AGENCY FOR HEALTH CARE ADMINISTRATION

SFY 2021-2022

External Quality Review Technical Report

April 2023

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

Glossary of Acronyms

42 CFR	Title 42 of the Code of Federal Regulations
AAAHC	Accreditation Association for Ambulatory Health Care
AAPD	American Academy of Pediatric Dentistry
ADHD	Attention-Deficit/Hyperactivity Disorder
ADT	Admission, Discharge, Transfer
Agency	Florida Agency for Health Care Administration
AI	Audacious Inquiry
AIRS	Adverse Incident Reporting System
ANDP	Annual Network Development Plan
AOD	Alcohol or Other Drug
BC-DR	Business Continuity-Disaster Recovery Plan
BH	Behavioral Health
BMI	Body Mass Index
C-section	Caesarean Section
CAP	Corrective Action Plan
CCM	Chronic Care Management
CHF	Congestive Heart Failure
CHIP	Children's Health Insurance Program
CHW	Case Health Worker
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus Disease 2019
CQS	Comprehensive Quality Strategy
CSR	Customer Service Representative
CSU	Crisis Stabilization Unit
CY	Calendar Year
DOH	Department of Health
DRTS	Denied, Reduced, Terminated Suspended Services
DY	Demonstration Year
ECGA	Enrollee Complaints, Grievances & Appeals Report System
ED	Emergency Department
EDV	Encounter Data Validation
ENS	Encounter Notification Service

EQR.....External Quality Review
EQRO.....External Quality Review Organization
FMEA.....Failure Modes and Effects Analysis
FAR.....Final Audit Report
FFS.....Fee-for-Service
FFY.....Federal Fiscal Year
FPQC.....Florida Perinatal Quality Collaborative
HbA1c.....Hemoglobin A1c
HCBS.....Home and Community-Based Services
HEDIS®,*.....Healthcare Effectiveness Data and Information Set
HHS.....United States Department of Health and Human Services
HIE.....Health Information Exchange
HIPAA.....Health Insurance Portability and Accountability Act
HIV/AIDS.....Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HPV.....Human Papillomavirus
HRA.....Health Risk Assessment
HSAG.....Health Services Advisory Group, Inc.
IC.....Inpatient Coordinator
ICD-10.....International Classification of Diseases, 10th Revision
IP.....Inpatient
IRR.....Interrater Reliability
IS.....Information Systems
ITN.....Invitation to Negotiate
IVR.....Interactive Voice Response
LARC.....Long-acting Reversible Contraceptive
LO.....Licensed Organization
LTC.....Long-Term Care
LTSS.....Long-Term Services and Supports
MCO.....Managed Care Organization
MCP.....Managed Care Plan
MCRC.....Managed Care Rule Compliance
MFAO.....Medicaid Fiscal Agent Operations
MLTSS.....Managed Long-Term Services and Supports
MMA.....Managed Medical Assistance

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

MMIS	Medicaid Management Information System
MPIP	MMA Physician Incentive Program
MRRV	Medical Record Review Validation
MSR	Member Service Representative
MTM	Medication Therapy Management
MY	Measurement Year
NA	Not Applicable
NABD	Notice of Adverse Benefit Determination
NAS	Neonatal Abstinence Syndrome
NCQA	National Committee for Quality Assurance
NPI	National Provider Identifier
NR	Not Reported
OB/GYN	Obstetrician/Gynecologist
OCR	Office of Clinical Research
PAHP	Prepaid Ambulatory Health Plan
PCCM	Primary Care Case Management
PCP	Primary Care Practitioner
PDP	Primary Dental Practitioner
PDSA	Plan-Do-Study-Act
PHE	Public Health Emergency
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PMV	Performance Measure Validation
PNOU	Provider Network Oversight Unit
P&P	Policy and Procedure
PPA	Potentially Preventable Admission
PPE	Potentially Preventable Event
PPR	Potentially Preventable Readmission
PPV	Potentially Preventable ED Visit
PR	Provider Relations
PRM	Provider Relations Management
QAPI	Quality Assessment and Performance Improvement; also Quality Assurance and Performance Improvement
QI	Quality Improvement
RY	Reporting Year
SAPO	State-Authorized Portable Order

SBIRT	Screening, Brief Intervention and Referral for Treatment Regarding Substance Use Disorders
SFY	State Fiscal Year
SME	Subject Matter Expert
SMI	Serious Mental Illness
SMMC	Statewide Medicaid Managed Care
SUD	Substance Use Disorder
Tdap	Tetanus, Diphtheria, and Pertussis
TOC	Transition of Care
TPID	Trading Partner Identifier
UM	Utilization Management
UMPD	Utilization Management Program Description

Executive Summary

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Introduction to the Annual Technical Report

Overview and Purpose Statement

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

The purpose of this state fiscal year (SFY) 2021–2022 External Quality Review Technical Report is to draw conclusions about the quality, timeliness, and access to healthcare services provided by the contracted MCOs.

Overview of Florida's Managed Care Program

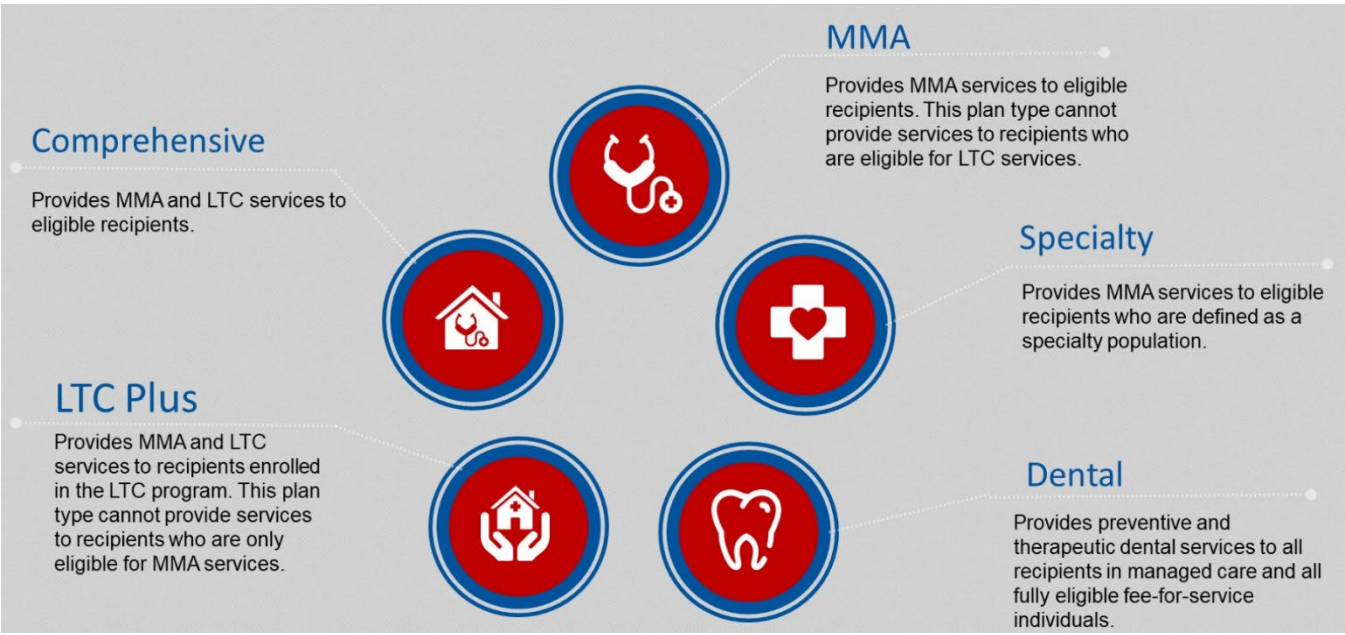
Statewide Medicaid Managed Care Program

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

[1-1] Centers for Medicare & Medicaid Services. CMS-R-305, External Quality Review (EQR) of Medicaid Managed Care, EQR Protocols, and Supporting Regulations. Available at: https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-R-305.html. Accessed on: Mar 9, 2023.

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

Figure 1-1—Florida Plan Types



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

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

Please see Appendix A for a list of the plans.

Florida Medicaid Managed Care Demographics

The demographics of the Florida Medicaid population (excluding the fee-for-service [FFS] population) as of June 30, 2022, were as follows.[1-2]

- Approximately 3.8 million were enrolled in a comprehensive or standard MMA plan.
- Approximately 200,000 were enrolled in a specialty plan.
- Approximately 124,000 were enrolled in the LTC program.
- Approximately 4.5 million were enrolled in a dental plan.

Figure 1-2 through Figure 1-6 show plan Medicaid enrollment as of June 30, 2022.

Figure 1-2—Comprehensive Plan Enrollment as of June 30, 2022

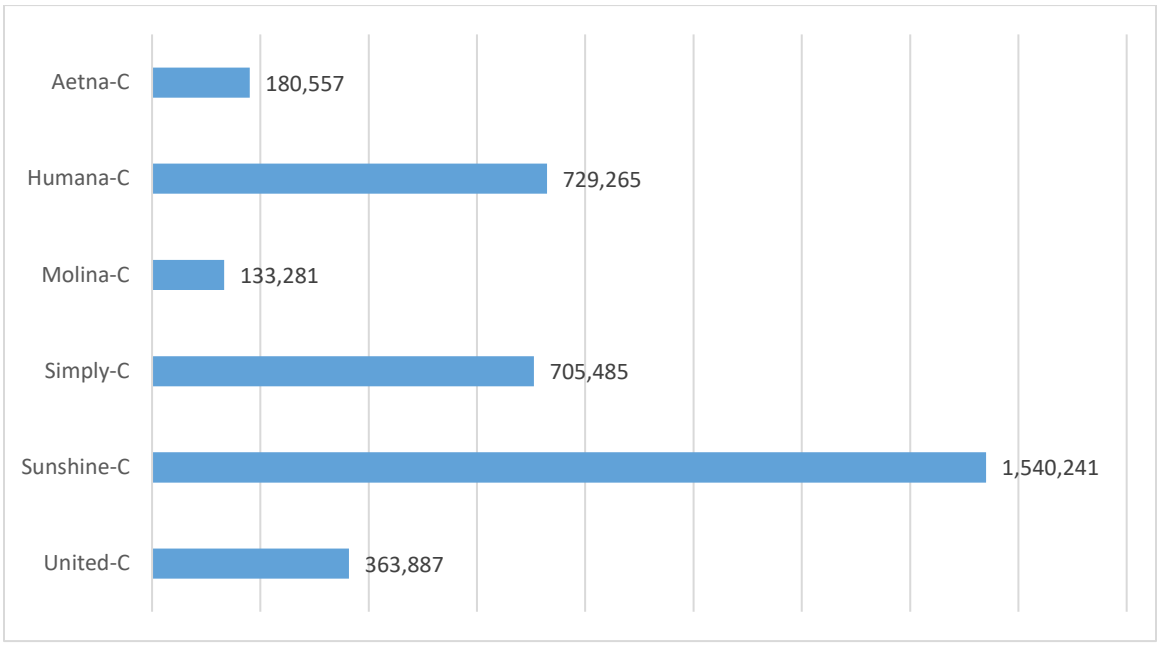
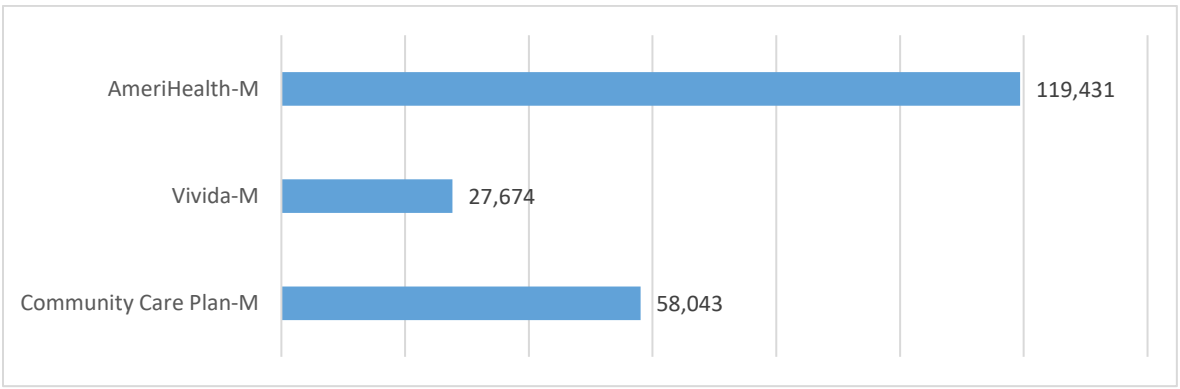


Figure 1-3—MMA Plan Enrollment as of June 30, 2022



[1-2] Agency for Health Care Administration. Florida Statewide Medicaid Monthly Enrollment Report. Available at: https://ahca.myflorida.com/medicaid/finance/data_analytics/enrollment_report/index.shtml. Accessed on: Mar 9, 2023.

Figure 1-4—Specialty Plan Enrollment as of June 30, 2022

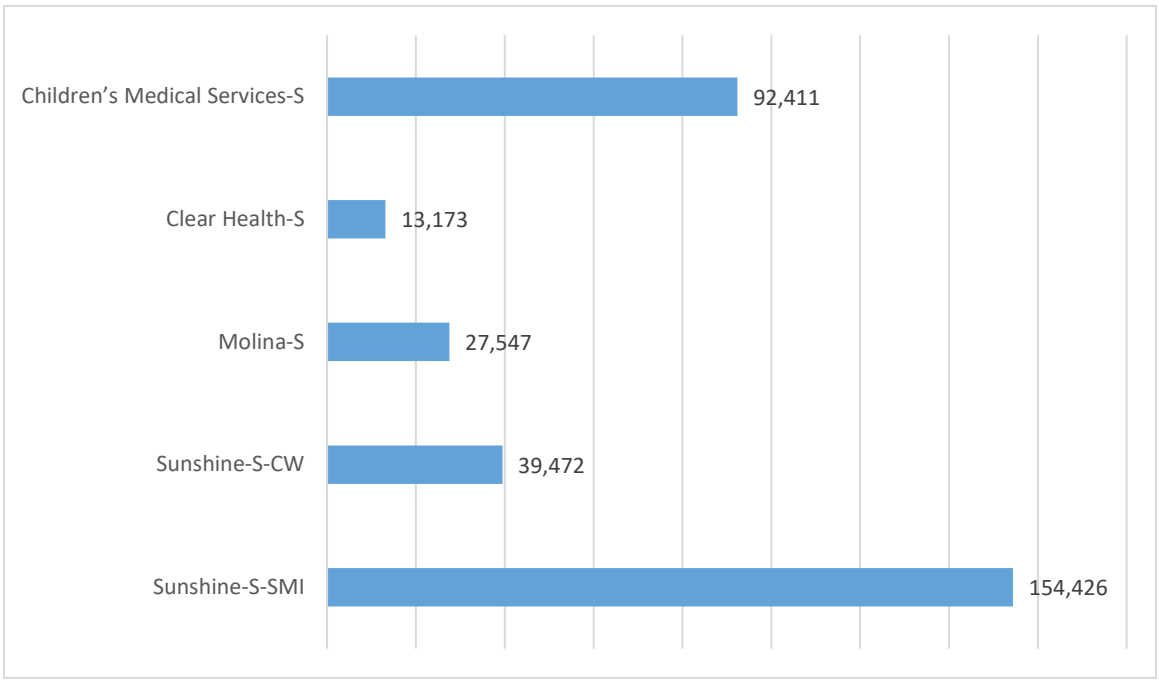


Figure 1-5—LTC Plan Enrollment as of June 30, 2022

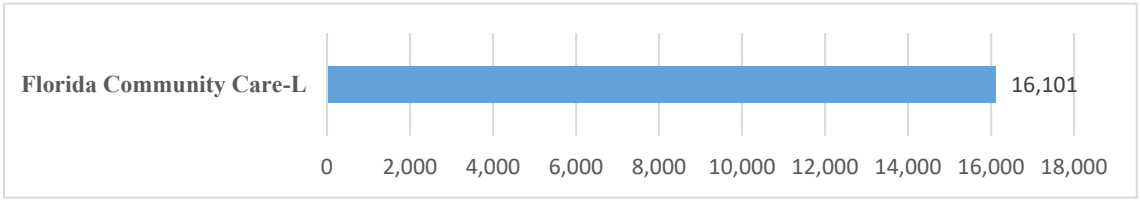
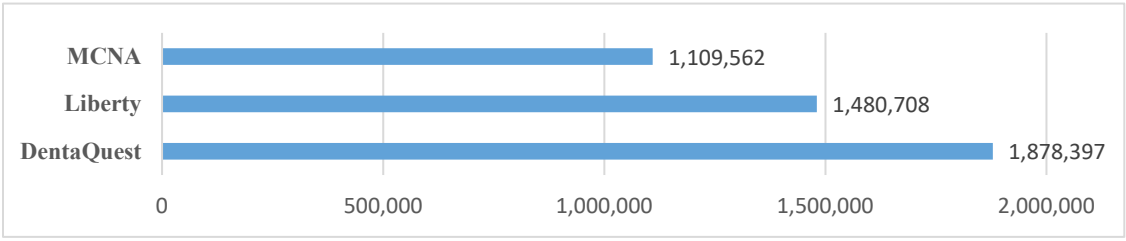


Figure 1-6—Dental Plan Enrollment as of June 30, 2022

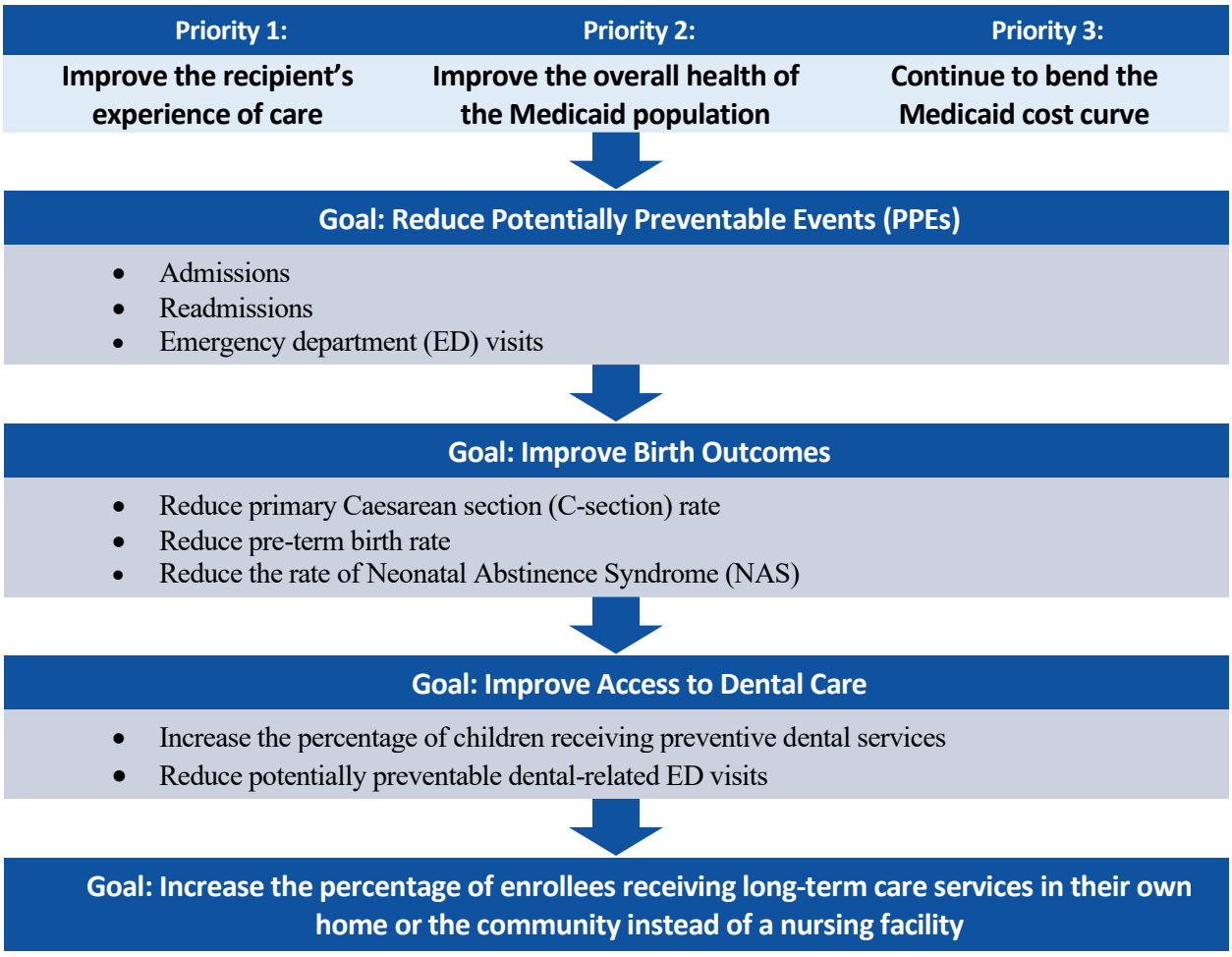


Quality Strategy

CMS Medicaid managed care regulations at 42 CFR §438.340 require Medicaid state agencies operating Medicaid managed care programs to develop and implement a written quality strategy for assessing and improving the quality of healthcare services offered to their enrollees and update it every three years. The Comprehensive Quality Strategy (CQS) outlines Florida's strategy for assessing and improving the quality of healthcare and services furnished by the plans and other providers within the Florida Medicaid

system.[1-3] The Agency began the process of updating the CQS during demonstration year (DY) 13 and completed this process during DY 14 (July 1, 2019, through June 30, 2020). The updated CQS addresses various strategies to assess progress toward meeting the Agency's goals. The Agency's established goals seek to build upon the success of the SMMC program and to ensure that quality improvement (QI) is a continual process. In line with the Agency's goals outlined in its quality strategy, the Agency identified three priorities for Florida Medicaid. Related to each priority are specific, measurable goals to guide the program's priority quality initiatives. These efforts are designed to measurably improve the health outcomes of enrollees in the most efficient, innovative, and cost-effective ways possible. The Agency strives to provide high-quality care to all enrollees, regardless of their race or ethnicity, sex, age, disability, socioeconomic status, or geographic location. The Agency considers health disparities in the development and implementation of all QI initiatives.

Figure 1-7—Three Priorities and Corresponding Goals[1-4]



[1-3] Agency for Health Care Administration. Comprehensive Quality Strategy. Available at: https://ahca.myflorida.com/medicaid/policy_and_quality/quality/docs/Comprehensive_Quality_Strategy_Report.pdf. Accessed on: Mar 9, 2023.
[1-4] Ibid

Scope of External Quality Review Activities

To conduct this assessment, HSAG used the results of mandatory and optional EQR activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by CMS (CMS EQR protocols).[1-5] The purpose of these activities, in general, is to improve states' ability to oversee and manage plans they contract with for services, and help plans improve their performance with respect to quality, timeliness, and access to care. Effective implementation of the EQR-related activities will facilitate state efforts to purchase high-value care and to achieve higher-performing healthcare delivery systems for their Medicaid and Children's Health Insurance Program (CHIP) members. For the SFY 2021–2022 assessment, HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-1 to derive conclusions and make recommendations about the quality, timeliness, and access to care and services provided by each plan.

Table 1-1—EQR Activities

Activity	Description	CMS EQR Protocol
Mandatory Activities*		
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by a plan used sound methodology in its design, implementation, analysis, and reporting.	**Protocol 1.** Validation of Performance Improvement Projects
Performance Measure Validation (PMV)	This activity assesses whether the performance measures calculated by a plan are accurate based on the measure specifications and state reporting requirements.	**Protocol 2.** Validation of Performance Measures
Compliance with Standards**	This activity determines the extent to which a Medicaid and CHIP plan is in compliance with federal standards and associated state-specific requirements, when applicable.	**Protocol 3.** Review of Compliance with Medicaid and CHIP Managed Care Regulations
Optional Activities		
Encounter Data Validation (EDV)	The activity validates the accuracy and completeness of encounter data submitted by a plan.	**Protocol 5.** Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan

* Until the CMS network adequacy validation protocol is issued, there are only three mandatory EQR-related activities.

** HSAG received the documentation for compliance monitoring for this activity from the Agency.

[1-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 9, 2023.

Aggregating and Analyzing Statewide Data

For each comprehensive, standard, and specialty plan, HSAG analyzed the results obtained from each EQR activity. HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality, timeliness, and access to care furnished by each plan, as well as the program overall. To produce Florida's SFY 2021–2022 Technical Report, HSAG performed the following steps to analyze the data obtained and draw statewide conclusions about the quality, timeliness, and access to care and services provided by the plans.

Step 1: HSAG analyzed the quantitative results obtained from each EQR activity for each plan to identify strengths and weaknesses in each domain of quality, timeliness, and access to services furnished by the plan for the EQR activity.

Step 2: From the information collected, HSAG identified common themes and the salient patterns that emerged across EQR activities for each domain and drew conclusions about overall quality, timeliness, and access to care and services furnished by the plans.

Step 3: From the information collected, HSAG identified common themes and the salient patterns that emerged across all EQR activities related to strengths and opportunities for improvement in one or more of the domains of, quality, timeliness, and access to care and services furnished by the plans.

Step 4: HSAG identified any patterns and commonalities that exist across the program to draw conclusions about the quality, timeliness, and access to care for the program.

Detailed information about each activity's methodology is provided in Appendix B of this report. For a detailed, comprehensive discussion of the strengths, weaknesses, conclusions, and recommendations for each plan, please refer to the results of each activity in sections 2 through 4 of this report, as well as in Appendix C for a plan-specific analysis.

Quality, Timeliness, and Access

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



Quality

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

Timeliness

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

Access

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

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

How Conclusions Were Drawn From EQRO Activities

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

Table 1-2—EQR and Agency Activities and Domains

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

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

Florida Managed Care Program Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from SFY 2021–2022 to comprehensively assess the plans' performance in providing quality, timely, accessible healthcare services to Agency Medicaid and CHIP members. For each plan reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the plans' performance, which can be found in sections 2 through 4 and Appendix C of this report. The overall findings and conclusions for all plans were also compared and analyzed to develop overarching conclusions and recommendations for the Florida managed care program. Table 1-3 highlights substantive findings and actionable state-specific recommendations, when applicable, for the Agency to further promote its CQS goals and objectives.

Table 1-3—Florida Managed Care Program Substantive Findings

Program Strengths	
	**Quality** • **Overall**: The PIPs were methodologically sound. The implemented targeted interventions were linked to the identified barriers and actively engaged the enrollees or providers to improve access to, quality of, and timeliness of care. • **Overall**: Most plans reported achievement of significant improvement in PIP performance indicator outcomes or achievement of significant clinical or programmatic improvement. • **MMA Program**: The statewide average for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure (all three indicators) met or exceeded the performance target. The results suggest that children and adolescents 3–17 years of age received adequate weight assessment and counseling for nutrition and physical activity. • **MMA Program**: The statewide average for the *Asthma Medication Ratio—Total* measure indicator met or exceeded the performance target. The results suggest that members with persistent asthma received recommended care and are better able to manage their chronic condition. • **LTC Program**: All seven statewide rates met or exceeded the Agency's MY 2021 performance target. The results suggest that members receiving long-term services and supports (LTSS) were appropriately assessed, comprehensive care plans were created for members within specific measure timelines, and care plans were shared with the members' primary care practitioner (PCP). • **LTC Program**: The statewide rate for the *LTSS Reassessment/Care Plan Update After Inpatient Discharge—Reassessment and Care Plan Update After Inpatient Discharge* measure indicator improved more than 18 percentage points. The results indicate that the plans have established documentation of assessments and implemented tools to promote the coordination of LTSS, and have conducted assessments and created care plans with their members within specific measure timelines. • **Dental Plans**: Four dental measure indicators improved more than 3 percentage points from MY 2020 to MY 2021. The results suggest that children received dental treatment services to prevent dental caries, one of the

Program Strengths	
	most common chronic diseases. Receiving comprehensive, periodic oral evaluation, and oral treatment services helps prevent progression of decay and crumbling of teeth. • **Dental Plans**: All dental plans received a *Met* overall PIP validation status for both dental PIPs.
+	**Timeliness and Access** • **MMA Program**: For the *Administration of the Transportation Benefit* PIP, eight out of 12 plans reported a CY 2020 rate at or above the goal of 90 percent. • **MMA Program**: The statewide average for three of four indicators for the *Child and Adolescent Well-Care Visits* measure met or exceeded the performance target. The results suggest that children and adolescents received one or more well-care visits from a PCP or obstetrician/gynecologist (OB/GYN).

Program Weaknesses	
−	*Note: When referring to the performance target comparisons bulleted below, caution should be used between the comparisons due to the impact of the coronavirus disease 2019 (COVID-19) public health emergency (PHE). Additionally, COVID-19-related factors may have led to a decline in performance indicator rates for CY 2020 resulting in impacts to PIP results.* **Quality** • **Overall**: The performance indicator rates for some PIPs declined. The plans may not be revising the interventions based on the intervention evaluation data, or the interventions deemed successful did not reach enough of the eligible population to impact the performance indicator rates. Additionally, COVID-19-related factors may have led to a decline in performance indicator rates for CY 2020. • **Overall**: Although regular compliance monitoring, oversight, and reviews of plans occurred, the Agency did not demonstrate compliance with the CMS Medicaid Managed Care Rule requirements for conducting a comprehensive compliance review every three years. The Agency has developed a plan to conduct compliance reviews in 2023. • **MMA Program**: The statewide average declined for measures pertaining to the immunizations of children and adolescents, and the indicator rates for *Childhood Immunizations Status—Combination 10* and *Immunizations for Adolescents—Combination 1* fell below the minimum performance target. • **MMA Program**: The statewide average rate for the *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total* measure indicator declined more than 16 percentage points and fell below the minimum performance target. In addition, the *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies—Total* statewide average rate fell below the minimum performance target.

Program Weaknesses	
	• **LTC Program**: The statewide average for the *LTSS Minimizing Institutional Length of Stay* measure declined more than 4 percentage points from MY 2020 to MY 2021. • **Dental Program**: The statewide average for the *Follow-Up After ED Visits for Dental Caries in Children—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators declined more than 11 percentage points from MY 2020 to MY 2021.
−	**Quality, Timeliness, and/or Access** • **MMA Program**: The statewide average rates for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Lead Screening in Children* measure indicators declined more than 3 percentage points from MY 2020 to MY 2021. • **MMA Program**: The statewide average rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator declined more than 5 percentage points and fell below the minimum performance target. The statewide average rate for the *Prenatal and Postpartum Care—Postpartum Care* measure indicator fell below the minimum performance target. • **MMA Program**: The statewide average rates for the *Follow-Up After ED Visit for Mental Illness* and the *Follow-Up After ED Visit for AOD Abuse or Dependence* measures fell below the minimum performance targets. • **MMA Program**: The statewide average rate for the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total* measure indicator declined more than 4 percentage points from MY 2020 to MY 2021. • **MMA Program**: The statewide average rates for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* measure indicators declined more than 5 percentage points from MY 2020 to MY 2021.

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

HSAG's EQR results and guidance on actions assist the Agency in evaluating the plans' performance and progress in achieving the goals of the program's quality strategy. These actions, if implemented, may assist the Agency and the plans in achieving and exceeding goals. In addition to providing each plan with specific guidance, HSAG offers the Agency the following recommendations, which should positively impact the quality, accessibility, and timeliness of services provided to Medicaid members.

Domain	Program Recommendations	Quality Strategy Priority & Goal
Quality	HSAG recommends that the Agency implement its planned process to conduct compliance reviews of all plans within the required three-year cycle. The Agency should use the tools provided by HSAG to ensure that all standards required in the CMS Medicaid Managed Care Rule are reviewed during the compliance reviews. Complete results of each plan's compliance reviews and follow-up on corrective actions should be submitted to HSAG annually to demonstrate compliance with conducting compliance reviews.	**Priorities:** • Improve the recipient's experience of care. • Continue to bend the Medicaid cost curve.
	For unsuccessful PIP interventions, HSAG recommends that the plans make data-driven decisions to revise or discontinue the current intervention and implement new interventions. The plans should consider using QI science tools such as process mapping, failure modes and effects analysis, or a key driver diagram to identify and prioritize barriers and opportunities for improvement. The plans should consider seeking enrollee input to better understand enrollee-related barriers toward access to care. The interventions deemed successful when tested on a small scale using Plan-Do-Study-Act (PDSA) cycles should be ramped up and adopted planwide in order to impact the entire eligible population.	**Priorities:** • Improve the recipient's experience of care. • Improve the overall health of the Medicaid population. **Goals:** • Reduce PPEs. • Improve birth outcomes.
	HSAG recommends that the plans serving the MMA program identify best practices for ensuring children receive all preventive vaccinations.	**Priorities:** • Improve the overall health of the Medicaid population. **Goals:** • Reduce PPEs.

Domain	Program Recommendations	Quality Strategy Priority & Goal
Quality	HSAG recommends that the plans serving the MMA Program conduct a root cause analysis or focus study to determine why members are not quitting tobacco use. Upon identification of a root cause, the plans should implement appropriate interventions and develop measurable and timebound goals specifically focused on evaluating these interventions' impact toward improving the performance related to smoking cessation.	**Priorities:** • Improve the overall health of the Medicaid population. • Continue to bend the Medicaid cost curve. **Goals:** • Reduce PPEs.
	HSAG recommends that the plans serving the LTC Program evaluate their care coordination processes to determine if there are opportunities to enhance the methods in which the plans engage with members and facilities to support successful discharges to the community. Additionally, plans should assess if they have adequate community supports in place to facilitate members successfully transitioning to reside in a community setting within 100 days of admission to a facility.	**Priorities:** • Improve the recipient's experience of care. • Improve the overall health of the Medicaid population. • Continue to bend the Medicaid cost curve. **Goals:** • Reduce PPEs. • Increase the percentage of enrollees receiving LTC services in their own home or the community instead of a nursing facility.
	HSAG recommends that the dental plans conduct a root cause analysis or focus study to determine any barriers that prevent children from receiving a dental treatment service to prevent dental caries, which is one of the most common chronic diseases.	**Priorities:** • Improve the overall health of the Medicaid population. **Goals:** • Reduce PPEs. • Improve access to dental care.
Quality Timeliness and/or Access	HSAG recommends that the plans serving the MMA Program conduct a root cause analysis or focus study to: • Identify barriers experienced by providers in following the recommended guidelines for follow-up and monitoring of prescribed ADHD medication. • Determine why some children did not receive blood lead tests by their second birthday. Upon identification of any root causes contributing to these gaps in care, the plans should implement appropriate interventions to improve use of evidence-based practices specifically related to these pediatric services.	**Priorities:** • Improve the recipient's experience of care. • Improve the overall health of the Medicaid population. **Goals:** • Reduce PPEs.

