasizes quality patient outcomes. The state may restrict the plan's enrollment activities if acceptable quality improvement and performance indicators based on

HEDIS and other outcome measures to be determined by the state are not met. Such restrictions may include the termination of mandatory assignments.

For MCOs and PIHPs that operate under Florida’s 1115 Medicaid waiver with a state approved customized benefit package, the plans are required to provide all mandatory and specified optional services in the contract and as approved by the state. The customized benefit packages may change on a contract year basis only if approved by the Agency in writing. The managed care plans shall submit to the Agency a Plan Evaluation Tool (PET) for proposed customized benefit packages for evaluation of actuarial equivalency and sufficiency standards no later than the date established by the Agency each year.

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

The state requires the MCOs and PIHPs to have a quality improvement and quality utilization program which includes, among others items, a service authorization system. The state approves the plans’ written services authorization system policies and procedures. The plans are required to maintain written confirmation of all denials of authorization to providers.

The reference to the contract provisions which incorporates these requirements can be found by contract in Table 17.

Table 17 Coverage of Services 42 CFR 438.210(a)(1)(2)(3)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section II, D.13 and 9; Section V, A.1, c-d, a, b
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section II, D.13 and 9; Section V, A.1, c-d, a, b

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

The state requires that the MCO and PIHP contracts define the term “medically necessary or medical necessity” as “services provided in accordance with 42 CFR section 438.210(a)(4) and as defined in section 59G-1.010(166), Florida Administrative Code, to include that medical or allied care, goods, or services furnished or ordered must 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 which incorporate this requirement can be found by contract in Table 18.

Table 18 Medically Necessary Services 42 CFR 438.210(a)(4)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section I and Section II, D.13
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section I and Section II, D.13

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

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

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

The state requires the MCOs and PIHPs 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, 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, 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 non-contracting provider solely based on the period between the date of service and the date of clean claim submission unless that period exceeds 365 days.
- The plans are responsible for payment of covered services to the existing treating provider at a prior negotiated rate or lesser of the provider's usual and customary rate or the established Medicaid fee-for-service rate for such services until the plan is able to evaluate the need for ongoing services.

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

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

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

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

less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

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

- Service authorization protocols for prior authorization and denial of services; the process used to evaluate prior and concurrent authorization; mechanisms to ensure consistent application of review criteria for authorization decisions; consultation with the requesting Provider when appropriate; hospital discharge planning; physician profiling; and a retrospective review of both inpatient and ambulatory claims, meeting the predefined criteria below. The MCOs and PIHPs are responsible for ensuring the consistent application of review criteria for authorization decisions and consulting with the requesting provider when appropriate.
 1. The 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, which may be requested by a provider or the enrollee, after the issuance of a denial.
 5. 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).
 6. 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 which incorporate the prior authorization requirements can be found by contract in Table 19.

Table 19 Service Authorization Policies & Procedures. 42 CFR 438.210(b)(d)(1)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section II, D.20; Section IV, A.7.a.(8); Section VII, G.4.a and G.2.e
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section II, D.20; Section IV, A.7.a.(8); Section VII, G.4.a and G.2.e

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

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

The reference to the contract provision which incorporates this requirement can be found by contract in Table 20.

Table 20	
Appropriate Health Care Professional / Denial of Services	
42 CFR 438.210(b)(3)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VII, G.4.a
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VII, G.4.a

C. Detailed Information Related to Access to Care Standards

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

The state requires the MCOs and PIHPs to implement mechanisms for identifying, and ensuring the existence of a treatment plan for individuals with special health care needs. Mechanisms shall include evaluation of health risk assessments, claims data, and, if available CPT/ICD-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 PIHPs to assess new enrollees using a health risk assessment tool to identify persons with special health care needs. The MCO and PIHP

contracts provide the following definition for Individuals with Special Health Care Needs - November 6, 2000 Report to Congress - Individuals with special health care needs are adults and children who daily face physical, mental, or environmental challenges that place at risk their health and ability to fully function in society. They include, for example, individuals with 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 PIHPs to provide case management.

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

The state requires the plans to provide a written descriptive QI program that identifies 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 which incorporates this requirement can be found by contract in Table 21.

Table 21	
Identification of Persons with Special Health Care Needs	
42 CFR 438.208(c)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, B.2.b; Exhibit A, Section V, E.2.b
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, B.2.b; Exhibit A, Section V, E.2.b

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

The state requires the MCOs and PIHPs 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 which incorporates this requirement can be found by contract in Table 22.

Table 22 Treatment Plan Standard 42 CFR 438.208(c)(3)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Exhibit A, Section V, E.4.c.(8)
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Exhibit A, Section V, E.4.c.(8)

D. Standards for Structure and Operations and Contract Provisions

1. Provider Selection

The state requires the MCOs and PIHPs to comply with the requirements specified in 42 CFR 438.214, which include: selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination. The state requires the plans to have written policies and

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

The reference to the contract provisions which incorporate this requirement can be found by contract in Table 23.

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
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, C.2., C.5., C.2.a., C.2.a.(4), C.5.b.; Section VIII, F.4.d.(12-13)
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, C.2., C.5., C.2.a., C.2.a.(4), C.5.b.; Section VIII, F.4.d.(12-13)

2. Enrollee Information

The state requires the MCOs and PIHPs 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.

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

- Table of contents;
- Terms, conditions and procedures for enrollment including the reinstatement process and enrollee rights and protections;
- Enrollee rights and procedures for enrollment and disenrollment, including the toll-free telephone number for the Agency's enrollment broker. The managed care plan shall include the following language verbatim in the enrollee handbook:

Enrollment: "If you are a mandatory enrollee required to enroll in a plan, once you are enrolled in [INSERT MANAGED CARE PLAN NAME] or the state enrolls you in a plan, you will have 90 days from the date of your first enrollment to try the managed care plan. During the first 90 days you can change managed care plans for any reason. After the 90 days, if you are still eligible for Medicaid, you will be enrolled in the plan for the next nine months. This is called "lock-in."

Open Enrollment: "If you are a mandatory enrollee, the state will send you a letter 60 days before the end of your enrollment year telling you that you can change plans if you want to. This is called "open enrollment." You do not have to change managed care plans. If you choose to change plans during open enrollment, you will begin in the new plan at the end of your current enrollment year. Whether you pick a new plan or stay in the same plan, you will be locked into that plan for the next 12 months. Every year you may change managed care plans during your 60 day open enrollment period."

Disenrollment: "If you are a mandatory enrollee and you want to change plans after the initial 90-day period ends or after your open enrollment period ends, you must have a state-approved good cause reason to change plans. The following are state-approved cause reasons to change managed care plans: [INSERT CAUSE LIST FROM THIS SECTION]."

- Procedures for filing a request for disenrollment for cause. As noted in the section, the state-approved for-cause reasons listed shall 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/InspectorGeneral/fraud_complaintform.aspx;

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 about the Beneficiary Assistance Program (BAP) process, including an explanation that a review by the BAP must be requested within one (1) year after the date of the occurrence that initiated the appeal, how to initiate a review by the BAP and the BAP address and telephone number:

Agency for Health Care Administration
 Beneficiary Assistance Program
 Building 3, MS #26
 2727 Mahan Drive, Tallahassee, FL 32308
 (850) 412-4502
 (888) 419-3456 (toll-free)

- 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 enrollee's 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 non-compliance with advance 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 which incorporate this requirement can be found by contract in Table 24.

Table 24 Enrollee Information Section 1932(b)(3), of Social Security Act and 42 CFR 438.10(f)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section III, B.1.f., C.1.b., B.1.d; Section IV, B.1.c., 7.a. 6-7, A.7.a.2., A.10.a.(2).; Section V, C.2.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section III, B.1.f., C.1.b., B.1.d; Section IV, B.1.c., 7.a. 6-7, A.7.a.2., A.10.a.(2).; Section V, C.2.

3. Confidentiality

During the initial MCO and PIHP contract application process, the state ensures the plans establish and implement procedures consistent with Federal and state regulations including confidentiality requirements in 45 CFR parts 160 and 164 and 42 CFR 438.224. The 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.

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The reference to the contract provisions which incorporates this requirement can be found by contract in Table 25.

Table 25	
Confidentiality	
45 CFR parts 160 and 164, 42 CFR 438.224	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section V, E.2.a.(7)
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section V, E.2.a.(7)

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, pre-existing condition, or need for health care services. The plans are required to accept new enrollees throughout the contract period up to the authorized maximum enrollment levels approved in each plan's contract.

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

- 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 PIHP's contract:

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

- b. The plan shall ensure that it does not restrict the enrollee's right to disenroll voluntarily in any way.
- c. The plan or its agents shall not provide or assist in the completion of a disenrollment request or assist the Agency's choice counselor/enrollment broker in the disenrollment process.
- d. The plan shall ensure that enrollees that are disenrolled and wish to file an appeal have the opportunity to do so. All enrollees shall be afforded the right to file an appeal except for the following reasons for disenrollment:
 - (1) Moving out of the service area;
 - (2) Loss of Medicaid eligibility; and
 - (3) Enrollee death.
- e. An enrollee may submit to the state or its agent a request to disenroll from the plan without cause during the 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 PIHP 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 shall be submitted in accordance with the reporting requirements specified in the plan's contract. The plan shall maintain documentation of its inability to contact the enrollee and that it has no record of providing services to the enrollee, or to another family unit member, in the enrollee's file.
- g. The plan may submit an involuntary disenrollment request to the state or its agent after providing to the enrollee at least one 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 PIHPs to ensure that all community outreach, pre-enrollment, enrollee, disenrollment, and grievance materials developed for the Medicaid population adhere to the following policies and procedures:

- a. All materials developed for the Medicaid population must be at or near the fourth-grade comprehension level so that the materials are understandable (in accordance with section 1932(a)(5) of the Social Security Act as enacted by section 4701 of the Balanced Budget Act of 1997), and be available in alternative communication methods (such as large print, video or audio recordings, or Braille) appropriate for persons with disabilities.
- b. The plan shall assure that appropriate foreign language versions of all materials are developed and available to members and potential members. The plan shall provide interpreter services in person where practical, but otherwise by telephone, for applicants or members whose primary language is a foreign language. Foreign language versions of materials are required if, as provided annually by the Agency, the population speaking a particular foreign (non-English) language in a county is greater than five percent.
- c. 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 PIHP 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 PIHPs are permitted by contract to engage in the following activities under the supervision and with the written approval of the state:

- a. The plan may attend health fairs/public events upon request by the sponsor and after written notification to the state.
- b. The plan may leave state community outreach materials at health fairs/public events at which the plan participates.