Domain	Program Recommendations	Quality Strategy Priority & Goal
Quality Timeliness and/or Access	HSAG recommends that the plans serving the MMA Program consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care. In addition, HSAG recommends that the plans analyze their data and consider whether there are disparities within the plans' populations that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that the plans implement appropriate interventions to improve the quality, accessibility, and timeliness of prenatal and postpartum care.	**Priorities:** • Improve the recipient's experience of care. • Improve the overall health of the Medicaid population. • Continue to bend the Medicaid cost curve. **Goals:** • Improve birth outcomes. • Reduce PPEs.
	HSAG recommends that the plans serving the MMA Program conduct a root cause analysis to determine why members who access the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care. HSAG recommends that the plans use the information learned from the root cause analysis to establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, HSAG recommends the plans increase the use of telehealth services to ensure timely follow-up services. Additionally, HSAG recommends that the plans enhance communication and collaboration with hospitals to improve the effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.	**Priorities:** • Improve the recipient's experience of care. • Improve the overall health of the Medicaid population. • Continue to bend the Medicaid cost curve. **Goals:** • Reduce PPEs.
	HSAG recommends that the plans serving the MMA program conduct a root cause analysis or focus study to: • Determine why some adolescents and adults with a new episode of AOD dependence were not accessing timely treatment. • Evaluate opportunities to enhance care coordination to support members to access timely follow-up care after hospitalization for mental illness and identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness. Upon identification of a root cause, each plan should implement appropriate interventions to improve the performance and in doing so, consider the nature and scope of the issue.	**Priorities:** • Improve the recipient's experience of care. • Improve the overall health of the Medicaid population. • Continue to bend the Medicaid cost curve. **Goals:** • Reduce PPEs.

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

Review of Compliance

The compliance review evaluates plan compliance with federal and state requirements and includes all required CMS standards and related Florida-specific plan contract requirements. The Agency conducts compliance review activities for each plan at least once during each three-year EQR cycle. In addition, the Agency conducts compliance monitoring activities for each plan at least once during each three-year EQR cycle. The compliance review and the compliance monitoring standards are derived from the requirements as set forth in the *Department of Human Services, Division of Health Care Financing and Policy Request for Proposal No. 3260 for Managed Care*, and all attachments and amendments in effect during the review period. During 2022, the Agency finalized the compliance review tool and planned the plan onsite compliance reviews for 2023. In addition, during 2022, the Agency monitored the plans' implementation of federal and state-specific requirements.

Federal regulations also allow the Agency to deem or exempt an MCO, PIHP, or PAHP from a review of certain administrative functions when the plan's Medicaid contract has been in effect for at least two consecutive years before the effective date of the exemption, and during those two years the plan has been subject to EQR and found to be performing acceptably for the quality, timeliness, and access to healthcare services it provides to Medicaid beneficiaries. The Agency applied deeming for the plan compliance review activity. The Agency used the results of plan national accreditation surveys, where allowed, to meet a portion of the compliance review requirements.

Performance Improvement Projects

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

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

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

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

Through the procurement process, the plans committed to meeting specific targets related to potentially preventable hospital events and birth outcomes, while the dental plans committed to meeting specific targets related to potentially preventable dental-related ED visits and preventive dental services for children. The Agency contractually required all plans to conduct PIPs in selected areas to align the plans

in achieving the Agency's program goals and to focus the plans' efforts toward meeting the targets they set for each area.

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

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

During SFY 2021–2022, the plans submitted four state-mandated PIPs to HSAG for either validation or a high-level review. SFY 2021–2022 was the fourth year for the validation and review of all PIPs except the Behavioral Health PIP, which was initiated in SFY 2020–2021.

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

Table 1-4—SFY 2021–2022 PIP Topics and Review Type for Plans

PIP Topic	Review Type
Administration of the Transportation Benefit	Validation
Behavioral Health PIP	Validation
Youth Transitions to Adult Care *Reducing Asthma Related PPEs for Pediatric Enrollees* (Plan-Selected, Children's Medical Services-S only)	Validation
*Improving Birth Outcomes**,^	High-Level Review
*Reducing PPEs**	High-Level Review

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

^ This PIP topic was not submitted by Florida Community Care-L because the PIP topic is not applicable to the LTC Plus population served by the plan.

The dental plans submitted three state-mandated PIPs. Table 1-5 displays the PIP topics and the type of review conducted by HSAG for the dental plans. SFY 2021–2022 was the fourth year for the validation and review of all three topics.

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

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

Performance Measure Validation

HSAG conducted PMV activities for the measures calculated and reported by the comprehensive plans, MMA plans, specialty plans, dental plans, and one LTC Plus plan for SFY 2021–2022. All plan measure indicator data were audited by an NCQA LO in line with the NCQA HEDIS Compliance Audit policies and procedures. HSAG's role in the validation of performance measures was to ensure that audit activities conducted by the LO were consistent with the CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019 (CMS Protocol 2).[1-7] This included validating the audit process to ensure key audit activities were performed and verifying that performance measure indicator rates were collected, reported, and calculated according to the specifications required by the state.

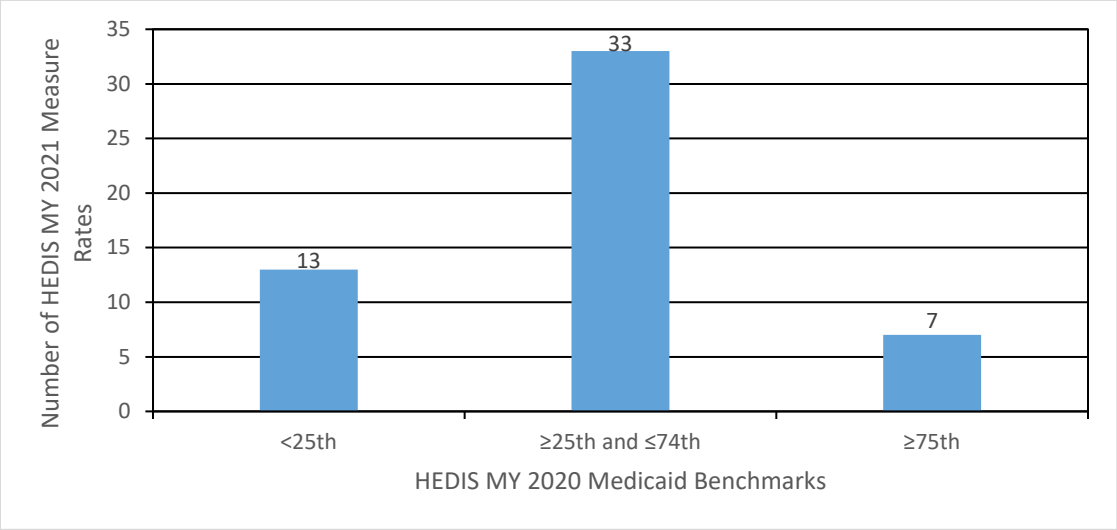
Comprehensive, MMA, and Specialty Plans

Plans were required to report 88 performance measure indicators. The Agency established performance targets for 54 of the measure indicators based on the HEDIS measurement year (MY) 2020 Quality Compass national Medicaid All Lines of Business 75th percentile. Minimum performance targets were also established based on the 25th percentile. When referring to the performance target comparisons, caution should be used between the comparisons due to the impact of the COVID-19 PHE. Factors that may have contributed could include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The measure indicators were grouped into six domains (Pediatric Care, Women's Care, Living With Illness, Behavioral Health, Access/Availability of Care, and Appropriate Treatment and Utilization). In addition to the 83 measure indicators, comprehensive plans were required to report on the 15 LTC measure indicators. Out of the 83 measure indicators, five measure indicators were to be reported by the specialty plans only. HSAG received final audit reports (FARs) that contained IS capability findings from all comprehensive, standard, and specialty plans. For the current MY, all plans were fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.

Fifty-three performance measure indicators comparable to benchmarks and related to **quality** were evaluated as part of the Pediatric Care, Women's Care, Living With Illness, Behavioral Health, and Access/Availability of Care domains. Of the 53 measure indicators related to quality, seven (13.2 percent) met or exceeded the Agency-established performance targets (the 75th percentile). The statewide average met or exceeded the Agency's minimum performance targets (the 25th percentile) for 40 of 53 (75.5 percent) measure indicators.

[1-7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 9, 2023.

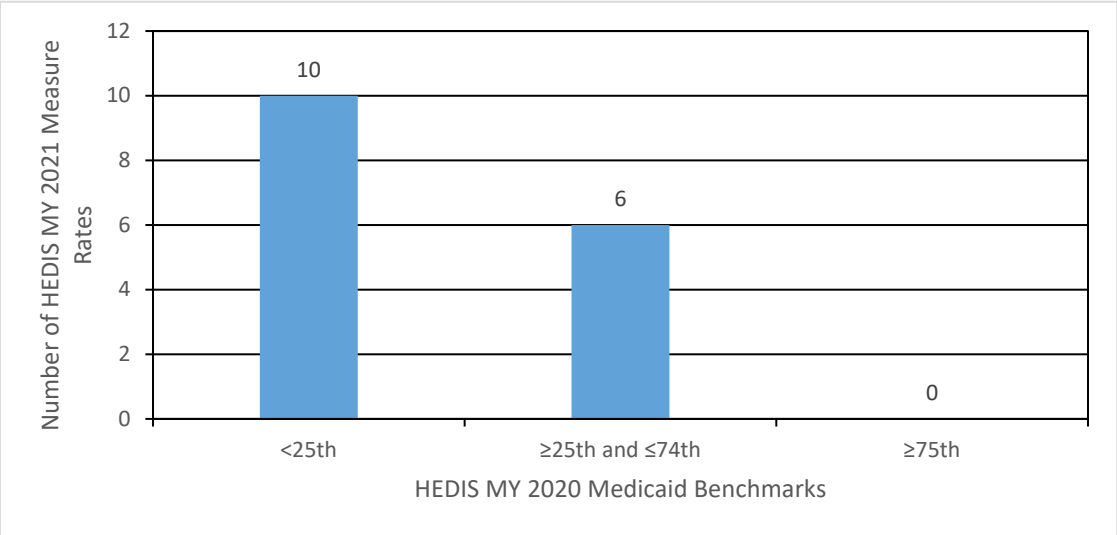
Figure 1-8—Performance Indicator Results Related to Quality



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

Sixteen performance measure indicators comparable to benchmarks and related to **timeliness** were evaluated as part of the Pediatric Care, Women's Care, and Behavioral Health domains. None of the 16 measure indicators in this area met or exceeded the Agency-established performance targets. The statewide average met or exceeded the Agency's minimum performance targets for six of 16 (37.5 percent) measure indicators.

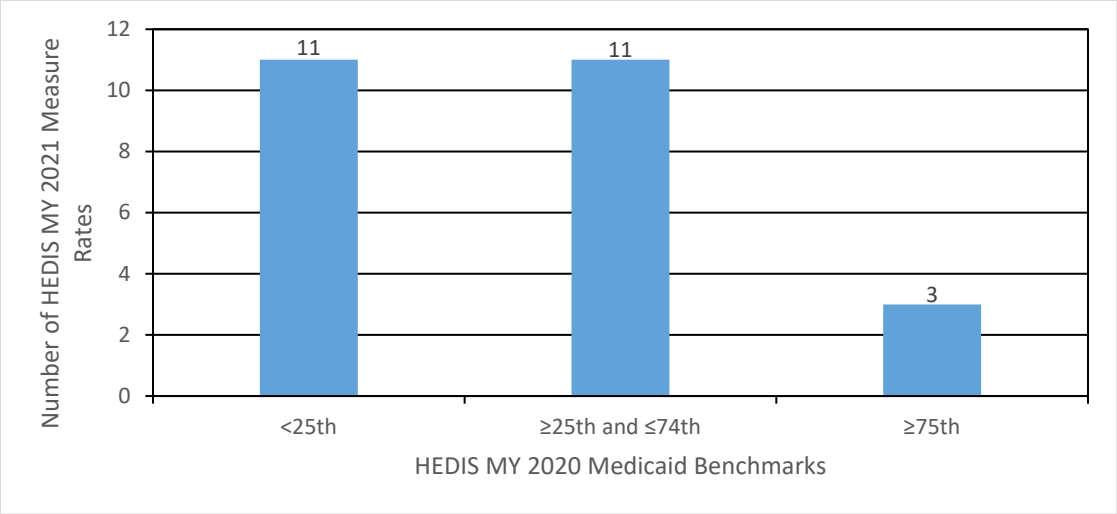
Figure 1-9—Performance Indicator Results Related to Timeliness



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

Twenty-five performance measure indicators comparable to benchmarks and related to **access** were evaluated as part of the Pediatric Care, Women's Care, Behavioral Health, Access/Availability of Care, and Appropriate Treatment and Utilization domains. Three of the 25 (12.0 percent) measure indicators in this area met or exceeded the Agency-established performance targets. The statewide average met or exceeded the Agency's minimum performance targets for 14 of 25 (56.0 percent) measure indicators.

Figure 1-10—Performance Indicator Results Related to Access



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

Long-Term Care Program

For MY 2021, the six comprehensive plans and the one LTC Plus plan were required to report 15 Agency-required measure indicators. The Agency established performance targets for seven of those measure indicators. HSAG had no concerns with the data systems and processes used by the plans for LTC measure calculations based on the information presented in the FARs and/or final audit statements. The plans reporting LTC measures continued to have adequate validation processes in place to ensure data completeness and accuracy. All seven (100 percent) measure indicators for which performance targets were established met or exceeded the performance targets for reported LTC Managed Long-Term Services and Supports (MLTSS)/HEDIS measures (85 percent for each measure indicator). HSAG received FARs that contained IS capability findings from all MMA and LTC plans. For the current MY, all plans were fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.

Dental Plans

For MY 2021, the dental plans were required to report 12 dental measure indicators. HSAG had no concerns with the data systems and processes used by the plans for dental measure calculations based on the information presented in the FARs and/or final audit statements. HSAG received FARs that contained

IS capability findings from all three dental plans. For the current MY, all plans were fully compliant with the requirement that all three plans be audited by an LO.

Performance Snapshot

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

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

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

Table 1-6—Performance Snapshot SFY 2021–2022

Domain of Care	# of Rates	Met or exceeded the performance target (75th percentile)	Ranked below the minimum performance target (25th percentile)	↑ Improved from prior year*	↓ Declined from prior year**
Pediatric Care	**17**	▪ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total* ▪ *Child and Adolescent Well-Care Visits—Ages 3—11 Years, Ages 12—17 Years,* and *Total*	▪ *Childhood Immunization Status—Combination 10* ▪ *Immunizations for Adolescents—Combination 1*	▪ *None*	▪ *Lead Screening in Children* ▪ *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase*
Women's Care	**5**	▪ *None*	▪ *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*	▪ *None*	▪ *Breast Cancer Screening* ▪ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
Living With Illness	**14**	▪ *Asthma Medication Ratio—Total*	▪ *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total* and *Discussing Cessation Strategies—Total*	▪ *None*	▪ *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total*
Behavioral Health	**16**	▪ *None*	▪ *Initiation and Engagement of Alcohol or Other Drug (AOD) Abuse or Dependence Treatment—Engagement of AOD Treatment—Total* ▪ *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* ▪ *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* ▪ *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*	▪ *Antidepressant Medication Management—Effective Acute Phase Treatment* ▪ *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total* ▪ *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	▪ *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total* ▪ *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*

Domain of Care	# of Rates	Met or exceeded the performance target (75th percentile)	Ranked below the minimum performance target (25th percentile)	↑ Improved from prior year*	↓ Declined from prior year**
Access/ Availability of Care	1	▪ *None*	▪ *Adults' Access to Preventive/Ambulatory Health Services—Total*	▪ *None*	▪ *Adults' Access to Preventive/Ambulatory Health Services—Total*
Appropriate Treatment and Utilization	1	▪ *None*	▪ *Ambulatory Care (per 1,000 Member Months)—Emergency Department (ED) Visits Total*	▪ *None*	▪ *None*
Long-Term Care^	15	▪ *Long-Term Services and Supports (LTSS) Comprehensive Assessment and Update—Assessment of Core Elements* and *Assessment of Supplemental Elements* ▪ *LTSS Comprehensive Care Plan and Update—Care Plan With Core Elements* and *Care Plan With Supplemental Elements* ▪ *LTSS Shared Care Plan With PCP* ▪ *LTSS Reassessment/Care Plan Update After Inpatient Discharge—Reassessment After Inpatient Discharge and Reassessment* and *Care Plan Update After Inpatient Discharge*	▪ *None*	▪ *LTSS Reassessment/Care Plan Update After Inpatient Discharge—Reassessment After Inpatient Discharge and Reassessment and Care Plan Update After Inpatient Discharge* ▪ *Screening, Risk Assessment, and Plan of Care to Prevent Future Falls—Falls Part 2—Plan of Care for Falls* ▪ *LTSS Admission to an Institution from the Community—Medium-Term Stay and Long-Term Stay*	▪ *LTSS Shared Care Plan With PCP* ▪ *LTSS Minimizing Institutional Length of Stay* ▪ *LTSS Admission to an Institution from the Community—Short-Term Stay*
Dental Care#	12	▪ *None*	▪ *None*	▪ *Oral Evaluation—Total* ▪ *Topical Fluoride for Children at Elevated Caries Risk—Total* ▪ *Sealant Receipt on Permanent 1st Molars—Received a Sealant on At Least One Permanent First Molar Tooth* and *Received a Sealant on All Four Permanent First Molars* ▪	▪ *Follow-Up After ED Visits for Dental Caries in Children—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*

* Statewide rate demonstrated an increase of more than 3 percentage points from MY 2020 to MY 2021.
** Statewide rate demonstrated a decline of more than 3 percentage points from MY 2020 to MY 2021.
# A plan-specific target was identified by the Agency for one dental measure, *Annual Dental Visit—Total*.
^ The Agency established performance targets for four reported LTC MLTSS/HEDIS measures (85 percent for each measure indicator).

Review of Compliance

2

Background

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

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

Table 2-1—Florida Compliance Reviews for All Plans

Standard #	Standard	SFY 2022	Quality	Timeliness	Access
Provider Network Management					
I	Availability of Services	✓	✓	✓	✓
II.	Assurance of Adequate Capacity and Services	✓	✓	✓	✓
V.	Provider Selection	✓	✓	✓	✓
VIII.	Subcontractual Relationships and Delegation	✓	✓	✓	✓
Member Services and Experiences					
III.	Coordination and Continuity of Care	✓	✓	✓	✓
IV.	Coverage and Authorization of Services	✓	✓	✓	✓
VI.	Confidentiality	✓	✓		
VII.	Grievance and Appeal System	✓	✓	✓	✓
XIII.	Enrollee Rights	✓	✓		
XIV.	Emergency and Poststabilization Services	✓	✓	✓	✓

Standard #	Standard	SFY 2022	Quality	Timeliness	Access
Managed Care Operations					
IX.	Practice Guidelines	✓	✓		
X.	Health Information Systems	✓	✓	✓	✓
XI.	Quality Assessment and Performance Improvement (QAPI) Program	✓	✓	✓	✓
XII.	Disenrollment Requirements and Limitations	✓		✓	✓

Accreditation

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

Table 2-2—Plan Private Accreditation Status

Plan	Accrediting Body (Full Accreditation)	Other NCQA Accreditations, Certifications, and Distinctions	Expiration Date of Full Accreditation
Aetna-C (AET-C)	NCQA	• Electronic Clinical Data • Health Equity Accreditation	03/25/23
AmeriHealth-M (AMH-M) (On 8/24/2021, Florida True Health/Prestige Health Choice's name changed to AmeriHealth Caritas Florida, Inc.)	NCQA	• Electronic Clinical Data • Health Equity Accreditation • Multicultural Care	10/12/24
Children's Medical Services-S (CMS-S) (Sunshine-C)	NCQA	• Accreditation certificates were provided to the Agency, but not found on the NCQA site.	02/25/25
Clear Health-S (CHA-S) (Simply)	NCQA	• Health Equity Accreditation • Health Equity Accreditation Plus • Long Term Services and Supports (LTSS) • Multicultural Care	06/22/25

Plan	Accrediting Body (Full Accreditation)	Other NCQA Accreditations, Certifications, and Distinctions	Expiration Date of Full Accreditation
Community Care Plan-M (CCP-M)	NCQA	• Health Equity Accreditation • Multicultural Care	12/02/24
DentaQuest-D (DQT-D)	URAC		01/01/25
		• Credentialing	03/23/23
Florida Community Care Plan-L (FCC-L)	AAAHC	• None	12/11/25
Humana-C (HUM-C)	NCQA	• Electronic Clinical Data • LTSS • Multicultural Care	12/07/25
Liberty-D (LIB-D)	URAC		07/01/22
	NCQA	• Credentialing • Utilization Management	11/12/24
MCNA-D (MCA-D)	URAC		12/01/23
	NCQA	• Credentialing	04/15/25
Molina-C (MOL-C)	NCQA	• LTSS • Multicultural Care	01/22/23
Molina-S (MOL-S)	NCQA	• Health Equity Accreditation • LTSS • Multicultural Care	01/17/23
Simply-C (SIM-C) Sunshine–C (SUN-C) Sunshine-S-CW (SUN-S-CW)	NCQA	• Health Equity Accreditation • Health Equity Accreditation Plus • LTSS • Multicultural Care	04/01/25
Sunshine-S-SMI (SUN-S-SMI)	NCQA	• LTSS	11/05/24
United-C (UNI-C)	NCQA	• Electronic Clinical Data • Health Equity Accreditation • LTSS	01/20/25
Vivida-M (VIV-M)	NCQA	• None	12/08/23

Federal regulations allow the Agency to exempt a plan from a review of certain administrative functions when the plan's Medicaid contract has been in effect for at least two consecutive years before the effective date of the exemption, and during those two years the plan has been subject to EQR and found to be performing acceptably for the quality of, timeliness of, and access to healthcare services it provides to Medicaid beneficiaries. The Agency requires the plans to be accredited, which allows the Agency to leverage or deem certain review findings from a private national accrediting organization that CMS has approved as applying standards at least as stringently as Medicaid under the procedures in 42 CFR §422.158 to meet a portion of the EQR compliance review requirements. The Agency has exercised the deeming option to meet a portion of the EQR compliance review requirements. The Agency followed the requirements in 42 CFR §438.362, which include obtaining:

- Information from a private national accrediting organization's review findings. Each year, the State must obtain from each plan the most recent private accreditation review findings reported on the plan, including:
  - All data, correspondence, and information pertaining to the plan's private accreditation review.
  - All reports, findings, and other results pertaining to the plan's most recent private accreditation review.
  - Accreditation review results of the evaluation of compliance with individual accreditation standards, noted deficiencies, CAPs, and summaries of unmet accreditation requirements.
  - All measures of the plan's performance.

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

Table 2-3—2022 Deemed Compliance Review Elements

Standard #	Standard Name	Total Elements in Standard	Plans												
			AET-C	CMS-S	CCP-M	DQT-D	FCC-L	HUM-C	LIB-D	MCA-D	MOL-C	AMH-M	SIM-C	SUN-C	UNI-C
			Next Accreditation Survey (deeming review required)												
			3/23	2/25	12/24	1/25	9/24	12/22	7/22	12/23	1/23	10/24	4/25	11/24	1/25
			Number of Elements Deemed												
I	Enrollment and Disenrollment	8	0	0	0	0	0	0	0	0	0	0	0	0	0
II	Member Rights and Confidentiality	7	0	0	0	0	0	0	0	0	0	0	0	0	0
III	Member Information	21	15	15	15	11	7	15	11	15	15	15	15	15	15

Standard #	Standard Name	Total Elements in Standard	Plans												
			AET-C	CMS-S	CCP-M	DQT-D	FCC-L	HUM-C	LIB-D	MCA-D	MOL-C	AMH-M	SIM-C	SUN-C	UNI-C
			Next Accreditation Survey (deeming review required)												
			3/23	2/25	12/24	1/25	9/24	12/22	7/22	12/23	1/23	10/24	4/25	11/24	1/25
			Number of Elements Deemed												
IV	Emergency and Poststabilization Services	12	1	1	1	1	0	1	1	1	1	1	1	1	1
V	Adequate Capacity and Availability of Services	16	8	8	8	3	6	8	3	8	8	8	8	8	8
VI	Coordination and Continuity of Care	9	5	5	5	2	2	5	2	5	5	5	5	5	5
VII	Coverage and Authorization of Services	20	2	2	2	1	1	2	1	2	2	2	2	2	2
VIII	Provider Selection	10	2	2	2	2	1	2	2	2	2	2	2	2	2
IX	Subcontractual Relationships and Delegation	4	1	1	1	1	1	1	1	1	1	1	1	1	1
X	Practice Guidelines	3	3	3	3	0	3	3	0	3	3	3	3	3	3
XI	Health Information Systems	20	0	0	0	0	0	0	0	0	0	0	0	0	0
XII	Quality Assessment and Performance Improvement	8	4	4	4	2	3	4	2	4	4	4	4	4	4
XIII	Grievance and Appeal Systems	28	8	8	8	3	0	8	3	8	8	8	8	8	8
XIV	Program Integrity	14	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Score	**180**	**49**	**49**	**49**	**26**	**24**	**49**	**26**	**49**	**49**	**49**	**49**	**49**	**49**

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

2022 Plan Compliance Monitoring and Oversight

The Agency's ongoing monitoring, oversight, and compliance review tool was developed using the federal requirements and the state contract provisions as required under Subpart D of 42 CFR §438 and the quality assessment and performance improvement requirements described in 42 CFR §438.330. The tool was developed for the following lines of business and included all plans: comprehensive, LTC Plus, standard MMA, and specialty. All plans in each line of business were included in the monitoring, oversight, and compliance review process conducted by the Agency. The Agency required any identified deficiencies to be corrected until the plan was determined compliant with requirements. The monitoring, oversight, and compliance review tool used by the Agency includes all mandatory federal standards and also includes the corresponding state contract requirements. Table 2-4 includes the types of documentation reviewed by the Agency for each plan, by standard, during the Agency's monitoring and oversight process.

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

Standard #	Standard	CFR	Regulations Included	Documentation Reviewed for Compliance with Requirements
I.	Availability of Services	438.206	438.3 438.68 438.206 438.207	• Policies and procedures checklist – Policies and procedures • Provider agreement checklist – Provider agreements • Provider handbook checklist – Provider handbook • Contract template checklist – Provider contract templates • Cultural competency checklist – Cultural competency plan • Network adequacy reports • Ratio adequacy report • Quest provider network oversight unit (PNOU) summary report • Ratio adequacy report • Quest PNOU time and distance summary report • Enrollee materials checklist – Enrollee materials • Provider network validation file • Ratio, time and distance report • Online directories • Utilization management program description (UMPD) tool and UMPD • ANDP checklist • AWT deficiencies summary

Standard #	Standard	CFR	Regulations Included	Documentation Reviewed for Compliance with Requirements
				• Appointment wait times report • Home and community-based assessment tool • Printable provider directory • Online provider directory • UM program description tool • Denials, grievances, and appeals system comprehensive compliance review tool • Executed sub review checklist • PCP assignment policies and procedures • Organization chart checklist and staffing plan • Virtual site visit with plan, as needed
II.	Assurance of Adequate Capacity and Services	438.207	438.207	• Policies and procedures checklist – Policies and procedures • Provider agreement checklist – Provider agreement template • Provider handbook checklist – Provider handbook • Provider contract templates • Cultural competency checklist – Cultural competency plan • Network adequacy reports • Ratio adequacy report • Quest PNOU summary report • Quest PNOU time and distance summary report • Enrollee materials checklist – Enrollee materials • Provider network validation file • Online directories • UMPD tool and UMPD • ANDP checklist • AWT deficiencies summary • Appointment wait times report • Provider network validation file summary report • Provider ratio time and distance report findings, LTC two per county report findings • Home and community-based assessment tool • Policies and procedures • PNOU tool for adverse changes

Standard #	Standard	CFR	Regulations Included	Documentation Reviewed for Compliance with Requirements
III.	Coordination and Continuity of Care	438.208	438.208	• Policies and procedures • Continuity of care screening tool • Oral health risk assessment screening tool • Oral health risk assessment report • Transition of care screening tool • Enrollee record review strategy tool – Enrollee record review strategy • UMPD tool and UMPD • Coverage policy tool Service authorization performance outcome screening guidelines • Service authorization performance outcomes (SAPO) reports • Monthly SAPO dashboard • SAPO monthly trending report • Grievance and appeals process checklist • NABD template • Denials, grievances and appeal system, subcontractor change checklist • PCP/primary dental practitioner (PDP) appointment report • Enhanced care coordination report • Transition of care (TOC) report • Enrollee roster report • Quarterly health risk assessment report • Annual enrollee review strategy monitoring tool • Care coordination/case management program description tools • Clinical review summary form • Coordination and continuity of care documentation
IV.	Coverage and Authorization of Services	438.210	422.113 438.211 438.213 438.214 438.114 438.210 438.3 438.404	• Policies and procedures • Continuity of care screening tool • Oral health risk assessment screening tool • Oral health risk assessment report • Case management program descriptions audit tool – Case management program description • Transition of care screening tool • Enrollee record review strategy • Enrollee record review strategy tool

Standard #	Standard	CFR	Regulations Included	Documentation Reviewed for Compliance with Requirements
				• Clinical review summary form • Case file review • Service authorization performance outcome screening guidelines • UMPD tool and UMPD • Coverage policy tool • SAPO reports • Monthly SAPO dashboard • SAPO monthly trending report • Grievance and appeals process checklist • NABD template • Denials, grievances and appeal system, subcontractor change checklist • UMPD • DRTS report • Quarterly enrollee case files • Denial, grievance, and appeal system • Enhanced care coordination report • Clinical review summary form • Strategic monitoring • Virtual site visit with plan, as needed
V.	Provider Selection	438.214	438.12 438.102 438.214 438.608 438.610438.214 42 CFR Part 455 Subpart B State-Determined Requirements	• Policies and procedures • Online link for materials checklist • Welcome materials checklist • Enrollee materials checklist • Network development plan • LTC recredentialing nursing home providers • Review of sample provider denial letters • Provider agreement checklist • Denied, suspended, terminated provider report • Review of executed provider agreement • Provider directory • Desk guides related to claims processing • PNOU credentialing committee review tool and checklist • PNOU checklist for online searchable provider Directory Content • PNOU monthly printed directory revision tracker

Standard #	Standard	CFR	Regulations Included	Documentation Reviewed for Compliance with Requirements
VI.	Confidentiality	438.224	438.224	• Health Insurance Portability and Accountability Act (HIPAA) requirements checklist • Privacy incidents/breaches reporting form • Draft breach notifications to HHS/Office of Clinical Research (OCR) • HHS/OCR breach notification annual attestation • Strategic monitoring • Virtual site visit with plan, as needed
VII.	Grievance and Appeal Systems	438.228	438.400 438.402 438.406 438.408 438.410 438.414 438.416 438.420 438.424	• Policies and procedures • Medicaid complaint module-health track task note (web) • Grievance and appeals process checklist • Grievance and appeals letter template checklist • Grievance and appeals report • UMPD screening tool and UMPD • Monthly SAPO report • DRTS report • NABD template and NABD sample letters • Enrollee material checklist • Welcome materials checklist • Model enrollee handbook checklist – Enrollee handbook • Distributing written enrollee materials policy and procedure (P&P) • Grievance and appeal acknowledgement letters • NPAR template • Provider nondiscrimination checklist • Provider handbook checklist • Model provider handbook • Provider network file report • ECGA report data summary • Medicaid complaint module/HT web • Fair hearing documentation
VIII.	Subcontractual Relationships and Delegation	438.230	438.230	• Policies and procedures • UM program description • Executed subcontractor checklist • Subcontractor agreement template • Subcontractor change checklist

Standard #	Standard	CFR	Regulations Included	Documentation Reviewed for Compliance with Requirements
				• Medicaid Fiscal Agent Operations (MFAO) compliance monitoring plan master • Encounter data • Encounter accuracy trend report • Encounter timeliness trend report • ECGA data summary report • Information management systems checklist • Risk recon security scanning • Encounter combined data accuracy top 10 denial errors • BC-DR checklist and – BC-DR submission • Network access forms
IX.	Practice Guidelines	438.236	438.236	• Policies and procedures • UMPD review tool
X.	Health Information Systems	438.242	438.242 45 CFR 164.404 45 CFR 164.408 45 CFR 164.410	• Information management systems checklist • Grievance and appeals process checklist • Encounter data
XI.	QAPI Program	438.330	438.240 438.330	• Policies and procedures • QI plan checklist • Quality assessment performance improvement program description • PIP submission forms • EQRO PIP validation tool • EQRO PIP high-level review feedback • Agency PIP review findings summary forms • AIRS system • Summary critical incidents report • Performance measures report • PIP summary forms • SAPO report • Enhanced care coordination report • Critical incident policies and procedures checklist • Submission tracking log

Standard #	Standard	CFR	Regulations Included	Documentation Reviewed for Compliance with Requirements
XII.	Disenrollment: Requirements and Limitations	438.56	438.3 438.52 438.56	• Disenrollment process P&P checklist and P&Ps • Enrollment process P&P checklist – Non-discrimination P&Ps • Member handbook template – Non-discrimination policies and procedures • Medicaid complaint module-health track task notes – Member requests • Strategic monitoring • Virtual site visit with plan, as needed
XIII.	Enrollee Rights	438.100	438.10 422.128 438.10 438.100 438.106 438.108 438.110 438.224	• P&P checklist • Model enrollee handbook template; • Plan website • On-line link for materials checklist • Provider agreement checklist • Non-discrimination compliance plan • MCO/BBA incident tracking spreadsheet • Submission of HIPAA breach attestations • Member welcome materials checklist • Enrollee materials and scripts checklist • Distribution of member welcome materials • Healthy behaviors checklist and report • Provider directory checklist • Online searchable directory checklist • Grievance and appeal letters checklist • NABD template • Provider handbook checklist – Provider handbook • Strategic monitoring • Case file review • Virtual site visit with plan, as needed
XIV.	Emergency and Poststabilization Services	438.114	422.113 438.10 438.114	• Policies and procedures • Emergency services checklist • UMPD screening tool – UMPD • Strategic monitoring • Virtual site visit with plan, as needed

Compliance with Standards Review

The compliance review standards were derived from the requirements as set forth in the *Department of Human Services, Division of Health Care Financing and Policy Request for Proposal No. 3260 for Managed Care*, and all attachments and amendments in effect during the review period of July 1, 2021, through June 30, 2022. To conduct the compliance review, the Agency follows the guidelines set forth in CMS' EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019 (CMS Protocol 3).[2-1] The Agency established a timeline and process to ensure that all federal standards are reviewed over the three-year compliance review cycle of January 1, 2022–December 2024.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 10, 2023.

Comprehensive Plans

Table 2-5 presents a summary of the CY 2022 comprehensive plan compliance monitoring review results for the following plans: Aetna-C, Humana-C, Molina-C, Simply-C, Sunshine-C, and United-C.

Table 2-5—Monitoring, Oversight, and Compliance Scores for the Three-Year Period: CY 2021–2023

Standard #	Standard Name	CFR	Comprehensive Plans		
			2021	2022	2023
I.	Availability of Services	438.206	100%		
II.	Assurance of Adequate Capacity and Services	438.207	100%		
III.	Coordination and Continuity of Care	438.208	100%		
IV.	Coverage and Authorization of Services	438.210	100%		
V.	Provider Selection	438.214	100%		
VI.	Confidentiality	438.224	100%		
VII.	Grievance and Appeal Systems	438.228	100%		
VIII.	Subcontractual Relationships and Delegation	438.230	100%		
IX.	Practice Guidelines	438.236	100%		
X.	Health Information Systems	438.242	100%		
XI.	QAPI Program	438.330	100%		
XII.	Disenrollment: Requirements and Limitations	438.56	100%		
XIII.	Enrollee Rights	438.100	100%		
XIV	Emergency and Poststabilization Services	438.114	100%		
TOTAL SCORE			**100%**		

LTC Plus Plan

Table 2-6 presents a summary of the LTC Plus plan compliance monitoring review results for the following plan: Florida Community Care-L.