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

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

Table 26	
Enrollment & Disenrollment	
42 CFR 438.56, 438.6, 42 CFR 438.10, 42 CFR 422.208, 42 CFR 422.210, 42 CFR 431.230, 42 CFR 438.400 through 42 CFR 438.424	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section III, B.1.f., C.1.b., B.1.d.; Section IV, B.1.c., 7.a.6 and 7, A.7.a.2, 14-15, 7-8, 9, 6-10, A.7.b., A.2.a. and C.1.4.e(2)., A.1., A.7a.1(14-16), A.7.a(21).b., A.7.a(22).b.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section III, B.1.f., C.1.b., B.1.d.; Section IV, B.1.c., 7.a.6 and 7, A.7.a.2, 14-15, 7-8, 9, 6-10, A.7.b., A.2.a. and C.1.4.e(2)., A.1., A.7a.1(14-16), A.7.a(21).b., A.7.a(22).b.

1. Grievance System

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

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

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

- 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 DCF address for pursuing a fair hearing, which is:

Office of Appeal Hearings
1317 Winewood Boulevard, Building 5, Room 255
Tallahassee, Florida 32399-0700
Phone: (850) 488-1429
Fax: (850) 487-0662
Email: Appeal_Hearings@dcf.state.fl.us
 - 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 PIHP 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 PIHP 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 PIHPs 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 may 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.

c. Submission to the Beneficiary Assistance Program (BAP) for FFS PSN or the Statewide Subscriber Program (SAP) for prepaid health plans. After the BAP program sunsets in October 2014, submission will be to the Subscriber Assistance Program (SAP).

- 1) The original grievance must be filed with the plan in writing.
- 2) The submission of the grievance to the BAP/SAP must be done within one year of the date of the occurrence which initiated the grievance.
- 3) The grievance may be filed if it concerns:
 - a) The quality of health care services; or
 - b) Matters pertaining to the contractual relationship between an enrollee and the plan.

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

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 must follow an oral filing with a written, signed appeal. For oral filings, time frames for resolution begin on the date the plan receives the oral filing.

a. 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;
 - c) A Medicaid fair hearing decision adverse to the enrollee is made; or
 - d) 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 Florida Department of Children and Families address for pursuing a Medicaid fair hearing, which is:

Office of Appeal Hearings
1317 Winewood Boulevard, Building 5, Room 255
Tallahassee, Florida 32399-0700
Phone: (850) 488-1429
Fax: (850) 487-0662
Email: Appeal_Hearings@dcf.state.fl.us
 - c) Notice of the right to continue to receive benefits pending a Medicaid fair hearing;
 - d) Information about how to request the continuation of benefits; and
 - e) 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.

b. 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.

c. 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:

- 1) Inform the enrollee of the limited time available for the enrollee to present evidence and allegations of fact or law, in person and/or in writing.
- 2) Resolve each expedited appeal and provide notice, as expeditiously as the enrollee's health condition requires, not to exceed 72 hours after the plan receives the appeal.
- 3) Provide written notice of disposition that includes the results and date of expedited appeal resolution, and for decisions not wholly in the enrollee's favor, that includes:
 - 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 Florida Department of Children and Families address for pursuing a fair hearing, which is:

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Email: Appeal_Hearings@dcf.state.fl.us

- 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.
- 4) 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.
- d. Submission to the BAP for FFS PSN and the SAP for Prepaid Health Plans.
 - 1) The submission of the appeal to the BAP or the SAP must be done within one year of the date of the occurrence that initiated the appeal.
 - 2) An enrollee may submit an appeal to the BAP or SAP if it concerns:
 - a) The availability of health care services or the coverage of benefits, or an adverse determination about benefits made pursuant to UM; or
 - b) Claims payment, handling, or reimbursement for benefits.
 - 3) If the enrollee has taken the appeal to a Medicaid fair hearing, the enrollee cannot submit the appeal to the BAP or SAP.

7. Medicaid Fair Hearing System

a. Request for a 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 Florida Department of Children and Families at:

Office of Appeal Hearings
1317 Winewood Boulevard, Building 5, Room 255
Tallahassee, Florida 32399-0700
Phone: (850) 488-1429
Fax: (850) 487-0662
Email: Appeal_Hearings@dcf.state.fl.us

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 which incorporate the grievance system requirements can be found by contract in Table 27.

Table 27 Grievance System 42 CFR 431.200 and 438, Subpart F	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section I, A; Section VII, G.6.b.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section I, A; Section VII, G.6.b.

8. Subcontractual Relationship & Delegation

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

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

During the initial MCO and PIHP contracting process, the state ensures the plans' subcontractual relationships and delegations comply with 42 CFR 438.6(l), 42 CFR 438.230(a),

42 CFR 438.230(b)(1),(2),(3), SMM 2087.4. The state conducts annual on-site surveys and desk reviews of the plans to ensure each plan’s subcontractual relationships and delegations remain in compliance with 42 CFR 438.6(l), 42 CFR 438.230(a), 42 CFR 438.230(b)(1),(2),(3), SMM 2087.4.

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

Table 28 Subcontracted Relationships & Delegation 42 CFR 438.6(l), 42 CFR 438.230(a), 42 CFR 438.230(b)(1),(2),(3), SMM 2087.4	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VIII, B.1-3.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VIII, B.1-3.

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. The references to the contract provision which incorporates the grievance requirements can be found by contract in Table 27.

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

- ▶ Administration and Management Policy and Procedures
- ▶ Staffing
- ▶ Disaster Plan
- ▶ Minority Retention and Recruitment Plan
- ▶ Insurance documents
- ▶ Member Identification Care
- ▶ Credentialing and Recredentialing Policy and Procedures
- ▶ Credentialing files
- ▶ Medical Record Requirements Policy and Procedures
- ▶ Member Handbook
- ▶ Provider Directories

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

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 PIHPs to adopt practice guidelines that meet the following requirements:

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

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

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

Table 29 Practice Guidelines 42 CFR 438.236(b)(c)(d)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VII, G.3.a.b.c.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VII, G.3.a.b.c.

2. Quality Assessment & Performance Improvement Program

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

The state requires the plans to provide a written descriptive QI program that identifies 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.

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

Table 30 Quality Assessment & Performance Program 42 CFR 438.240(a)(1)(a)(2)(b)(3)(4)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VII, A.1.a.; Section VI, B.2.d.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VII, A.1.a.; Section VI, B.2.d.

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

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

- (a) The plan's QI governing body shall monitor, evaluate, and oversee results to improve care. The governing body shall have written guidelines and standards defining their responsibilities for:
 - Supervision and maintenance of an active QI committee;
 - Ensuring ongoing QI activity coordination with other management activity, demonstrated through written, retrievable documentation from meetings or activities;
 - Planning, decisions, interventions, and assessment of results to demonstrate coordination of QI processes;
 - Oversight of QI program activities; and
 - A written diagram that demonstrates the QI system process.
- (b) Each plan is required to have a quality improvement review authority which shall:
 - Direct and review quality improvement activities;
 - Assure that quality improvement activities take place throughout the plan;
 - Review and suggest new or improved quality improvement activities;
 - Direct task forces/committees in the review of focused concern;

- Designate evaluation and study design procedures;
 - Publicize findings to appropriate staff and departments within the plan;
 - Report findings and recommendations to the appropriate executive authority; and
 - Direct and analyze periodic reviews of members' service utilization patterns.
- (c) Each plan is required to provide for quality improvement staff specifically trained to handle the Medicaid business which have the responsibility for: identifying their Medicaid enrollees' needs and problems related to quality of care for covered health care and professional services, measuring how well these needs are met, and improving processes to meet these needs. Each plan is required to evaluate ways in which care is provided, identify outliers to specific indicators, determine what shall be accomplished, ascertain how to determine if a change is an improvement, and initiate interventions that will result in an improved quality of care for covered health care and professional services. Each plan is required to prioritize problem areas for resolution and design strategies for change, implement improvement activities and measure success.
- (d) The systematic process of quality assessment and improvement shall be objective in systematically monitoring and evaluating the quality and appropriateness of care and service delivery (or the failure of delivery) to the Medicaid population through quality of care projects and related activities. Opportunities for improvement shall be identified on an ongoing basis. The plans are required to assess, evaluate, decrease inappropriate care, decrease inappropriate service denials, and increase coordination of care. The plans are required to document in their QI programs that they are monitoring the range of quality of care across services and all treatment modalities. This review of the range of care shall be carried out over multiple review periods and not only on a concurrent basis.
- (e) At least four state-approved Performance Improvement Projects (PIPs) must be performed by each 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 438.240, the state requires the projects to focus on clinical care and non-clinical areas (i.e. health services delivery). These projects must be designed to

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

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

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

Table 31	
Performance Improvement Projects	
42 CFR 438.240(b)(1)(b)(2)(c)(d)(1)(2)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VII, A.1.d.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VII, A.1.d.

3. Health Information Systems

The state requires the plans to comply with all the reporting requirements established by the state and specified in the plan's contract. The plans are responsible for assuring the accuracy, completeness, and timely submission of each report. Deadlines for report submission referred to in the plan's contract specify the actual time of receipt at the state, not the date the file was postmarked or transmitted. Before October 1 of each contract year, the plans are required to deliver to the state certifications by a State of Florida approved independent auditor that the Child Health Check Up screening rate reports have been fairly and accurately presented. In addition, by July 1, the plans are required to deliver to the state a certification by a State of Florida approved independent auditor that the quality indicator data reported for the previous calendar year have been fairly and accurately presented. The state furnishes the plans with the appropriate reporting formats, instructions, submission timetables and technical assistance as required.

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

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

(a) General Provisions

1. *Systems Functions.* The plans are required to have Information management processes and Information Systems (hereafter referred to as Systems) that enable the plan to meet state and federal reporting requirements and other contract requirements and that are in compliance with the contract and all applicable state and federal laws, rules and regulations including HIPAA.
2. *Systems Capacity.* The plans' Systems are required to possess capacity sufficient to handle the workload projected for the begin date of operations and that will be scalable and flexible so they can be adapted as needed, within negotiated timeframes, in response to changes in contract requirements, increases in enrollment estimates, etc.
3. *E-Mail System.* The plans are required to provide a continuously available electronic mail communication link (E-mail system) with the state. This system shall be available from the workstations of the designated plan contacts and capable of attaching and sending documents created using software products other than the plan's systems, including the state's currently installed version of Microsoft Office and any subsequent upgrades as adopted.
4. *Participation in Information Systems Work Groups/Committees.* The state requires the plans to meet, as requested by the state, to coordinate activities and develop cohesive systems strategies across vendors and agencies.
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 so as to maintain the logical relationships between certain documents and certain data.
4. *Information Retention.* The state requires the information in plans' systems to be maintained in electronic form for three years in live systems and, for audit and reporting purposes, for seven years in live and/or archival systems.
5. *Information Ownership.* All Information, whether data or documents, and reports that contain or make references to said Information, involving or arising out of the contract, is owned by the state. The plans are expressly prohibited from sharing or publishing the state information and reports without the prior written consent of the state. In the event of a dispute regarding the sharing or publishing of information and reports, the state's decision on this matter shall be final and not subject to change.

(c) System and Data Integration Requirements

1. Adherence to Standards for Data Exchange.
 - a. The plan's systems are required to be able to transmit, receive and process data in HIPAA-compliant formats that are in use as of the plan's contract execution date; these formats are detailed in plan's contract.
 - b. The plan's Systems are required to be capable of transmitting, receiving and processing data in the state-specific formats and/or methods that are in use on the plan's contract execution date, as specified in plan's contract.
 - c. The plan's systems are required to conform to future federal and/or state specific standards for data exchange within 120 calendar days of the standard's effective date or, if earlier, the date stipulated by CMS or the state. The plans are required to partner

with the state in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other federal effort. The plans are required to conform to these standards as stipulated in the plan to implement such standards.

2. HIPAA Compliance Checker.

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

3. Data and Report Validity and Completeness.

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

4. State/Agency Website/Portal Integration.

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

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

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

6. Functional Redundancy with FMMIS.

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

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

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

8. Address Standardization.

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

9. Eligibility and Enrollment Data Exchange Requirements:

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

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

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

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

(f) Information Systems Documentation Requirements

1. Types of Documentation.

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

2. Content of System Process and Procedure Manuals.

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

3. Content of System User Manuals.

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

4. Changes to Manuals.

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

5. Availability of/Access to Documentation.

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

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

1. Reporting Requirements.

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

2. Reporting Capabilities.

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

(h) Other Requirements

Community Health Record/Electronic Medical Record and Related Efforts

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

- e. National Council for Prescription Drug Programs (NCPDP)
- f. International Classification of Diseases (ICD-9)
- g. Diagnosis Related Group (DRG)
- h. Claim Adjustment Reason Codes
- i. Remittance Remarks Codes

2. Compliance with Other Code Sets.

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

- a. As described in all 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 PIHP Systems are required to conform to the following HIPAA-compliant standards for information exchange effective the first day of operations in the applicable service region:

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 which incorporates these requirements can be found by contract in Table 32.

Table 32 Health Information Systems 42 CFR 438.242(a)(b)(1)(2)(3)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section I, C.10.; Section II, D.22.; Section VIII, C.3.c., C.3.f.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section I, C.10.; Section II, D.22.; Section VIII, C.3.c., C.3.f.

Table 33 provides a summary list of the reports required by the state for contracts operated under the 1115 Demonstration Waiver as of October 1, 2014. The SMMC Report Guide containing detailed instructions for these reports can be accessed at:

http://ahca.myflorida.com/medicaid/statewide_mc/mma_plans_report_guides.shtml

Table 33 Medicaid Managed Care Required Reports		
Contract Section	Report Name	Frequency
Section IX and XIV	Achieved Savings Rebate Financial Reports	Annually Quarterly
Section XII and XIV	Administrative Subcontractors and Affiliates Report	Quarterly , within fifteen (15) calendar days after the end of the reporting quarter.
Section VIII and XIV	Annual Fraud and Abuse Activity Report	Annually , by September 1 st .
Section X and XIV	Audited Annual and Unaudited Quarterly Financial Reports	Audited - Annually , on or before April 1 following the end of each reporting calendar year; Unaudited - Quarterly , within 45 calendar days after the end of each reporting quarter.

**Table 33
Medicaid Managed Care Required Reports**

Contract Section	Report Name	Frequency
Section VII and XIV	Code 15 Report	Variable , within fifteen (15) calendar days after the Managed Care Plan received information about the incident.
Exhibit II-A, Section V and XIV	CHCUP (CMS-416) & FL 80% Screening	Unaudited - Annually , on or before January 15 following the end of the reporting federal fiscal year (October 1 through September 30); Audited - Annually , on or before October 1 following the end of the reporting federal fiscal year (October 1 through September 30).
Section VII and XIV	Critical Incident Report	Variable , immediately upon occurrence and no later than twenty-four (24) hours after detection of notification.
Exhibit II-A, Section V and XIV	Hernandez Settlement Ombudsman Log	Quarterly , fifteen (15) calendar days after the end of the reporting quarter.
Exhibit II-A, Section V and XIV	Hernandez Settlement Agreement Survey	Annually , on or before August 1 of each year.
Section VII and XIV	Critical Incident Summary Report	Monthly , by the fifteenth (15 th) calendar day of the month following the reporting month and rolled up for quarter and year.
Section IV and XIV	Enrollee Complaints, Grievances, and Appeals Report	Monthly , within fifteen (15) calendar days after the end of the reporting month.
Section IV. D.5.h. and XIV	Enrollee Help Line Statistics Report	Monthly
Section IV. D.5.g. and XIV	Marketing Agent Termination Report	Variable , two weeks prior to any outreach or marketing activities to be performed by the marketing agent (variable); Quarterly , within forty-five (45) calendar days after the end of the reporting quarter.
Section IV. B.5.a. and XIV	Market/Educational Events Report	Monthly , no later than the twentieth (20 th) calendar day of the month prior to the event month; Variable , amendments to the report are due no later than two weeks prior to the event.
Section VII; Exhibit II-B, Section V and VII; Exhibit II-A, Section V	Performance Measures Report – LTC and MMA	Annually , by July 1, for the prior calendar year.

**Table 33
Medicaid Managed Care Required Reports**

Contract Section	Report Name	Frequency
Section VI and XIV	Provider Complaint Report	Monthly , within fifteen (15) calendar days after the end of the reporting month.
Section VI and XIV	Provider Network File	Weekly , on Thursday by 5:00 p.m. EST.
Section VI and XIV	Provider Termination and New Provider Notification Report	Weekly , on Wednesday by 5:00 p.m. EST.
Section VIII and XIV	Quarterly Fraud & Abuse Activity Report	Quarterly , within fifteen (15) calendar days after the end of the quarter being reported.
Section VIII and XIV	Suspected/Confirmed Fraud and Abuse Reporting	Variable , within fifteen (15) calendar days of detection.
Exhibit II-B, Section V and XIV	Case Management File Audit Report	Quarterly , within 30 calendar days after the end of the reporting quarter.
Exhibit II-B, Section V and XIV	Case Management Monitoring and Evaluation Report	Quarterly , within 30 calendar days after the end of the quarter; Annual roll-up , within 30 calendar days after the end of the fourth (4 th) calendar quarter.
Exhibit II-B, Section V and XIV	Case Manager Caseload Report	Monthly , within fifteen (15) calendar days after the end of the reporting month.
Exhibit II-B, Section V and XIV	Denial, Reduction, Suspension or Termination of Services Report	Monthly , within fifteen (15) calendar days after the end of the reporting month.
Exhibit II-B, Section V and XIV	Enrollee Roster and Facility Residence Report	Monthly , within fifteen (15) calendar days after the beginning of the reporting month.
Section VIII and XIV	Claims Aging Report & Supplemental Filing Report	Quarterly , within forty-five (45) calendar days after the end of the reporting quarter; 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 V and XIV	Missed Services Report	Monthly , within thirty (30) calendar days after the end of the reporting month.
Section X and XIV	Audited Annual and Unaudited Quarterly Financial Reports	Audited – Annually , Unaudited – Quarterly ,

**Table 33
Medicaid Managed Care Required Reports**

Contract Section	Report Name	Frequency
Exhibit II-B, Section V and XIV	Participant Direction Option (PDO) Roster Report	Monthly, within fifteen (15) calendar days after the end of the reporting month.
Exhibit II-B, Section V and XIV	Patient Responsibility Report	Annually, by October 1, for the prior Contract year.
Exhibit II-A, Section VI and XIV	Additional Network Adequacy Standards Report	Monthly
Exhibit II-A, Section V and XIV	ACA PCP Payment Increase Report	Quarterly, by the last day of the month after the end of the reporting quarter.
Exhibit II-A, Section V and XIV	Customized Benefit Notification Report	Monthly
Exhibit II-A, Section VI and XIV	Electronic Health Records Standards Report	Quarterly
Exhibit II-A, Section V and XIV	ER Visits for Enrollees without PCP Appointment Report	Monthly
Exhibit II-A, Section V and XIV	Healthy Behaviors Report	Quarterly
Exhibit II-A, Section V and XIV	Patient Centered Medical Home (PCMH) Providers Report	Quarterly
Exhibit II-A, Section V and XIV	PCP Appointment Report	Annually
Exhibit II-A, Section VI and XIV	Timely Access/PCP Wait Times Report	Annually, on or before February 1, following the reported calendar year.

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 which incorporates this requirement can be found by contract in Table 34.

Table 34	
Assessment of the Quality & Appropriateness of Care and Services	
42 CFR 438.208(c)(2)(3)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, B.2.b.; Attachment II, Exhibit A, Section V, E.2.b., E.4.c.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, B.2.b.; Attachment II, Exhibit A, Section V, E.2.b., E.4.c.

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 can be found by contract in Table 35.