Table 2-6—Monitoring, Oversight, and Compliance Scores for the Three-Year Period: CY 2021–2023

Standard #	Standard Name	CFR	LTC Plus		
			2021	2022	2023
I.	Availability of Services	438.206	100%		
II.	Assurance of Adequate Capacity and Services	438.207	100%		
III.	Coordination and Continuity of Care	438.208	100%		
IV.	Coverage and Authorization of Services	438.210	100%		
V.	Provider Selection	438.214	100%		
VI.	Confidentiality	438.224	100%		
VII.	Grievance and Appeal Systems	438.228	100%		
VIII.	Subcontractual Relationships and Delegation	438.230	100%		
IX.	Practice Guidelines	438.236	100%		
X.	Health Information Systems	438.242	100%		
XI.	QAPI Program	438.330	100%		
XII.	Disenrollment: Requirements and Limitations	438.56	100%		
XIII.	Enrollee Rights	438.100	100%		
XIV	Emergency and Poststabilization Services	438.114	100%		
TOTAL SCORE			**100%**		

MMA Plans

Table 2-7 presents a summary of the standard MMA plan compliance monitoring review results for the following plans: AmeriHealth-M, Vivida-M, and Community Care Plan-M.

Table 2-7—Monitoring, Oversight, and Compliance Scores for the Three-Year Period: CY 2021–2023

Standard #	Standard Name	CFR	MMA Plans		
			2021	2022	2023
I.	Availability of Services	438.206	100%		
II.	Assurance of Adequate Capacity and Services	438.207	100%		
III.	Coordination and Continuity of Care	438.208	100%		
IV.	Coverage and Authorization of Services	438.210	100%		
V.	Provider Selection	438.214	100%		
VI.	Confidentiality	438.224	100%		
VII.	Grievance and Appeal Systems	438.228	100%		
VIII.	Subcontractual Relationships and Delegation	438.230	100%		
IX.	Practice Guidelines	438.236	100%		
X.	Health Information Systems	438.242	100%		
XI.	QAPI Program	438.330	100%		
XII.	Disenrollment: Requirements and Limitations	438.56	100%		
XIII.	Enrollee Rights	438.100	100%		
XIV	Emergency and Poststabilization Services	438.114	100%		
TOTAL SCORE			**100%**		

Specialty Plans

Table 2-8 presents a summary of the specialty plan compliance monitoring review results for the following plans: Children's Medical Services-S, Clear Health-S, Molina-S, Sunshine-S-CW, and Sunshine-S-SMI.

Table 2-8—Monitoring, Oversight, and Compliance Scores for the Three-Year Period: CY 2021–2023

Standard #	Standard Name	CFR	Specialty Plans		
			2021	2022	2023
I.	Availability of Services	438.206	100%		
II.	Assurance of Adequate Capacity and Services	438.207	100%		
III.	Coordination and Continuity of Care	438.208	100%		
IV.	Coverage and Authorization of Services	438.210	100%		
V.	Provider Selection	438.214	100%		
VI.	Confidentiality	438.224	100%		
VII.	Grievance and Appeal Systems	438.228	100%		
VIII.	Subcontractual Relationships and Delegation	438.230	100%		
IX.	Practice Guidelines	438.236	100%		
X.	Health Information Systems	438.242	100%		
XI.	QAPI Program	438.330	100%		
XII.	Disenrollment: Requirements and Limitations	438.56	100%		
XIII.	Enrollee Rights	438.100	100%		
XIV	Emergency and Poststabilization Services	438.114	100%		
TOTAL SCORE			**100%**		

Dental Plans

Table 2-9 presents a summary of the dental plan compliance monitoring review results for the following plans: DentaQuest-D, Liberty-D, and MCNA-D.

Table 2-9—Monitoring, Oversight, and Compliance Scores for the Three-Year Period: CY 2021–2023

Standard #	Standard Name	CFR	Dental Plans		
			2021	2022	2023
I.	Availability of Services	438.206	100%		
II.	Assurance of Adequate Capacity and Services	438.207	100%		
III.	Coordination and Continuity of Care	438.208	100%		
IV.	Coverage and Authorization of Services	438.210	100%		
V.	Provider Selection	438.214	100%		
VI.	Confidentiality	438.224	100%		
VII.	Grievance and Appeal Systems	438.228	100%		
VIII.	Subcontractual Relationships and Delegation	438.230	100%		
IX.	Practice Guidelines	438.236	100%		
X.	Health Information Systems	438.242	100%		
XI.	QAPI Program	438.330	100%		
XII.	Disenrollment: Requirements and Limitations	438.56	100%		
XIII.	Enrollee Rights	438.100	100%		
XIV	Emergency and Poststabilization Services	438.114	100%		
TOTAL SCORE			**100%**		

Conclusions and Recommendations Related to Quality, Timeliness, and Access

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

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

Performance Measures

3

Objectives

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

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

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

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

Measures

Table 3-1 shows HSAG's assignment of the HEDIS MY 2021 performance measures into the domains of quality, timeliness, and access.

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

Performance Measure	Quality	Timeliness	Access
Pediatric Care			
Childhood Immunization Status—Combination 3, *Combination 7*, and *Combination 10*	✓		✓
Child and Adolescent Well-Care Visits—Ages 3-11 Years, Ages 12-17 Years, Ages 18-21 Years, and *Total*	✓		✓
Lead Screening in Children	✓	✓	
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and *Continuation and Maintenance Phase*	✓	✓	✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total, *Counseling for Nutrition*, and *Counseling for Physical Activity—Total*	✓		
Immunizations for Adolescents—Combination 1 and *Combination 2*	✓		
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits and *Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits*	✓		✓
Women's Care			
Cervical Cancer Screening	✓		
Chlamydia Screening in Women—Total	✓		
Breast Cancer Screening	✓		
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Living With Illness			
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg), *Hemoglobin A1c (HbA1c) Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*	✓		
Controlling High Blood Pressure	✓	✓	
Kidney Health Evaluation for Patients with Diabetes—Ages 18–64 Years, Ages 65–74 Years, Ages 75–85 Years, and *Total*	✓		
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total, *Discussing Cessation Medications—Total*, and *Discussing Cessation Strategies—Total*	✓		
Asthma Medication Ratio—Total	✓		

Performance Measure	Quality	Timeliness	Access
Behavioral Health			
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total and *Engagement of AOD Treatment—Total*	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	✓	✓	✓
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total	✓	✓	✓
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total and 30-Day Follow-Up—Total	✓	✓	✓
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	✓		✓
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total, Cholesterol Testing—Total, and *Blood Glucose and Cholesterol Testing—Total*	✓		
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	✓		✓
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓	✓	✓
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services—Total		✓	✓
Appropriate Treatment and Utilization			
Ambulatory Care (per 1,000 Member Months)—ED Visits—Total	NA	NA	NA
Plan All-Cause Readmissions	✓		

Plan Names and Enrollment

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

MMA Program

The Agency required that each plan undergo an NCQA HEDIS Compliance Audit of the performance measures selected for reporting. These audits were performed by NCQA LOs in 2022 on data collected during 2021.

Results by Domain

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

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

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

Statewide Results—Pediatric Care

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

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

Measure	Measure Source	MY 2020	MY 2021
Childhood Immunization Status			
Combination 3	HEDIS	70.81%	68.80%
Combination 7	HEDIS	—	60.43%

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

Measure	Measure Source	MY 2020	MY 2021
Combination 10	HEDIS	—	31.47%
Lead Screening in Children			
Lead Screening in Children	HEDIS	75.56%	69.69%
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	HEDIS	47.65%	44.55%
Continuation and Maintenance Phase	HEDIS	62.67%	60.12%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	HEDIS	86.05%	84.27%
Counseling for Nutrition—Total	HEDIS	—	80.25%
Counseling for Physical Activity—Total	HEDIS	—	77.64%
Child and Adolescent Well-Care Visits			
Ages 3–11 Years	HEDIS	—	63.06%
Ages 12–17 Years	HEDIS	—	54.29%
Ages 18–21 Years	HEDIS	—	27.39%
Total	HEDIS	—	55.00%
Immunizations for Adolescents			
Combination 1	HEDIS	73.72%	73.66%
Combination 2	HEDIS	37.42%	38.56%
Well-Child Visits in the First 30 Months of Life			
Age 15 Months	HEDIS	—	59.53%
Age 15–30 Months	HEDIS	—	72.09%

— indicates that the rate is not presented because the plan was not required to report the measure for MY 2020.

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

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

Six of 17 (35.3 percent) statewide average rates within the Pediatric Care domain met or exceeded the Agency's applicable MY performance target (*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total;* and *Child and Adolescent Well-Care Visits—Ages 3–11 Years, Ages 12–17 Years,* and *Total*). Two statewide average rates fell below the minimum performance target (*Childhood Immunizations Status—Combination 10* and *Immunizations for Adolescents—Combination 1*). Two statewide average rates (*Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Lead Screening in Children*) demonstrated a decline of more than 3 percentage points from MY 2020 to MY 2021.

Statewide Results—Women's Care

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

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

Measure	Measure Source	MY 2020	MY 2021
Cervical Cancer Screening			
Cervical Cancer Screening	HEDIS	54.47%	55.21%
Chlamydia Screening in Women			
Total	HEDIS	63.94%	61.07%
Breast Cancer Screening			
Breast Cancer Screening	HEDIS	54.45%	48.62%
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	HEDIS	83.33%	77.68%
Postpartum Care	HEDIS	72.42%	70.43%

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

None of the five statewide average rates in the Women's Care domain met or exceeded the Agency's applicable MY performance targets. Two of the five (40.0 percent) statewide average rates fell below the minimum performance target, demonstrating opportunities for statewide improvement in the Women's Care domain.

Statewide Results—Living With Illness

Table 3-4 displays the statewide averages calculated by HSAG for MY 2020 and MY 2021 for all measures in the Living With Illness domain and whether performance met or exceeded, or was below, the Agency-identified performance targets (for applicable measures). Cells shaded in green indicate performance rates that met or exceeded the Agency's applicable MY performance targets. Cells shaded in yellow indicate performance rates that fell below the minimum performance target for the applicable MY. To review the Living With Illness measure indicator rates by plan, please see the Comparative Analysis section.

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

Measure	Measure Source	MY 2020	MY 2021
Comprehensive Diabetes Care			
Blood Pressure Control (<140/90 mm Hg)	HEDIS	—	55.29%
HbA1c Testing	HEDIS	82.37%	82.60%
*HbA1c Poor Control (>9.0%)**	HEDIS	47.57%	48.90%
HbA1c Control (<8.0%)	HEDIS	45.58%	44.56%
Eye Exam (Retinal) Performed	HEDIS	45.52%	45.86%
Controlling High Blood Pressure			
Controlling High Blood Pressure	HEDIS	—	58.22%
Medical Assistance With Smoking and Tobacco Use Cessation			
Advising Smokers and Tobacco Users to Quit—Total	HEDIS	77.11%	60.49%
Discussing Cessation Medications—Total	HEDIS	48.75%	50.51%
Discussing Cessation Strategies—Total	HEDIS	42.73%	42.71%
Asthma Medication Ratio			
Total	HEDIS	73.94%	71.15%
Kidney Health Evaluation for Patients with Diabetes			
18–64 Years	HEDIS	—	34.97%
65–74 Years	HEDIS	—	40.89%
75–85 Years	HEDIS	—	41.78%
Total	HEDIS	—	36.00%

** Lower rates indicate better performance for this measure.*
— indicates that the rate is not presented because the plan was not required to report the measure for MY 2020.

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

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

One of the 14 (approximately 7.1 percent) statewide average rates within the Living With Illness domain met or exceeded the Agency's applicable MY performance targets (*Asthma Medication Ratio—Total*). Two of the 14 (approximately 14.3 percent) statewide average rates fell below the minimum performance target, demonstrating opportunities for statewide improvement in the Living With Illness domain.

Statewide Results—Behavioral Health

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

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

Measure	Measure Source	MY 2020	MY 2021
Initiation and Engagement of AOD Abuse or Dependence Treatment			
Initiation of AOD Treatment—Total	HEDIS	46.58%	42.10%
Engagement of AOD Treatment—Total	HEDIS	8.09%	6.91%
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up	HEDIS	30.69%	25.61%
30-Day Follow-Up	HEDIS	50.37%	43.57%
Follow-Up After ED Visit for Mental Illness			
7-Day Follow-Up—Total	HEDIS	27.92%	28.80%
30-Day Follow-Up—Total	HEDIS	42.97%	42.42%
Follow-Up After ED Visit for AOD Abuse or Dependence			
7-Day Follow-Up—Total	HEDIS	6.47%	6.05%
30-Day Follow-Up—Total	HEDIS	9.51%	9.20%
Antidepressant Medication Management			
Effective Acute Phase Treatment	HEDIS	55.62%	59.93%
Effective Continuation Phase Treatment	HEDIS	40.27%	42.24%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	HEDIS	61.13%	60.22%
Metabolic Monitoring for Children and Adolescents on Antipsychotics			
Blood Glucose Testing—Total	HEDIS	47.01%	51.20%
Cholesterol Testing—Total	HEDIS	34.86%	36.53%
Blood Glucose and Cholesterol Testing–Total	HEDIS	31.88%	34.59%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics			
Total	HEDIS	62.71%	61.34%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	HEDIS	74.53%	77.86%

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

None of the 16 statewide average rates met or exceeded the Agency's applicable MY performance targets in the Behavioral Health domain. Seven of the 16 (43.8 percent) statewide average rates fell below the minimum performance target, demonstrating opportunities for statewide improvement in the Behavioral Health domain. Three statewide average rates (*Antidepressant Medication Management—Effective Acute Phase Treatment, Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total,* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications)* demonstrated an increase of more than 3 percentage points.

Statewide Results—Access/Availability of Care

Table 3-6 displays the statewide averages calculated by HSAG for MY 2020 and MY 2021 for the one measure in the Access/Availability of Care domain and whether performance met or exceeded, or was below, the Agency-identified performance target (for applicable measures). Cells shaded in yellow indicate that the performance rate fell below the minimum performance target for the MY. To review the Access/Availability of Care measure indicator rates by plan, please see the Comparative Analysis section.

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

Measure	Measure Source	MY 2020	MY 2021
Adults' Access to Preventive/Ambulatory Health Services			
Total	HEDIS	73.38%	67.96%

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

The only statewide average rate in the Access/Availability of Care domain fell below the minimum performance target, demonstrating opportunities for statewide improvement in the Access/Availability of Care domain.

Statewide Results—Appropriate Treatment and Utilization

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

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

Measure	Measure Source	MY 2020	MY 2021
Ambulatory Care (per 1,000 Member Months)			
*ED Visits—Total**	HEDIS	48.51	55.46

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

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

The only statewide average rate in the Appropriate Treatment and Utilization domain fell below the minimum performance target, demonstrating opportunities for statewide improvement in this domain.

Comparative Analysis—Plan-Specific Results

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

Comparative Analysis—Pediatric Care

Table 3-8 shows the performance measure names and associated measure name abbreviations for measures included in the Pediatric Care domain and whether performance met or exceeded, or was below, the Agency-identified performance targets (for applicable measures).

Table 3-8—Pediatric Care Domain Performance Measure Abbreviations

Performance Measure	Abbreviation
Childhood Immunization Status—Combination 2	CIS-3
Childhood Immunization Status—Combination 7	CIS-7
Childhood Immunization Status—Combination 10	CIS-10
Lead Screening in Children	LSC
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	ADD-I
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	ADD-C
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	WCC-B

Performance Measure	Abbreviation
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	WCC-N
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	WCC-P
Child and Adolescent Well-Care Visits—Ages 3–11 Years	WCV-311
Child and Adolescent Well-Care Visits—Ages 12–17 Years	WCV-1217
Child and Adolescent Well-Care Visits—Ages 18–21 Years	WCV-1821
Child and Adolescent Well-Care Visits—Total	WCV-Tot
Immunizations for Adolescents—Combination 1	IMA-1
Immunizations for Adolescents—Combination 2	IMA-2
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	W30-6+
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	W30-2+

Table 3-9 and Table 3-10 show the results for the plans for measures within the Pediatric Care domain and whether performance met or exceeded, or was below, the Agency-identified performance targets (for applicable measures). Full plan names are listed in Appendix A.

Table 3-9—Pediatric Care Domain Performance Measure Results

Measure	AET-C	AMH-M	CCP-M	CHA-S	CMS-S	HUM-C	MOL-C
CIS-3	68.13%	74.45%	64.72%	50.00%	76.64%	67.40%	81.27%
CIS-7	61.31%	66.18%	53.77%	43.33%	48.66%	54.74%	72.02%
CIS-10	32.60%	34.31%	33.33%	23.33%	26.03%	24.82%	42.09%
LSC	71.78%	76.40%	74.70%	53.33%	74.21%	68.86%	70.23%
ADD-I	43.00%	42.33%	33.97%	NA	48.76%	38.93%	41.04%
ADD-C	56.38%	69.23%	NA	NA	60.65%	54.97%	50.00%
WCC-B	86.62%	86.14%	87.35%	89.94%	80.54%	91.85%	85.40%
WCC-N	85.40%	84.88%	82.73%	81.76%	75.91%	86.67%	81.02%
WCC-P	84.91%	81.40%	81.27%	75.47%	72.51%	85.56%	78.59%
WCV-311	64.85%	72.18%	68.57%	49.13%	69.60%	64.49%	68.89%
WCV-1217	55.93%	66.28%	60.72%	43.24%	63.19%	55.73%	60.64%
WCV-1821	30.18%	36.15%	33.35%	24.23%	39.53%	30.40%	36.21%
WCV-Tot	56.64%	65.70%	61.39%	36.88%	63.63%	56.82%	61.43%
IMA-1	79.81%	82.25%	75.67%	NA	76.86%	70.78%	78.83%
IMA-2	38.44%	49.24%	34.55%	NA	40.17%	35.32%	46.47%
W30-6+	64.00%	66.72%	63.59%	NA	33.25%	59.26%	68.50%
W30-2+	75.46%	80.86%	71.56%	NA	82.41%	71.25%	78.73%

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

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

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

Table 3-10—Pediatric Care Domain Performance Measure Results

Measure	MOL-S	SIM-C	SUN-C	SUN-S-SMI	SUN-S-CW	UNI-C	VIV-M
CIS-3	—	70.56%	68.37%	—	72.51%	64.38%	58.39%
CIS-7	—	61.31%	62.29%	—	58.39%	54.80%	51.58%
CIS-10	—	34.79%	32.85%	—	31.87%	24.30%	34.79%
LSC	—	73.48%	68.61%	—	75.38%	65.84%	57.66%
ADD-I	NA	43.67%	44.81%	55.50%	51.40%	42.15%	42.25%
ADD-C	NA	57.36%	61.07%	62.79%	63.32%	62.14%	NA
WCC-B	71.29%	87.10%	80.05%	80.05%	83.21%	88.32%	85.16%
WCC-N	58.88%	82.97%	76.64%	73.48%	76.89%	82.73%	81.02%
WCC-P	53.53%	81.51%	73.24%	71.78%	74.70%	78.35%	78.83%
WCV-311	35.07%	65.25%	60.53%	55.91%	69.79%	58.61%	52.87%
WCV-1217	34.12%	57.52%	51.58%	48.67%	58.03%	48.30%	41.61%
WCV-1821	15.85%	30.34%	24.50%	22.87%	36.60%	22.98%	17.23%
WCV-Tot	24.03%	57.68%	52.69%	36.16%	64.21%	49.95%	44.22%
IMA-1	46.81%	74.45%	73.72%	75.18%	75.67%	67.40%	63.26%
IMA-2	22.98%	42.34%	37.71%	42.34%	38.20%	34.06%	34.55%
W30-6+	—	60.71%	57.48%	—	52.75%	61.81%	53.51%
W30-2+	—	74.04%	70.49%	—	84.26%	68.56%	70.83%

NA indicates that the plan followed the specifications, but the denominator was too small to report a valid rate.
— indicates that the rate is not presented because the plan was not required to report the measure for MY 2021.
Indicates that the performance measure indicator rate for MY 2021 met or exceeded the performance target.
Indicates that the performance measure indicator rate for MY 2021 ranked below the minimum performance target.

Within the Pediatric Care domain, AmeriHealth-M, Molina-C, Sunshine-S-CW, and Community Care Plan-M were the highest-performing plans, with at least eight rates meeting or exceeding the Agency's MY 2021 performance targets. Additionally, at least 10 plans met or exceeded the Agency's MY 2021 performance targets for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total* measure indicators.

Conversely, Molina-S, Clear Health-S, and Vivida-M were the lowest-performing plans, with five or more measure indicator rates falling below the minimum performance target. Of note, four plans (Community Care Plan-M, Children's Medical Services-S, Humana-C, and United-C) had two or more measure indicator rates fall below the minimum performance target. Six of the 14 (42.9 percent) plans with a reportable measure rate fell below the minimum performance target for the *Immunizations for Adolescents—Combination 1* measure indicator.

Comparative Analysis—Women's Care

Table 3-11 shows the performance measure names and associated measure name abbreviations for measures included in the Women's Care domain and whether performance met or exceeded, or was below, the Agency-identified performance targets (for applicable measures).

Table 3-11—Women's Care Domain Performance Measure Abbreviations

Performance Measure	Abbreviation
Cervical Cancer Screening	CCS
Chlamydia Screening in Women—Total	CHL
Breast Cancer Screening	BCS
Prenatal and Postpartum Care—Timeliness of Prenatal Care	PPC-Pre
Prenatal and Postpartum Care—Postpartum Care	PPC-Pst

Table 3-12 and Table 3-13 show the results for the plans for measures within the Women's Care domain and whether performance met or exceeded, or was below, the Agency-identified performance targets (for applicable measures).

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

Measure	AET-C	AMH-M	CCP-M	CHA-S	CMS-S	HUM-C	MOL-C
CCS	59.37%	63.40%	58.88%	60.10%	—	54.50%	63.99%
CHL	66.45%	70.44%	64.50%	64.16%	47.55%	63.04%	62.69%
BCS	47.15%	51.05%	51.90%	47.57%	—	50.62%	61.03%
PPC-Pre	86.86%	86.92%	86.37%	74.51%	61.74%	81.02%	91.97%
PPC-Pst	77.37%	80.77%	80.05%	65.69%	62.61%	76.89%	80.78%

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

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

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

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

Measure	MOL-S	SIM-C	SUN-C	SUN-S-SMI	SUN-S-CW	UNI-C	VIV-M
CCS	47.45%	62.29%	53.28%	45.74%	—	58.39%	45.99%
CHL	61.06%	62.13%	59.74%	62.26%	62.94%	58.67%	54.94%
BCS	39.80%	54.57%	46.34%	43.93%	—	48.26%	42.86%
PPC-Pre	58.88%	87.59%	72.99%	67.15%	61.76%	80.54%	71.78%
PPC-Pst	54.01%	77.37%	66.18%	58.64%	66.67%	72.51%	78.35%

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

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

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

Within the Women's Care domain, Molina-C was the highest-performing plan, with all five measure indicator rates meeting or exceeding the Agency's MY 2021 performance targets. Additionally, nine of

the 14 (64.3 percent) plans met or exceeded the Agency's MY 2021 performance target for the *Chlamydia Screening in Women—Total* measure.

Conversely, Molina-S and Sunshine-S-SMI were the lowest-performing plans, with four out of the five measure indicator rates falling below the minimum performance target. Additionally, at least six plans fell below the minimum performance target for the *Breast Cancer Screening* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators.

Comparative Analysis—Living With Illness

Table 3-14 shows the performance measure names and associated measure name abbreviations for measures included in the Living With Illness domain and whether performance met or exceeded, or was below, the Agency-identified performance targets (for applicable measures).

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

Performance Measure	Abbreviation
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	CDC-BP
Comprehensive Diabetes Care—HbA1c Testing	CDC-T
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)	CDC-9
Comprehensive Diabetes Care—HbA1c Control (<8.0%)	CDC-8
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	CDC-E
Controlling High Blood Pressure	CBP
Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV) Viral Load Suppression—18–64 Years	VLS-18
HIV Viral Load Suppression—65+ Years	VLS-65
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total	MSC-A
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications—Total	MSC-M
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies—Total	MSC-S
Asthma Medication Ratio—Total	AMR
Kidney Health Evaluation for Patients with Diabetes—18–64 Years	KED-18
Kidney Health Evaluation for Patients with Diabetes—65–74 Years	KED-65
Kidney Health Evaluation for Patients with Diabetes—75–85 Years	KED-75
Kidney Health Evaluation for Patients with Diabetes—Total	KED-T

Table 3-15 and Table 3-16 show the results for the plans for measures within the Living With Illness domain and whether performance met or exceeded, or was below, the Agency-identified performance targets (for applicable measures).

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

Measure	AET-C	AMH-M	CCP-M	CHA-S	CMS-S	HUM-C	MOL-C
CDC-BP	58.88%	57.91%	59.37%	59.12%	45.74%	64.72%	61.56%
CDC-T	82.97%	83.70%	84.67%	85.40%	80.29%	87.83%	86.37%
CDC-9*	41.85%	42.58%	43.80%	37.71%	78.59%	38.20%	36.74%
CDC-8	47.93%	49.39%	49.39%	59.37%	18.00%	51.82%	53.77%
CDC-E	41.85%	36.25%	44.04%	37.71%	39.17%	61.56%	50.85%
CBP	61.07%	65.45%	64.96%	56.93%	45.28%	66.18%	64.23%
MSC-A	NA	NA	15.79%	NA	—	NA	NA
MSC-M	NA	NA	NA	NA	—	NA	NA
MSC-S	NA	NA	NA	NA	—	NA	NA
AMR	72.22%	76.70%	70.24%	35.60%	83.83%	68.42%	75.34%
KED-18	41.39%	38.41%	45.21%	26.47%	32.84%	38.47%	42.64%
KED-65	51.61%	45.88%	52.94%	36.26%	—	45.75%	56.74%
KED-75	57.35%	55.74%	49.09%	NA	—	48.38%	58.04%
KED-T	42.54%	39.61%	46.39%	27.50%	32.84%	39.80%	44.52%

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

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

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

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

Measure	MOL-S	SIM-C	SUN-C	SUN-S-SMI	SUN-S-CW	UNI-C	VIV-M
CDC-BP	55.23%	66.42%	45.74%	47.69%	NA	64.72%	52.52%
CDC-T	80.05%	84.91%	79.56%	79.56%	NA	84.43%	79.25%
CDC-9*	56.93%	38.44%	57.18%	63.99%	NA	38.93%	54.40%
CDC-8	35.28%	58.15%	36.98%	31.87%	NA	51.34%	35.85%
CDC-E	29.68%	47.69%	42.82%	37.23%	NA	45.26%	11.95%
CBP	58.39%	64.48%	51.34%	52.55%	NA	63.75%	54.01%
MSC-A	NA	NA	NA	NA	—	NA	NA
MSC-M	NA	NA	NA	NA	—	NA	NA
MSC-S	NA	NA	NA	NA	—	NA	NA
AMR	52.26%	67.94%	71.51%	55.97%	78.78%	71.70%	69.07%
KED-18	28.69%	41.58%	32.18%	30.10%	NA	33.77%	25.79%
KED-65	NA	48.64%	36.50%	36.83%	—	31.96%	42.55%
KED-75	NA	47.46%	36.90%	37.55%	—	32.91%	35.29%
KED-T	29.13%	43.17%	32.92%	30.69%	NA	33.48%	29.13%

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

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

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

Within the Living With Illness domain, Humana-C and Molina-C were the highest-performing plans, with five of the 14 (35.7 percent) reportable measure indicator rates meeting or exceeding the Agency's MY 2021 performance targets. Additionally, seven plans met or exceeded the Agency's MY 2021 performance target for the *Asthma Medication Ratio—Total* measure. Conversely, Children's Medical Services-S, Sunshine-S-SMI, Molina-S, and Sunshine-C were the lowest-performing plans, with five or more rates falling below the minimum performance target. Additionally, nine plans fell below the minimum performance target for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator for MY 2021.

Comparative Analysis—Behavioral Health

Table 3-17 shows the performance measure names and associated measure name abbreviations for measures included in the Behavioral Health domain and whether performance met or exceeded, or was below, the Agency-identified performance targets (for applicable measures).

Table 3-17—Behavioral Health Domain Performance Measure Abbreviations

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

Table 3-18 and Table 3-19 show the results for the plans for measures within the Behavioral Health domain and whether performance met or exceeded, or was below, the Agency-identified performance targets (for applicable measures).

Table 3-18—Behavioral Health Domain Performance Measure Results

Measure	AET-C	AMH-M	CCP-M	CHA-S	CMS-S	HUM-C	MOL-C
IET-I	36.67%	46.28%	31.75%	52.66%	47.74%	42.36%	35.10%
IET-E	4.57%	7.44%	4.27%	7.63%	5.53%	6.38%	5.29%
FUH-7	35.67%	35.32%	27.27%	16.94%	30.33%	33.22%	33.50%
FUH-30	56.24%	58.36%	45.99%	29.89%	51.91%	55.45%	58.09%
FUM-7	32.04%	30.40%	27.27%	21.51%	41.42%	31.97%	37.89%
FUM-30	41.99%	46.40%	31.82%	27.91%	62.43%	44.31%	56.84%
FUA-7	7.11%	10.18%	3.92%	8.55%	3.45%	5.89%	8.93%
FUA-30	11.11%	14.37%	3.92%	10.26%	3.45%	9.18%	12.50%
AMM-A	55.45%	57.70%	46.24%	51.62%	58.26%	56.78%	58.62%
AMM-C	42.31%	44.26%	27.96%	36.49%	40.00%	39.90%	43.15%
SAA	65.59%	58.86%	57.81%	43.30%	63.53%	64.04%	65.01%
APM-B	57.03%	58.77%	40.35%	NA	52.75%	53.47%	51.17%
APM-C	39.84%	53.08%	29.82%	NA	38.02%	38.78%	39.44%
APM-BC	38.67%	50.24%	28.07%	NA	35.97%	37.21%	37.56%
APP	67.11%	78.82%	33.33%	NA	53.95%	61.01%	76.24%
SSD	80.25%	78.44%	77.63%	94.46%	71.68%	83.23%	81.13%

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

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

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

Table 3-19—Behavioral Health Domain Performance Measure Results

Measure	MOL-S	SIM-C	SUN-C	SUN-S-SMI	SUN-S-CW	UNI-C	VIV-M
IET-I	50.31%	37.74%	41.09%	47.50%	53.40%	36.28%	42.92%
IET-E	5.94%	7.41%	6.96%	7.77%	9.13%	5.90%	9.91%
FUH-7	21.69%	33.76%	22.94%	17.86%	42.59%	27.03%	6.25%
FUH-30	39.85%	56.90%	39.38%	30.57%	70.20%	46.70%	11.61%
FUM-7	31.91%	32.63%	26.09%	23.14%	49.61%	26.32%	41.18%
FUM-30	47.19%	47.54%	39.17%	35.13%	69.38%	41.61%	52.94%
FUA-7	3.10%	6.30%	5.73%	6.93%	0.00%	5.04%	4.48%
FUA-30	6.44%	9.31%	8.62%	10.29%	2.53%	9.08%	5.97%
AMM-A	59.81%	65.57%	60.44%	58.62%	55.00%	61.80%	65.33%
AMM-C	46.73%	49.29%	41.10%	40.93%	31.67%	45.21%	49.33%
SAA	65.19%	66.99%	62.65%	52.59%	NA	66.86%	NA
APM-B	60.38%	50.77%	46.50%	55.37%	54.47%	49.95%	41.86%
APM-C	42.45%	34.65%	33.10%	38.05%	40.64%	33.00%	25.58%
APM-BC	42.45%	33.42%	30.55%	36.55%	38.62%	32.09%	23.26%
APP	60.29%	64.81%	62.04%	57.69%	69.57%	47.92%	NA
SSD	70.87%	79.77%	79.66%	74.29%	85.23%	78.45%	NA

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

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

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

Within the Behavioral Health domain, Sunshine-S-CW, Molina-S, Aetna-C, AmeriHealth-M, and Molina-C were the highest-performing plans, with at least four measure indicator rates meeting or exceeding the Agency's MY 2021 performance targets. Additionally, at least six plans with reportable measure indicator rates met the Agency's MY 2021 performance target for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure indicators.

Conversely, Community Care Plan-M, Clear Health-S, United-C, and Sunshine-S-SMI were the lowest-performing plans, with at least eight measure indicator rates falling below the minimum performance target. At least 10 plans fell below the minimum performance target for the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total* and *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators.

Comparative Analysis—Access/Availability of Care

Table 3-20 shows the performance measure name and associated measure name abbreviation for the one measure included in the Access/Availability of Care domain and whether performance met or exceeded, or was below, the Agency-identified performance target (for applicable measures).

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

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

Table 3-21 and Table 3-22 show the results for the plans for the one measure within the Access/Availability of Care domain and whether performance met or exceeded, or was below, the Agency-identified performance target (for applicable measures).

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

Measure	AET-C	AMH-M	CCP-M	CHA-S	CMS-S	HUM-C	MOL-C
AAP	63.10%	64.52%	56.56%	80.80%	75.57%	72.91%	70.42%

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

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

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

Measure	MOL-S	SIM-C	SUN-C	SUN-S-SMI	SUN-S-CW	UNI-C	VIV-M
AAP	66.70%	67.50%	65.53%	74.11%	69.35%	66.58%	54.10%

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

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

Within the Access/Availability of Care domain, none of the plans met or exceeded the Agency's MY 2021 performance target for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator.

Additionally, 10 of the 12 (83.3 percent) plans with a reportable measure rate fell below the minimum performance target for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator.

Comparative Analysis—Appropriate Treatment and Utilization

Table 3-23 shows the performance measure name and associated measure name abbreviation for the one measure included in the Appropriate Treatment and Utilization domain.

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

Performance Measure	Abbreviation
Ambulatory Care (per 1,000 Member Months)—ED Visits—Total	AMB-E

Table 3-24 and Table 3-25 show the results for the plans for the one measure within the Appropriate Treatment and Utilization domain and whether performance was below the Agency-identified performance target.

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

Measure	AET-C	AMH-M	CCP-M	CHA-S	CMS-S	HUM-C	MOL-C
AMB-E*	49.21	45.39	41.11	105.96	52.36	55.28	50.24

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

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

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

Measure	MOL-S	SIM-C	SUN-C	SUN-S-SMI	SUN-S-CW	UNI-C	VIV-M
AMB-E*	88.32	47.95	55.76	110.76	42.15	53.22	44.81

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

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

Within the Appropriate Treatment and Utilization domain, none of the plans met or exceeded the Agency's MY 2021 performance target for the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* measure indicator.

Additionally, 10 out of the 14 (71.4 percent) plans had rates falling below the minimum performance target set by the Agency for MY 2021.

LTC Program

The Agency contracted with six comprehensive plans and one LTC Plus plan to provide LTC services to Medicaid enrollees. The plans were required to report 15 performance measure indicators for SFY 2021–2022 using 2021 data. For four reported LTC MLTSS/HEDIS measures (with a total of seven measure indicators), the Agency established performance targets of 85 percent for each measure indicator. Plans underwent a PMV audit to ensure that the rates calculated and reported for these measures were valid and

accurate. The Agency intended that an NCQA HEDIS Compliance Audit be conducted for all plans. All audits were conducted by LOs.