Table 35	
Identification and Assessment of Individuals with Special Health Care Needs	
42 CFR 438.208(c)(2)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, B.2.b.; Attachment II, Exhibit A, Section V, E.2.b.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, B.2.b.; Attachment II, Exhibit A, Section V, E.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 PIHPs, the state conducts on-site surveys to document the plan’s capacity to assess the quality and appropriateness of care and services to Medicaid enrollees and individuals with special health care needs. The state conducts annual on-site quality of care surveys and desk reviews to ensure the plan maintains compliance with the plan’s contract including all applicable federal and state quality measurement and improvement regulations. The state quarterly monitors MCOs and PIHPs, which have been approved to provide services to Medicaid-eligible children with special health care needs as specified in s. 409.9126, Florida Statutes, each plan based on the plan’s provider network capacity to serve children with special health care needs. The state also utilizes the required health information system reports specified in each plan’s contract to monitor and assess the quality and appropriateness of care and services furnished by the plans to Medicaid enrollees and to individuals with special health care needs.

MCO/PIHP Contractual Compliance

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

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

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

Table 36 Monitoring and Evaluation 42 CFR 438.240(d)(2)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VII, A.5.d.4.(b).
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VII, A.5.d.4.(b).

Intermediate Sanctions

The MCO and PIHP intermediate sanctions are designed to address identified quality of care problems in support of the state's quality strategy and these sanctions meet, at a minimum, the requirements specified in 42 CFR 438 Subpart I. In accordance with section 4707 of the Balanced Budget Act of 1997, and section 409.912, F.S., the state may impose any of the following sanctions against the plan if the state determines that the plan has violated any provision of its contract, or the applicable statutes or rules governing the MCO or PIHP:

- a. Suspension of the plan's voluntary enrollments and participation in the assignment process for Medicaid enrollment.
- b. Suspension or revocation of payments to the plan for Medicaid enrollees enrolled during the sanction period. If the plan has violated the contract, the state may order the plan to reimburse the complainant for out-of-pocket medically necessary expenses incurred or order the plan to pay non-network plan providers who provide medically necessary services.
- c. Suspension of all marketing activities to Medicaid enrollees.

- d. Imposition of a fine for violation of the contract with the state, pursuant to section 409.912, F.S. With respect to any nonwillful violation, such fine shall not exceed \$2,500 per violation. In no event shall such fine exceed an aggregate amount of \$10,000 for all nonwillful violations arising out of the same action. With respect to any knowing and willful violation of section 409.912, F.S., or the contract with the state, the state may impose a fine upon the entity in an amount not to exceed \$20,000 for each such violation. In no event shall such fine exceed an aggregate amount of \$100,000 for all knowing and willful violations arising out of the same action.
- e. Termination pursuant to paragraph III.B. (3) of the state's core contract and the section on termination procedures, if the plan fails to carry out substantive terms of its contract or fails to meet applicable requirements in sections 1932, 1903(m) and 1905(t) of the Social Security Act. After the state notifies the plan that it intends to terminate the contract, the state may give the plan's enrollees written notice of the state's intent to terminate the contract and allow the enrollees to disenroll immediately without cause.
- f. The state may impose intermediate sanctions in accordance with 42 CFR 438.702, including:
 - 1. Civil monetary penalties in the amounts specified in section 409.912, F.S.
 - 2. Appointment of temporary management for the plan. Rules for temporary management pursuant to 42 CFR 438.706 are as follows:
 - (a) The state may impose temporary management only if it finds (through onsite survey, enrollee complaints, financial audits, or any other means) that—
 - (1) There is continued egregious behavior by the plan, including but not limited to behavior that is described in 42 CFR 438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Social Security Act; or
 - (2) There is substantial risk to enrollees' health; or
 - (3) The sanction is necessary to ensure the health of the plan's enrollees -
 - (i) While improvements are made to remedy violations under 42 CFR 438.700; or
 - (ii) Until there is an orderly termination or reorganization of the plan.
 - (b) The state must impose temporary management (regardless of any other sanction that may be imposed) if it finds that a plan has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act or 42 CFR 438.706. The state must also grant enrollees the right to terminate enrollment without cause, as described in 42 CFR 438.702(a)(3), and must notify the affected enrollees of their right to terminate enrollment.
 - (c) The state may not delay imposition of temporary management to provide a hearing before imposing this sanction.
 - (d) The state may not terminate temporary management until it determines that the plan can ensure that the sanctioned behavior will not recur.
 - 3. Granting enrollees the right to terminate enrollment without cause and notifying affected enrollees of their right to disenroll.
 - 4. Suspension or limitation of all new enrollment, including default enrollment, after the effective date of the sanction.

5. Suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS or the state is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
6. Denial of payments provided for under the contract for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with 42 CFR 438.730.

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

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

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

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

Table 37 MCO Intermediate Sanctions 42 CFR 438 Subpart I	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section XI, A.-D., A.2.; Section XIII, B.; Section III, C.3.b.(9).
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section XI, A.-D., A.2.; Section XIII, B.; Section III, C.3.b.(9).

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Attachment II

Long-term Care Program Quality Strategy

INTRODUCTION AND OVERVIEW

Florida Medicaid, in cooperation with the Florida Department of Elder Affairs, has consolidated four of the former 1915(c) waivers for elders and adults with disabilities into a 1915(b)(c) waiver for the provision of managed long-term care and home and community-based services. This Long-term Care program ensures quality by utilizing a multi-pronged approach that includes:

- I. Selection of the most qualified managed care plans
- II. Ensuring plan readiness and network adequacy
- III. Establishing performance and quality measures
- IV. Monitoring the managed care plans for compliance with requirements
- V. Providing incentives for quality
- VI. Applying penalties and sanctions for poor performance
- VII. Conducting an independent assessment

OVERVIEW OF THE LONG-TERM CARE PROGRAM

In 2011, the Florida Legislature created Part IV of Chapter 409, Florida Statutes, directing the Agency for Health Care Administration to create the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has two key components: The Managed Medical Assistance program and the Long-term Care (LTC) program.

The LTC component of SMMC was implemented between August 1, 2013 and March 1, 2014. The Agency for Health Care Administration (Agency), in cooperation with the Florida Department of Elder Affairs (DOEA or Department), consolidated four of the former 1915(c) waivers into a 1915(b)(c) waiver for the provision of managed long-term care and home and community-based services (HCBS). This LTC waiver focuses on quality improvement by monitoring quality, outcomes, and enrollee satisfaction. The Agency and DOEA, working with the National Quality Enterprise (NQE), created enhanced measures for the new program. Florida will continue to work with its stakeholders to further refine its performance measures, tracking tools, remediation and system improvement plans to aid in developing a comprehensive quality improvement strategy related to the six assurances: Level of Care, Service Plans, Qualified Providers, Health and Welfare of Participants, Administrative Authority, and Financial Accountability, along with the associated sub-assurances. This strategy includes methods for resolving deficiencies or non-compliance identified during the monitoring process.

LTC plans were required to develop, implement, and maintain a risk-management program and an adverse incident reporting and management system for incidents that occur in a home and community-based long-term care service delivery setting and are related to the provision of a covered home and community-based service (HCBS), including: community-based residential alternatives; other HCBS provider sites; and an enrollee's home. All LTC plans must achieve, through ongoing measurement and intervention, significant improvement to the quality of care and service delivery, sustained over time, in areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

The Agency established a Quality Improvement Team for the LTC program that includes staff from the Agency and DOEA. The team is responsible for reviewing all program reports related to quality improvement activities as well as trending, prioritizing, and developing recommendations for implementation of system quality improvements. An annual program report will include performance measure results for individual LTC plans as well as the overall program performance on measures related to the assurances and sub-assurances, complaints, adverse incidents, and other program data. The approved annual report will be available on the Agency's website. The Agency, in consultation with DOEA, is responsible for identifying needed policy changes, implementing program modifications and following up on program results.

The following is a list of contractual requirements for the LTC plans, broken into three domains: General Requirements, Quality Requirements, and Administration and Management Requirements.

General Requirements

- Requires collection and reporting of HEDIS and other performance measures, with results published on each managed care plan's website.
- Requires the ability to transition from ICD-9 codes to the new ICD-10 codes.
- Requires development and maintenance of an annual network development and management plan.
- Requires managed care plans to maintain an electronic database of contracted service providers, including licensure or registration information, location and hours of operation, specialty credentials, and performance indicators, and include this information on their website.
- Requires managed care plans to contract with certain essential service providers for at least a year.
- Requires termination of service providers (that were terminated from the Agency) within five calendar days of notice from the Agency.
- Adds additional service provider contract specifications:
 - Acknowledgement by the service provider of its duty to supervise and be responsible for the service provided and for claims preparation and submission;
 - Ensure such services were actually furnished and were medically necessary;
 - Specifying that failure to cooperate in reviews and audits may result in immediate termination of the contract; and
 - Requiring service providers to comply with the terms of the managed care plan's provider handbook.

Quality Requirements

- Requires monitoring the quality and performance of participating service providers.
- Requires specific components of a provider complaint system and includes timeframe requirements for complaint review and response and a monthly provider complaint report.
- Specifies that the submission of incomplete or inaccurate performance measure data is considered deficient and is subject to penalties, and provides notice to the managed care plan that the Agency may refer such cases to Medicaid Program Integrity for review.
- Requires conducting an annual enrollee survey and provides specifications for annual provider satisfaction surveys.
- Requires accreditation within eighteen months of contract execution.

Administration and Management Requirements

- Specifies adequate staffing and information system capability to ensure the ability to manage financial transactions, recordkeeping, data collection and other administrative functions.
- Reduces the timeframe requirement for submission of encounter data from 60 days to 7 days following the date on which the plan adjudicated the claim.
- Requires compliance with the Agency's reporting requirements for the Medicaid Encounter Data System.
- Requires participation in an achieved savings rebate program.
- Specifies that the fraud and abuse compliance plan include a description of the methods for verifying with members whether services billed by service providers were received.
- Specifies liquidated damages for failure to meet certain contract requirements.
- Specifies sanctions related to failure to submit or implement an anti-fraud plan or to timely report suspected or confirmed instances of provider or recipient fraud or abuse.
- Establishes a five-year contract.
- Requires a performance bond in case the contract is terminated by the managed care plan prior to the end of the contract period.
- Requires financial penalties for managed care plans that leave a region or reduce enrollment levels, including reimbursing the Agency for the cost of enrollment changes and other transition activities.
- Requires for departing provider service networks, a per-enrollee penalty of up to three months' payment and requires continuation of services for up to 90 days; requires all other plans to pay a penalty of 25 percent of their minimum surplus requirement pursuant to s. 641.225(1), F.S. (See s. 409.967(2)(h)1., F.S.)
- Requires managed care plans to provide at least 180 days' notice before withdrawing from a region. (See s. 409.967(2)(h)1., F.S.)
- Requires the Agency to terminate a managed care plan's contracts in all regions if a managed care plan leaves a region before the end of the contract term. (See s. 409.967(2)(h)1., F. S.)
- Specifies that upon receipt of a managed care plan's request for termination or withdrawal, the Agency will remove the managed care plan from receipt of new voluntary enrollments, assignments, and reinstatements.
- Specifies that failure to meet plan readiness requirements by an Agency-specified timeframe will result in contract termination.

Long-Term Care Covered Services

The managed care plan must ensure the provision of the following covered services, including those covered under s. 409.98(1) through (19), Florida Statutes:

- a. Adult Companion Care — Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.
- b. Adult Day Health Care — Services provided pursuant to Chapter 429, Part III, F.S. Services furnished in an outpatient setting which encompass both the health and social services needed to ensure optimal functioning of an enrollee, including social services to help with personal and family problems and planned group therapeutic activities. Adult

day health care includes nutritional meals. Meals are included as a part of this service when the patient is at the center during meal times. Adult day health care provides medical screening emphasizing prevention and continuity of care, including routine blood pressure checks and diabetic maintenance checks. Physical, occupational and speech therapies indicated in the enrollee's plan of care are furnished as components of this service. Nursing services, which include periodic evaluation, medical supervision and supervision of self-care services directed toward activities of daily living and personal hygiene, are also a component of this service. The inclusion of physical, occupational and speech therapy services, and nursing services as components of adult day health services does not require the managed care plan to contract with the adult day health provider to deliver these services when they are included in an enrollee's plan of care. The managed care plan may contract with the adult day health care provider for the delivery of these services or the managed care plan may contract with other providers qualified to deliver these services pursuant to the terms of the contract.

- c. Assistive Care Services – An integrated set of 24-hour services only for Medicaid-eligible residents in assisted living facilities, adult family care homes and residential treatment facilities in accordance with Attachment D-II, Section I, Definitions and Acronyms.
- d. Assisted Living — A service comprising personal care, homemaker, chore, attendant care, companion care, medication oversight, and therapeutic social and recreational programming provided in a home-like environment in an assisted living facility, licensed pursuant to Chapter 429 Part I, F.S., in conjunction with living in the facility. Service providers must ensure that enrollees reside in a facility offering care with the following home-like environmental characteristics: choice of private or semi-private rooms; choice of roommate for semi-private rooms; locking door to living unit; access to telephone as well as length of use; flexible eating and snack preparation schedule; and participation in facility and community activities of their choice. Home-like environmental characteristics also include the ability to have: unlimited visitation and personal sleeping schedule. This service includes 24 hour onsite response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Individualized care is furnished to persons who reside in their own living units (which may include dual occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The resident has a right to privacy. Living units may be locked at the discretion of the resident, except when a physician or mental health professional has certified in writing that the resident is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. The facility must have a central dining room, living room or parlor, and common activity areas, which may also serve as living rooms or dining rooms. The resident retains the right to assume risk, tempered only by a person's ability to assume responsibility for that risk. Care must be furnished in a way that fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect. Assisted living services may also include: physical therapy, occupational therapy, speech therapy, medication administration and periodic nursing evaluations. The managed care plan may arrange for other authorized service providers to deliver care to residents of assisted living facilities in the same manner as those services would be delivered to a person in their own home. ALF administrators, direct service personnel and other outside service personnel such as physical therapists have a responsibility to encourage enrollees to take part in social, educational and recreational activities they

are capable of enjoying. All services provided by the assisted living facility shall be included in a care plan maintained at the facility with a copy provided to the enrollee's case manager. The managed care plan shall be responsible for placing enrollees in the appropriate assisted living facility setting based on each enrollee's choice and service needs.

- e. Attendant Care — Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by state law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity. Unskilled attendant care must have supervision provided by a registered nurse, licensed to practice in the state.
- f. Behavioral Management — This service provides behavioral health care services to address mental health or substance abuse needs of managed care plan members. These services are in excess of those listed in the Community Behavioral Health Services Coverage and Limitations Handbook and the Mental Health Targeted Case Management Coverage and Limitations Handbook. The services are used to maximize reduction of the enrollee's disability and restoration to the best possible functional level and may include, but are not limited to: an evaluation of the origin and trigger of the presenting behavior; development of strategies to address the behavior; implementation of an intervention by the provider; and assistance for the caregiver in being able to intervene and maintain the improved behavior.
- g. Caregiver Training — Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to enrollees. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion or co-worker who provides uncompensated care, training, guidance, companionship or support to an enrollee. This service may not be provided to train paid caregivers. Training includes instruction about treatment regimens and other services included in the plan of care, use of equipment specified in the plan of care, and includes updates as necessary to safely maintain the enrollee at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the enrollee. All training for individuals who provide unpaid support to the enrollee must be included in the enrollee's plan of care.
- h. Care Coordination/Case Management – Services that assist enrollees in gaining access to needed waiver and other State plan services, as well as other needed medical, social, and educational services, regardless of the funding source for the services to which access is gained. Case management services contribute to the coordination and integration of care delivery through the ongoing monitoring of service provision as prescribed in each enrollee's plan of care.
- i. Home Accessibility Adaptation Services — Physical adaptations to the home required by the enrollee's plan of care which are necessary to ensure the health, welfare and safety of the enrollee or which enable the enrollee to function with greater independence in the home and without which the enrollee would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems to

accommodate the medical equipment and supplies, which are necessary for the welfare of the enrollee. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the enrollee, such as carpeting, roof repair or central air conditioning. Adaptations which add to the total square footage of the home are not included in this service. All services must be provided in accordance with applicable state and local building codes.

- j. Home Delivered Meals — Nutritionally sound meals to be delivered to the residence of an enrollee who has difficulty shopping for or preparing food without assistance. Each meal is designed to provide a minimum 33.3% of the current Dietary Reference Intake (DRI). The meals shall meet the current Dietary Guidelines for Americans, the USDA My Pyramid Food Intake Pattern and reflect the predominant statewide demographic.
- k. Homemaker Services — General household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services, and pest control may be included in this service.
- l. Hospice — Services are forms of palliative medical care and services designed to meet the physical, social, psychological, emotional and spiritual needs of terminally ill recipients and their families. Hospice care focuses on palliative care rather than curative care. An individual is considered to be terminally ill if he has a medical diagnosis with a life expectancy of six months or less if the disease runs its normal course.
- m. Intermittent and Skilled Nursing — The scope and nature of these services do not differ from skilled nursing furnished under the State Plan. This service includes the home health benefit available under the Medicaid state plan as well as expanded nursing services coverage under this waiver. Services listed in the plan of care that are within the scope of Florida's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the state. Skilled nursing services must be listed in the enrollee's plan of care and are provided on an intermittent basis to enrollees who either do not require continuous nursing supervision or whose need is predictable.
- n. Medical Equipment and Supplies — Medical equipment and supplies, specified in the plan of care, include: (a) devices, controls or appliances that enable the enrollee to increase the ability to perform activities of daily living; (b) devices, controls or appliances that enable the enrollee to perceive, control or communicate the environment in which he or she lives; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment that is necessary to address enrollee functional limitations; (e) necessary medical supplies not available under the State Plan including consumable medical supplies such as adult disposable diapers. This service includes the durable medical equipment benefits available under the state plan service as well as expanded medical equipment and supplies coverage under this waiver. All items shall meet applicable standards of manufacture, design and installation. This service also includes repair of such items as well as replacement parts.
- o. Medication Administration — Assistance with self-administration of medications, whether in the home or a facility, includes taking the medication from where it is stored and

delivering it to the enrollee; removing a prescribed amount of medication from the container and placing it in the enrollee's hand or another container; helping the enrollee by lifting the container to their mouth; applying topical medications; and keeping a record of when an enrollee receives assistance with self-administration of their medications.

- p. Medication Management — Review by the licensed nurse of all prescriptions and over-the-counter medications taken by the enrollee, in conjunction with the enrollee's physician. The purpose of the review is to assess whether the enrollee's medication is accurate, valid, non-duplicative, and correct for the diagnosis; that therapeutic doses and administration are at an optimum level; that there is appropriate laboratory monitoring and follow-up taking place; and that drug interactions, allergies and contraindications and being assessed and prevented.
- q. Nutritional Assessment/Risk Reduction Services — An assessment, hands-on care, and guidance to caregivers and enrollees with respect to nutrition. This service teaches caregivers and enrollees to follow dietary specifications that are essential to the enrollee's health and physical functioning, to prepare and eat nutritionally appropriate meals and promote better health through improved nutrition. This service may include instructions on shopping for quality food and food preparation.
- r. Nursing Facility Services — Services furnished in a health care facility licensed under Chapter 395 or Chapter 400, F.S. per the Nursing Facility Coverage and Limitations Handbook.
- s. Personal Care — A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.
- t. Personal Emergency Response Systems (PERS) — The installation and service of an electronic device that enables enrollees at high risk of institutionalization to secure help in an emergency. The PERS is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The enrollee may also wear a portable "help" button to allow for mobility. PERS services are generally limited to those enrollees who live alone or who are alone for significant parts of the day and who would otherwise require extensive supervision.
- u. Respite Care — Services provided to enrollees unable to care for themselves furnished on a short-term basis due to the absence or need for relief of persons normally providing the care. Respite care does not substitute for the care usually provided by a registered nurse, a licensed practical nurse or a therapist. Respite care is provided in the home/place of residence, Medicaid licensed hospital, nursing facility or assisted living facility.
- v. Occupational Therapy — Treatment to restore, improve or maintain impaired functions aimed at increasing or maintaining the enrollee's ability to perform tasks required for independent functioning when determined through a multi-disciplinary assessment to improve an enrollee's capability to live safely in the home setting.