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

LTC Program Results

Table 3-26—Florida Medicaid LTC Program Statewide Averages

Measure	Measure Source	MY 2020	MY 2021
LTSS Comprehensive Assessment and Update			
Assessment of Core Elements	MLTSS/HEDIS	87.70%	87.80%
Assessment of Supplemental Elements	MLTSS/HEDIS	86.22%	87.65%
LTSS Comprehensive Care Plan and Update			
Care Plan With Core Elements	MLTSS/HEDIS	88.06%	90.98%
Care Plan With Supplemental Elements	MLTSS/HEDIS	88.04%	90.84%
LTSS Shared Care Plan With PCP			
LTSS Shared Care Plan With PCP	MLTSS/HEDIS	89.68%	86.53%
LTSS Reassessment/Care Plan Update After Inpatient Discharge			
Reassessment After Inpatient Discharge	MLTSS/HEDIS	34.44%	44.77%
Reassessment and Care Plan Update After Inpatient Discharge	MLTSS/HEDIS	26.53%	37.99%
Screening, Risk Assessment, and Plan of Care to Prevent Future Falls[1]			
Falls Part 1—Screening	MLTSS	95.22%	97.95%
Falls Part 2—Falls Risk Assessment	MLTSS	90.43%	91.30%
Falls Part 2—Plan of Care for Falls	MLTSS	53.02%	66.81%
LTSS Admission to an Institution from the Community[1]			
Short-Term Stay	MLTSS	11.70	18.43
Medium-Term Stay	MLTSS	10.59	7.29
Long-Term Stay	MLTSS	26.73	18.62
LTSS Minimizing Institutional Length of Stay[1]			
LTSS Minimizing Institutional Length of Stay	MLTSS	20.91%	16.28%
LTSS Successful Transition After Long-Term Institutional Stay[1]			
LTSS Successful Transition After Long-Term Institutional Stay	MLTSS	14.08%	17.03%

[1] *Indicates a performance target was not established by the Agency. Rate is displayed for information only.*

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

Of the seven measure indicators for which performance targets were established, all seven statewide rates in the LTC program met or exceeded the Agency's MY 2021 performance targets. The statewide rate for

the *LTSS Reassessment/Care Plan Update After Inpatient Discharge—Reassessment and Care Plan Update After Inpatient Discharge* measure indicator improved more than 18 percentage points.

LTC Comparative Analysis

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

Table 3-27—LTC Performance Measure Abbreviations

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

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

Table 3-28—LTC Performance Measure Results

Measure	AET-C	FCC-L	HUM-C	MOL-C	SIM-C	SUN-C	UNI-C
CAU-1	92.94%	94.16%	83.21%	91.00%	94.16%	85.64%	87.35%
CAU-2	92.94%	94.16%	83.21%	90.02%	94.16%	85.64%	86.13%
CPU-1	97.08%	96.35%	83.94%	97.57%	96.59%	96.11%	74.21%
CPU-2	97.08%	96.11%	83.94%	97.57%	96.59%	95.86%	73.97%
SCP	99.75%	83.45%	90.75%	97.32%	93.92%	85.64%	66.91%
UIC-1	46.47%	22.84%	37.11%	36.25%	64.48%	48.42%	34.06%
UIC-2	44.77%	22.84%	25.77%	35.28%	61.56%	43.80%	23.11%
PFF-1	100.00%	97.81%	98.54%	99.50%	99.03%	96.84%	96.84%
PFF-2	100.00%	58.39%	98.98%	12.77%	100.00%	97.57%	94.89%

Measure	AET-C	FCC-L	HUM-C	MOL-C	SIM-C	SUN-C	UNI-C
PFF-3	65.45%	25.06%	98.21%	14.89%	66.91%	72.99%	89.05%
AIC-S	30.80	9.71	0.63	13.40	3.38	19.42	56.24
AIC-M	23.63	15.47	0.70	16.62	8.10	8.34	9.54
AIC-L	14.71	24.68	54.43	25.42	6.21	8.45	4.00
MIS	12.93%	32.26%	31.16%	6.29%	31.93%	10.21%	13.36%
TIS	7.29%	11.76%	0.76%	79.55%	8.24%	7.06%	74.71%

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

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

Dental Plans

The Agency contracted with three dental plans to provide dental services to Medicaid enrollees. The dental plans were required to report 12 performance measure indicators for SFY 2021–2022 using 2021 data. The three dental plans were audited by an LO. Plan-specific targets were established for one dental measure included in this report, as discussed in the Comparative Analysis section.

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

Dental Statewide Results

Table 3-29—Florida Dental Plan Statewide Averages

Measure	Measure Source	MY 2020	MY 2021
Annual Dental Visit[1]			
Total	HEDIS	40.34%	42.95%
Ambulatory Care Sensitive ED Visits for Dental Caries in Adults[*]			
Total	Agency-Defined	7.07	19.66
Oral Evaluation			
Total	Dental Quality Alliance	32.26%	35.74%
Topical Fluoride for Children at Elevated Caries Risk			
Total	Dental Quality Alliance	19.05%	23.63%
Ambulatory Care Sensitive ED Visits for Dental Caries in Children[*]			
Total	Dental Quality Alliance	1.01	5.05

Measure	Measure Source	MY 2020	MY 2021
Follow-Up After ED Visits for Dental Caries in Children			
7-Day Follow-Up—Total	Dental Quality Alliance	34.11%	22.87%
30-Day Follow-Up—Total	Dental Quality Alliance	51.94%	40.82%
Caries Risk Documentation			
Total	Dental Quality Alliance	—	6.29%
Follow-Up After Dental-Related ED Visits			
Follow-Up After Dental-Related ED Visits	Agency-Defined	33.14%	35.77%
Sealant Receipt on Permanent 1st Molars			
Received a Sealant on At Least One Permanent First Molar Tooth	Medicaid Child Core Set	24.69%	37.84%
Received a Sealant on All Four Permanent First Molars	Medicaid Child Core Set	14.67%	24.37%
Treatment Services (Pediatric Measure)			
Total	Dental Quality Alliance	14.64%	17.64%

[1] *Indicates a plan-specific target was identified by the Agency.*
— Indicates that the MY 2020 rate is not presented because the dental plans were not required to report the measure until MY 2021.
** Lower rates indicate better performance for this measure.*

Seven statewide rates demonstrated improvement from MY 2020 to MY 2021. Two statewide average rates (*Sealant Receipt on Permanent 1st Molars—Received a Sealant on At Least One Permanent First Molar Tooth* and *Received a Sealant on All Four Permanent First Molars*) measure indicators demonstrated an increase of more than 9 percentage points from the previous MY.

Conversely, the statewide average rates for *Follow-Up After ED Visits for Dental Caries in Children—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators demonstrated a decline of more than 11 percentage points from MY 2020 to MY 2021.

Dental Comparative Analysis

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

Table 3-30—Dental Performance Measure Abbreviations

Performance Measure	Abbreviation
Annual Dental Visit—Total	ADV
Ambulatory Care Sensitive ED Visits for Dental Caries in Adults—Total	EDV-A-A
Oral Evaluation—Total	OEV-CH-A

Performance Measure	Abbreviation
Topical Fluoride for Children at Elevated Caries Risk—Total	TLF-CH-A
Ambulatory Care Sensitive ED Visits for Dental Caries in Children—Total	EDV-CH-A
Follow-Up After ED Visits for Dental Caries in Children—7-Day Follow-Up—Total	EDF-CH-A-7
Follow-Up After ED Visits for Dental Caries in Children—30-Day Follow-Up—Total	EDF-CH-A-30
Caries Risk Documentation—Total	CRD
Follow-Up After Dental-Related ED Visits—Total	FUD
Sealant Receipt on Permanent 1st Molars—Received a Sealant on At Least One Permanent First Molar Tooth	SFM-CH-1
Sealant Receipt on Permanent 1st Molars—Received a Sealant on All Four Permanent First Molars	SFM-CH-2
Treatment Services (Pediatric Measure)—Total	TRT-CH-A

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

Table 3-31—Dental Performance Measure Results

Measure	DQT-D	LIB-D	MCA-D
ADV	44.40%	43.48%	39.09%
EDV-A-A	17.86	21.23	20.16
OEV-CH-A	39.25%	34.15%	31.76%
TLF-CH-A	23.04%	23.44%	27.36%
EDV-CH-A	5.93	4.63	3.99
EDF-CH-A-7	18.01%	27.87%	27.60%
EDF-CH-A-30	38.84%	42.21%	44.00%
CRD	3.64%	11.66%	3.28%
FUD	38.84%	34.97%	31.91%
SFM-CH-1	37.69%	37.84%	38.16%
SFM-CH-2	24.13%	24.01%	25.55%
TRT-CH-A	17.96%	19.97%	13.36%

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

DentaQuest, Liberty, and MCNA fell below the plan-specific targets identified by the Agency for the *Annual Dental Visit—Total* measure indicator

Conclusions and Recommendations Related to Quality, Timeliness, and Access

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

MMA Program

Pediatric Care

Strengths	
⊕	The statewide average for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total* measure indicators met or exceeded the performance target. The results indicate that children and adolescents had an outpatient visit with a PCP or OB/GYN and received BMI documentation, counseling for nutrition, and counseling for physical activity.
⊕	The statewide average for the *Child and Adolescent Well-Care Visits—Ages 3–11 Years, Ages 12–17 Years,* and *Total* measure indicators met or exceeded the performance target. The results suggest that children received one or more well-care visits from a PCP or OB/GYN.

Weaknesses and Recommendations	
⊖	**Weakness:** The statewide average declined for measures pertaining to the immunizations of children and adolescents, and the indicator rates for *Childhood Immunizations Status—Combination 10* and *Immunizations for Adolescents—Combination 1* fell below the minimum performance target. Childhood vaccines protect children from a number of serious and potentially life-threatening diseases, such as diphtheria, measles, meningitis, polio, tetanus, and whooping cough, at a time in their lives when they are most vulnerable to disease.[3-2] The identified declines in routine pediatric vaccine ordering and doses administered might indicate that children in the United States and their communities face increased risks for outbreaks of vaccine-preventable diseases. Continued coordinated efforts between healthcare providers and public health officials at the local, state, and federal levels will be necessary to achieve rapid catch-up vaccination.[3-3]

[3-2] National Committee for Quality Assurance. Childhood Immunization Status. Available at: https://www.ncqa.org/hedis/measures/childhood-immunization-status/. Accessed on: Feb 21, 2023.
[3-3] The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Feb 21, 2023.

Weaknesses and Recommendations	
	Recommendations: HSAG recommends that the plans identify best practices for ensuring children receive medically appropriate preventive vaccinations. Plans should consider whether there are disparities within their populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause of children not receiving medically appropriate immunizations, plans should implement appropriate interventions to improve the immunization rates.
−	**Weakness:** The statewide average rates for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Lead Screening in Children* measure indicators declined more than 3 percentage points from MY 2020 to MY 2021. Proper follow-up care is essential to manage ADHD medication. To ensure that medication is prescribed and managed correctly, it is important that children are monitored by a pediatrician with prescribing authority.[3-4] The rate for lead screening declined indicating children 2 years of age were not always receiving a capillary or venous lead blood test for lead poisoning by their second birthday. If not found early, exposure to lead and high blood lead levels can lead to irrevocable effects on a child's physical and mental health.[3-5] **Recommendations:** HSAG recommends that the plans conduct a root cause analysis or focus study to identify barriers to providers following the recommended guidelines for follow-up and monitoring of prescribed ADHD medication, as well as an analysis to determine why some children did not receive lead blood tests by their second birthday. Upon identification of any root causes contributing to these gaps in care, HSAG recommends that the plans implement appropriate interventions to improve use of evidence-based practices related specifically to these pediatric services.

[3-4] National Committee for Quality Assurance. Follow-Up Care for Children Prescribed ADHD Medication. Available at: https://www.ncqa.org/hedis/measures/follow-up-care-for-children-prescribed-adhd-medication/. Accessed on: Feb 21, 2023.

[3-5] National Committee for Quality Assurance. Lead Screening in Children (LSC). Available at: https://www.ncqa.org/hedis/measures/lead-screening-in-children/. Accessed on: Feb 21, 2023.

Women's Care

Strengths	
+	None identified.

Weaknesses and Recommendations	
−	**Weakness:** The statewide average rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator declined more than 5 percentage points and fell below the minimum performance target. In addition, the statewide average rate for the *Prenatal and Postpartum Care—Postpartum Care* measure indicator fell below the minimum performance target. Timeliness of prenatal care reduces the risks for complications. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.[3-6] **Recommendations:** HSAG recommends that the plans serving the MMA program consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care. In addition, HSAG recommends that the plans analyze their data and consider whether there are disparities within the plans' populations that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that the plans implement appropriate interventions to improve quality of, access to, and timeliness of prenatal and postpartum care.

[3-6] National Committee for Quality Assurance. Prenatal and Postpartum Care. Available at: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/. Accessed on: Feb 21, 2023.

Living With Illness

Strengths	
+	The statewide average for the *Asthma Medication Ratio—Total* measure indicator met or exceeded the performance target. The results suggest that members with persistent asthma are receiving recommended care and are better able to control their chronic condition.

Weaknesses and Recommendations	
−	**Weakness:** The statewide average rate for the *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total* measure indicator declined more than 16 percentage points and fell below the minimum performance target. In addition, the *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies—Total* statewide average rate fell below the minimum performance target. Advising smokers and tobacco users to quit can improve the overall health of members. Smoking and tobacco use are the largest causes of preventable disease and death in the United States.[3-7] **Recommendations:** HSAG recommends that the plans conduct a root cause analysis or focus study to determine why members are not quitting tobacco use. Upon identification of a root cause, HSAG recommends that the plans implement appropriate interventions and develop measurable, timebound goals specifically focused on evaluating these interventions' impact toward improving the performance related to smoking cessation.

[3-7] National Committee for Quality Assurance. Medical Assistance With Smoking and Tobacco Use Cessation. Available at: https://www.ncqa.org/hedis/measures/medical-assistance-with-smoking-and-tobacco-use-cessation/. Accessed on: Feb 21, 2023.

Behavioral Health

Strengths	
+	None identified.

Weaknesses and Recommendations	
−	**Weakness:** The statewide average for the *Follow-Up After ED Visit for Mental Illness* and the *Follow-Up After ED Visit for AOD Abuse or Dependence* measures fell below the minimum performance targets. Follow-up care by trained mental health clinicians is critical for successful transition out of an ED setting, as well as preventing future admissions. **Recommendation:** HSAG recommends that the plans conduct a root cause analysis to determine why members who access the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, HSAG recommends that the plans increase the use of telehealth services. Additionally, HSAG recommends that the plans enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.
−	**Weakness:** The statewide average rate for the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total* measure indicator declined more than 4 percentage points from MY 2020 to MY 2021. Treatment, including medication-assisted treatment, in conjunction with counseling or other behavioral therapies, has been shown to reduce AOD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending. [3-8] **Recommendation:** HSAG recommends that the plans conduct a root cause analysis or focus study to determine why some adolescents and adults with a new episode of AOD dependence were not accessing timely treatment. Upon identification of a root cause, each plan should implement appropriate interventions to improve the performance related to the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total* measure. In doing so, each plan should consider the nature and scope of the issue (e.g., whether the issues were related to barriers such as a lack of patient and provider communication or education).

[3-8] National Committee for Quality Assurance. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment. Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/. Accessed on: Feb 21, 2023.

Weaknesses and Recommendations	
–	**Weakness:** The statewide average rates for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* measure indicators declined more than 5 percentage points from MY 2020 to MY 2021. Individuals hospitalized for mental health disorders often do not receive adequate follow-up care. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes and decrease the likelihood of re-hospitalization and the overall cost of outpatient care.[3-9] **Recommendation:** HSAG recommends that the plans evaluate opportunities to enhance care coordination to support members to access timely follow-up care after hospitalization for mental illness. Additionally, plans should partner with their contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.

[3-9] National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness. Available at: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/. Accessed on: Feb 21, 2023.

LTC Program

Strengths	
⊕	Seven statewide rates in the LTC program that could be compared met or exceeded the Agency's MY 2021 performance targets. The statewide rate for the *LTSS Reassessment/Care Plan Update After Inpatient Discharge—Reassessment and Care Plan Update After Inpatient Discharge* measure indicator improved more than 11 percentage points. The results indicate that the plans have established documentation of comprehensive assessments, comprehensive care plans, shared care plans, and reassessment care plans to promote the coordination of LTSS. The results also indicate that plans are conducting assessments and creating care plans with their members within specific measure timelines.

Weaknesses and Recommendations	
⊖	**Weakness:** The statewide average for the *LTSS Minimizing Institutional Length of Stay* measure declined more than 4 percentage points from MY 2020 to MY 2021. **Recommendation:** HSAG recommends that plans evaluate their care coordination processes to determine whether there are opportunities to enhance the methods in which the plans engage with members and facilities to support successful discharges to the community. For example, plans should determine if they are effectively using all available data and information collected during a member's initial facility admission, as well as upon hospital discharges to the facility, so that effective discharge planning occurs. Additionally, plans should assess whether they have adequate community supports in place to facilitate members successfully transitioning to reside in a community setting within 100 days of admission to a facility.

Dental Plans

Strengths	
⊕	The statewide average for the following measure indicators improved at least 3 percentage points from MY 2020 to MY 2021: • *Oral Evaluation—Total* • *Topical Fluoride for Children at Elevated Caries Risk—Total* • *Sealant Receipt on Permanent 1st Molars—Received a Sealant on At Least One Permanent First Molar Tooth* and *Received a Sealant on All Four Permanent First Molars* • *Treatment Services (Pediatric Measure)—Total* The results suggest that children received dental treatment services to prevent common chronic diseases known as dental caries. Identifying comprehensive, periodic oral evaluation and oral treatment services helps prevent progression of decay and crumbling of teeth.

Weaknesses and Recommendations	
⊖	**Weakness:** The statewide average for the following measure indicators declined more than11 percentage points from MY 2020 to MY 2021: • *Follow-Up After ED Visits for Dental Caries in Children—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* **Recommendations:** HSAG recommends that the dental plans conduct a root cause analysis or focus study to determine any barriers that prevent children from receiving a dental treatment service to prevent dental caries, which is one of the most common chronic diseases. Identifying caries early helps prevent progression of decay and crumbling of teeth. Upon identification of a root cause, HSAG recommends that the dental plans implement appropriate interventions to improve access to care. If access to care is the reason for lower rates, the dental plans should also evaluate their networks to ensure enough providers are available for services for members, and ensure those providers have appropriate appointment availability.

Performance Improvement Projects

Introduction

PIP Validation

For SFY 2021–2022, most plans submitted two PIPs for annual validation—*Administration of the Transportation Benefit* and *Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and ED Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence* (Behavioral Health PIP).

Children's Medical Services-S also submitted the *Reducing Asthma Related PPEs for Pediatric Enrollees* PIP and the *Youth Transitions to Adult Care* PIP for annual validation. Each dental plan also submitted two PIPs for annual validation—*Coordination of Transportation Services With the SMMC Plans* and *Preventive Dental Services for Children*.

This section presents the results of the PIP validation activities conducted by HSAG during SFY 2021–2022.

High-Level Review

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

Most plans submitted two PIPs—*Improving Birth Outcomes* and *Reducing PPEs*—for high-level review. The only exceptions were Florida Community Care-L, an LTC Plus plan, and Children's Medical Services-S, a specialty plan. The *Improving Birth Outcomes* PIP was not initiated by Florida Community Care-L and Children's Medical Services-S because the topic was not applicable to the population served by these plans. Children's Medical Services-S did not initiate the statewide *Reducing PPEs* PIP; however, the plan conducted the *Reducing Asthma Related PPEs for Pediatric Enrollees* PIP.

For high-level review, each dental plan submitted the *Reducing Potentially Preventable Dental-Related ED Visits* PIP. Additional information and results of the high-level review process are included in Appendix D.

Plan Names and Enrollment

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

Status of PIP Topics

In a PIP, the plans are required to have a baseline measurement period to determine the baseline performance indicator rate and at least two remeasurement periods to measure and assess achievement of improvement in the performance indicator rates over the baseline performance. The plans should determine the PIP measurement periods during the PIP Design stage. The measurement periods should be selected based on the availability of data at the time of the PIP submission, and if the PIP performance indicators are based on nationally recognized measures, the plans may choose the measurement periods in alignment with the measurement periods defined for the nationally recognized measures. For example, the performance indicator for the *Preventive Dental Services for Children* PIP is based on the *CMS-416* measure and has federal fiscal year (FFY)-based measurement periods. The HEDIS-based performance indicators in the *Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and ED Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence* PIP have CY-based measurement periods.

Table 4-1 displays the PIP topics, type of review conducted, progression status, and the measurement periods for the PIPs during SFY 2021–2022.

Table 4-1—PIP Topics and Status

PIP Topic	Review Type	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in SFY 2021–2022
Improving Birth Outcomes	High-Level Review	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	CY 2016	10/01/19–09/30/20 (Remeasurement 2)
Reducing PPEs	High-Level Review	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	SFY 2015–2016	10/01/19–09/30/20 (Remeasurement 2)

PIP Topic	Review Type	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in SFY 2021–2022
Administration of the Transportation Benefit	Validation	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	CY 2018 for health plans operating throughout 2018; CY 2019 for new health plans*	CY 2020 (Remeasurement 1/ Remeasurement 2)
*Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and ED Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence***	Validation	PIP Design and Implementation Stages (Steps 1 through 8)	CY 2019	CY 2020 (Implementation Year)
Reducing Potentially Preventable Dental–Related ED Visits	High-Level Review	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	SFY 2016–2017	10/01/19–09/30/20 (Remeasurement 2)
Coordination of Transportation Services	Validation	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	CY 2019*	CY 2020 (Remeasurement 1)
Preventive Dental Services for Children	Validation	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	FFY 2019	FFY 2021 (Remeasurement 2)

* Four plans reported CY 2018 as the baseline.

** This PIP topic is also referred to as the Behavioral Health PIP throughout this technical report.

Plans and PIP Topics

In Florida, 18 plans serve the Medicaid population (six comprehensive plans, three MMA plans, five specialty plans, one LTC plan, and three dental plans). Although 18 plans serve Florida's Medicaid population, the Agency did not require its comprehensive plans to submit separate PIPs for their specialty plans. However, some of the comprehensive plans did report separate performance indicator rates for their specialty populations for certain PIPs. Table 4-2 shows the comprehensive plans, with their associated specialty plan (when applicable) and the PIP topics conducted.

Of note, Staywell Health Plan of Florida, Inc. (Staywell-C/STW-C) was acquired by Sunshine-C as of October 1, 2021. However, prior to acquisition, Staywell-C submitted PIP data for validation for the *Administration of the Transportation Benefit* PIP and the Behavioral Health PIP. Therefore, Staywell-C is included in this section of the report but is not included in the overall report.

Table 4-2—Comprehensive and MMA Plans and PIP Topics

Plan	Inclusion of Specialty Plan in PIP	PIP Topics
Comprehensive Plans		
Aetna-C	None.	**For Validation** – *Administration of the Transportation Benefit* – Behavioral Health PIP **For High-Level Review** – *Improving Birth Outcomes* – *Reducing PPEs*
Humana-C	None.	
Molina-C	Included Molina-S in comprehensive plan PIPs; reported separate rates for Molina-S for all PIPs.	
Simply-C	Included Clear Health-S in comprehensive plan PIPs; reported separate rates for Clear Health-S for the Behavioral Health PIP and high-level review PIPs.	
Staywell-C	Included Staywell-S in comprehensive plan PIPs; reported separate rates for Staywell-S for high-level review PIPs.	
Sunshine-C	Included Sunshine-S-CW and Sunshine-S-SMI in comprehensive plan PIPs; reported separate rates for Sunshine-S-CW for the Behavioral Health PIP and high-level review PIPs.	
United-C	None.	
MMA Plans		
AmeriHealth-M*	No.	**For Validation** – *Administration of the Transportation Benefit* – Behavioral Health PIP **For High-Level Review** – *Improving Birth Outcomes* – *Reducing PPEs*
Vivida-M	No.	
Community Care Plan-M	No.	

* On 8/24/2021, Florida True Health/Prestige Health Choice's name changed to AmeriHealth Caritas Florida, Inc.

Table 4-3 shows the specialty and LTC plans, indicates if a specialty plan's population was included by its operating comprehensive plan (when applicable), and the PIP topics conducted by each plan.

Table 4-3—Specialty and LTC Plans and PIP Topics

Plan	Included in Comprehensive Plan PIP	PIP Topics
Specialty Plans		
Children's Medical Services-S	No.	**For Validation** – *Administration of the Transportation Benefit* – Behavioral Health PIP – *Youth Transitions to Adult Care* – *Reducing Asthma Related PPEs for Pediatric Enrollees*
Clear Health-S	Yes; A specialty plan operated by Simply-C.	N/A
Molina-S	Yes; A specialty plan operated by Molina-C.	N/A
Staywell-S	Yes; A specialty plan operated by Staywell-C.	N/A
Sunshine-S-CW	Yes; A specialty plan operated by Sunshine-C.	N/A
Sunshine-S-SMI	Yes; A specialty plan operated by Sunshine-C.	N/A
LTC Plan		
Florida Community Care-L	No.	**For Validation** – *Administration of the Transportation Benefit* – Behavioral Health PIP **For High-Level Review** – *Reducing PPEs*

All three dental plans were required to conduct three PIPs, as shown in Table 4-4.

Table 4-4—Dental Plans Included in PIP Results

Dental Plan	PIP Topics
DentaQuest-D	**For Validation** – *Coordination of Transportation Services With the SMMC Plans* – *Preventive Dental Services for Children* **For High-Level Review** – *Reducing Potentially Preventable Dental-Related ED Visits*
Liberty-D	
MCNA-D	

Domains of Care

Table 4-5 lists all PIP topics and the assigned domains of care (quality, timeliness, and/or access to care).

Table 4-5—PIP Topics—Domains of Care

PIP Name	Quality	Timeliness	Access
Administration of the Transportation Benefit		✓	✓
Behavioral Health PIP	✓	✓	✓
Improving Birth Outcomes	✓	✓	✓
Reducing PPEs	✓	✓	✓
Reducing Potentially Preventable Dental-Related ED Visits	✓	✓	✓
Coordination of Transportation Services With the SMMC Plans		✓	✓
Preventive Dental Services for Children	✓	✓	✓
Youth Transitions to Adult Care	✓	✓	✓
Reducing Asthma Related PPEs for Pediatric Enrollees	✓	✓	✓

Validation Status

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

HSAG validated the *Administration of the Transportation Benefit* PIP and the Behavioral Health PIP for 12 plans (seven comprehensive plans, three MMA plans, one LTC plan, and Children's Medical Services-S). These PIPs were not applicable to the three dental plans, and four specialty plans were included in the PIP conducted by their operating comprehensive plan. All PIPs validated for SFY 2021–2022 had progressed to reporting to the Implementation stage (Steps 1 through 8). The Outcomes stage (Step 9) was assessed for the PIPs wherein remeasurement data were reported. The plans did not report remeasurement data for the Behavioral Health PIP, and 11 plans reported remeasurement data for the *Administration of the Transportation Benefit* PIP. Aetna Better Health-C did not report remeasurement data because it only had one month of data for CY 2019; therefore, the plan will reassign CY 2020 as the new baseline for its PIP.

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 9, 2023.

Children's Medical Services-S finalized Remeasurement 1 (CY 2020) results for the *Youth Transitions to Adult Care* and *Reducing Asthma Related PPEs for Pediatric Enrollees* PIPs.

All three dental plans reported remeasurement data for both dental PIPs that were validated.

Description of Data Obtained

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

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

For the Behavioral Health PIP and the *Youth Transitions to Adult Care* and *Reducing Asthma Related PPEs for Pediatric Enrollees* PIPs, the plans used claims and encounters data to calculate the indicator rates for the selected PIP topic.

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

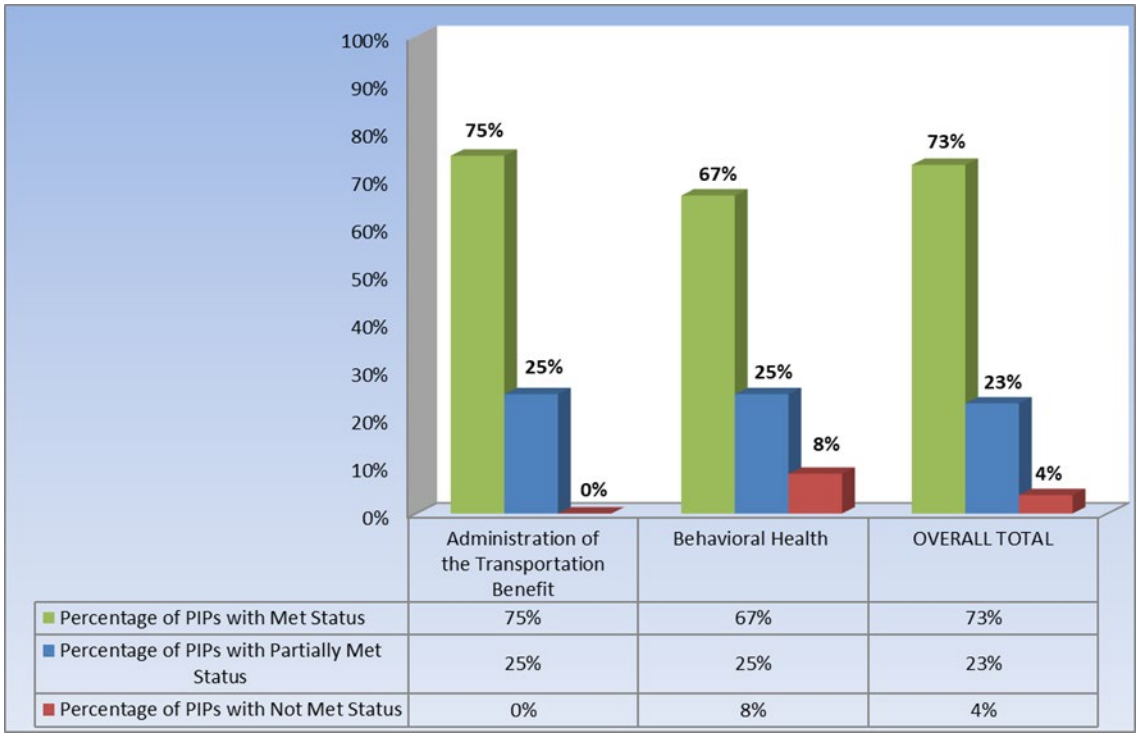
Plan PIP Validation Results

Administration of the Transportation Benefit and Behavioral Health PIP

Overall PIP Validation Status

Figure 4-1 displays the percentage of plan PIPs receiving a *Met, Partially Met,* and *Not Met* overall validation status by PIP topic. A total of 12 plans submitted 26 PIPs. The green bars represent the percentage of PIPs with an overall *Met* validation status, the blue bars represent the percentage of PIPs with a *Partially Met* validation status, and the red bars represent the percentage of PIPs with a *Not Met* validation status.

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



	Administration of the Transportation Benefit	Behavioral Health	OVERALL TOTAL
Percentage of PIPs with Met Status	75%	67%	73%
Percentage of PIPs with Partially Met Status	25%	25%	23%
Percentage of PIPs with Not Met Status	0%	8%	4%

Overall, 73 percent (19/26) of PIPs received a *Met* validation status. For the *Administration of the Transportation Benefit* PIP, three PIPs received a *Partially Met* validation status. There were opportunities for improvement in the narrative interpretation of results, documentation of improvement strategies, evaluation results of the interventions, and achievement of improvement in PIP outcomes. For the Behavioral Health PIP, three PIPs received a *Partially Met* validation status, and one PIP received a *Not Met* validation status. There were opportunities for improvement in the documentation of the performance indicators, data collection process, and evaluation of interventions for effectiveness. In addition to the *Administration of the Transportation Benefit* and the Behavioral Health PIPs, the two additional PIPs

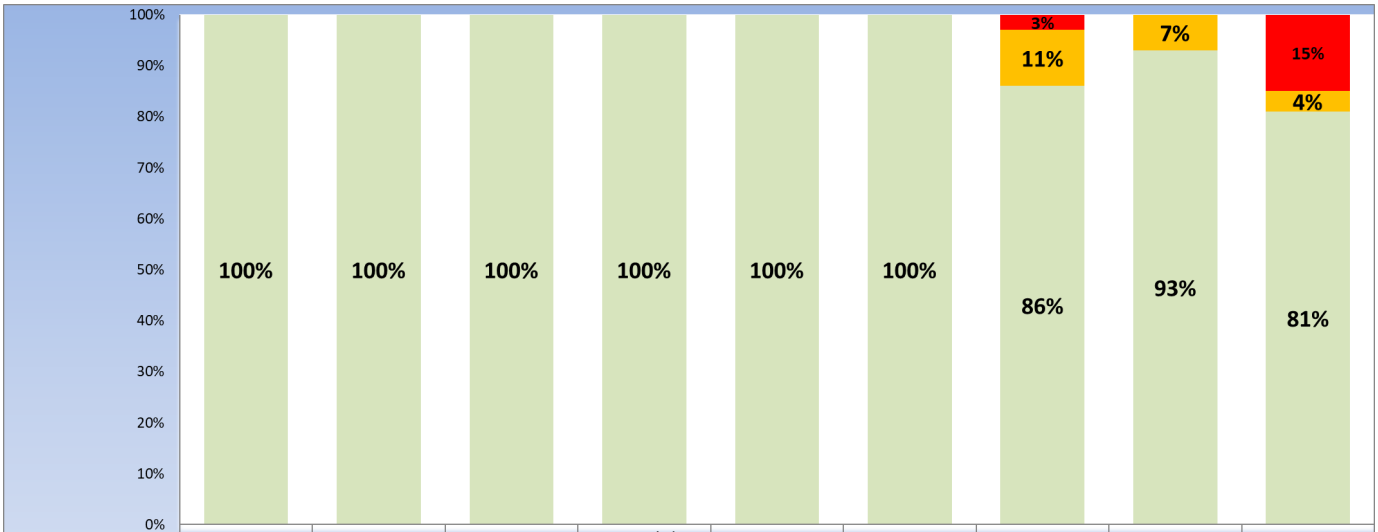
initiated by Children's Medical Services-S were included in the overall total score, and both PIPs received a *Met* validation status.