- w. Physical Therapy — Treatment to restore, improve or maintain impaired functions by use of physical, chemical and other properties of heat, light, electricity or sound, and by massage and active, resistive or passive exercise. There must be an explanation that the patient's condition will be improved significantly (the outcome of the therapies must be measureable by the attending medical professional) in a reasonable (and generally predictable) period of time based on an assessment of restoration potential, or a determination that services are necessary to a safe and effective maintenance program for the enrollee, using activities and chemicals with heat, light, electricity or sound, and by massage and active, resistive or passive exercise when determined through a multi-disciplinary assessment to improve an enrollee's capability to live safely in the home setting.
- x. Respiratory Therapy — Treatment of conditions that interfere with respiratory functions or other deficiencies of the cardiopulmonary system. Services include evaluation and treatment related to pulmonary dysfunction.
- y. Speech Therapy — The identification and treatment of neurological deficiencies related to feeding problems, congenital or trauma-related maxillofacial anomalies, autism, or neurological conditions that effect oral motor functions. Therapy services include the evaluation and treatment of problems related to an oral motor dysfunction when determined through a multi-disciplinary assessment to improve an enrollee's capability to live safely in the home setting.
- z. Transportation – Non-emergent transportation services shall be offered in accordance with the enrollee's plan of care and coordinated with other service delivery systems. This non-emergency transportation service includes trips to and from services offered by the LTC program.

I. SELECTION OF HIGH QUALITY HEALTH PLANS (Chapter 409.966(2), Florida Statutes)

QUALITY SELECTION CRITERIA AND ELIGIBLE PLAN SELECTION

The Agency selected seven managed care plans to participate in the Long-Term Care program using invitations to negotiate in accordance with s. 287.057(3)(a), Florida Statutes.

Separate and simultaneous procurements were conducted in each of the following regions:

Region 1 - Escambia, Okaloosa, Santa Rosa and Walton Counties.

Region 2 - Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington Counties.

Region 3 - Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union Counties.

Region 4 - Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia Counties.

Region 5 - Pasco and Pinellas Counties.

Region 6 - Hardee, Highlands, Hillsborough, Manatee and Polk Counties.

Region 7 - Brevard, Orange, Osceola and Seminole Counties.

Region 8 - Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota Counties.

Region 9 - Indian River, Martin, Okeechobee, Palm Beach and St. Lucie Counties.

Region 10 - Broward County.

Region 11 - Miami-Dade and Monroe Counties.

- (a) The invitation to negotiate specified the criteria and the relative weight of the criteria that was used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiated. In addition to criteria established by the Agency, the Agency considered the following factors in the selection of eligible managed care plans:
1. Accreditation by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body.
 2. Experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations.
 3. Establishment of community partnerships with providers that create opportunities for reinvestment in community-based services.
 4. Organization commitment to quality improvement and documentation of achievements in specific quality improvement projects, including active involvement by organization leadership.
 5. Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes.
 6. Evidence that an eligible managed care plan has written agreements or signed contracts or has made substantial progress in establishing relationships with service providers before the managed care plan submitting a response.
 7. Comments submitted in writing by any enrolled Medicaid provider relating to a specifically identified managed care plan participating in the procurement in the same region as the submitting provider.
 8. Documentation of policies and procedures for preventing fraud and abuse.
 9. The business relationship an eligible managed care plan has with any other eligible managed care plan that responds to the invitation to negotiate.
- (b) An eligible managed care plan was required to disclose any business relationship it has with any other eligible managed care plan that responds to the invitation to negotiate. The Agency may not select managed care plans in the same region for the same managed care program that have a business relationship with each other. Failure to disclose any business relationship shall result in disqualification from participation in any region for the first full contract period after the discovery of the business relationship by the Agency. For the purpose of this section, "business relationship" means an ownership or controlling interest, an affiliate or subsidiary relationship, a common parent, or any mutual interest in any limited partnership, limited liability partnership, limited liability company, or other entity or business association, including all wholly or partially owned subsidiaries, majority-owned subsidiaries, parent companies, or affiliates of such entities, business associations, or other enterprises, that exists for the purpose of making a profit.
- (c) After negotiations were conducted, the Agency selected the eligible managed care plans that were determined to be responsive and provided the best value to the state. Preference was given to managed care plans with the following qualifications:
1. Organizations that are based in and perform operational functions in this state, in-house or through contractual arrangements, by staff located in this state. Using a tiered approach, the highest number of points was awarded to a managed care plan that had all or substantially all of its operational functions performed in the state. The second highest number of points was awarded to a managed care plan that has a majority of its operational functions performed in the state. The Agency had the authority to establish a third tier; however, preference points may not be awarded to managed care plans that

perform only community outreach, medical director functions, and state administrative functions in the state. For purposes of this subparagraph, operational functions include claims processing, member services, provider relations, utilization and prior authorization, case management, disease and quality functions, and finance and administration. For purposes of this subparagraph, the term "based in this state means that the entity's principal office is in this state and the managed care plan is not a subsidiary, directly or indirectly through one or more subsidiaries of, or a joint venture with, any other entity whose principal office is not located in the state.

2. Have a claims payment process that ensures that claims that are not contested or denied will be promptly paid pursuant to s. 641.3155, Florida Statutes.

II. ENSURING PLAN READINESS AND NETWORK ADEQUACY

MANAGED CARE PLAN READINESS REQUIREMENTS

Managed care plans that were awarded a LTC contract were required to go through a plan readiness review process.

The *first phase* was a desk readiness review which encompassed the following elements:

- Agency conducted provider network review and approval in its entirety
- Agency conducted executed contracts review and approval (includes provider, subcontractor, facility, etc.)
- Agency conducted any follow up financial review and approval
- Agency conducted any follow up organizational and administration review and approval
- Agency conducted quality review and approval of policies and procedures
- Agency conducted member and provider correspondence review and approval
- Managed care plan conducted test conductivity and file transfer with Agency

The *second phase* was an on-site operational readiness review which encompassed the following elements:

- Managed care plan staff interviews
- Fraud and abuse program review
- Demonstrations of various systems (enrollment/disenrollment, member services, claims processing, report production, case management/care coordination, utilization management, quality improvement)
- Staff training plan and schedule
- Provider training manual and training schedule
- Provider monitoring plan and schedule
- A list of all delegated services and pre-delegation audit reports of those services
- Credentialing
- All Board of Directors and committee meeting minutes

The elements outlined above are not all-inclusive and additional information could be requested at any time during the readiness review process. Upon completion of the first phase, Agency staff members conducted the second phase on-site operational review.

III. ESTABLISHING PERFORMANCE AND QUALITY MEASURES

Quality Measures for the 1915 (c) Waiver

The LTC waiver performance measures have been reported to the Centers for Medicare and Medicaid Services each quarter since the implementation of the program on August 1, 2013. Of the forty-two measures, twenty-four were designed to be reported quarterly and eighteen measures were designed to be reported annually. The Agency anticipates that the next waiver amendment in October 2014 will include some revisions to the LTC performance measures.

Waiver Assurance---The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.
Percentage of long-term care program level of care determinations processed by DOEA CARES by the effective date of enrollment.
Percentage of waiver expenditures less than or equal to approved legislative appropriations.
Percentage of LTC performance improvement plans (PIPs) reviewed annually by DOEA.
Percentage of LTC direct calls (non-abandoned) processed by the enrollment broker monthly.
Percentage of hours enrollment broker call system is operational monthly.
Percentage of program policies and procedures that are reviewed and approved by Medicaid before implementation by DOEA on an annual basis.
Percentage of LTC monitoring reports furnished by DOEA to the Agency.
Percentage of case record reviews conducted by DOEA in accordance with the approved sampling methodology.
Percentage of LTC managed care plans' performance improvement projects evaluated annually by the External Quality Review Organization (EQRO).
Percentage of ALF subcontract templates reviewed by the Agency prior to execution that include approved home and community-based characteristics and community integration language.
Appendix B ---Evaluation/Re-evaluation of Level of Care (LOC)
Waiver Sub-assurance---Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.
Percentage of new applicants receiving a level of care evaluation prior to enrollment.
Waiver Sub-assurance---The levels of care of enrolled participants are re-evaluated at least annually or as specified in the approved waiver.
Percentage of enrollees receiving annual redeterminations performed within 365 days of previous level of care determination.
Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

Percentage of managed care plan members having a current level of care based on the state approved assessment tool.
Percentage of level of care determinations made by qualified evaluators.

Appendix C---Participants-Qualified Providers
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Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services

Percentage of all new managed care plans that satisfy waiver service provider qualifications prior to delivery of services.
Percentage of licensed subcontractors, by type, within managed care plans' provider networks evaluated by the managed care plan that meet service provider qualifications prior to delivering services.
Percentage of licensed subcontractors, by type, within managed care plan's provider networks evaluated by the managed care plan that meet service provider qualifications continuously.
Percentage of managed care plans continually qualified as program providers on an annual basis.

Sub-Assurance: The State monitors non-licensed/non-certified service providers to assure adherence to waiver requirements.

Percentage of non-licensed/non-certified service providers, by type, within the managed care plan network satisfying waiver service provider qualifications prior to the delivery of services.
Percentage of non-licensed/non-certified service providers, by type, within the managed care plan network satisfying waiver service provider qualifications continually.

Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

Percentage of subcontractors with staff mandated to report abuse, neglect and exploitation, verified by managed care plan that staff have received the appropriate training.
Percentage of case managers or subcontracted case managers satisfying abuse, neglect and exploitation, and Alzheimer's disease and dementia training requirements.

Appendix D---Participant-Centered Planning and Service Delivery
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Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Percentage of enrollees with care plans meeting all assessed needs and risks.

Percentage of enrollees with care plans documenting personal goal setting and community integration goal setting.
Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.
Percentage of enrollee plans of care being distributed within 10 days of development to the enrollee's primary care providers (PCP).
Percentage of plans of care/summaries where enrollee participation is verified by signatures.
Percentage of managed care plan members' care plans reviewed on a face to face basis at least every three months and updated as appropriate.
Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.
Percentage of managed care plan members' care plans updated at least annually.
Percentage of enrollees whose care plans are updated when needs change.
Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.
Percentage of enrollee services delivered according to the plan of care as to service, type, amount, frequency, duration and scope.
Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.
Percentage of new enrollees with signed freedom of choice forms indicating managed care provider choice in their enrollment packets.
Percentage of new enrollees with signed freedom of choice forms indicating choice between waiver services and institutional care in their enrollment packets.
Percentage of all new enrollees with signatures on the care plan indicating choice of services and subcontractors.
Appendix G---Participant Safeguards
Waiver Assurance---The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.
Percentage of enrollees provided with handbooks containing directions on reporting abuse, neglect and exploitation.
Percentage of enrollee case files that include evidence that advance directives were discussed with the enrollee.
Percentage of health, safety and welfare issues reported in adverse incident reports within 48 hours.
Percentage of enrollees with reports of abuse, neglect or exploitation whose investigations were commenced within 24 hours of being reported to Adult Protective Services.

Percentage of managed care plan members with substantiated reports of abuse, neglect, or exploitation that had appropriate follow-up with the managed care plan.
Percentage of enrollees who received a telephone contact at least every thirty days to assess their health status, satisfaction with services, and any additional needs.
Percentage of enrollees provided with information on reporting grievance and complaint procedures as evidenced by a signed acknowledgement present in the case record.
Percentage of enrollees' grievances that received recommended follow-up.
Appendix I---Financial Accountability
Waiver Assurance---State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.
Percentage of monthly capitation payments made to capitated managed care plans for qualified enrollees.
Percentage of capitation payments issued to managed care plans using appropriate rate.

PERFORMANCE MEASURES – HEDIS and other LTC measures

All Long-term Care plans will collect and report the following performance measures, certified via qualified auditor:

HEDIS

Care for Older Adults (COA)
 Call Abandonment (CAB)
 Call Answer Timeliness (CAT)

Agency-Defined Measures

Required Record Documentation (RRD)
 Face-To-Face Encounters (F2F)
 Case Manager Training (CMT)
 Timeliness of Services (TOS)

Other Measures

Prevalence of antipsychotic drug use in long-stay dementia residents.

Due to continuous enrollment requirements for the majority of performance measures, LTC plans could only report on a maximum of three measures for calendar year 2013: Face-to-Face Encounters, Case Manager Training, and Timeliness of Services. These measures were reported in July 2014 and are being reviewed by the Agency.

The state is researching additional quality measures that focus on enrollee outcomes and that have been tested and validated, and that rely upon data that is available to the long-term care plans. These measures will be added to the managed care plan contracts. Examples of additional performance measures that may be included are avoidable hospitalizations; hospital readmissions; prevalence of pressure ulcers; prevalence of use of restraints; rates of antipsychotic drug use; prevalence of dehydration among enrollees; and prevalence of Baker Act-related (mental health) hospitalizations.

MONITORING THE PLANS FOR COMPLIANCE WITH REQUIREMENTS

The Department of Elder Affairs implemented a number of processes to monitor Long-term Care plans for compliance with federal waiver requirements and subassurances, as well as for compliance with Florida Statutes. Specifically, DOEA monitors and remediates managed care plans in the following federal subassurance areas: Participant Access and Eligibility, Participant Services, Participant Centered Planning and Service Delivery and other areas covered within the HCBS Quality Framework. These different monitoring processes include an Annual Compliance Desk Review, an On-site Monitoring Review, and Client File Review/Client Visitations. In addition to the three key monitoring activities, the Department of Elder Affairs receives the required reports from the managed care plans on a monthly, quarterly, and annual basis. These reports are used by the Department of Elder Affairs, in partnership with the Agency, to ensure managed care plan compliance with contract requirements and standards.

Annual Compliance Desk Review

An Annual Desk Review is performed during each new contract year. The annual submission includes a review of the managed care plan's policies and procedures (P&P), accreditation documents, organizational structure, licensure, enrollee materials (handbooks, directory, brochures, letters) staff training materials, insurance information, and optional expanded benefits. The annual compliance information is reviewed and approved by the Department of Elder Affairs and in partnership with the Agency.

For the policies and procedures review, the Department of Elder Affairs analysts review all policies and procedures the managed care plans use to conduct the daily operations of the program. Specifically, the analysts review the policies and procedures related to the following areas: Claims Processing, Medicare Co-payments and Deductibles, Medicaid Pending, Enrollment and Disenrollment, Coordination and Continuity of Care, Assessments and Reassessments, Level of Care, Records Management and Health Information Systems, Utilization Management, Incident Adult Protective Services Reporting, Grievance and Appeals, Medicaid Fair Hearings, General Provisions, Availability/Accessibility of Services, Network Expansions, Provider Relations and Subcontracts, Credentialing and Re-credentialing (including processes for monitoring subcontractors), Prospective Enrollee Materials, Prohibited Activities, Payment Discrepancies, Data Integrity and Safeguarding Information, Transition Care Planning, Orientation, Annual Notification to Enrollees, Care Plan and Service Delivery Requirements, Quality Assurance and Committee, Quality Improvement and Performance Measures, Staffing Levels, and any other processes deemed necessary for review.

In addition to the policies and procedures, the analysts review Licensure, Accreditation Documentation, Care Plan and Care Plan Summary Templates and other pertinent documentation that ensures that the managed care plans stay qualified to provide services to enrollees.

The policy and procedure tools were developed to ensure that the managed care plans' policies and procedures and internal protocols used to assist managed care plan employees in executing these policies and procedures meet the requirements outlined in contract. These reviews also include any protocols that demonstrate each managed care plan's oversight processes for these areas, including information on how the managed care plan defines and implements specific oversight processes. The purpose of reviewing the internal protocols and the accompanying oversight processes is to provide the contract manager with an

understanding of how the managed care plan is implementing and executing the contract and to determine if the managed care plan is in compliance.

Once the review is complete, managed care plans are sent documentation of the preliminary findings for both the Annual Compliance Desk Review Tools and Policy and Procedure Annual Review Tools. Managed care plans are required to correct deficiencies within 30 calendar days of receipt. The state may require a shorter timeframe for correction at its discretion.

On-Site Monitoring Review

On-site monitoring is conducted annually to review information that can best be examined at the managed care plan's location rather than in a desk review. The monitoring consists of face-to-face interviews with key administration (Plan Administrator, Case Management Supervisor, Medical Director, Utilization Management Supervisor, Information Systems Supervisor, Compliance Officer, QA Staff) and case managers. The on-site visit also includes a review of claims for active enrollees to ensure that services on the care plan are being provided and paid for in accordance with s.641.3155, F.S.; an evaluation of employee records to ensure the staff are qualified and receiving all required training; and a review to ensure that subcontractor credentials are being verified on an annual basis and that no negative findings have occurred. Analysts will note the deficiencies and send them to the managed care plan within 10-calendar days upon returning to the office. Managed care plans are responsible for correcting any deficiencies within 30-calendar days. Final compliance letters are sent once all documentation is received and approved. The state may require a shorter timeframe for correction at its discretion.

Case File Reviews/Client Visitations

Client files are reviewed for compliance through case file reviews and client face-to-face visits. A sample of client files, using a CMS approved sampling methodology, is requested from each service provider and reviewed by the Department of Elder Affairs. The Department reviews the files and arranges client visits for each service provider in the area being monitored. By reviewing the client files prior to a face-to-face visit, the review team can get an accurate picture of what should be included on a care plan and ensure that the needs of the clients are being adequately met by the service provider. During the face-to-face visits, the team also monitors for compliance with the Home and Community-Based Characteristics Framework developed to ensure compliance with home like environment and community integration goals.

Throughout the contract year, the monitoring team reviews a sample of client files. When they complete the client file review and face-to-face visits in each region, the findings are forwarded to the appropriate contract manager within ten calendar days of their return to the office. If immediate action is needed for the health and safety of the enrollee, the review team requires immediate corrective action.

At the end of the year, the team will create an aggregated report with the findings for each managed care plan. Results for the client visits and case file reviews will be sent to each managed care plan for review. Because the managed care plans are required to engage in corrective actions to address deficiencies throughout the year, there is no need for a response or further corrective action from the managed care plan.

Monthly, Quarterly, and Annual Report Submissions

In addition to the annual submission for the desk review, contract managers also receive monthly, quarterly, and annual reports from managed care plans. Contract managers review the submissions as they are submitted to the Department's and Agency's joint FTP Secure Website. Monthly, quarterly, and annual required reports, and all required submissions are found in Attachment II-D, Section XII, Required Reporting, of the new LTC contract.

Managed care plans that do not submit reports timely are notified of the deficiencies, including but not limited to, letters to the managed care plan to inform them that they are out of compliance and the assessment of liquidated damages and sanctions. In addition to ensuring timely submission, contract managers ensure that the reports have been accurately filled out by the managed care plan and notify the managed care plan of any deficiencies and require that they correct the issue.

Waiver Quality Assurance Performance Measures and Program Improvement Plans

For the LTC program, the Department, in partnership with the Agency, has developed over forty performance measures to enhance monitoring reporting regarding subassurance areas such as health, safety, and welfare, level of care, service provision, network qualifications, and financial oversight.

In addition to these performance measures, all managed care plans are required to work with the federally mandated External Quality Review Organization (EQRO) to develop Performance Improvement Projects (PIPs). Each managed care plan is required to participate in two Agency approved PIPs, one (1) clinical PIP and one (1) non-clinical PIP. The Department and the Agency will review all PIPs submitted to the EQRO and ensure that managed care plans meet all submission deadlines.

V. PROVIDING INCENTIVES FOR QUALITY

Plan Incentives

The Agency may offer incentives to high-performing managed care plans. The Agency will notify the managed care plan annually on or before December 31st of the incentives that will be offered for the following calendar year. Incentives may be awarded to all high-performing managed care plans or may be offered on a competitive basis. Incentives may include, but are not limited to: quality designations, quality awards, and enhanced auto-assignments. The Agency, at its discretion, may disqualify a managed care plan for any reason the Agency deems appropriate including, but not limited to managed care plans that received a monetary sanction for performance measures or any other sanctionable offense. In accordance with s. 409.967(3) (g), Florida Statutes, as part of the achieved savings rebate process, a managed care plan that exceeds Agency-defined quality measures in the reporting period may retain an additional one percent of revenue.