Overall Performance on Each Step of the PIP Validation Tool

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

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

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

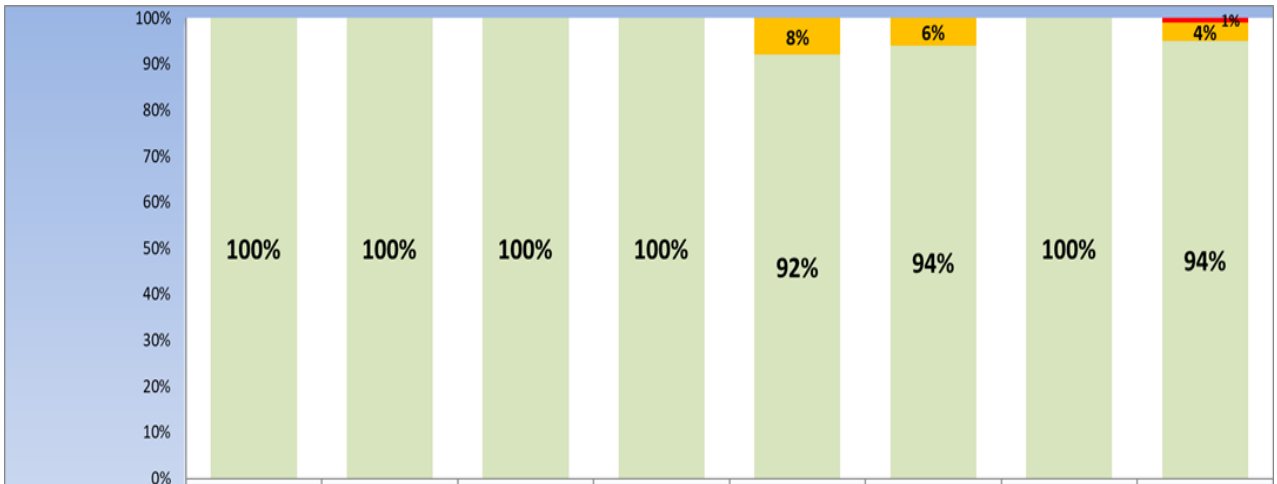


	1. Appropriate PIP Topic	2. Clearly Defined PIP Aim Statement	3. Correctly Identified PIP Population	4. Valid Sampling Techniques (if sampling was used)	5. Clearly Defined Performance Indicator	6. Accurately Defined Data Collection Process	7. Accurate Data Reporting and Analysis	8. Appropriate Improvement Strategies	9. Assessment of Improvement Achieved
Not Met	0%	0%	0%	0%	0%	0%	3%	0%	15%
Partially Met	0%	0%	0%	0%	0%	0%	11%	7%	4%
Met	100%	100%	100%	100%	100%	100%	86%	93%	81%
Plans Evaluated	12	12	12	12	12	12	12	12	11

The plans performed well on Steps 1 through 6. This performance demonstrates that most plans followed the Agency-defined specifications and provided accurate documentation for the PIP design. In Step 7 (Accurate Data Reporting and Analysis), two plans (Vivida-M and Florida Community Care-L) had opportunities for improving the narrative interpretation of data and addressing factors that impact the comparability and validity of the reported data. In Step 8 (Appropriate Improvement Strategies), Vivida-M documented that it did not perform any QI activities because the baseline performance was above the state-mandated goal of 90 percent. Aetna Better Health-C had an opportunity for improvement in the

evaluation of interventions for effectiveness. In Step 9 (Assessment of Improvement Achieved), two plans (Florida Community Care-L and Sunshine-C) were unable to achieve any improvement, and two plans (AmeriHealth-M and United-C) were unable to sustain the statistically significant improvement in the performance indicator rates achieved during Remeasurement 1.

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



	1. Appropriate PIP Topic	2. Clearly Defined PIP Aim Statement	3. Correctly Identified PIP Population	4. Valid Sampling Techniques (if sampling was used)	5. Clearly Defined Performance Indicator	6. Accurately Defined Data Collection Process	7. Accurate Data Reporting and Analysis	8. Appropriate Improvement Strategies
Not Met	0%	0%	0%	0%	0%	0%	0%	1%
Partially Met	0%	0%	0%	0%	8%	6%	0%	4%
Met	100%	100%	100%	100%	92%	94%	100%	94%
Plans Evaluated	12	12	12	12	12	12	12	12

All plans were evaluated for the Design and Implementation stages (Steps 1 through 8) of the Behavioral Health PIP. The plans will be assessed for achievement of improvement in the next validation cycle. Molina-C had opportunities to improve the documentation for performance indicator specifications and administrative data completeness. Vivida-M had opportunities for improvement related to the data collection process and providing an adequate description of the interventions. Vivida-M and Community Care Plan-M had opportunities to improve the evaluation of interventions for effectiveness.

Plan-Specific Results

Table 4-6 depicts the plan-specific validation results for the plan PIPs. For SFY 2021–2022, nine of 12 plans received an overall *Met* validation status for the *Administration of the Transportation Benefit* PIP, and eight plans received an overall *Met* validation status for the Behavioral Health PIP.

Table 4-6—Plan-Specific PIP Validation Results

Plan Name	PIP Name	Validation Status	Percentage Score of Critical Elements Met	Percentage Score of Evaluation Elements Met
AmeriHealth-M	*Administration of the Transportation Benefit*	*Met*	100%	95%
	Behavioral Health PIP	*Not Met*	89%	94%
Aetna-C	*Administration of the Transportation Benefit*	*Partially Met*	89%	88%
	Behavioral Health PIP	*Met*	100%	100%
Children's Medical Services-S	*Administration of the Transportation Benefit*	*Met*	100%	100%
	Behavioral Health PIP	*Met*	100%	100%
	Youth Transitions to Adult Care	*Met*	100%	95%
	Reducing Asthma Related PPEs for Pediatric Enrollees	*Met*	100%	100%
Community Care Plan-M	*Administration of the Transportation Benefit*	*Met*	100%	95%
	Behavioral Health PIP	*Partially Met*	89%	94%
Florida Community Care-L	*Administration of the Transportation Benefit*	*Partially Met*	100%	79%
	Behavioral Health PIP	*Met*	100%	100%
Humana-C	*Administration of the Transportation Benefit*	*Met*	100%	100%
	Behavioral Health PIP	*Met*	100%	100%
Molina-C	*Administration of the Transportation Benefit*	*Met*	100%	94%
	Behavioral Health PIP	*Partially Met*	89%	88%
Simply-C	*Administration of the Transportation Benefit*	*Met*	100%	100%
	Behavioral Health PIP	*Met*	100%	100%
Staywell-C	*Administration of the Transportation Benefit*	*Met*	100%	100%
	Behavioral Health PIP	*Met*	100%	100%
Sunshine-C	*Administration of the Transportation Benefit*	*Met*	100%	94%
	Behavioral Health PIP	*Met*	100%	100%

Plan Name	PIP Name	Validation Status	Percentage Score of Critical Elements Met	Percentage Score of Evaluation Elements Met
United-C	*Administration of the Transportation Benefit*	*Met*	100%	95%
	Behavioral Health PIP	*Met*	100%	100%
Vivida-M	*Administration of the Transportation Benefit*	*Partially Met*	71%	69%
	Behavioral Health PIP	*Partially Met*	78%	81%

Evaluation Elements

Table 4-7 displays the PIP Validation Tool evaluation elements for Appropriate Improvement Strategies (Step 8) and Assessment of Improvement Achieved (Step 9) that were assessed and the performance of the plans on those evaluation elements.

Table 4-7—Overall Performance of the Plans on the PIP Validation Tool Step 8 and Step 9 Evaluation Elements

PIPs	Administration of Transportation Benefit				Behavioral Health PIP			
Evaluation Elements	Met	Partially Met	Not Met	NA	Met	Partially Met	Not Met	NA
A causal/barrier analysis with a clearly documented team, process/steps, and QI tools. C*	11	1	0	0	12	0	0	0
Barriers that were identified and prioritized based on results of data analysis and/or other QI processes.	10	1	0	0	12	0	0	0
Interventions that were logically linked to identified barriers and have the potential to impact PIP indicator outcomes. C*	11	0	0	0	11	1	0	0
Interventions that were implemented in a timely manner to allow for impact of PIP indicator outcomes.	11	0	0	0	12	0	0	0
An evaluation of effectiveness for each individual intervention. C*	10	1	0	0	9	2	1	0
Interventions that were continued, revised, or discontinued based on evaluation results.	9	2	0	0	8	0	0	4
The remeasurement methodology was the same as the baseline methodology.	11	0	0	0	0	0	0	0

PIPs	Administration of Transportation Benefit				Behavioral Health PIP			
Evaluation Elements	Met	Partially Met	Not Met	NA	Met	Partially Met	Not Met	NA
At least one of the following was demonstrated: • Statistically significant improvement over baseline indicator performance (95 percent confidence level, $p < 0.05$). • Significant clinical improvement in processes and outcomes. • Significant programmatic	8	1	2	0	0	0	0	0
Sustained improvement was demonstrated through repeated measurements over time.	2	0	2	7	0	0	0	0

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

Plan Performance Indicator Results

For the *Administration of the Transportation Benefit* PIP, most plans reported CY 2020 data as the Remeasurement 1 period for the PIP performance indicator(s). The measurement periods for this state-defined PIP were based on CY at the PIP initiation. Only four plans (Community Care Plan-M, AmeriHealth-M, United-C, and Staywell-C) reported CY 2020 data as Remeasurement 2 rates. Eight rates reported for CY 2020 were at or above the goal of 90 percent. The PIP performance indicator rates as reported by the plans are identified in Table 4-8. The data in green font represent statistically significant improvement over the baseline. Six plans reported achievement of statistically significant improvement over the baseline during CY 2020.

Table 4-8—Performance Indicator Rates for the Administration of the Transportation Benefit PIP

Plan Name	Measurement Period~	Performance Indicator Rate*
Aetna Better Health-C^	CY 2019	83.0%
	CY 2020	88.4%
AmeriHealth-M^^	CY 2018	94.1%
	CY 2019	97.1%
	CY 2020	89.1%
Children's Medical Services-S	CY 2019	90%
	CY 2020	94.9%

Plan Name		Measurement Period~	Performance Indicator Rate*
Community Care Plan-M		CY 2018	81.4%
		CY 2019	90.1%
		CY 2020	92.7%
Florida Community Care-L		CY 2019	93.13%
		CY 2020	93.34%
Humana-C		CY 2019	85.1%
		CY 2020	89.7%
Molina^^^	Molina-C	CY 2019	97.8%
		CY 2020	95.9%
	Molina-S	CY 2019	96.1%
		CY 2020	95.4%
Simply-C		CY 2019	89.5%
		CY 2020	92.0%
Staywell-C		CY 2018	84.1%
		CY 2019	87.2%
		CY 2020	90.8%
Sunshine-C		CY 2019	88.5%
		CY 2020	88.2%
United-C		CY 2018	93.3%
		CY 2019	95.0%
		CY 2020	86.4%
Vivida-M		CY 2019	91.5%
		CY 2020	94.7%

~ Four plans reported CY 2018 as the baseline.

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

^ Aetna Better Health-C will report CY 2020 as the new baseline measurement in the next submission because the plan was able to collect only December 2019 data for CY 2019.

^^ AmeriHealth-M reported transportation vendor-specific data for CY 2020. HSAG provided feedback that the plan should provide a comprehensive rate in the next submission. HSAG calculated the reported cumulative CY 2020 rate by adding the vendor-specific data.

^^^ Molina-C reported data by line of business for the comprehensive and specialty populations.

For the Behavioral Health PIP, the plans reported CY 2020 data as the implementation year. The performance indicator rates as reported by the plans are in Table 4-9 below. The plans will be assessed for achievement of statistically significant improvement in the PIP performance indicator outcomes and achievement of clinically significant or programmatically significant improvement after finalized Remeasurement 1 (CY 2021) data are reported.

Table 4-9—Performance Indicator Rates for the Behavioral Health PIP

Plan Name		Measurement Period~	7-Day FUH Rate*	7-Day FUM Rate**	7-Day FUA Rate***
Aetna Better Health-C		CY 2019	36.9%	26.5%	4.5%
		CY 2020	36.9%	27.7%	5.7%
AmeriHealth-M		CY 2019	31.0%	25.2%	10.7%
		CY 2020	39.9%	25.6%	13.9%
Children's Medical Services-S		CY 2019	41.9%	40.6%	2.3%
		CY 2020	45.7%	35.1%	0.0%
Community Care Plan-M		CY 2019	36.0%	30.2%	3.1%
		CY 2020	31.3%	27.1%	1.9%
Florida Community Care-L		CY 2019	11.9%	20.0%	0.0%
		CY 2020	10.4%	6.3%	12.5%
Humana-C		CY 2019	36.6%	27.2%	4.4%
		CY 2020	34.5%	28.7%	6.0%
Molina^	Molina-C	CY 2019	38.8%	22.6%	5.8%
		CY 2020	37.8%	30.0%	6.9%
	Molina-S	CY 2019	20.4%	28.9%	6.0%
		CY 2020	23.7%	22.8%	5.5%
Simply^	Simply-C	CY 2019	15.4%	33.6%	4.9%
		CY 2020	34.2%	37.2%	7.7%
	Clear Health-S	CY 2019	8.1%	30.1%	5.3%
		CY 2020	14.6%	24.5%	8.2%
Staywell-C		CY 2019	27.5%	25.0%	6.5%
		CY 2020	29.1%	26.8%	6.3%
Sunshine^	Sunshine-C	CY 2019	31.3%	25.3%	4.6%
		CY 2020	32.7%	21.4%	6.5%
	Sunshine-S-CW	CY 2019	45.6%	52.2%	1.3%
		CY 2020	48.4%	57.5%	2.9%

Plan Name	Measurement Period~	7-Day FUH Rate*	7-Day FUM Rate**	7-Day FUA Rate***
United-C	CY 2019	29.6%	25.8%	7.7%
	CY 2020	28.9%	23.1%	5.9%
Vivida-M	CY 2019	25.0%	1.8%	18.5%
	CY 2020	15.5%	25.0%	13.0%

~ CY 2019 is the baseline and CY 2020 is the implementation year for this PIP. CY 2020 rates were not assessed for statistically significant improvement.
* *Follow-Up After Hospitalization for Mental Illness—7-Days*
** *Follow-Up After ED Visit for Mental Illness—7-Days*
*** *Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence—7-Days*
^ Data by line of business for the comprehensive and specialty populations.

Plan Improvement Strategies

A plan's success in achieving significant improvement in PIP outcomes is strongly influenced by the improvement strategies and interventions implemented during the PIP. As part of the PIP validation process, HSAG reviewed the interventions employed by the plans for appropriateness to the barriers identified, and timeliness of the implementation of the interventions. Table 4-10 displays the interventions as documented by the plans for the *Administration of the Transportation Benefit* PIP, and Table 4-11 displays the interventions for the Behavioral Health PIP

Table 4-10—Interventions Implemented/Planned for the *Administration of the Transportation Benefit* PIP

Plan Name	Interventions Implemented/Planned
Aetna-C	• ModivCare schedules "ride along" with transportation providers not meeting timeliness metrics. • Identify enrollee no-shows and distribute a report identifying those enrollees monthly.
AmeriHealth-M	• Evaluate and initiate performance improvement plan, capitation on trip volume, and termination of providers (transportation vendors) not meeting targets.
Children's Medical Services-S	• New tracking software to track performance of the vendors. • CAPs for providers (transportation vendors) not meeting targets.
Community Care Plan-M	• Placed transportation company on CAP. Plan required weekly updates to Account Services and monthly updates to plan Quality Improvement Committee (QIC). • Transportation company implemented a ride app (LCAD) that reports trip completion in real time.
Florida Community Care-L	• Evaluated and initiated performance improvement plan, capitation on trip volume, and termination of providers (transportation vendors) not meeting targets.
Humana-C	• Targeted on-site visits with Adult Day Care Centers that have the highest volume of LTC membership, provide their own transportation, and do not meet the 90 percent threshold.

Plan Name	Interventions Implemented/Planned
Molina-C (includes Molina-S)	• Transportation vendor provides coaching of protocols to the employees who do not abide by the Transportation Manual. • Provide enrollee education during transportation appointments scheduled by Molina representatives (i.e., educating enrollees about average wait time on return ride home). • Transportation vendor will flag and monitor transportation providers with a decrease in on-time performance. A reduction in the number of future trips and services by the providers may be done until improvement is made. • For the specialty population, transportation vendor (Veyo) requires each provider to share demographic data. Information received is validated by Veyo supply staff regularly to ensure there are no gaps in network adequacy. • Veyo works with subcontractor(s) drivers to allow for more time for arriving to pick-up point and for transport to scheduled appointment including using an app prior to leaving to select the quickest route. • The plan staff will educate enrollees (particularly those with a history of being late three or more times in a three-month period) about the importance of being ready for pick-up.
Simply-C (includes Clear Health-S)	• Identify and engage enrollees with prior transportation issues. • Develop an effective predictive modeling strategy in order to take a more proactive approach toward improving the percentage of scheduled Leg A trips that are on time for their scheduled appointment. This includes: – Obtaining a missed/late trip report monthly from the transportation vendors. – Analysis of performance trends month over month by region, county, and ZIP Code. – Analysis of performance trends by area, provider, and facility. • Finalize targets and allocate resources for support based on findings.
Staywell-C	• Implemented a new tracking software to track performance of the vendors. • CAPs implemented for transportation vendors not meeting targets.
Sunshine-C (includes Sunshine-S-CW and Sunshine-S-SMI)	• Enrollee Advocate Escalation Unit will handle real-time enrollee transportation complaints and provide additional collaboration with LogistiCare (vendor). • Use the Secret Shopper program as a random check on courtesy and completeness of the vendor's agents' call interactions with enrollees. • Conduct an "After-Ride" enrollee satisfaction survey. • Provide provider education materials and conduct training. • Provide enrollee education materials.
United-C	• Improve network capacity. • Identify underperforming providers, assess network coverage, and adjust volume down immediately. Target bottom tier providers for behavior modification through a) lowered volume, and b) improvement action plans. Target bottom 5% of fleet for replacement/reassignment of volume with random targeted inspections.

Plan Name	Interventions Implemented/Planned
	• Rewarding transportation providers who are performing above expectations with more standing orders. • Escalations and Monitoring: Place four specialists dedicated to recovery and active trip monitoring. Modified cancelation/no-show process to capture trips, which would potentially result in a complaint or missed trip. Implemented new online recommendation-based routing tool. Updated routing plans aimed at reducing recurring complaints. • Go-Digital Initiative implemented in 2021: Expanded text messaging communications to the entire Transportation Provider Network. Enhancements include enrollee appointment reminders, confirmation of reservation details, initiating return ride home (Leg-B), reservation cancellation, vehicle estimated time of arrival, vehicle identifying information, and enrollee opt-out option.
Vivida-M	• NR

Table 4-11—Interventions Implemented/Planned for the Behavioral Health PIP

Plan Name	Interventions Implemented/Planned
Aetna-C	• Using Florida's ENS to facilitate timely outreach to the enrollee to schedule follow-up visits with eligible providers. • Outreach calls to enrollees to coordinate or verify scheduling of seven-day follow-up appointments. • Behavioral health liaisons conduct in-service trainings with the discharge planning teams and leadership at behavioral health facilities that did not schedule the recommended seven-day follow-up appointments. During these meetings, the behavioral health liaisons: – Educate the staff on the *FUH* HEDIS measure. – Identify barriers to scheduling appointments. – Discuss best practices.
AmeriHealth-M	• AmeriHealth will use Florida's ENS to improve AmeriHealth's awareness of ED visit and hospital admission information daily in order to prompt the process and alert the AmeriHealth TOC coordinator to review the discharge plan and initiate and coordinate follow-up appointment. • Identify ED and inpatient (IP) providers through collected TOC information and recorded in the benefit and case management system (JIVA). Information is given to the provider network management department for outreach by the assigned account executive with provider education about valid follow-up appointment requirements. TOC coordinator to initiate discharge and will communicate with enrollee and provider to assist with follow-up appointment. • High-risk indicators are established. Flag the enrollees with high-risk indicator(s) per case management record.

Plan Name	Interventions Implemented/Planned
Children's Medical Services-S	• Utilize Florida's ENS real-time hospital admission, discharge, transfer (ADT) data to identify enrollees for outreach to schedule follow-up visits with primary care and/or behavioral health providers. • UM team notifies the primary care manager, back-up care manager, supervisor, and behavioral health manager about admissions and discharges from Crisis Stabilization Units (CSUs).
Community Care Plan-M	• Improve efforts to obtain real-time hospital admission ED visit notifications through Florida's ENS to facilitate timely outreach to the enrollee to schedule follow-up visits with primary care and behavioral health providers. • Improve discharge planning and care transitions through weekly all department huddles with a focus on behavioral health.
Florida Community Care-L	• Care managers will obtain real-time hospital admission and ED visit notifications through Florida's ENS. Care managers will confirm if the enrollee is linked to a PCP and help with facilitating follow-up visits with primary care and mental health providers. • Outreach and education to increase awareness of the availability of mental health services. Family caregiver engagement in discharge planning. Arrange for and coordinate community resources as needed. • Upon notification of ED visit or IP admission, care manager will determine if enrollee has been diagnosed with or has self-reported mental illnesses, alcohol and other drug abuse, or dependencies. Care manager will reach out to the IP facility to assist with follow-up appointment before discharge.
Humana-C	• Improve efforts to obtain real-time hospital admission and ED visit notifications through ENS to facilitate timely outreach to the enrollee to schedule follow-up visits with primary care and behavioral health providers. • Enhance discharge planning, care transitions, and post-discharge care coordination. • Enhance care coordination, education, and enrollee and provider engagement post-ED visit. • Promote telehealth utilization and expansion for seven-day follow-up appointments. • Implement a provider scorecard to enhance provider (hospital) compliance and engagement with coordination of care, transitions, and scheduling of post-discharge appointments.
Molina-C	• Identification of additional enrollee information through internal and external tools for enrollees in the discharge, aftercare, and ENS reports. • Outreach and education to increase awareness of the availability of behavioral health services. • Education to high utilizing hospitals and primary care physicians. • Assist with scheduling timely follow-up appointments.

Plan Name	Interventions Implemented/Planned
	• For specialty populations, the plan will improve efforts to obtain real-time hospital admission and ED visit notifications through Florida's ENS to facilitate timely outreach to the enrollee to schedule follow-up visits. • The specialty plan care coordinator will confirm the enrollee is linked to a PCP or behavioral health provider, assist with the scheduling of a timely follow-up appointment within seven days of discharge, schedule transportation if needed, and call the enrollee to verify compliance with the appointment. • Specialty plan teams, including health services and provider network, will improve collaboration with local hospitals to improve coordination with outpatient behavioral health providers and provide education to ensure follow-up care occurs within seven days of discharge/ED visit.
Simply-C	• Improving ENS notifications. • Plan engaged three behavioral health providers who agreed to participate in this test and requested that participating providers contact every enrollee discharged from a behavioral health hospitalization within 24 hours and provide an immediate telehealth behavioral health visit, which will address the *FUH—7 Days* population. • Provide enrollees with a $25 gift card for completion of each of the 7- and 30-day follow-up appointments following an ED visit.
Staywell-C	• Utilize Florida's ENS real-time hospital ADT data to identify enrollees for outreach to schedule follow-up visits with primary care and/or behavioral health providers. The UM team notifies the primary care manager, backup care manager, supervisor, and behavioral health manager about behavioral health-related admissions and discharges from hospitals and CSUs.
Sunshine-C	• Utilize Florida's ENS real-time hospital ADT data to identify enrollees for outreach to provide education regarding the importance and need for a follow-up appointment, to offer assistance with scheduling the appointment, to provide education regarding the option of using telehealth for the follow-up appointment, and to provide assistance with arranging transportation if an in-person appointment is preferred by the enrollee.
United-C	• Optum Chronic Care Management (CCM) program is designed to support enrollees with behavioral health needs, including those related to mental health and substance use. • Optum virtual case health worker (CHW) team: Enrollees discharged for a low-risk behavioral health condition are assigned a virtual CHW, who ensures enrollee has follow-up appointment within the appropriate time frame. • Daily ENS behavioral health custom report to be used by Optum CCM and virtual CHW program. • Behavioral health care management team to begin using portal maintained by Audacious Inquiry (AI) health information exchange (HIE). Portal houses enrollee contact information from the most recent ED or hospital visited by the enrollee. • ENS Data QIs: AI is collaborating with the plan to improve data quality and reduce missing data coming through the HIE. AI is working to improve fields such as hospital National Provider Identifier (NPI), attending doctor, serving facility, diagnosis

Plan Name	Interventions Implemented/Planned
	codes/description/type and more. Consistent inclusion of data is necessary for effective follow-up by plan teams. • Value-based Contracting: This model for outpatient providers offers a shared savings opportunity based on a reduction of IP costs and achievement of one or more quality metrics (three metrics in all) including *FUH*. This model targets Community Mental Health Centers and large providers. • Value-based Contracting (Health Home): This model is the Optum Behavioral National Model developed to drive total cost of care value and improved health outcomes through a managed health home model paired with a monthly case rate and potential shared savings opportunity. This model targets large outpatient providers.
Vivida-M	• Improve efforts to obtain real-time hospital admission and notifications through Florida's ENS to facilitate timely outreach to the enrollee to schedule follow-up visits with primary care and behavioral health providers following an ED visit. • Outreach and education to increase awareness of the availability of behavioral health services.

Children's Medical Services-S Two Additional PIPs Validation Results

Children's Medical Services-S submitted two alternative PIPs—*Youth Transitions to Adult Care* and *Reducing Asthma Related PPEs for Pediatric Enrollees* for validation. For SFY 2021–2022, both PIPs received an overall *Met* validation status and achieved a 100 percent *Met* score for all the evaluation elements.

Performance Indicator Results

For SFY 2021–2022, Children's Medical Services-S reported finalized Remeasurement 1 (CY 2020) results for the *Youth Transitions to Adult Care* and *Reducing Asthma Related PPEs for Pediatric Enrollees* PIPs. For the *Youth Transitions to Adult Care* PIP, Children's Medical Services-S reported an increase in the performance indicator rate; however, the increase was not statistically significant over the baseline. The plan did not report any evidence of significant clinical or programmatic improvement. For the *Reducing Asthma Related PPEs for Pediatric Enrollees* PIP, Children's Medical Services-S reported a statistically significant increase over the baseline for both performance indicators. The PIP performance indicators' rates as reported by Children's Medical Services-S are displayed in Table 4-12 and Table 4-13. The data in green font represent statistically significant improvement over the baseline.

Table 4-12—Performance Indicator Rates for the *Youth Transitions to Adult Care* PIP

PIP Name	Measurement Period	Performance Indicator Rate*
Youth Transitions to Adult Care	CY 2019	0.8%
	CY 2020	1.3%

* Performance Indicator: The percentage of enrollees 18 to 21 years of age who transitioned from a pediatric provider to an adult care provider during the measurement period.

Table 4-13—Performance Indicator Rates for the *Reducing Asthma Related PPEs for Pediatric Enrollees* PIP

PIP Name	Measurement Period	Performance Indicator 1 Rate*	Performance Indicator 2 Rate**
Reducing Asthma Related PPEs for Pediatric Enrollees	CY 2019	71.6%	94.2%
	CY 2020	95.4%	99.4%

* Performance Indicator 1: The percentage of enrollees 5 to 18 years of age who did not have an asthma-related ED visit.

** Performance Indicator 2: The percentage of enrollees 5 to 18 years of age who did not have an asthma-related hospital admission.

Performance Improvement Strategies

Table 4-14 displays the interventions as documented by Children's Medical Services-S for the two additional PIPs.

Table 4-14—Interventions for the Children's Medical Services-S PIP

PIP Name	Interventions Implemented/Planned
Youth Transitions to Adult Care	• Created transition assessment tool to guide care managers while they evaluate enrollee transition readiness or progress. • Created transition care plan template for care managers to assist enrollees with transitioning from pediatric to adult providers. • Educate enrollees regarding how to search for adult providers using the online provider search tool. • Developed a training program for care managers regarding the steps necessary to support enrollees with transitioning from pediatric to adult providers. • Imbed alerts into care management system to assist care managers with identifying when transition assessment and planning need to occur.
Reducing Asthma Related PPEs for Pediatric Enrollees	• Developed "Asthma Action Plan" for enrollee education. This plan is pending approval from the DOH. This three-step written plan for enrollees is to help them self-direct their care and know when to contact their doctor. Enrollees complete this tool with their PCP. • "My Asthma Diary" is a booklet designed to help children and parents/caregivers identify and learn to manage/avoid their asthma triggers. The booklet will be mailed to the enrollee, and the care manager will follow up to provide further education. • Expanded benefits provide carpet cleaning, HEPA filter vacuum cleaner, hypoallergenic bedding, and pest control services to eligible enrollees to make their home environment more asthma-control friendly.

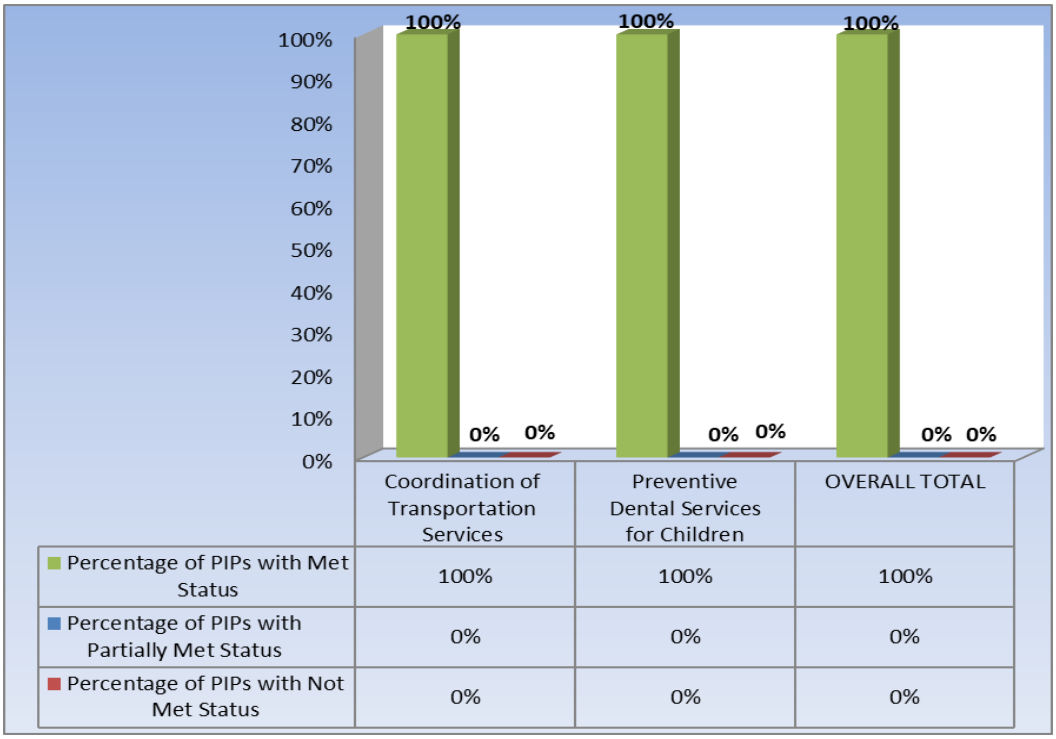
Dental Plans PIP Validation Results

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

Overall Validation Status

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

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



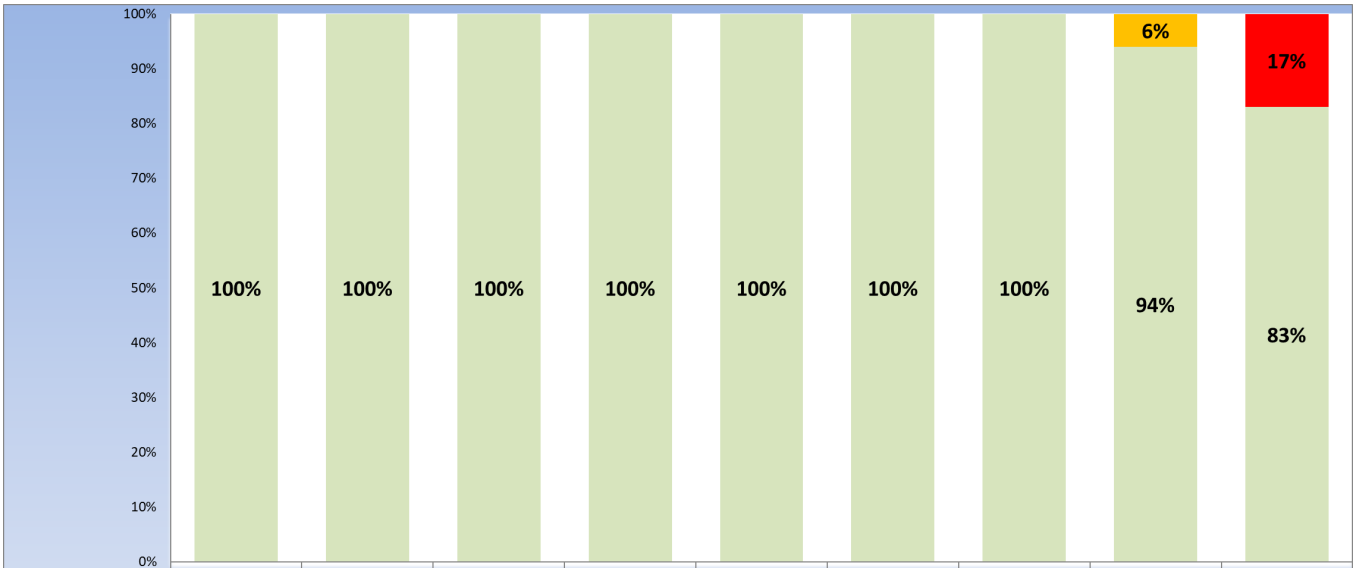
	Coordination of Transportation Services	Preventive Dental Services for Children	OVERALL TOTAL
Percentage of PIPs with Met Status	100%	100%	100%
Percentage of PIPs with Partially Met Status	0%	0%	0%
Percentage of PIPs with Not Met Status	0%	0%	0%

All six dental PIPs (100 percent) received an overall *Met* validation status, indicating an improvement in performance over last year's validation for which 50 percent of the PIPs received a *Met* validation status.