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VI. APPLYING PENALTIES AND SANCTIONS FOR POOR PERFORMANCE

Intermediate Sanctions

The managed care plan and PIHP intermediate sanctions are designed to address identified quality of care problems in support of the state's quality strategy and these sanctions meet, at a minimum, the requirements specified in 42 CFR 438 Subpart I. In accordance with section 4707 of the Balanced Budget Act of 1997, and section 409.912, F.S., the state may impose any of the following sanctions against the managed care plan if the state determines that the managed care plan has violated any provision of this contract, or the applicable statutes or rules governing the health plan or PIHP:

- a) Suspension of the managed care plan's voluntary enrollments and participation in the assignment process for Medicaid enrollment;
- b) Suspension or revocation of payments to the managed care plan for Medicaid recipients enrolled during the sanction period. If the managed care plan has violated the contract, the state may order the managed care plan to reimburse the complainant for out-of-pocket medically necessary expenses incurred or order the managed care plan to pay non-network plan providers who provide medically necessary services;
- c) Suspension of all marketing activities to Medicaid enrollees;
- d) Imposition of a fine for violation of the contract with the state, pursuant to section 409.912, F.S. With respect to any nonwillful violation, such fine shall not exceed \$2,500 per violation. In no event shall such fine exceed an aggregate amount of \$10,000 for all nonwillful violations arising out of the same action. With respect to any knowing and willful violation of section 409.912, F.S. or the contract with the state, the state may impose a fine upon the entity in an amount not to exceed \$20,000 for each such violation. In no event shall such fine exceed an aggregate amount of \$100,000 for all knowing and willful violations arising out of the same action.
- e) Termination pursuant to paragraph III.B. (3) of the state's core contract and the section on termination procedures, if the managed care 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 managed care 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 managed care plan. Rules for temporary management pursuant to 42 CFR 438.706 are as follows:
 - (a) The state may impose temporary management only if it finds (through onsite survey, enrollee complaints, financial audits, or any other means) that—
 - (1) There is continued egregious behavior by the managed care plan, including but not limited to behavior that is described in 42 CFR 438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Social Security Act; or
 - (2) There is substantial risk to enrollees' health; or
 - (3) The sanction is necessary to ensure the health of the managed care 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 managed care plan.
 - (b) The state must impose temporary management (regardless of any other sanction that may be imposed) if it finds that a managed care plan has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act or 42 CFR 438.706. The state must also grant enrollees the right to terminate enrollment without cause, as described in 42 CFR 438.702(a) (3), and must notify the affected enrollees of their right to terminate enrollment.
 - (c) The state may not delay imposition of temporary management to provide a hearing before imposing this sanction.
 - (d) The state may not terminate temporary management until it determines that the plan can ensure that the sanctioned behavior will not recur.
3. Granting enrollees the right to terminate enrollment without cause and notifying affected enrollees of their right to disenroll.
 4. Suspension or limitation of all new enrollments, including default enrollment, after the effective date of the sanction.
 5. Suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS or the state is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
 6. Denial of payments provided for under the contract for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with 42 CFR 438.730.

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

Performance Measure Sanctions

1. The Agency shall sanction the managed care plan for failure to achieve minimum scores on performance measures after the first year of poor performance on any measure as specified in the table below. The Agency may impose monetary sanctions and Performance Measure Action Plans (PMAP) or PMAPs alone as described below.
2. Two HEDIS measures will be compared to the National Committee for Quality Assurance HEDIS National Means and Percentiles. The HEDIS Call Abandonment measure and Agency-defined measures have threshold rates (percentages) that may trigger a sanction.

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Performance Measure Sanction Table – Effective 8/01/2013 – 8/31/2018

HEDIS Measures	Rate and applicable sanction
Care for Older Adults	Rate < 25th percentile - immediate monetary sanction and PMAP may be imposed
Call Answer Timeliness	Rate < 50th percentile - PMAP may be required
Call Abandonment	Rate > 5% - immediate monetary sanction and PMAP may be imposed
Agency-defined Measures	Rate and applicable sanction
Required Record Documentation – numerators 1-4	Rate < 85% - immediate monetary sanction and PMAP may be imposed
Face-to-Face Encounters Care Manager Training Timeliness of Service	Rate < 90% - PMAP may be required

3. **PMAP Sanctions**

The managed care plan may be required to complete a PMAP for measures that meet the thresholds given in the above table, as determined by the Agency.

4. **Monetary sanctions**

The managed care plan may receive a monetary sanction for measures for which their scores meet the thresholds given in the above table for the first offense. Managed care plans shall receive a monetary sanction for measures for which their scores meet the thresholds given in the above table for the second offense and subsequent offenses. For the HEDIS and Agency-defined measures, if the managed care plan has a score/rate that triggers an immediate monetary sanction, the managed care plan may be sanctioned \$500 for each case in the denominator not present in the numerator. If the managed care plan fails to improve these performance measures in subsequent years, the Agency shall impose a sanction of \$1,000 per case.

5. The Agency may amend the performance measure thresholds and sanctions and will notice the managed care plans prior to the start of the applicable measurement year or with an amount of notice mutually agreed upon by the Agency and the managed care plans. Amendments to the performance measure thresholds and sanctions may include, but are not limited to, adding and removing performance measures from the sanction strategy, changing thresholds for sanctions, and changing the monetary amounts of sanctions.

Other Sanctions

A. General Provisions

1. The managed care plan shall comply with all requirements and performance standards set forth in the Long-term Care program contract. The following is the specific contract language:

- a. In the event the Agency identifies a violation of or other non-compliance with the Contract (to include the failure to meet performance standards), the Agency may sanction the managed care plan pursuant to any of the following: s. 409.912 (21), F.S., s. 409.91212, F.S.; Rule 59A-12.0073, F.A.C.; s. 409.967; F.S., 42 CFR part 438 subpart I (Sanctions) and s.1932 of the Social Security Act or s.1903 (m) of the Social Security Act. The Agency may impose sanctions in addition to any liquidated damages imposed pursuant to Section XVII.
 - b. For purposes of this section, violations involving individual, unrelated acts shall not be considered arising out of the same action.
 - c. In addition to imposing sanctions for a contract violation or other non-compliance, the Agency may require the managed care plan to submit to the Agency a performance measure action plan (PMAP) within a timeframe specified by the Agency. The Agency may also require the managed care plan to submit a Corrective Action Plan (CAP) for a violation of or any other non-compliance with this contract.
 - d. Pursuant to s. 409.967(2)(h)2., Florida Statutes, if the managed care plan fails to comply with the encounter data reporting requirements as specified in this contract for 30 calendar days, the Agency shall assess the managed care plan a fine of five thousand dollars (\$5,000) per day for each day of noncompliance beginning on the 31st calendar day. On the 31st calendar day, the Agency must notify the managed care plan that the Agency will initiate contract termination procedures on the 90th calendar day unless the managed care plan comes into compliance before that date.
2. If the Agency imposes monetary sanctions, the managed care plan must pay the monetary sanctions to the Agency within 30 calendar days from receipt of the notice of sanction. If the Deputy Secretary determines that the Agency should reduce or eliminate the amount imposed, the Agency will return the appropriate amount to the managed care plan within 60 days from the date of a final decision rendered.

B. Performance Measure Action Plans (PMAP) and Corrective Action Plans (CAP)

1. If a PMAP or CAP is required as determined by the Agency, the Agency will either approve or disapprove a proposed PMAP or CAP from the managed care plan. If the Agency disapproves the PMAP or CAP, the managed care plan shall submit a new PMAP or CAP within ten 10 business days, or an expedited timeframe if required by the Agency, that addresses the concerns identified by the Agency.
2. Upon receiving Agency approval of the CAP, the managed care plan will implement the action steps set forth in the CAP within the timeframes specified by the Agency.
3. The Agency may impose a monetary sanction of \$200 per calendar day on the managed care plan for each calendar day that the managed care plan does not implement, to the satisfaction of the Agency, the approved PMAP or CAP. Managed care plans shall receive a monetary sanction for measures for which their scores meet the thresholds reflected in Attachment D-II, Exhibit 14 for the second offense and subsequent offenses.

C. Notice of Sanction

1. Except as noted in 42 CFR part 438, subpart I (Sanctions), before imposing any of the sanctions specified in this section, the Agency will give the managed care plan written notice that explains the basis and nature of the sanction, cites the specific contract section(s) and/or provision of law and the methodology for calculation of any fine.
2. If the Agency decides to terminate the managed care plan's contract for cause, the Agency will provide advance written notice of intent to terminate including the reason for termination and the effective date of termination. The Agency will also notify managed care plan enrollees of the termination along with information on their options for receiving services following Contract termination.
3. Unless the Agency specifies the duration of a sanction, a sanction will remain in effect until the Agency is satisfied that the basis for imposing the sanction has been corrected and is not likely to recur.
4. For non-risk managed care plans, the Agency reserves the right to withhold all or a portion of the managed care plan's monthly administrative allocation for any amount owed pursuant to this section.

D. Disputes

1. To dispute an Agency's interpretation of the contract, the managed care plan must request that the Agency's Deputy Secretary for Medicaid or designee, hear and decide the dispute. The managed care plan must submit, within 21 calendar days after the issuance of a contract Interpretation, a written dispute of the contract interpretation directly to the Deputy Secretary or designee. This submission shall include all arguments, materials, data, and information necessary to resolve the dispute (to include all evidence, documentation and exhibits). The managed care plan waives any dispute not raised within 21 calendar days of receiving the contract interpretation. It also waives any arguments it fails to raise in writing within 21 calendar days of receiving a contract interpretation, and waives the right to use any materials, data, and/or information not contained in or accompanying the managed care plan's submission submitted within the 21 calendar days following its receipt of the contract interpretation in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court and any possible administrative venue).
2. The Deputy Secretary or his/her designee will decide the dispute under the reasonableness standard, reduce the decision to writing and serve a copy to the managed care plan. This written decision will be final.
3. The exclusive venue of any legal or equitable action that arises out of or relating to the contract, including an appeal of the final decision of the Deputy Secretary or his/her designee, will be Circuit Court in Leon County, Florida; in any such action, the managed care plan agrees that the Circuit Court can only review the final decision for reasonableness, and Florida law shall apply. In the event the Agency issues any action under Florida Statutes or Florida Administrative Code apart from this contract, the Agency will notice the managed care plan of the appropriate administrative remedy.

VII. CONDUCTING AN INDEPENDENT ASSESSMENT FOR THE LONG-TERM CARE 1915(B) WAIVER

As a requirement of the 1915(b) waiver, Florida will contract with an independent assessment entity for the first two waiver periods to supplement and confirm programmatic information obtained by the state for the Long-term Care program. The independent assessment will evaluate or measure:

- **Access to services** – A recipient’s access to services in the new managed care program must be equal to or better than the accessibility of services prior to or without the waiver;
- **Quality of services** – Service quality in the new program must be equal to or better than the quality of services prior to or without the waiver;
- **Cost effectiveness** – Total costs under the new program (including program benefits and administrative costs) must be equal to or less than the cost of providing like services without the waiver.

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