Overall Validation Status on Each Step of the PIP Validation Tool

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

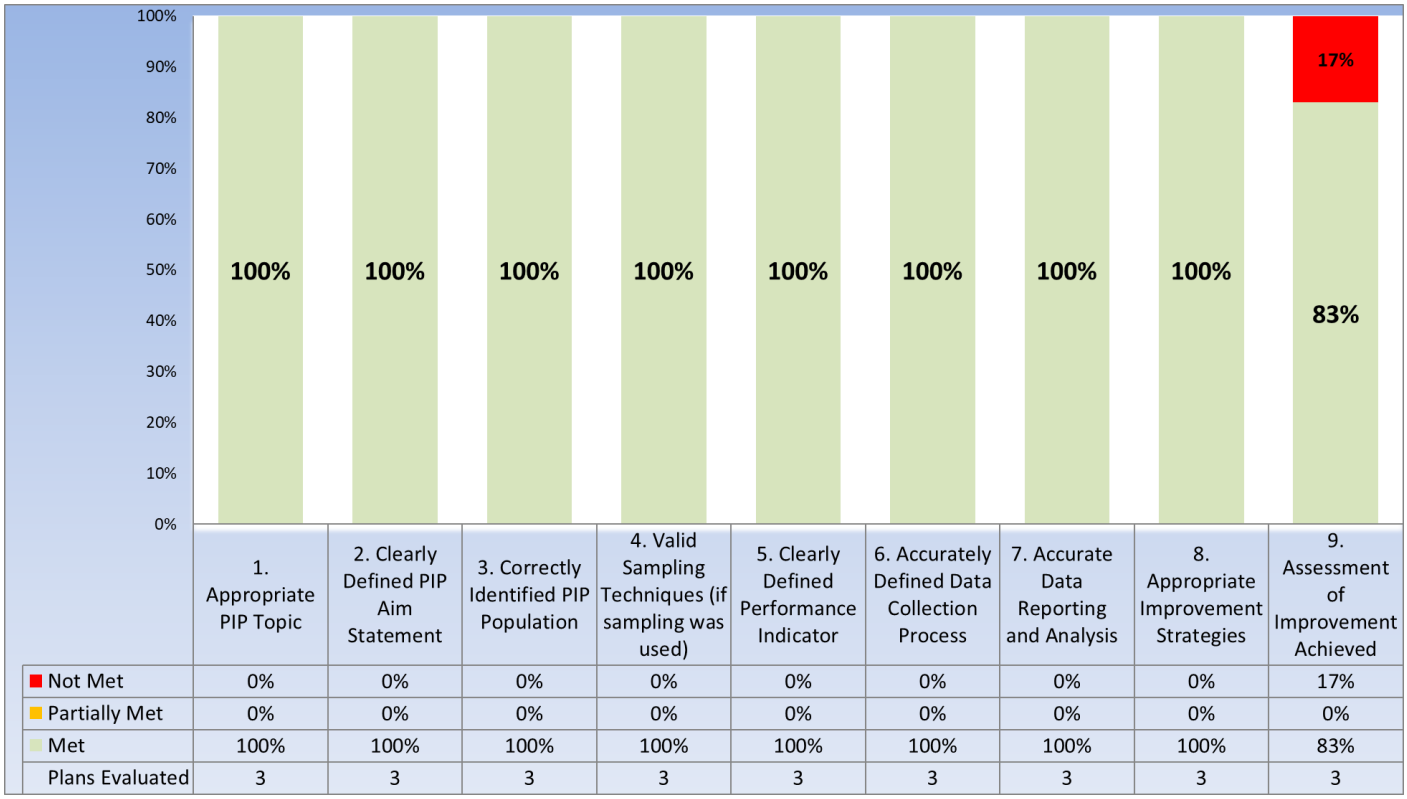
Figure 4-5—Overall Performance on Each Step of the PIP Validation Tool for the *Preventive Dental Services for Children* PIP



	1. Appropriate PIP Topic	2. Clearly Defined PIP Aim Statement	3. Correctly Identified PIP Population	4. Valid Sampling Techniques (if sampling was used)	5. Clearly Defined Performance Indicator	6. Accurately Defined Data Collection Process	7. Accurate Data Reporting and Analysis	8. Appropriate Improvement Strategies	9. Assessment of Improvement Achieved
Not Met	0%	0%	0%	0%	0%	0%	0%	0%	17%
Partially Met	0%	0%	0%	0%	0%	0%	0%	6%	0%
Met	100%	100%	100%	100%	100%	100%	100%	94%	83%
Plans Evaluated	3	3	3	3	3	3	3	3	3

All three dental plans were evaluated for the Design, Implementation, and Outcomes stages (Steps 1 through 9) of the PIP. Liberty had an opportunity to improve the process for evaluation of interventions, and DentaQuest did not achieve any improvement.

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



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

All three dental plans were evaluated for the Design, Implementation, and Outcomes stages (Steps 1 through 9) of the PIP. All dental plans performed well in the Design and Implementation stages (Steps 1 through 8); however, in Step 9 (Assessment of Improvement Achieved) DentaQuest did not report improvement in PIP outcomes.

Dental Plan-Specific Results

Table 4-15 depicts and compares the dental plan-specific SFY 2021–2022 PIP validation results for the dental PIPs.

Table 4-15—Dental Plan-Specific PIP Validation Results

Dental Plan Name	PIP Name	Validation Status	Percentage Score of Critical Elements Met	Percentage Score of Evaluation Elements Met
DentaQuest	*Coordination of Transportation Services With the SMMC Plans*	*Met*	100%	95%
	Preventive Dental Services for Children	*Met*	100%	95%

Dental Plan Name	PIP Name	Validation Status	Percentage Score of Critical Elements Met	Percentage Score of Evaluation Elements Met
Liberty	*Coordination of Transportation Services With the SMMC Plans*	*Met*	100%	100%
	Preventive Dental Services for Children	*Met*	100%	95%
MCNA	*Coordination of Transportation Services With the SMMC Plans*	*Met*	100%	100%
	Preventive Dental Services for Children	*Met*	100%	100%

Evaluation Elements

Table 4-16 displays the evaluation elements for Step 8 (Appropriate Improvement Strategies) and Step 9 (Assessment of Improvement Achieved) that were assessed and the performance of the dental plans on those evaluation elements.

Table 4-16—Overall Performance of the Dental Plans on the PIP Validation Tool Step 8 and Step 9 Evaluation Elements

PIPs	*Coordination of Transportation Services With the SMMC Plans*				*Preventive Dental Services for Children*			
Evaluation Elements	**Met**	**Partially Met**	**Not Met**	**NA**	**Met**	**Partially Met**	**Not Met**	**NA**
A causal/barrier analysis with a clearly documented team, process/steps, and QI tools. C*	3	0	0	0	3	0	0	0
Barriers that were identified and prioritized based on results of data analysis and/or other QI processes.	3	0	0	0	3	0	0	0
Interventions that were logically linked to identified barriers and have the potential to impact PIP indicator outcomes. C*	3	0	0	0	3	0	0	0
Interventions that were implemented in a timely manner to allow for impact of PIP indicator outcomes.	3	0	0	0	3	0	0	0
An evaluation of effectiveness for each individual intervention. C*	3	0	0	0	3	0	0	0

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

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

Dental Plan PIP Performance Indicator Results

For the *Preventive Dental Services for Children* PIP, the dental plans reported completed Remeasurement 1 (FFY 2020) rates for the PIP performance indicator. This PIP is based on the CMS416 measure which is reported as FFY. All three plans had a decline in the performance indicator rates; however, Liberty and MCNA provided intervention evaluation data-driven evidence of significant clinical and programmatic improvement in PIP outcomes. The dental plans documented that COVID-19 pandemic-related factors may have led to a decline in the overall PIP performance indicator rate during FFY 2020.

For the *Coordination of Transportation Services With the SMMC Plans* PIP, the dental plans reported finalized Remeasurement 1 (CY 2020) rates for the PIP performance indicator(s). The measurement periods for this state-defined PIP were based on CY at the PIP initiation. Liberty and MCNA reported a baseline and Remeasurement 1 rate of 100 percent for Performance Indicator 1. Liberty also demonstrated a statistically significant increase in Performance Indicator 2 results. MCNA provided intervention evaluation data-driven evidence of significant clinical improvement in PIP outcomes. DentaQuest did not report any improvement in PIP outcomes.

The PIP performance indicators' rates as reported by the dental plans are displayed in Table 4-17 and Table 4-18. The data in green font represent statistically significant improvement over the baseline.

Table 4-17—Performance Indicator Rates for the *Preventive Dental Services for Children* PIP

Dental Plan Name	Measurement Period*	Performance Indicator Rate**
DentaQuest	FFY 2019	36.3%
	FFY 2020	32.7%
	FFY 2021	33.0%
Liberty	FFY 2019	34.5%
	FFY 2020	31.6%
	FFY 2021	NR
MCNA	FFY 2019	36.0%
	FFY 2020	31.1%
	FFY 2021	31.1%

* Two plans reported interim data for FFY 2021 as available on the October 1, 2021, PIP submission due date. The plans will update the FFY 2021 data in the next submission.

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

Table 4-18—Performance Indicator Rates for the *Coordination of Transportation Services With the SMMC Plans* PIP

Dental Plan Name	Measurement Period	Performance Indicator 1 Rate*	Performance Indicator 2 Rate**
DentaQuest	CY 2019	96.3%	NR
	CY 2020	90.5%	NR
Liberty	CY 2019	100%	9.8%
	CY 2020	100%	23.4%
MCNA	CY 2019	100%	62.0%
	CY 2020	100%	54.6%

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

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

Dental Plan Improvement Strategies

Table 4-19 displays the interventions as documented by the dental plans for the *Preventive Dental Services for Children* PIP, and Table 4-20 displays the interventions for the *Coordination of Transportation Services With the SMMC Plans* PIP.

Table 4-19—Interventions Implemented/Planned for the *Preventive Dental Services for Children* PIP

Dental Plan Name	Interventions Implemented/Planned
DentaQuest	• Healthy Behavior Program to encourage enrollees to receive preventive treatment; also offering a $20 Walmart gift card to enrollees receiving preventive dental care within 180 days of enrollment. • Reimbursement fee increased for teledentistry and preventive dentistry codes.
Liberty	• 1st Tooth, 1st Birthday campaign, which includes outreach to parents/guardians and providers to promote awareness of the American Academy of Pediatric Dentistry's (AAPD's) recommendation to "Get it Done in Year One." • Enrollee incentive programs to motivate enrollees to seek preventive dental care. • A tiered payment incentive for primary dental providers. • Text message outreach campaign to target non-utilizers of preventive care.
MCNA	• Hygienist Helpline—This service enables enrollees, or their parents or guardians, to speak with a professional about their dental issues and to help enrollees find the best providers for their needs. The hygienists ensure enrollees with emergent conditions are immediately routed to providers with after-hours availability, including weekends or holidays, and those with non-emergent needs are connected with the next available appointment with their provider based on their clinical needs. • Care Gap Alerts—Member service representatives (MSRs) offer assistance with scheduling an appointment when an alert is triggered in the DentalTrac system during inbound calls that indicates the enrollee is overdue for a preventive dental visit. • Enrollee Pre-Authorization Outbound Calls—MCNA's Provider Relations (PR) team conducts outbound calls to provider offices with a high volume of unused pre-authorization requests and provides them with a list of enrollees. • Provider Portal Preventive Service Gaps—Real-time preventive dental service gaps visible to providers at the time of eligibility verification in MCNA's provider portal. • Targeted PR Outreach for Treatment Services—Targeted PR visits to dentists who, based on dental record review, have not completed documented treatment needs.

Table 4-20—Interventions Implemented/Planned for the *Coordination of Transportation Services With the SMMC Plans* PIP

Dental Plan Name	Interventions Implemented/Planned
DentaQuest	• Created and distributed an informational sheet on DentaQuest contact information to SMMC dental plan liaisons. • Training the MSRs on enrollee assistance with the transportation requests and the tracking and reporting of enrollee transportation requests. • Enrollees who inquire about transportation are contacted via an interactive voice response (IVR) call to ensure that transportation was scheduled. Enrollees will receive follow-up calls the following month after the initial request for transportation information from DentaQuest.
Liberty	• Include information in enrollee handbook, provider reference guide, Liberty Dental Plan website, and any newsletters. • Live outreach to non-utilizing enrollees to inform them of transportation availability. • Liberty customer service representative (CSR) to act as liaison to coordinate with, or on behalf of, enrollee with transportation vendor directly.
MCNA	• Inbound Education and Assistance—MSRs and case management educate and assist enrollees with scheduling transportation to their dental appointments through inbound calls. • Provider Portal Banner—Eligibility screen in the provider portal that reminds providers that enrollees can receive transportation assistance. • Enrollee Outreach for Missed Appointments—Collaborate with Community Care Plan-M for monthly data exchange of enrollees who miss more than two scheduled transportation trips to a dental appointment.

Strengths, Opportunities for Improvement, and Recommendations

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

Strengths	
+	The PIPs were methodologically sound. The implemented targeted interventions were linked to the identified barriers and actively engage the enrollees or providers to improve access to, quality of, and timeliness of care.
+	For the *Administration of the Transportation Benefit* PIP, eight out of 12 plans reported a CY 2020 rate at or above the goal of 90 percent.
+	All dental plans received a *Met* overall PIP validation status for both dental PIPs.
+	Most plans reported achievement of significant improvement in performance indicator outcomes or achievement of significant clinical or programmatic improvement.

Weaknesses and Recommendations	
−	**Weakness:** The performance indicator rates and goals documented by the plans for *Improving Birth Outcomes* and *Reducing PPEs* PIPs differed from the Agency-provided data. **Recommendations**: The plans must ensure that the reported data and corresponding analysis in the submitted PIP form are accurate. The plans must communicate with the Agency and HSAG regarding the data to be included for the *Improving Birth Outcomes* and *Reducing PPEs* PIPs.
−	**Weakness:** Not all plans reported complete intervention evaluation data for the PIPs. The plans included intervention evaluation data for CY 2020; however, with a submission date of October 2021, the plans should have included intervention evaluation data for CY 2021 to date. **Recommendations:** Intervention evaluation data should be collected frequently (weekly, biweekly, monthly, quarterly, etc.) unlike the annual performance indicator data. Frequent assessment of the interventions helps determine the changes that need to be made to the interventions in a timely manner to achieve improvement. The plans must report to-date evaluation data for each intervention in the next annual submission.
−	**Weakness:** The performance indicator rates for some PIPs declined. The plans may not be revising the interventions based on the intervention evaluation data, or the interventions deemed successful did not reach enough of the eligible population to impact the performance indicator rates. **Recommendations:** For unsuccessful interventions, the plans should make data-driven decisions to revise the current intervention or discontinue it and implement new interventions.

Weaknesses and Recommendations	
	• The plans should consider using QI science tools such as process mapping, failure modes and effects analysis, or a key driver diagram to identify and prioritize barriers and opportunities for improvement. • The plans should consider seeking enrollee input to better understand enrollee-related barriers toward access to care. • The interventions deemed successful when tested on a small scale using Plan-Do-Study-Act (PDSA) cycles should be ramped up and adopted planwide in order to impact the entire eligible population.
−	**Weakness:** Some PIP interventions did not include enough details. **Recommendations:** The plans should provide adequate details for HSAG and the Agency to better understand the interventions. For example, the plans should document how they will improve efforts to obtain real-time notifications from Florida's ENS and how the plans will use those data. For outreach interventions, the plans should include the mode and frequency of outreach.
−	**Weakness:** The plans did not address all of HSAG's validation feedback from the previous year. **Recommendations:** The plans must address all *Partially Met* and *Not Met* scores and any validation feedback provided throughout the validation tool.

Optional Activities

Introduction

EQR-related activities are the mandatory and optional activities, as set forth in 42 CFR §438.358, which produce the data and information that the EQRO analyzes when performing the EQR. EQR-related activities are intended to improve states' ability to oversee and manage the plans they contract with for services and help improve their performance with respect to the quality of, timeliness, of and access to care. In addition to the mandatory sections described in the prior sections of this report, CMS designates six optional activities. The state has discretion to determine which optional EQR-related activities, if any, it wishes to conduct and include in the annual EQR. For SFY 2021–2022, the Agency contracted HSAG to conduct the optional activities described in this section.

Encounter Data Validation (EDV)

Accurate and complete encounter data are critical to the success of any managed care program. State Medicaid agencies rely on the quality of the encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of the state's overall management and oversight of its Medicaid managed care program and in demonstrating its responsibility and stewardship. Federal regulations at 42 CFR Part 438 include several provisions related to encounter data.

During SFY 2021–2022, the Agency contracted with HSAG to conduct an EDV study. The goal of the SFY 2021–2022 EDV study was to examine the extent to which the LTC encounters submitted to the Agency by its plans are complete and accurate.

In alignment with the CMS EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity, October 2019*[5-1], HSAG conducted the following core evaluation activities for the EDV activity:

- Comparative analysis—Analysis of the Agency's electronic encounter data completeness and accuracy through a comparison between the Agency's electronic encounter data and the data extracted from the plans' data systems. The comparative analysis of the encounter data involved a series of analyses divided into two analytic sections:
  1. HSAG assessed **record-level data completeness** using the following metrics for each LTC encounter type:
     - *Record omission*—The percentage of records present in the plan-submitted files that were not found in the Agency-submitted files.
     - *Record surplus*—The percentage of records present in the Agency-submitted files that were not found in the plan-submitted files.
  2. Based on the number of records present in both data sources, HSAG examined **data element-level completeness and accuracy** for key data elements based on the following metrics:
     - *Element omission*—The percentage of records with values present in the plan-submitted files but not present in the Agency-submitted files.
     - *Element surplus*—The percentage of records with values present in the Agency-submitted files but not present in the plan-submitted files.
     - *Element accuracy*—The percentage of records with the same values in both the Agency- and plan-submitted files.
- LTC service record and plan of care review—Analysis of the Agency's electronic encounter data completeness and accuracy by comparing the Agency's electronic encounter data to the information documented in the corresponding enrollees' LTC service records and plans of care.

Strengths, Opportunities for Improvement, and Recommendations

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

[5-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 15, 2023.

Strengths	
+	The comparative analysis results indicated a high degree of element completeness and accuracy for most key data elements evaluated across both the LTC professional and LTC institutional encounters.
+	Overall, the comparative analysis for encounters that could be matched between the Agency- and plan-submitted data showed that the encounter data elements exhibited a high level of completeness across both LTC encounter types.
+	The comparative analysis demonstrated that the overall record omission and surplus rates were low (i.e., at or below 5.0 percent) for the LTC professional encounters, suggesting low discrepancies at the record level when comparing the Agency-submitted files to the plan-submitted files.
+	The LTC record and plan of care review found that the overall encounter data omission rates were very low for each of the key data elements, indicating that all key data elements found in the submitted LTC records were well supported by the information found in the Agency's encounter data.
+	When key data elements were present in both the Agency's encounter data and the enrollees' LTC records and were evaluated independently, the data elements were found to be accurate—each had an accuracy rate of greater than 99.0 percent.

Weaknesses and Recommendations	
−	**Weakness:** The Trading Partner ID (TPID) may not be appropriate for identifying an encounter as an LTC encounter. **Recommendations:** HSAG recommends that the Agency, the Medicaid Management Information System (MMIS) data vendor, and the plans collaborate to develop a method to determine encounters that would constitute as LTC encounters.
−	**Weakness:** The comparative analysis identified key data elements with low accuracy rates. **Recommendations:** HSAG recommends that the specific plan(s) with low data accuracy for the associated data element(s) review the Agency submission requirements including how the data are collected and reported. The plans should also investigate the root cause of the discrepancies.
−	**Weakness:** The plans' LTC record submissions were low which affected the LTC record omission study indicators for all key data elements evaluated. Plans cited "non-responsive provider" or "provider did not respond in a timely manner" as the major reasons for LTC record non-submissions. **Recommendations:** To ensure the plans' accountability for record procurement requirements, HSAG recommends that the Agency consider strengthening and/or enforcing its contract requirements with the plans regarding provision of oversight activities in this area. HSAG recommends that the plans include language in the contract with their provider network/subcontractors to address submitting records for audits, inspection, and/or examination of enrollees' LTC service records and/or documentation. Additionally, HSAG recommends that the Agency consider setting

Weaknesses and Recommendations	
	record submission standards to ensure the plans are more responsive in procuring requested records.
–	**Weakness:** Some components of the plan of care documentation were not complete and/or did not support information documented in the LTC records. **Recommendations:** HSAG recommends that plans or case management be involved in care plan development, implementation, and oversight. To allow for proper oversight of clinical services and care management activities, HSAG recommends that contracts include requirements for the development and submission of supporting documentation. HSAG also recommends that the plan contract include language which outlines minimum documentation requirements and expected templates for plans of care.

Overall Assessment of Progress in Meeting EQRO Recommendations

Program-Level Assessment

During previous years, HSAG made recommendations in the annual reports for each of the activities that were conducted. Table 6-1 is a summary of the follow-up actions per activity that the Agency completed in response to HSAG's recommendations during SFY 2020–2021.

Table 6-1—HSAG Recommendations with Agency Actions

HSAG Recommendation	Agency Action
Performance Improvement Projects	
The Agency and HSAG should include both organizations in all PIP communications sent out to the plans.	The Agency established a PIP communication plan with HSAG to ensure that HSAG and the plans were aware of any changes made to PIP submissions and requirements.
Performance Measure Validation	
Conduct a focus study to determine why pregnant enrollees were not obtaining prenatal care and receiving timely screenings. Once the root causes are identified, the plans and the Agency should work with providers and enrollees to establish potential performance improvement strategies and solutions to increase rates related to quality and access to care.	The plans are focused on prenatal care as part of their birth outcomes performance improvement projects. The Agency is monitoring more recent data to determine if additional intervention is needed.
Focus efforts on identifying the factors contributing to the low rates for measure indicators in the Living With Illness domain (e.g., are the barriers related to accessing outpatient care and pharmacies or the need for provider training, investigation of prescribing patterns, or the need for improved community outreach and education) and implement strategies to improve care for enrollees with diabetes. Additionally, the Agency may consider exploring interventions to improve performance related to the *Comprehensive Diabetes Care* and *Medical Assistance With Smoking and Tobacco Use Cessation* measures.	The Agency is considering which approach to use in having plans focus efforts on identifying the factors contributing to the low rates for Living With Illness measures, including the measures for services for individuals diagnosed with diabetes. The Agency is looking at more recent plan performance in these areas to determine if improvement has occurred over the prior year. The Agency plans to discuss these areas with the plans during the next quarterly quality improvement check-in calls.

HSAG Recommendation	Agency Action
It may be beneficial for the plans and the Agency to develop enhanced communication and collaboration with hospitals to improve the effectiveness of transitions of care, discharge planning, and handoffs to community settings for enrollees with behavioral health needs. In addition, the plans should implement appropriate interventions to improve performance related to metabolic testing. The Agency and the plans may find it beneficial to evaluate other potential barriers to enrollees receiving timely and appropriate follow-up by evaluating whether factors such as the provider networks or transportation services are possibly contributing to the lower rates.	The Agency encouraged plans to develop enhanced discharge process plans to improve rates for behavioral health follow-up indicators as a part of their annual PIP submissions. Additionally, plans are focused on discharge planning and working with hospitals to reduce potential preventable readmissions. To facilitate better discharge planning and coordination between hospitals and plans, the Agency updated its public-facing Health Plan Resource page to include behavioral and mental health general resources. The page can be found at this link.[6-1] The pages were created to provide consistent information for hospitals and providers looking for information specific to each plan, including a listing of the behavioral health supports provided, after-hours contacts, along with an escalation contact, and care coordination and discharge planning. Similar information is also required for case management and transportation. The information is available within two clicks of the plan's landing page and is updated quarterly.
Conduct root cause analyses for the low access to care rates to determine the nature and scope of the issue (e.g., are the issues related to barriers to accessing care, a lack of family planning service providers, or the need for improved community outreach and education). Once the root causes are identified, the Agency should work with providers and enrollees to establish potential performance improvement strategies and solutions to increase the access to care rates. Improvement in these rates may also result in improvement related to the quality of care provided, as evidenced by poor performance in the outpatient setting related to other performance measure domains.	The Agency is considering which approach to use in having plans conduct root cause analyses to determine the nature and scope of the issue. The Agency is reviewing the plans' most recent data to see if there was improvement from the previous year. If there was little to no improvement, the Agency will identify plan-specific areas of concern and add the topics to the next quarterly quality improvement check-in calls that are held with each plan individually.
Review of Compliance with Standards	
Implement its planned process to conduct compliance reviews of all plans within the required three-year cycle. The Agency should utilize the tools provided by HSAG to ensure that all standards required in the CMS Medicaid Managed Care Rule are reviewed during the compliance	The Agency finalized the updated monitoring tool for each plan. Data and information was requested from the plans for review, as needed. The tool was updated with the results of the review. The

[6-1] https://ahca.myflorida.com/Medicaid/Policy_and_Quality/Policy/health_plan_resources.shtml

HSAG Recommendation	Agency Action
reviews. Complete results of each plan's compliance reviews and follow-up on corrective actions should be submitted to HSAG annually to demonstrate compliance with conducting compliance reviews.	Agency is planning onsite compliance visits for early 2023.
Encounter Data Validation	
The Agency can work with the MMIS data vendor and the plans to develop a mechanism or method to determine encounters that would constitute as LTC encounters.	LTC encounters can be identified by the TPID. The Agency will send provider alerts to remind plans to use the correct TPID to submit their encounters.
The Agency should work with the specific plan(s) in resolving how the associated data element(s) should be submitted, collected, and reported. HSAG also recommends that the Agency encourage plans to communicate and investigate the root cause of the discrepancies with the Agency.	The Agency will work individually with those plans who have low accuracy rates in their LTC encounter data.
To ensure the plans' accountability for record procurement requirements, the Agency may consider strengthening and/or enforcing its contract requirements with the plans regarding provision of oversight activities in this area. HSAG recommends that the plans have language within their contract with their provider network/subcontractors addressing submission of records for the purpose of audits, inspection, and/or examination of enrollees' LTC service records and/or documentation. Additionally, the Agency could consider setting record submission standards to ensure the plans are more responsive in procuring requested records.	The Agency will consider measures to verify and spot-check encounter claims to ensure the correct TPID is being used. The Agency is considering setting record submission standards to ensure the plans are more responsive in procuring requested records.
Work with the plans to ensure plan or case management involvement in the care plan development, implementation, and oversight. To allow for proper oversight of clinical services and care management activities, expectations regarding the development and submission of supporting documentation can be included in contracts. The contract should include language that outlines minimum documentation requirements and expected templates for plans of care..	The Agency will consider additional contract language to specify expectations. However, the Agency generally does not dictate templates as plans have other lines of business and use their own corporate forms.
Quality Improvement Plans and Program Descriptions	
Produce a template QI program description, QI program evaluation, and QI work plan to provide a best practice example to plans.	The Agency will take this recommendation into consideration and discuss internally.
Require plans to utilize Agency templates.	The Agency will take this recommendation into consideration and discuss internally.

HSAG Recommendation	Agency Action
Establish priority areas of improvement that align with the Agency's quality strategy goals and require that all plans align their QI programs with those priorities.	The Agency requested that plans follow this recommendation and implement prior to this year's QI plan submissions.
Set performance goals for each priority area of improvement and require plans to report progress toward meeting those metrics in their QI program evaluations.	The plans have established goals/targets for Agency goals in their current contracts and were provided this recommendation as part of our feedback last year, however we will be sure to include it as a formal request when we provide them with our feedback for this year's submissions.
Require plans to identify SMART goals for each priority area of improvement and the mechanisms that will be used to track progress toward those goals.	The Agency requested that plans follow this recommendation and implement it prior to this year's QI plan submissions.

Plan-Specific Assessment

Appendix E contains a summary of the follow-up actions per activity that the plans completed in response to HSAG's SFY 2020–2021 recommendations. Please note that the responses in this section were provided by the plans and have not been edited or altered by HSAG.

Appendix A. Plan Names/Abbreviations

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

COMPREHENSIVE PLANS

- Aetna Better Health of Florida, Inc. (*Aetna-C / AET-C*)
- Humana Medical Plan, Inc. (*Humana-C / HUM-C*)
- Molina Healthcare of Florida, Inc. (*Molina-C / MOL-C*)
- Simply Healthcare Plan, Inc. (*Simply-C / SIM-C*)
- Sunshine State Health Plan, Inc. (*Sunshine-C / SUN-C*)
- UnitedHealthcare of Florida, Inc. (*United-C / UNI-C*)

SPECIALTY PLANS

- Children's Medical Services Network[A-1] (*Children's Medical Services-S / CMS-S*)
- Clear Health Alliance (HIV/AIDS Specialty Plan) (*Clear Health-S / CHA-S*)[A-2]
- Molina Specialty Plan SMI *(Molina-S / MOL-S)*
- Sunshine Child Welfare Specialty Plan (*Sunshine-S-CW / SUN-S-CW*)
- Sunshine SMI Specialty Plan (*Sunshine-S-SMI / SUN-S-SMI*)

MANAGED MEDICAL ASSISTANCE (MMA) PLANS

- AmeriHealth Caritas Florida, Inc. *(AmeriHealth-M / AMH-M*)[A-3]
- Best Care Assurance DBA Vivida Health (*Vivida-M / VIV-M*)
- South Florida Community Care Network, DBA Community Care Plan (*Community Care Plan-M / CCP-M*)

LONG-TERM CARE (LTC) PLUS PLAN

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

DENTAL PLANS

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

[A-1] Operated by Sunshine State Health Plan, Inc.
[A-2] Operated by Simply Healthcare Plan, Inc.
[A-3] On 8/24/2021, Florida True Health/Prestige Health Choice's name changed to AmeriHealth Caritas Florida, Inc.

Assessment of Compliance With Medicaid Managed Care Regulations

Compliance reviews are mandatory activities used to determine the extent to which Medicaid and CHIP managed care plans (MCPs) are in compliance with federal standards. The U.S. Department of Health & Human Services (HHS) developed standards for MCPs, which are codified at 42 CFR §§438 and 457, as revised by the Medicaid and CHIP managed care final rule issued in 2020. Federal regulations require MCPs to undergo a review at least once every three years to determine their compliance with federal standards as implemented by the state.

The Agency divided the federal regulations into 14 standards consisting of related regulations and contract requirements. Table B-1 describes the standards and associated regulations and requirements reviewed for each standard during the Compliance Reviews.

Table B-1—Summary of Compliance Standards and Associated Regulations

Standard	Federal Requirements Included	Standard	Federal Requirements Included
Standard I—Enrollment and Disenrollment	42 CFR §438.3(d) 42 CFR §438.56	Standard VIII—Provider Selection	42 CFR §438.12 42 CFR §438.102 42 CFR §438.106 42 CFR §438.214
Standard II—Member Rights and Confidentiality	42 CFR §438.100 42 CFR §438.224 42 CFR §422.128	Standard IX—Subcontractual Relationships and Delegation	42 CFR §438.230
Standard III—Member Information	42 CFR §438.10	Standard X—Practice Guidelines	42 CFR §438.236
Standard IV—Emergency and Poststabilization Services	42 CFR §438.114	Standard XI—Health Information Systems*	42 CFR §438.242
Standard V—Adequate Capacity and Availability of Services	42 CFR §438.206 42 CFR §438.207	Standard XII—Quality Assessment and Performance Improvement	42 CFR §438.330
Standard VI—Coordination and Continuity of Care	42 CFR §438.208	Standard XIII—Grievance and Appeal Systems	42 CFR §438.228 42 CFR §438.400- 42 CFR §438.424
Standard VII—Coverage and Authorization of Services	42 CFR §438.210 42 CFR §438.404	Standard XIV—Program Integrity	42 CFR §438.602(b) 42 CFR §438.608 42 CFR §438.610

*Requirement §438.242: Validation of IS standards for each MCP was conducted under the PMV activity.

Objectives

Private accreditation organizations, state licensing agencies, and state Medicaid agencies all recognize that having standards is only the first step in promoting safe and effective healthcare. Making sure that the standards are followed is the second step. During CY 2023–2024 the Agency will conduct a full review of the Part 438 Subpart D and QAPI standards for all plans to ensure compliance with federal requirements. The objective of each review is to provide meaningful information to the Agency and the plans regarding:

- The plans' compliance with federal managed care regulations and contract requirements in the areas selected for review.
- Strengths, opportunities for improvement, recommendations, or required actions to bring the plans into compliance with federal managed care regulations and contract requirements in the standard areas reviewed.
- The quality and timeliness of, and access to care and services furnished by the plans, as addressed within the specific areas reviewed.
- Possible additional interventions recommended to improve the quality of the plans' care provided and services offered related to the areas reviewed.

Technical Methods of Data Collection

To assess for plans' compliance with regulations, the Agency will conduct the five activities described in CMS' EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* October 2019.[B-1] Table B-2 describes the five protocol activities and the specific tasks that the Agency will perform to complete each activity.

Table B-2—Protocol Activities Performed for Assessment of Compliance With Regulations

For this protocol activity,	The Agency completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	These activities will be conducted before the review to assess compliance with federal managed care regulations and the Agency's contract requirements: a. The Agency will participate in virtual meetings to determine the timing and scope of the reviews, as well as scoring strategies. b. The Agency will develop monitoring tools, record review tools, report templates, and agendas, and set review dates. c. The Agency will conduct training for all reviewers to ensure consistency in scoring across the plans.

[B-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 2, 2023.

For this protocol activity,	The Agency completed the following activities:
Activity 2:	**Perform Preliminary Review**
	• The Agency will conduct a plan training webinar to describe the Agency's processes and allow the plans the opportunity to ask questions about the review process and plan expectations. • The Agency will confirm a primary plan contact person for the review and assigned Agency reviewers to participate. • No less than 60 days prior to the scheduled date of the review, the Agency will notify the plan in writing of the request for desk review documents via email delivery of a desk review form, the compliance monitoring tool, and a webinar review agenda. The desk review request will include instructions for organizing and preparing the documents to be submitted. Thirty days prior to the review, the plan will provide data files from which the Agency will choose sample grievance, appeal, and denial cases to be reviewed. The Agency will provide the final samples to the plans via the Agency's secure access file exchange site. No less than 30 days prior to the scheduled review, the plan will provide documentation for the desk review, as requested. • Examples of documents submitted for the desk review and compliance review include the completed desk review form, the compliance monitoring tool with the plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The Agency's review team will review all documentation submitted prior to the scheduled virtual review and prepare a request for further documentation and an interview guide to use during the webinar.
Activity 3:	**Conduct Plan Review**
	• During the review, the Agency met with the plan's key staff members to obtain a complete picture of the plan's compliance with Medicaid and CHIP managed care regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the plan's performance. • The Agency will request, collect, and review additional documents, as needed. • At the close of the virtual review, the Agency will provide plan staff members and Agency personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• The Agency will use a CY 2023–2024 Compliance Review Report Template to compile the findings and incorporate information from the compliance review activities. • The Agency will analyze the findings and calculate final scores based on the Agency's approved scoring strategies. • The Agency will determine opportunities for improvement, recommendations, and corrective actions required based on the review findings.

For this protocol activity,	The Agency completed the following activities:
Activity 5:	**Report Results**
	• The Agency will populate the report template. • The Agency will submit the draft report to the plans for review and comment. • The Agency will incorporate the plan's comments, as applicable, and finalize the report. • The Agency will include a pre-populated CAP template in the final report for all requirements determined to be out of compliance with managed care regulations (i.e., received a score of *Not Met*). • The Agency will distribute the final report to the plan.

Description of Data Obtained

The following are examples of documents reviewed by the Agency and sources of the data obtained:

- Committee meeting agendas, minutes, and reports
- Policies and procedures
- Management/monitoring reports
- Quarterly reports
- Provider manual and directory
- Member handbook and informational materials
- Staff training materials and documentation of training attendance
- Applicable correspondence or template communications
- Records or files related to administrative tasks (grievances and appeals)
- Interviews with key plan staff members conducted virtually

How Data Were Aggregated and Analyzed

The Agency aggregated and analyzed the data resulting from the desk review; the review of grievance, appeal, denial records, and provider and subcontractor agreements provided by each plan; virtual interviews conducted with key plan personnel; and any additional documents submitted as a result of the interviews. These data included:

- Documented findings describing the plan's performance in complying with each standard requirement.
- Scores assigned to the plan's performance for each requirement.
- The total percentage-of-compliance score calculated for each standard.
- The overall percentage-of-compliance score calculated across the standards.

- Documentation of the actions required to bring performance into compliance with the requirements for which the Agency assigned scores of *Not Met*.
- Recommendations for program enhancements.

Based on the results of the data aggregation and analysis, the Agency prepared and forwarded draft reports to each plan's staff members for their review and comment prior to issuing final reports.

The Agency analyzed the quantitative results obtained from the above compliance activity to identify strengths and weaknesses in each domain of quality, timeliness, and access to services furnished by each plan. The Agency then identified common themes and the salient patterns that emerged across plans related to the compliance activity conducted.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to care and services provided by the plans, the Agency assigned each of the components reviewed for assessment of compliance with regulations to one or more of those domains of care. Each standard may have involved assessment of more than one domain of care due to the combination of individual requirements within each standard. To draw conclusions and make recommendations, the Agency then analyzed the individual requirements within each standard that assessed the quality and timeliness of, or access to care and services provided by the plans. Table B-3 depicts assignment of the standards to the domains of care.

Table B-3—Assignment of Compliance Standards to the Quality, Timeliness, and Access Domains

Compliance Review Standard	Quality	Timeliness	Access
Standard I—Enrollment and Disenrollment	✓		✓
Standard II—Member Rights and Confidentiality			✓
Standard III—Member Information			✓
Standard IV—Emergency and Poststabilization Services		✓	✓
Standard V—Adequate Capacity and Availability of Services		✓	✓
Standard VI—Coordination and Continuity of Care	✓	✓	✓
Standard VII—Coverage and Authorization of Services		✓	✓
Standard VIII—Provider Selection	✓	✓	✓
Standard IX—Subcontractual Relationships and Delegation	✓		
Standard X—Practice Guidelines	✓		
Standard XI—Health Information Systems	✓		✓
Standard XII—Quality Assessment and Performance Improvement	✓		
Standard XIII—Grievance and Appeal Systems	✓	✓	✓
Standard XIV—Program Integrity	✓	✓	✓

PMV Methodology

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

MMA Program

Table B-4 presents critical elements and approaches that HSAG used to conduct the PMV activities for the plans.

Table B-4—Key PMV Steps Performed by HSAG for the Plans

PMV Step	Associated Activities Performed by HSAG
Pre-On-Site Visit Call/Meeting	HSAG verified that the LOs addressed key topics such as timelines and on-site review dates.
HEDIS Roadmap Review	HSAG examined the completeness of the Roadmap and looked for evidence in the FARs that the LOs completed a thorough review of all Roadmap components.
Software Vendor	If a plan used a software vendor to produce measure indicator rates, HSAG assessed whether the plan contracted with a vendor that achieved NCQA Measure Certification[SM,B-2] for the reported HEDIS measure. Where applicable, the NCQA Measure Certification letter was reviewed to ensure that each measure was under the scope of certification. Otherwise, HSAG examined whether source code review was conducted by the LOs (see next step).
Source Code Review	HSAG ensured that if a software vendor with HEDIS Certified Measures[SM, B-3] was not used, the LOs reviewed the plan's programming language for HEDIS measures. For all non-HEDIS measures, HSAG ensured that the LOs reviewed the plan's programming language. Source code review was used to determine compliance with the performance measure definitions, including accurate numerator and denominator identification, sampling, and algorithmic compliance (ensuring that rate calculations were performed correctly, medical record and administrative data were combined appropriately, and numerator events were counted accurately).
Primary Source Verification	HSAG verified that the LOs conducted appropriate checks to ensure that records used for performance measure reporting match with the primary data source. This step occurs to determine the validity of the source data used to generate the measure indicator rates.

[B-2] NCQA Measure Certification[SM] is a service mark of the NCQA.
[B-3] HEDIS Certified Measures[SM] is a service mark of the NCQA.

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

LTC Program

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

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

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

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

Validation Audit

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

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

PIP Validation Approach and Methodology

Objectives

The purpose of PIPs is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical and nonclinical areas. For the projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, the PIPs must be designed, conducted, and reported using sound methodology and must be completed in a reasonable time. This structured method of assessing and improving plan processes is expected to have a favorable effect on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine the validity and reliability of a PIP through assessing a plan's compliance with the requirements of 42 CFR §438.330(d)(2) including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

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

Technical Methods of Data Collection

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

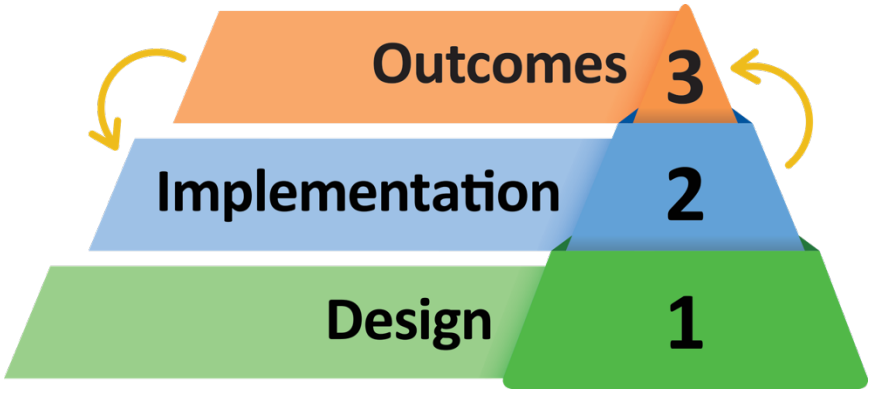
Description of Data Obtained

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

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

Figure B-1 illustrates the three stages of the PIP process—i.e., Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage (Steps 1 through 6) establishes the methodological framework for the PIP. The steps in this section include development of the PIP topic, Aim statement, population, sampling methods, performance indicators, and data collection. To implement successful improvement strategies, a methodologically sound PIP design is necessary.

Figure B-1—Stages



Once a plan establishes its PIP design, the PIP progresses into the Implementation stage (Steps 7 and 8). During this stage, the plan evaluates and analyzes its data, identifies barriers to performance, and develops interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve outcomes. The Outcomes stage (Step 9) is the final stage, which involves the evaluation of statistically, clinically, or programmatically significant improvement, and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when outcomes exhibit statistically significant improvement over the baseline performance over comparable time periods. This stage is the culmination of the previous two stages. If the outcomes do not improve, plans should revise their causal/barrier analysis processes and adapt QI strategies and interventions accordingly.

How Data Were Aggregated and Analyzed

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

Table B-5—CMS Protocol Steps

Protocol Steps	
Step Number	**Description**
1	Review the Selected PIP Topic
2	Review the PIP Aim Statement
3	Review the Identified PIP Population
4	Review the Sampling Method
5	Review the Selected Performance Indicator(s)
6	Review the Data Collection Procedures
7	Review the Data Analysis and Interpretation of PIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood That Significant and Sustained Improvement Occurred

Each required step was evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scored each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designated evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating for the PIP of *Not Met*. Plans would be given a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*. HSAG provides *Validation Feedback* with a *Met* validation score when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

How Conclusions Were Drawn

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

Met = high confidence/confidence in the reported findings
Partially Met = low confidence in the reported findings
Not Met = reported findings are not credible

Appendix B.

Encounter Data Validation

Objectives

Accurate and complete encounter data are critical to the success of any managed care program. State Medicaid agencies rely on the quality of the encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of the state's overall management and oversight of its Medicaid managed care program and in demonstrating its responsibility and stewardship.

During SFY 2021–22, the Agency has contracted with HSAG to conduct an EDV study. The goal of the SFY 2021–22 EDV study is to examine the extent to which the LTC encounters submitted to the Agency by its contracted MMA and LTC plans (collectively referred to as plans) are complete and accurate. Table B-6 lists the contracted plans included in this study. This section describes the proposed methodology for the SFY 2021–22 EDV study.

Table B-6—List of Contracted Plans

Plan Name	Plan Abbreviation	Shortened Name
Comprehensive Plans		
Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	COV-C	Aetna
Humana Medical Plan, Inc.	HUM-C	Humana
Molina Healthcare of Florida, Inc.	MOL-C	Molina
Simply Healthcare Plan, Inc.	SIM-C	Simply
Sunshine State Health Plan, Inc.	SUN-C	Sunshine
United Healthcare of Florida, Inc.	URA-C	United
Wellcare of Florida d/b/a Staywell Health Plan of Florida, Inc.	STW-C	Staywell
LTC Plan		
Florida Community Care	FCC-L	Florida Community Care

Methodology

In alignment with the CMS EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity,* October 2019,[B-4] HSAG will conduct the following core evaluation activities for the EDV activity:

- Comparative analysis—Analysis of the Agency's electronic encounter data completeness and accuracy through a comparison between the Agency's electronic encounter data and the data extracted from the plans' data systems.
- Clinical record and plan of care review—Analysis of the Agency's electronic encounter data completeness and accuracy by comparing the Agency's electronic encounter data to the information documented in the corresponding enrollees' clinical records and plans of care.

The SFY 2021–22 EDV study focused its review on the LTC encounter claim type.

Comparative Analyses

The goal of the comparative analysis is to evaluate the extent to which encounters submitted to the Agency by the plans are complete and accurate based on corresponding information stored in the plans' data systems. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in CMS Protocol 5. The comparative analysis will be performed on the LTC encounters submitted by the plans with dates of service between January 1, 2020, and December 31, 2020. The LTC encounter data from the MMA comprehensive plans and the LTC plan will be included in the study. The comparative analysis component will involve three key steps:

- Develop data submission requirements documents outlining encounter data submission requirements for the Agency and the plans, including technical assistance sessions.
- Conduct a file review of submitted encounter data from the Agency and the plans.
- Conduct a comparative analysis of the encounter data.

Development of Data Submission Requirements and Technical Assistance

Following the Agency's approval of the scope of work, HSAG will prepare and submit data submission requirements documents to the Agency and the plans. These documents will include a brief description of the SFY 2021–22 EDV study, a description of the review period, requested encounter data type(s), required data fields, and the procedures for submitting the requested data files to HSAG. The requested encounter data files will include key data elements to be evaluated in the EDV study. The Agency and the plans will be requested to submit all LTC encounter data records with dates of service between January 1,

[B-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity,* October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 2, 2023.

2020 and December 31, 2020, and submitted to the Agency on or before July 31, 2021. This anchor date will allow enough time for CY 2020 encounters to be submitted, processed, and available for evaluation in the Agency's data warehouse.

HSAG will conduct a technical assistance session with the plans to facilitate the accurate and timely submission of data. The technical assistance session will be conducted approximately one week after distributing the data submission requirements document, thereby allowing the plans time to review and prepare their questions for the session. During this technical assistance session, HSAG's EDV team will introduce the SFY 2021–22 EDV study, review the data submission requirements document, and address all questions related to data preparation and extraction. Both the Agency and the plans will have approximately one month to extract and prepare the requested files for submission to HSAG.

Preliminary File Review

Following receipt of the Agency's and the plans' encounter data submissions, HSAG will conduct a preliminary file review to determine if any data issues existed in the data files that would warrant a resubmission. The preliminary file review will include the following checks:

- Data extraction—Extracted based on the data requirements document.
- Percent present—Required data fields are present on the file and have values in those fields.
- Percent of valid values—The values are the expected values; e.g., valid International Classification of Diseases, 10th Revision (ICD-10) codes in the diagnosis field.
- Evaluation of matching claim numbers—The percentage of claim numbers matching between the data extracted from the Agency's data warehouse and the plans' data submitted to HSAG.

Based on the results of the preliminary file review, any major discrepancies, anomalies, or issues identified in the encounter data submissions will be communicated to the affected plan(s) and/or the Agency. The plans or the Agency will subsequently resubmit data, if necessary.

Conduct the Comparative Analyses

Once final data from the Agency and the plans have been received and processed, HSAG will conduct a series of analyses. To facilitate the presentation of findings, the comparative analyses will be divided into two analytic sections.

First, HSAG will assess record-level data completeness using the following metrics:

- The number and percentage of records present in the files submitted by the plans that were not found in the files submitted by the Agency (***record omission***).
- The number and percentage of records present in the files submitted by the Agency but not found in the files submitted by the plans (***record surplus***).

Second, based on the number of records present in both data sources, HSAG will further examine completeness and accuracy for key data elements listed in Table B-7. The analyses will focus on an element-level comparison for each date element.

Table B-7—Key Data Elements for Comparative Analysis

Key Data Elements	LTC encounters from 837I	LTC encounters from 837P
Enrollee ID	√	√
Header Service From Date	√	√
Header Service To Date	√	√
Detail Service From Date	√	√
Detail Service To Date	√	√
Admission Date	√	
Discharge Date	√	
Billing Provider NPI	√	√
Attending Provider NPI	√	
Rendering Provider NPI		√
Referring Provider NPI	√	√
Primary Diagnosis Code	√	√
Secondary Diagnosis Code	√	√
Procedure Code (CPT/HCPCS/CDT)*	√	√
Procedure Code Modifier	√	√
Units of Service	√	√
Primary Surgical Procedure Code	√	
National Drug Code (NDC)	√	√
Revenue Code	√	
Diagnosis Related Group (DRG)	√	
Header Paid Amount	√	√
Detail Paid Amount	√	√

*CPT = Current Procedural Terminology, HCPCS = Healthcare Common Procedure Coding System, CDT = Current Dental Terminology

Element-level completeness will focus on an element-level comparison between both sources of data and address the following metrics:

- The number and percentage of records with values present in the files submitted by the plans but not present in the files submitted by the Agency (***element omission***).
- The number and percentage of records with values present in the files submitted by the Agency but not present in the files submitted by the plans (***element surplus***).

Element-level accuracy will be limited to those records with values present in both the Agency's and the plans' submitted files. For a particular data element, HSAG will determine:

- The number and percentage of records with exactly the same values in both the Agency's and the plans' submitted files (***element accuracy***).
- The number and percentage of records present in both data sources with exactly the same values for select data elements relevant to each encounter data type (***all-element accuracy***).

Technical Assistance

As a follow-up to the comparative analysis activity, HSAG will provide technical assistance to the plans regarding the issues identified from the comparative analysis. First, HSAG will draft plan-specific encounter data discrepancy reports highlighting key areas for investigation. Second, upon the Agency's review and approval, HSAG will distribute the data discrepancy reports to the plans, along with data samples to assist the plans with their internal investigations. Based on their internal investigations, plans will be required to identify potential root causes of the key issues and provide written responses to the data discrepancy reports. Lastly, once HSAG reviews the written responses, it will follow up with the plans, for any further clarification, if appropriate.

Clinical Record and Plan of Care Review

As outlined in CMS Protocol 5, record review is a complex, resource-intensive process. Clinical records (including medical and treatment-related records) are considered the "gold standard" for documenting Medicaid enrollees' access to and quality of services. The second component of the EDV study is an assessment of data quality through investigating the completeness and accuracy of the Agency's encounters compared to the information documented in the corresponding clinical records and plans of care of Medicaid enrollees.

The review of clinical records will include services rendered between January 1, 2020, and December 31, 2020. The clinical review component of the study will answer the following question:

- *Are the data elements in Table B-8 found on the LTC encounters complete and accurate when compared to information contained within the clinical records?*

Table B-8—Key Data Elements for Clinical Record Review

Key Data Elements	
Date of Service	Diagnosis Code
Procedure Code	Procedure Code Modifier

Additionally, for individuals receiving home and community-based services (HCBS) or care in LTC facilities (e.g., nursing homes), HSAG will review the associated Plan of Care documentation. The review will evaluate whether the LTC services reported in the encounters are supported by enrollees' plans of care. HSAG will review the Plan of Care documentation for alignment with authorization dates, scheduled services, units of service, and service providers. As such, the Plan of Care documentation review component of the study will answer the following questions:

- *Is there a valid plan of care? If so, is the plan of care document signed*?
- *Is the selected date of service within the effective dates of the plan of care*?
- *Is there a servicing provider documented in the plan of care*? *If so, is the servicing provider identified in the clinical record supported by the plan of care*?
- *Are the procedures documented in the clinical record supported by the plan of care*?
- *Are the number of units documented in the clinical record supported by the plan of care*?

To answer the study questions, the clinical record and plan of care review will involve the following key steps:

- Identify the eligible population and generate samples from data submitted by the Agency for the study.
- Assist plans to procure clinical records and plan of care documents from their LTC providers, as appropriate.
- Review clinical records and plan of care documents against the Agency's encounter data.
- Calculate study indicators based on the reviewed/abstracted data.
- Draft report based on study results.

Study Population

To be eligible for the clinical record and plan of care review, an enrollee must be continuously enrolled in the same plan during the study period (i.e., between January 1, 2020, and December 31, 2020), and must have had at least one LTC service during the study period. For plans that do not have members enrolled with the same plan continuously during the study period, HSAG will adjust the continuous enrollment accordingly. In addition, enrollees with Medicare or other insurance coverage will be excluded from the eligible population since the Agency does not have complete encounter data for all services they received. In this document, HSAG refers to LTC services as the services that meet all criteria in Table B-9. In addition, after reviewing the encounter data from the Agency's data warehouse, HSAG may discuss additional changes to these criteria with the Agency, as needed.

Table B-9—Criteria for LTC Services Included in the Study

Data Element	Criteria
LTC Services	
Claim Type	Claim Type Code = LTC
Provider Type	LTC provider types shall include but are not limited to:* 01 – General Hospital 05 – Community Behavioral Health Services 07 – Specialized Mental Health Practitioner 10 – Skilled Nursing Facility 12 – Private ICF/DD Facility 13 – Swing Bed Facility 14 – Assistive Care Services 15 – Hospice 23 – Medical Foster Care / Personal Care Provider 25 – Physician (M.D.) 26 – Physician (D.O.) 27 – Podiatrist 29 – Physician Assistant

Data Element	Criteria
	30 – Nurse Practitioner (ARNP) 31 – Registered Nurse / Registered Nurse First Assistant 32 – Social Worker / Case Manager 65 – Home Health Agency 66 – Rural Health Clinic 67 – Home and Community Based Services Waiver 68 – Federally Qualified Health Center 81 – Professional Early Intervention Services 83 – Therapist (PT, OT, ST, RT) 91 – Case Management Agency
Trading Partner Identifier (TPID)	TPIDs as listed in Table B-10

*MD = medical doctor, DO = doctor of osteopathic medicine, ARNP = advanced registered nurse practitioner, PT = physical therapist, OT = occupational therapist, ST = speech-language therapist, RT = respiratory therapist

Sampling Strategy

Encounter data, enrollment and demographic data, and provider data from the Agency used in the comparative analyses will be used to select the record review samples. HSAG will use a two-stage sampling technique to select samples based on the data received from the Agency. HSAG will first identify all enrollees who met the study population eligibility criteria. HSAG will then randomly select the enrollees by plan based on the required sample size. Then, for each selected sample enrollee, HSAG will use the SURVEYSELECT procedure in SAS®,[B-5] to randomly select one LTC visit[B-6] that occurred in the study period (i.e., January 1, 2020, through December 31, 2020).

The final sample used in the evaluation will consist of a minimum of 146 cases randomly selected per plan. If a plan has less than 146 cases that are eligible for the study, all of the eligible cases will be included for review. An additional 25 percent oversample (or 37 cases per plan) will be sampled to replace records not procured. As such, plans with an adequate number of cases eligible for the study will be responsible for procuring a minimum of 183 total sampled enrollees' clinical records and plan of care documents per plan (i.e., 146 sample and 37 oversample) from their contracted LTC providers for services that occurred during the study period.

Clinical Record and Plan of Care Record Procurement

Upon receiving the final sample list from HSAG, plans will be responsible for procuring the sampled enrollees' clinical records and plans of care from their contracted providers for services that occurred

[B-5] SAS and all other SAS Institute Inc. product or service names are registered trademarks or trademarks of SAS Institute Inc. in the USA and other countries. ® indicates USA registration.

[B-6] To ensure that the clinical record review includes all services provided on the same date of service, encounters with the same date of service and same rendering provider will be consolidated into one visit for sampling.

during the study period. In addition, plans will be responsible for submitting the documentation to HSAG. To improve the procurement rate, HSAG will conduct a one-hour technical assistance session with the plans to review the EDV project and the procurement protocols after distributing the sample list. Plans will be instructed to submit the clinical records and plan of care documents electronically via a secure file transfer protocol site to ensure the protection of personal health information. During the procurement process, HSAG will work with the plans to answer questions and monitor the number of clinical records and plan of care documents submitted. For example, HSAG will provide an initial submission update when 40 percent of the documentation is expected to be submitted and a final submission status update following completion of the procurement period.

All electronic clinical records and plan of care documents that HSAG receives will be maintained on a secure site, which will allow HSAG's trained reviewers to validate the cases from a centralized location under supervision and oversight. As with all record reviews and research activities, HSAG has implemented a thorough HIPAA compliance and protection program in accordance with federal regulations which includes recurring training as well as policies and procedures that address physical security, electronic security, and day-to-day operations.

Review of Clinical Records and Plan of Care Documents

Concurrent with record procurement activities, HSAG will develop detailed training documents for the record review activity, train its review staff on specific study protocols, and conduct interrater reliability (IRR) and rate-to-standard testing. All reviewers must achieve a 95 percent accuracy rate prior to reviewing clinical records and plan of care documents and collecting data for the study.

During the clinical record and plan of care document review activity, HSAG's trained reviewers will collect and document findings in an HSAG-designed electronic data collection tool. IRR among reviewers, as well as reviewer accuracy, will be evaluated regularly throughout the study. Questions raised and decisions made during this evaluation process will be documented and communicated to all reviewers in a timely manner. In addition, HSAG analysts will periodically review the export files from the abstraction tool to ensure the abstraction results are complete, accurate, and consistent.

Clinical Record Review Indicators and Plan of Care Document Review Findings

Once the record review is completed, HSAG analysts will export information collected from the electronic tool, review the data, and conduct the analysis. HSAG will use four study indicators of data completeness and accuracy to report the record review results:

- ***Record/documentation omission rate***: the percentage of sampled dates of service identified in the electronic encounter data that are not found in the enrollees' clinical records. HSAG will also calculate this rate for the other key data elements in Table B-8.
- ***Encounter data omission rate***: the percentage of diagnosis codes, procedure codes, and procedure code modifiers associated with validated dates of service from the enrollees' clinical records that are not found in the electronic encounter data.

- ***Accuracy rate of coding***: the percentage of diagnosis codes, procedure codes, and procedure code modifiers associated with validated dates of service from the electronic encounter data that are correctly coded based on the enrollees' clinical records.
- ***Overall accuracy rate****:* the percentage of dates of service with all data elements coded correctly among all the validated dates of service from the electronic encounter data.

In addition to the clinical-related indicators, based on reviews of the plan of care documents, findings that include an evaluation of whether the LTC services documented for the selected dates of service are supported by the plans of care will be presented.

Reporting of Results

Based on the findings from the comparative analyses and the clinical record review, HSAG will prepare an aggregate EDV report. The main section will focus on the presentation of statewide average results with plan variations. The plan-specific results will be listed in the appendix for each plan. The comparative analyses and clinical record review findings will be provided along with recommendations to improve the quality of encounter data.

Prior to drafting the aggregate report, HSAG will submit a report outline to the Agency for review and approval. The draft report will follow the CMS EQR Protocol 5 to include key findings, conclusions, and recommendations. Based on the findings and experience working with other states, HSAG will provide recommendations that are specific and actionable. HSAG will submit the draft report to the Agency for review based on a mutually agreeable project timeline so that the Agency staff will have sufficient time to review. HSAG will then incorporate the Agency's feedback and deliver the final report.

Table B-10—List of Plans Included in the EDV Study

Plan Name	Plan Abbreviation	Shortened Name	Trading Partner Identifier (TPID)	Plan Base Medicaid ID
MMA Comprehensive Plans				
Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	COV-C	Aetna	301823	1001200
Humana Medical Plan, Inc.	HUM-C	Humana	301826	1000513
Molina Healthcare of Florida, Inc.	MOL-C	Molina	301827	1001399
Simply Healthcare Plan, Inc.	SIM-C	Simply	301828	1001206
Sunshine State Health Plan, Inc.	SUN-C	Sunshine	301865	1000516
United Healthcare of Florida, Inc.	URA-C	United	301829	1001219
Wellcare of Florida d/b/a Staywell Health Plan of Florida, Inc.	STW-C	Staywell	301830	1000545
LTC Plan				
Florida Community Care	FCC-L	Florida Community Care	301860	1000536

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

Introduction

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

Plan-Specific Conclusions

Comprehensive Plans

Aetna-C

Strengths Related to Quality	
	For the EDV plan of care review, Aetna-C documented the servicing provider information in all documents.
	Provided FARs that contained IS capability findings; fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
	Met or exceeded the Agency's MY 2021 performance target for: • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (all three indicators) • *Chlamydia Screening in Women—Total* • *Asthma Medication Ratio* • *Metabolic Monitoring for Children and Adolescents on Antipsychotics* (all three indicators)
	Met or exceeded the Agency's MY 2021 performance target for both *LTSS Comprehensive Assessment and Update* measure indicators, both *LTSS Comprehensive Care Plan and Update* measure indicators, and the *LTSS Shared Care Plan With PCP* measure.
Strengths Related to Access and Timeliness	
	Met or exceeded the Agency's MY 2021 performance target for: • *Child and Adolescent Well-Care Visits* (three of four measure indicators). • *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* • *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

Weaknesses and Recommendations	
–	**Weakness:** Aetna-C had an opportunity for improvement in the evaluation of PIP interventions for effectiveness. **Recommendations:** HSAG recommends that the plan implement processes to evaluate implemented PIP interventions for effectiveness. HSAG recommends that the plan use the PDSA process to determine next steps for successful and unsuccessful interventions.
–	**Weakness:** Aetna-C fell below the MY 2021 minimum performance target for: • *Breast Cancer Screening* • *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* • *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment* (both indicators) **Recommendations:** HSAG recommends that Aetna-C conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.
–	**Weakness:** The plan's rate for the *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* measure indicator fell below the MY 2021 minimum performance target. **Recommendations:** HSAG recommends that the plan evaluate opportunities to enhance care coordination to support members in accessing timely follow-up care after hospitalization for mental illness. Additionally, the plan should partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
–	**Weakness:** The plan's rate for the *Adults' Access to Preventive/Ambulatory Health Services* measure and the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* measure fell below the MY 2021 minimum performance target. **Recommendations:** HSAG recommends that Aetna-C conduct a root cause analysis or focus study to determine why members do not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.

Humana-C

Strengths Related to Quality	
+	For the EDV activity plan of care document review, Humana-C had the correct servicing provider information included in all documents.
+	For Humana-C, 98.2 percent of the EDV plan of care documents were from the plan.
+	Met or exceeded the Agency's MY 2021 performance target for: • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (all three indicators) • *Chlamydia Screening in Women—Total* • *Comprehensive Diabetes Care* (four of five indicators)
Strengths Related to Access and Timeliness	
+	Humana-C met or exceeded the Agency's MY 2021 performance target for: • *Child and Adolescent Well-Care Visits* (three of four measure indicators) • *Controlling High Blood Pressure* • *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* • *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* • *LTSS Shared Care Plan With PCP*
Weaknesses and Recommendations	
−	**Weakness:** Humana-C fell below the MY 2021 minimum performance target for: • *Childhood Immunization Status—Combination 10* • *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total* • *Immunizations for Adolescents—Combination 1* **Recommendations:** HSAG recommends that Humana-C conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.
−	**Weakness:** The plan's rate for the *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* measure indicator fell below the MY 2021 minimum performance target. **Recommendations:** HSAG recommends that Humana-C evaluate opportunities to enhance care coordination to support members in accessing timely follow-up care after hospitalization for mental illness. Additionally, the plan should partner with its contracted providers to identify barriers that impede providers from following

Weaknesses and Recommendations	
	recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
−	**Weakness:** The plan's rate on both measure indicators for *Follow-Up After ED Visit for AOD Abuse or Dependence* fell below the MY 2021 minimum performance target. **Recommendations:** HSAG recommends that the plan conduct a root cause analysis to determine why members who access the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, HSAG recommends that the plan increase the use of telehealth services. Additionally, HSAG recommends that the plan enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.
−	**Weakness:** The plan's rate for the *Adults' Access to Preventive/Ambulatory Health Services* measure and the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* measure fell below the MY 2021 minimum performance target.
	Recommendations: HSAG recommends that the plan conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.

Molina-C

Strengths Related to Quality	
+	Molina-C met or exceeded the Agency's MY 2021 performance target for: • *Childhood Immunization Status—Combination 3* and *Combination 7* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (all three indicators) • *Immunizations for Adolescents—Combination 2* • *Comprehensive Diabetes Care* (three of five indicators) • *Asthma Medication Ratio—Total* • *Metabolic Monitoring for Children and Adolescents on Antipsychotics* (two of three indicators) • *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* • *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
+	Molina-C was the highest-performing plan in the Women's Care domain; all five measure indicator rates met or exceeded the Agency's MY 2021 performance targets.
+	Within the LTC program, Molina-C was one of the highest-performing plans, with five measure indicator rates meeting or exceeding the Agency's MY 2021 performance targets.
Strengths Related to Access and Timeliness	
+	The plan met or exceeded the Agency's MY 2021 performance target for: • *Child and Adolescent Well-Care Visits* (all four measure indicators) • *Well-Child Visits in the First 30 Months of Life* (both indicators) • *Controlling High Blood Pressure*
Weaknesses and Recommendations	
−	**Weakness:** Molina-C fell below the MY 2021 minimum performance target for *Initiation and Engagement of AOD Abuse or Dependence Treatment* (both indicators). **Recommendations:** HSAG recommends that the plan conduct a root cause analysis or focus study to determine why some adolescents and adults with a new episode of AOD dependence were not accessing timely treatment. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance. In doing so, the plan should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or education).
−	**Weakness:** The plan's rate for the *Adults' Access to Preventive/Ambulatory Health Services* measure and the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* measure fell below the MY 2021 minimum performance target.

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

Simply-C

Strengths Related to Quality	
+	Simply-C was among the top performers in the EDV plan of care study, with high rates of valid plan of care documentation available for review (100 percent) and relatively few documented discrepancies noted within the submitted documents. Simply-C's plan of care documents available for review contained appropriate signatures (162 out of 163).
+	Simply-C met or exceeded the Agency's MY 2021 performance target for: • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (all three indicators) • *Comprehensive Diabetes Care* (two of five indicators) • *Antidepressant Medication Management* (both indicators) • *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
+	Within the LTC program, Simply-C was one of the highest-performing plans, with five measure indicator rates meeting or exceeding the Agency's MY 2021 performance targets.
Strengths Related to Access and Timeliness	
+	Simply-C met or exceeded the Agency's MY 2021 performance target for: • *Child and Adolescent Well-Care Visits* (three of four measure indicators) • *Chlamydia Screening in Women—Total* • *Controlling High Blood Pressure*
Weaknesses and Recommendations	
−	**Weakness:** Simply-C fell below the MY 2021 minimum performance target for *Immunizations for Adolescents—Combination 1*. **Recommendations:** HSAG recommends that the plan identify best practices for ensuring children receive all preventive vaccinations. HSAG recommends that the plan consider whether there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause of children not receiving some or all immunizations, HSAG recommends that the plan implement appropriate interventions to improve the immunization rates.
−	**Weakness:** Simply-C fell below the MY 2021 minimum performance target for both measure indicators for *Initiation and Engagement of AOD Abuse or Dependence Treatment*. **Recommendations:** HSAG recommends that the plan conduct a root cause analysis or focus study to determine why some adolescents and adults with a new episode of AOD dependence were not accessing timely treatment. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance. In doing so, HSAG

Weaknesses and Recommendations	
	recommends that Simply-C consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or education).
−	**Weakness:** The plan's rate for the *Adults' Access to Preventive/Ambulatory Health Services* measure and the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* measure fell below the MY 2021 minimum performance target.
	Recommendations: HSAG recommends that the plan conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that Simply-C implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.

Sunshine-C

Strengths Related to Quality	
+	Sunshine-C met or exceeded the Agency's MY 2021 performance target for: • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (two of three indicators) • *Asthma Medication Ratio—Total*
+	Within the LTC program, Sunshine-C was one of the highest-performing plans, with five measure indicator rates meeting or exceeding the Agency's MY 2021 performance targets.

Strengths Related to Access and Timeliness	
+	Sunshine-C met or exceeded the Agency's MY 2021 performance target for: • *Child and Adolescent Well-Care Visits—Ages 3–11 Years*

Weaknesses and Recommendations	
−	**Weakness:** In Step 9 (Assessment of Improvement Achieved) of the PIPs, Sunshine-C was unable to achieve any improvement. **Recommendations:** HSAG recommends that the plan complete the PDSA cycle, test interventions, and evaluate the effectiveness of the interventions.
−	**Weakness:** Sunshine-C fell below the MY 2021 minimum performance target for: • *Immunizations for Adolescents—Combination 1* • *Breast Cancer Screening* • *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total* **Recommendations:** HSAG recommends that Sunshine-C conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.
−	**Weakness:** The plan's rate for both measure indicators for *Prenatal and Postpartum Care* fell below the MY 2021 minimum performance target. **Recommendations:** HSAG recommends that the plan consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care. HSAG recommends that Sunshine-C analyze data and consider whether there are disparities within the plan's population that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the quality of, access to, and timeliness of prenatal and postpartum care.
	Weakness: The plan's rate for all five measure indicators for *Comprehensive Diabetes Care* fell below the MY 2021 minimum performance target.

Weaknesses and Recommendations	
–	**Recommendations:** HSAG recommends that the plan conduct a root cause analysis or focus study to determine why members are not receiving timely recommended screenings for diabetes and implement appropriate interventions to improve performance.
–	**Weakness:** The plan's rates for the following measures related to follow-up after a member visits the hospital or ED for mental health or AOD abuse or dependence fell below the MY 2021 minimum performance target: • *Follow-Up-After Hospitalization for Mental Illness* (both indicators) • *Follow-Up After ED Visit for Mental Illness* (both indicators) • *Follow-Up After ED Visit for AOD Abuse or Dependence* (both indicators) **Recommendations:** HSAG recommends that the plan conduct a root cause analysis to determine why members who access the hospital or ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, HSAG recommends that the plan increase the use of telehealth services. Additionally, HSAG recommends that the plan enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs. Additionally, HSAG recommends that the plan partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
–	**Weakness:** The plan's rate for the *Adults' Access to Preventive/Ambulatory Health Services* measure and the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* measure fell below the MY 2021 minimum performance target.
	Recommendations: HSAG recommends that the plan conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.

United-C

Strengths Related to Quality	
+	The EDV study revealed that United-C had servicing provider information documented in all plan of care documents.
+	United-C met or exceeded the Agency's MY 2021 performance target for: • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (all three indicators) • *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* • *Asthma Medication Ratio—Total* • *Antidepressant Medication Management—Effective Acute Phase Treatment* • *LTSS Comprehensive Assessment and Update—Assessment of Core Elements* • *LTSS Comprehensive Assessment and Update—Assessment of Supplemental Elements*
Strengths Related to Access and Timeliness	
+	United-C met or exceeded the Agency's MY 2021 performance target for: • *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* • *Controlling High Blood Pressure*
Weaknesses and Recommendations	
−	**Weakness:** United-C was unable to sustain the statistically significant improvement in the performance indicator rates achieved during PIP Remeasurement 1. **Recommendations:** HSAG recommends that the plan complete the PDSA cycle, test interventions, evaluate the effectiveness of the interventions, and implement new interventions to ensure that statistically significant improvement in the performance indicator rates is sustained.
−	**Weakness:** United-C fell below the MY 2021 minimum performance target for: • *Childhood Immunization Status—Combination 10* • *Immunizations for Adolescents—Combination 1* • *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* **Recommendations:** HSAG recommends that United-C conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that United-C implement appropriate interventions to improve the performance related to each measure.
−	**Weakness:** The plan's rates for the following measures related to follow-up after a member visits the hospital or ED for mental health or AOD abuse or dependence fell below the MY 2021 minimum performance target:

Weaknesses and Recommendations	
	• *Follow-Up-After Hospitalization for Mental Illness* (both indicators) • *Follow-Up After ED Visit for Mental Illness* (both indicators) • *Follow-Up After ED Visit for AOD Abuse or Dependence* (both indicators)
	Recommendations: HSAG recommends that the plan conduct a root cause analysis to determine why members who access the hospital or ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, HSAG recommends increasing the use of telehealth services. Additionally, HSAG recommends that the plan enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs. Additionally, HSAG recommends that the plan partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
−	United-C fell below the MY 2021 minimum performance target for both measure indicators for *Initiation and Engagement of AOD Abuse or Dependence Treatment*.
	Recommendations: HSAG recommends that the plan conduct a root cause analysis or focus study to determine why some adolescents and adults with a new episode of AOD dependence were not accessing timely treatment. Upon identification of a root cause, HSAG recommends that United-C implement appropriate interventions to improve the performance. In doing so, HSAG recommends that the plan should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or education).
−	**Weakness:** The plan's rate for the *Adults' Access to Preventive/Ambulatory Health Services* measure and the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* measure fell below the MY 2021 minimum performance target.
	Recommendations: HSAG recommends that United-C conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that United-C implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.

Specialty Plans

Children's Medical Services-S

Strengths Related to Quality	
+	Children's Medical Services-S met or exceeded the Agency's MY 2021 performance target for: • *Childhood Immunization Status—Combination 2* • *Child and Adolescent Well-Care Visits* (all four indicators) • *Asthma Medication Ratio—Total*

Strengths Related to Access and Timeliness	
+	Children's Medical Services-S submitted two additional PIPs: *Youth Transitions to Adult Care* and *Reducing Asthma Related PPEs for Pediatric Enrollees* for validation. For SFY 2021–2022, both PIPs received an overall *Met* validation status and achieved a 100 percent *Met* score for all the evaluation elements.
+	For the *Reducing Asthma Related PPEs for Pediatric Enrollees* PIP, Children's Medical Services-S reported a statistically significant increase over the baseline for both performance indicators.
+	The plan met or exceeded the Agency's MY 2021 performance target for: • *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits*

Weaknesses and Recommendations	
−	**Weakness:** For SFY 2021–2022, Children's Medical Services-S reported finalized PIP Remeasurement 1 (CY 2020) results for the *Youth Transitions to Adult Care* and *Reducing Asthma Related PPEs for Pediatric Enrollees* PIPs. For the *Youth Transitions to Adult Care* PIP, Children's Medical Services-S reported an increase in the performance indicator rate; however, the increase was not statistically significant over the baseline. The plan did not report any evidence of significant clinical or programmatic improvement. **Recommendations:** HSAG recommends that the plan complete the PDSA cycle, test interventions, evaluate the effectiveness of the interventions, and implement new interventions to ensure statistically significant improvement in the performance indicator rates and that it is able to sustain improvements.
−	**Weakness:** The plan fell below the MY 2021 minimum performance target for: • *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* • *Chlamydia Screening in Women—Total* • *Controlling High Blood Pressure* • *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total*

Weaknesses and Recommendations	
	• *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
	Recommendations: HSAG recommends that Children's Medical Services-S conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.
–	**Weakness:** The plan fell below the MY 2021 minimum performance target for the measure indicators of *Childhood Immunization Status—Combination 7* and *Childhood Immunization Status—Combination 10*. **Recommendations:** HSAG recommends that the plan identify best practices for ensuring children receive all preventive vaccinations. HSAG recommends that the plan consider whether there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause of children not receiving some or all immunizations, HSAG recommends that the plan implement appropriate interventions to improve the immunization rates.
–	**Weakness:** The plan's rate for both measure indicators for *Prenatal and Postpartum Care* fell below the MY 2021 minimum performance target. **Recommendations:** HSAG recommends that the plan consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care. HSAG recommends that the plan analyze data and consider whether there are disparities within the plan's population that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the quality of, access to, and timeliness of prenatal and postpartum care.
–	**Weakness:** The plan's rate for four of five measure indicators for *Comprehensive Diabetes Care* fell below the MY 2021 minimum performance target. **Recommendations:** HSAG recommends that the plan conduct a root cause analysis or focus study to determine why members are not receiving timely recommended screenings for diabetes. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve performance.
–	**Weakness:** The plan's rates for the following measures related to follow-up after a member visits the hospital or ED for mental health or AOD abuse or dependence fell below the MY 2021 minimum performance target: • *Follow-Up-After Hospitalization for Mental Illness* (both indicators) • *Follow-Up After ED Visit for AOD Abuse or Dependence* (both indicators) **Recommendations:** HSAG recommends that the plan conduct a root cause analysis to determine why members who access the hospital or ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions.

Weaknesses and Recommendations	
	If the COVID-19 PHE was a factor, HSAG recommends increasing the use of telehealth services. Additionally, HSAG recommends that the plan enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs. HSAG recommends that the plan also partner with contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
−	**Weakness:** The plan's rate for the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* measure fell below the MY 2021 minimum performance target.
	Recommendations: HSAG recommends that the plan conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends that the plan work with members to increase the use of telehealth services, when appropriate.

Clear Health-S

Strengths Related to Quality	
+	Clear Health-S met or exceeded the Agency's MY 2021 performance target for: • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (all three indicators) • *Chlamydia Screening in Women—Total* • *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* • *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
Strengths Related to Access and Timeliness	
+	Clear Health-S met or exceeded the Agency's MY 2021 performance target for: • *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total* • *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
Weaknesses and Recommendations	
−	**Weakness:** Clear Health-S fell below the MY 2021 minimum performance target for: • *Lead Screening in Children* • *Breast Cancer Screening* • *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* • *Asthma Medication Ratio—Total* • *Antidepressant Medication Management* (both indicators) • *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* • *Child and Adolescent Well-Care Visits—Total* **Recommendations:** HSAG recommends that Clear Health-S conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.
−	**Weakness:** Clear Health-S fell below the MY 2021 minimum performance target for the measure indicators of *Childhood Immunization Status—Combination 3, Combination 7,* and *Combination 10*. **Recommendations:** HSAG recommends that the plan identify best practices for ensuring children receive all preventive vaccinations. HSAG recommends that the plan consider whether there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause of children not receiving some or all immunizations, HSAG recommends that the plan implement appropriate interventions to improve the immunization rates.

Weaknesses and Recommendations	
–	**Weakness:** The plan's rate for both measure indicators for *Prenatal and Postpartum Care* fell below the MY 2021 minimum performance target. **Recommendations:** HSAG recommends that the plan consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care. HSAG recommends that the plan analyze data and consider whether there are disparities within the plan's population that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the quality of, access to, and timeliness of prenatal and postpartum care.
–	**Weakness:** The plan's rates for the following measures related to follow-up after a member visits the hospital or ED for mental health or AOD abuse or dependence fell below the MY 2021 minimum performance target: • *Follow-Up-After Hospitalization for Mental Illness* (both indicators) • *Follow-Up After ED Visit for Mental Illness* (both indicators) • *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total* **Recommendations:** HSAG recommends that the plan conduct a root cause analysis to determine why members who access the hospital or ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, HSAG recommends increasing the use of telehealth services. Additionally, HSAG recommends that the plan enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs. Additionally, HSAG recommends that the plan partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
–	**Weakness:** The plan's rate for the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* measure fell below the MY 2021 minimum performance target.
	Recommendations: HSAG recommends that the plan conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.

Molina-S

Strengths Related to Quality	
+	Molina-S met or exceeded the Agency's MY 2021 performance target for: • *Antidepressant Medication Management—Effective Continuation Phase Treatment* • *Metabolic Monitoring for Children and Adolescents on Antipsychotics* (all three indicators)

Strengths Related to Access and Timeliness	
+	Molina-S met or exceeded the Agency's MY 2021 performance target for: • *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total*

Weaknesses and Recommendations	
−	**Weakness:** Molina-S fell below the MY 2021 minimum performance target for: • *Cervical Cancer Screening* • *Breast Cancer Screening* • *Asthma Medication Ratio—Total* • *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total* • *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* **Recommendations:** HSAG recommends that Molina-S conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.
−	**Weakness:** In the Pediatric Care domain, Molina-S was the lowest-performing plan, with eight measure indicator rates falling below the minimum performance target including: • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (two of three indicators) • *Child and Adolescent Well-Care Visits—Ages 3–11 Years, Ages 12–17 Years, Ages 18–21 Years,* and *Total* • *Immunizations for Adolescents—Combination 1*and *Combination 2* **Recommendations:** HSAG recommends that Molina-S conduct a root cause analysis or focus study to determine barriers to child members having outpatient visits with a PCP or OB/GYN to receive well-care exams and/or BMI documentation, counseling for nutrition, and counseling for physical activity. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.

Weaknesses and Recommendations	
−	**Weakness:** Molina-S fell below the MY 2021 minimum performance target for the measure indicators of *Immunizations for Adolescents—Combination 1* and *Combination 2.* **Recommendations:** HSAG recommends that the plan identify best practices for ensuring adolescents receive all preventive vaccinations. HSAG recommends that the plan consider whether there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause of adolescents not receiving some or all immunizations, HSAG recommends that the plan implement appropriate interventions to improve the immunization rates.
−	**Weakness:** The plan's rate for both measure indicators for *Prenatal and Postpartum Care* fell below the MY 2021 minimum performance target. **Recommendations:** HSAG recommends that the plan consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care. HSAG recommends that the plan analyze data and consider whether there are disparities within the plan's population that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the quality of, access to, and timeliness of prenatal and postpartum care.
−	**Weakness:** The plan's rate for four of five measure indicators for *Comprehensive Diabetes Care* fell below the MY 2021 minimum performance target. **Recommendations:** HSAG recommends that the plan conduct a root cause analysis or focus study to determine why its members are not receiving timely recommended screenings for diabetes. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve performance related to the *Comprehensive Diabetes Care* measure.
−	**Weakness:** The plan's rates for the following measures related to follow-up after a member visits the hospital or ED for mental health or AOD abuse or dependence fell below the MY 2021 minimum performance target: • *Follow-Up-After Hospitalization for Mental Illness* (both indicators) • *Follow-Up After ED Visit for AOD Abuse or Dependence* (both indicators) **Recommendations:** HSAG recommends that the plan conduct a root cause analysis to determine why members who access the hospital or ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, HSAG recommends increasing the use of telehealth services. Additionally, HSAG recommends that the plan enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs. Additionally, HSAG recommends that the plan partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.

Weaknesses and Recommendations	
–	**Weakness:** The plan's rate for the *Adults' Access to Preventive/Ambulatory Health Services* measure and the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* measure fell below the MY 2021 minimum performance target.
	Recommendations: HSAG recommends that the plan conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends that the plan work with members to increase the use of telehealth services, when appropriate.

Sunshine-S-CW

Strengths Related to Quality	
+	Sunshine-S-CW met or exceeded the Agency's MY 2021 performance target for: • *Chlamydia Screening in Women—Total* • *Asthma Medication Ratio—Total* • *Metabolic Monitoring for Children and Adolescents on Antipsychotics* (all three indicators)
+	Within the Pediatric Care domain, Sunshine-S-CW was one of the highest-performing plans, with 10 measure indicator rates that met or exceeded the Agency's MY 2021 performance targets.
Strengths Related to Access and Timeliness	
+	The plan met or exceeded the Agency's MY 2021 performance target for: • *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment* • *Follow-Up-After Hospitalization for Mental Illness—30-Day Follow-Up—Total* • *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* • *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* • *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
Weaknesses and Recommendations	
−	**Weakness:** Sunshine-S-CW fell below the MY 2021 minimum performance target for: • *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total* • *Antidepressant Medication Management—Effective Continuation Phase Treatment* **Recommendations:** HSAG recommends that Sunshine-S-CW conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.
−	**Weakness:** The plan's rate for both measure indicators for *Prenatal and Postpartum Care* fell below the MY 2021 minimum performance target. **Recommendations:** HSAG recommends that the plan consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care. HSAG recommends that the plan analyze data and consider whether there are disparities within the plan's population that contributed to lower access to care.

Weaknesses and Recommendations	
	Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the quality of, access to, and timeliness of prenatal and postpartum care.
−	**Weakness:** The plan's rate on both measure indicators for *Follow-Up After ED Visit for AOD Abuse or Dependence* fell below the MY 2021 minimum performance target. **Recommendations:** HSAG recommends that the plan conduct a root cause analysis to determine why members who access the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, HSAG recommends that the plan increase the use of telehealth services. Additionally, HSAG recommends that the plan enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.

Sunshine-S-SMI

Strengths Related to Quality	
+	Sunshine-S-SMI met or exceeded the Agency's MY 2021 performance target for: • *Chlamydia Screening in Women—Total* • *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
Strengths Related to Access and Timeliness	
+	Sunshine-S-SMI met or exceeded the Agency's MY 2021 performance target for: • *Follow-Up Care for Children Prescribed ADHD Medication* (both indicators)
Weaknesses and Recommendations	
−	**Weakness:** Sunshine-S-SMI fell below the MY 2021 minimum performance target for: • *Child and Adolescent Well-Care Visits—Total* • *Cervical Cancer Screening* • *Breast Cancer Screening* • *Asthma Medication Ratio—Total* • *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total* • *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* **Recommendations:** HSAG recommends that Sunshine-S-SMI conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.
−	**Weakness:** The plan's rate for both measure indicators for *Prenatal and Postpartum Care* fell below the MY 2021 minimum performance target. **Recommendations:** HSAG recommends that the plan consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care. HSAG recommends that the plan analyze data and consider whether there are disparities within the plan's population that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the quality of, access to, and timeliness of prenatal and postpartum care.
−	**Weakness:** The plan's rate for all five measure indicators for *Comprehensive Diabetes Care* fell below the MY 2021 minimum performance target. **Recommendations:** HSAG recommends that the plan conduct a root cause analysis or focus study to determine why its members are not receiving timely recommended screenings for diabetes. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve performance related to the *Comprehensive Diabetes Care* measure.

Weaknesses and Recommendations	
–	**Weakness:** The plan's rates for the following measures related to follow-up after a member visits the hospital or ED for mental health or AOD abuse or dependence fell below the MY 2021 minimum performance target: • *Follow-Up-After Hospitalization for Mental Illness* (both indicators) • *Follow-Up After ED Visit for Mental Illness* (both indicators) • *Follow-Up After ED Visit for AOD Abuse or Dependence* (both indicators) **Recommendations:** HSAG recommends that the plan conduct a root cause analysis to determine why members who access the hospital or ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, HSAG recommends increasing the use of telehealth services. Additionally, HSAG recommends that the plan enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs. Additionally, HSAG recommends that the plan partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
–	**Weakness:** The plan's rate for the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* measure fell below the MY 2021 minimum performance target. **Recommendations:** HSAG recommends that the plan conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends that the plan work with members to increase the use of telehealth services, when appropriate.

Managed Medical Assistance Plans

AmeriHealth-M

Strengths Related to Quality	
+	AmeriHealth-M met or exceeded the Agency's MY 2021 performance target for: • *Chlamydia Screening in Women—Total* • *Controlling High Blood Pressure* • *Asthma Medication Ratio—Total*
+	Within the Pediatric Care domain, AmeriHealth-M was one of the highest-performing plans, with 13 measure indicator rates that met or exceeded the Agency's MY 2021 performance targets.
Strengths Related to Access and Timeliness	
+	AmeriHealth-M met or exceeded the Agency's MY 2021 performance target for: • *Prenatal and Postpartum Care—Postpartum Care* • *Metabolic Monitoring for Children and Adolescents on Antipsychotics* (all three indicators) • *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*
Weaknesses and Recommendations	
−	**Weakness:** AmeriHealth-M was unable to sustain the statistically significant improvement in performance indicator rates achieved during PIP Remeasurement 1. **Recommendations:** HSAG recommends that the plan complete the PDSA cycle, test interventions, evaluate their effectiveness, and implement new interventions to ensure statistically significant improvement in the performance indicator rates is sustained.
−	**Weakness:** AmeriHealth-M fell below the MY 2021 minimum performance target for: • *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* • *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total* **Recommendations:** HSAG recommends that AmeriHealth-M conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.
−	**Weakness:** The plan's rate for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure fell below the MY 2021 minimum performance target.
	Recommendations: HSAG recommends that the plan conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends that the plan work with members to increase the use of telehealth services, when appropriate.

Vivida-M

Strengths Related to Quality	
+	Vivida-M met or exceeded the Agency's MY 2021 performance target for: • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (all three indicators) • *Antidepressant Medication Management* (both indicators)

Weaknesses and Recommendations	
−	**Weakness:** In PIP Step 7 (Accurate Data Reporting and Analysis), Vivida-M had an opportunity for improving the narrative interpretation of data and addressing factors that impact the comparability and validity of the reported data. **Recommendations:** HSAG recommends that the plan develop and implement a process for improving the narrative interpretation of data and addressing factors that impact the comparability and validity of the reported data.
−	**Weakness:** In PIP Step 8 (Appropriate Improvement Strategies), Vivida-M documented that it did not perform any QI activities because the baseline performance was above the state-mandated goal of 90 percent. **Recommendations:** HSAG recommends that the plan document its efforts to sustain rates above the state-mandated goal of 90 percent.
−	**Weakness:** Vivida-M had opportunities for improving the PIP data collection process and providing an adequate description of the interventions. Vivida-M had an opportunity to improve the evaluation of interventions for effectiveness. **Recommendations:** HSAG recommends that the plan document its process to improve the data collection process. HSAG also recommends that the plan review its process and take steps to improve the evaluation of interventions for effectiveness.
−	**Weakness:** Vivida-M fell below the MY 2021 minimum performance target for: • *Lead Screening in Children* • *Child and Adolescent Well-Care Visits—Ages 18–21 Years* • *Immunizations for Adolescents—Combination 1* • *Cervical Cancer Screening* • *Breast Cancer Screening* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* • *Metabolic Monitoring for Children and Adolescents on Antipsychotics* (all three indicators) **Recommendations:** HSAG recommends that the plan conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.

Weaknesses and Recommendations	
−	**Weakness:** Vivida-M fell below the MY 2021 minimum performance target for the measure indicators of *Childhood Immunization Status—Combination 3* and *Combination 7.* **Recommendations:** HSAG recommends that the plan identify best practices for ensuring children receive all preventive vaccinations. HSAG recommends that the plan consider whether there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause of children not receiving some or all immunizations, HSAG recommends that the plan implement appropriate interventions to improve the immunization rates.
−	**Weakness:** The plan's rate for four of five measure indicators for *Comprehensive Diabetes Care* fell below the MY 2021 minimum performance target. **Recommendations:** HSAG recommends that the plan conduct a root cause analysis or focus study to determine why its members are not receiving timely recommended screenings for diabetes. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve performance related to the *Comprehensive Diabetes Care* measure.
−	**Weakness:** The plan's rates for the following measures related to follow-up after a member visits the hospital or ED for mental health or AOD abuse or dependence fell below the MY 2021 minimum performance target: • *Follow-Up-After Hospitalization for Mental Illness* (both indicators) • *Follow-Up After ED Visit for AOD Abuse or Dependence* (both indicators) **Recommendations:** HSAG recommends that the plan conduct a root cause analysis to determine why members who access the hospital or ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, HSAG recommends increasing the use of telehealth services. Additionally, HSAG recommends that the plan enhance communication and collaboration with hospitals to improve the effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs. Additionally, HSAG recommends that the plan partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
−	**Weakness:** The plan's rate for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure fell below the MY 2021 minimum performance target.
	Recommendations: HSAG recommends that the plan conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends that the plan work with members to increase the use of telehealth services, when appropriate.

Community Care Plan-M

Strengths Related to Quality	
+	Community Care Plan-M met or exceeded the Agency's MY 2021 performance target for: • *Chlamydia Screening in Women—Total* • *Controlling High Blood Pressure*
+	Within the Pediatric Care domain, Community Care Plan-M was one of the highest-performing plans, with eight measure indicator rates that met or exceeded the Agency's MY 2021 performance targets.
Strengths Related to Access and Timeliness	
+	Community Care Plan-M met or exceeded the Agency's MY 2021 performance target for: • *Prenatal and Postpartum Care—Postpartum Care*
Weaknesses and Recommendations	
−	**Weakness: Weakness:** The plan fell below the MY 2021 minimum performance target for: • *Childhood Immunization Status—Combination 7* • *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* • *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* • *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total* • *Antidepressant Medication Management* (both indicators) • *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total* • *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* **Recommendations:** HSAG recommends that Community Care Plan-M conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.
−	The plan fell below the MY 2021 minimum performance target for both measure indicators for *Initiation and Engagement of AOD Abuse or Dependence Treatment*. **Recommendations:** HSAG recommends that the plan conduct a root cause analysis or focus study to determine why some adolescents and adults with a new episode of AOD dependence were not accessing timely treatment. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance. In doing so, HSAG recommends that the plan consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or education).

Weaknesses and Recommendations	
−	**Weakness:** The plan's rates for the following measures related to follow-up after a member visits the hospital or ED for mental health or AOD abuse or dependence fell below the MY 2021 minimum performance target: • *Follow-Up-After Hospitalization for Mental Illness* (both indicators) • *Follow-Up After ED Visit for Mental Illness* (both indicators) • *Follow-Up After ED Visit for AOD Abuse or Dependence* (both indicators) **Recommendations:** HSAG recommends that the plan conduct a root cause analysis to determine why members who access the hospital or ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, HSAG recommends that the plan increase the use of telehealth services. Additionally, HSAG recommends that the plan enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs. Additionally, HSAG recommends that the plan partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
−	**Weakness:** The plan's rate for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure fell below the MY 2021 minimum performance target. **Recommendations:** HSAG recommends that the plan conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends that the plan work with members to increase the use of telehealth services, when appropriate.

Long-Term Care Plus Plan

Florida Community Care-L

Strengths Related to Quality	
+	For the EDV study, Florida Community Care-L was among the top performers, with a high rate of valid plan of care documentation available for review, 96.1 percent, and relatively few documented discrepancies noted within the submitted documents.
+	98.2 percent of Florida Community Care-L's EDV study plan of care documents were from the plan.
+	Florida Community Care-L met or exceeded the Agency's MY 2021 performance target for: • *LTSS Comprehensive Assessment and Update* (both indicators) • *LTSS Comprehensive Care Plan and Update* (both indicators)

Weaknesses and Recommendations	
−	**Weakness:** In PIP Step 9 (Assessment of Improvement Achieved), Florida Community Care-L was unable to achieve any improvement. **Recommendations:** HSAG recommends that the plan complete the PDSA cycle, test interventions, evaluate the effectiveness of the interventions, and implement new interventions to ensure statistically significant improvement in the performance indicator rates.

Dental Plans

DentaQuest-D

Strengths Related to Quality	
+	DentaQuest-D was evaluated for the Design, Implementation, and Outcomes stages (Steps 1 through 9) of the PIP. DentaQuest-D performed well in the Design and Implementation stages (Steps 1 through 8); however, in Step 9 (Assessment of Improvement Achieved), DentaQuest-D did not report improvement in PIP outcomes.

Weaknesses and Recommendations	
−	**Weakness:** For the *Coordination of Transportation Services With the SMMC Plans* PIP, DentaQuest-D reported finalized Remeasurement 1 (CY 2020) rates for the PIP performance indicator(s). DentaQuest-D did not report any improvement in PIP outcomes. **Recommendations:** HSAG recommends that the plan complete the PDSA cycle, test interventions, evaluate the effectiveness of the interventions, and implement new interventions to ensure statistically significant improvement in the PIP outcomes.
−	**Weakness:** DentaQuest-D fell below the plan-specific targets identified by the Agency for the *Annual Dental Visit—Total* measure indicator. **Recommendations:** HSAG recommends that the plan continue to monitor rates over time to identify the PHE's impact on rates, ensuring that lower access to dental care is not driven by a non-PHE cause, and adopt QI strategies to improve rates. If access to care is the reason for lower rates, HSAG recommends that the dental plan also evaluate its network to ensure enough providers are available to provide services to members.
−	**Weakness:** The statewide average rates for *Follow-Up After ED Visits for Dental Caries in Children—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators demonstrated a decline of more than 11 percentage points from MY 2020 to MY 2021. **Recommendations:** HSAG recommends that the plan conduct a root cause analysis or focus study to determine any barriers that prevent children from receiving a dental treatment service to prevent dental caries, which is one of the most common childhood chronic diseases. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve access to care. If access to care is the reason for lower rates, HSAG recommends that the plan also evaluate its network to ensure enough providers are available to provide services to members, and to ensure those providers have appropriate appointment availability.

Liberty-D

Strengths Related to Quality	
+	For the *Coordination of Transportation Services With the SMMC Plans* PIP, the dental plan reported finalized Remeasurement 1 (CY 2020) rates for the PIP performance indicator(s). Liberty-D reported a baseline and Remeasurement 1 rate of 100 percent for Performance Indicator 1. Liberty-D also demonstrated a statistically significant increase in Performance Indicator 2 results.

Weaknesses and Recommendations	
−	**Weakness:** Liberty-D was evaluated for the Design, Implementation, and Outcomes stages (Steps 1 through 9) of the PIP. Liberty-D had an opportunity to improve the process for evaluation of the effectiveness of interventions. **Recommendations:** HSAG recommends that Liberty-D complete the PDSA cycle and identify processes to improve the evaluation of the effectiveness of the interventions and implement new interventions, as appropriate and based on outcomes.
−	**Weakness:** Liberty-D fell below the plan-specific targets identified by the Agency for the *Annual Dental Visit—Total* measure indicator. **Recommendations:** HSAG recommends that the plan continue to monitor rates over time to identify the PHE's impact on rates, ensuring that lower access to dental care is not driven by a non-PHE cause, and adopt QI strategies to improve rates. If access to care is the reason for lower rates, HSAG recommends that the dental plan also evaluate its network to ensure enough providers are available to provide services to members.
−	**Weakness:** The statewide average rates for *Follow-Up After ED Visits for Dental Caries in Children—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators demonstrated a decline of more than 11 percentage points from MY 2020 to MY 2021. **Recommendations:** HSAG recommends that the plan conduct a root cause analysis or focus study to determine barriers that prevent children from receiving a dental treatment service to prevent dental caries, which is one of the most common childhood chronic diseases. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve access to care. If access to care is the reason for lower rates, HSAG recommends that the plan also evaluate its network to ensure enough providers are available to provide services to members, and to ensure those providers have appropriate appointment availability.

MCNA-D

Strengths Related to Quality	
+	For the *Coordination of Transportation Services With the SMMC Plans* PIP, MCNA-D reported finalized Remeasurement 1 (CY 2020) rates for the PIP performance indicator(s). MCNA-D reported a baseline and Remeasurement 1 rate of 100 percent for Performance Indicator 1.

Weaknesses and Recommendations	
−	**Weakness:** MCNA-D fell below the plan-specific targets identified by the Agency for the *Annual Dental Visit—Total* measure indicator. **Recommendations:** HSAG recommends that the plan continue to monitor rates over time to identify the PHE's impact on rates, ensuring lower access to dental care is not driven by a non-PHE cause, and adopt QI strategies to improve rates. If access to care is the reason for lower rates, HSAG recommends that the dental plan also evaluate its network to ensure enough providers are available to provide services to members.
−	**Weakness:** The statewide average rates for *Follow-Up After ED Visits for Dental Caries in Children—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators demonstrated a decline of more than 11 percentage points from MY 2020 to MY 2021. **Recommendations:** HSAG recommends that the plan conduct a root cause analysis or focus study to determine barriers that prevent children from receiving a dental treatment service to prevent dental caries, which is one of the most common childhood chronic diseases. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve access to care. If access to care is the reason for lower rates, HSAG recommends that the plan also evaluate its network to ensure enough providers are available to provide services to members, and to ensure those providers have appropriate appointment availability.

Appendix D. PIP High-Level Review Results

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

For SFY 2021–2022, the health and dental plans had progressed to reporting remeasurement data. The Agency provided statewide Remeasurement 1 rates by region and population served (i.e., specialty plans) for each high-level review PIP to the health and dental plans. HSAG reviewed the PIP indicators' rates and assessed whether the plans achieved the contractually agreed upon goals.

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

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

Plan Name	Regions Served	Regions Where *Improving Birth Outcomes* PIP Goal Was Met			Regions Where *Reducing PPEs* PIP Goal Was Met		
		Primary C-Section Rate	Preterm Delivery Rate	NAS per 1,000 Live Births	PPAs per 1,000 Enrollee Months	PPRs per 1,000 Hospital Admissions	PPVs per 1,000 Enrollee Months
Aetna Better Health-C	*6,7, and 11*	7 and 11	None	6 and 11	None	6	All regions
Community Care Plan-M	*10*	10	None	None	10	10	10
Florida Community Care-L**	*All regions*	Not Applicable (NA)	NA	NA	None	None	All regions
Humana-C	*All regions*	11	1 and 4	1, 2, 4, 6, and 10	9	1, 2, 4, 5, 6, 9, and 10	All regions
Molina-C	*8 and 11*	11	None	8	8	All regions	8
Molina-S	*4, 5, and 7*	All regions	None	NA	None	None	All regions
AmeriHealth-M[1]	*9 and 11*	11	None	All regions	All regions	9	None
Simply-C***	*5, 6, 7, 10, and 11*	Not Assessed	Not Assessed	Not Assessed	Not Assessed	Not Assessed	Not Assessed
ClearHealth-S***	*All regions*	Not Assessed	Not Assessed	Not Assessed	Not Assessed	Not Assessed	Not Assessed

[1]Florida True Health/Prestige Health Choice had a name change to AmeriHealth Caritas Florida, Inc., as of 8/24/2021.

Plan Name	Regions Served	Regions Where *Improving Birth Outcomes* PIP Goal Was Met			Regions Where *Reducing PPEs* PIP Goal Was Met		
		Primary C-Section Rate	Preterm Delivery Rate	NAS per 1,000 Live Births	PPAs per 1,000 Enrollee Months	PPRs per 1,000 Hospital Admissions	PPVs per 1,000 Enrollee Months
Staywell-C	*All regions except 10*	1, 3, 4, 5, 6, 7, 8, and 11	None	1, 2, 3, 4, 6, and 8	7, 8, 9, and 11	1, 3, 4, 5, 9, and 11	All regions
Staywell-S	*All regions*	All regions except 1	None	NA	9 and 11	1	All regions
Sunshine-C	*All regions*	3, 4, 6, and 7	3	2, 3, 4, 5, 7, 8, and 10	None	None	All regions
Sunshine-S	*All regions*	3, 5, 6, 7, 8, and 11	2, 4, 6, 7, 8, and 9	NR	1, 5, 6, 8, 9, and 11	None	All regions
United-C	*3, 4, 6, and 11*	3 and 4	None	3 and 4	None	4	All regions
Vivida-M	*8*	None	None	None	8	8	8

* The results in the table were determined met/not met based on the performance indicator(s) rates reported by the plans in the PIP submission.

** Florida Community Care-L reported CY 2019 and CY 2020 data. The plan calculated one cumulative rate for all regions served and indicated it achieved approval from the Agency for the revised measurement periods and the data reporting process.

*** Simply-C and Clear Health-S did not provide goals and did not include a comparison with goals in the PIP submission.

NA: Not applicable because the PIP was not initiated by the plan.

NR: The data were not reported in the PIP Submission Form.

For the *Improving Birth Outcomes* PIP, AmeriHealth-M met the goals for reducing NAS per 1,000 live births in all regions served by the plan. None of the plans met all the goals for all three PIP performance indicators.

For the *Reducing PPEs* PIP, all plans except Molina-C and AmeriHealth-M met the goals for reducing the PPVs in all regions they served. Community Care Plan-M and Vivida-M met all the goals for all three PIP performance indicators.

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

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

Plan Name	Measurement Period	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
Primary C-Section Rate												
Aetna Better Health-C	CY 2016						16.39%	17.10%				26.43%
	10/01/2018–09/30/2019						18.59%	15.26%				24.66%
	10/01/2019–09/30/2020						18.51%	15.67%				24.39%
Community Care Plan-M	CY 2016										19.11%	
	10/01/2018–09/30/2019										17.48%	
	10/01/2019–09/30/2020										16.67%	
Humana-C	CY 2016	16.90%	18.45%	17.67%	17.34%	16.87%	16.39%	17.10%	15.76%	18.00%	19.11%	26.43%
	10/01/2018–09/30/2019	14.24%	18.33%	24.94%	18.78%	19.12%	19.37%	26.90%	14.61%	27.04%	20.90%	22.82%
	10/01/2019–09/30/2020	14.52%	18.98%	23.68%	18.14%	22.05%	17.89%	22.93%	15.71%	24.36%	21.71%	22.82%
Molina-C	CY 2016								15.76%			26.43%
	10/01/2018–09/30/2019								14.92%			24.79%
	10/01/2019–09/30/2020								16.23%			25.16%
Molina-S	CY 2016				17.34	16.87		17.1				
	10/01/2018–09/30/2019				9.37	12.13		14.82				
	10/01/2019–09/30/2020				12.58	15.51		16.57				
AmeriHealth-M	CY 2016									18.00%		26.43%
	10/01/2018–09/30/2019									18.86%		23.39%
	10/01/2019–09/30/2020									18.35%		22.14%
Simply-C **	CY 2016					16.87%	16.39%	17.10%			19.11%	26.43%
	10/01/2018–09/30/2019					15.38%	16.03%	16.32%			20.47%	25.68%
	10/01/2019–09/30/2020					16.28%	15.42%	16.78%			20.71%	25.39%
Clear Health-S**	CY 2016	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	10/01/2018–09/30/2019	42.86%	0.00%	20.00%	0.00%	25.00%	33.33%	20.00%	0.00%	38.46%	14.29%	13.51%
	10/01/2019–09/30/2020	12.50%	25.00%	22.22%	0.00%	33.33%	25.00%	20.69%	0.00%	41.18%	20.00%	18.92%

Plan Name	Measurement Period	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
Staywell-C	CY 2016	16.90%	18.45%	17.67%	17.34%	16.87%	16.39%	17.10%	15.76%	18.00%		26.43%
	10/01/2018–09/30/2019	12.84%	18.66%	15.81%	16.50%	14.69%	13.85%	14.84%	13.99%	22.26%		19.51%
	10/01/2019–09/30/2020	12.98%	18.19%	14.84%	15.45%	14.43%	13.41%	14.19%	14.35%	21.53%		19.71%
Staywell-S	CY 2016	16.90%	18.45%	17.67%	17.34%	16.87%	16.39%	17.10%	15.76%	18.00%	19.11%	26.43%
	10/01/2018–09/30/2019	16.67%	18.13%	14.14%	11.71%	14.47%	12.16%	14.29%	13.06%	14.21%	12.50%	12.02%
	10/01/2019–09/30/2020	17.27%	17.31%	15.15%	14.56%	15.83%	13.59%	13.15%	12.02%	15.22%	13.81%	12.50%
Sunshine-C	CY 2016	16.90%	18.45%	17.67%	17.34%	16.87%	16.39%	17.10%	15.76%	18.00%	19.11%	26.43%
	10/01/2018–09/30/2019	16.79%	14.19%	16.47%	16.60%	17.34%	14.50%	15.75%	15.95%	19.17%	19.18%	24.92%
	10/01/2019–09/30/2020	16.51%	18.18%	16.46%	16.47%	17.22%	15.04%	14.82%	16.86%	19.54%	18.96%	25.86%
Sunshine-S-CW	CY 2016	16.90%	18.45%	17.67%	17.34%	16.87%	16.39%	17.10%	15.76%	18.00%	19.11%	26.43%
	10/01/2018–09/30/2019	NR	66.67%	25.00%	62.50%	30.00%	23.08%	7.14%	11.11%	10.00%	25.00%	10.00%
	10/01/2019–09/30/2020	0.00%	66.67%	12.50%	50.00%	10.00%	14.29%	8.33%	11.11%	25.00%	20.00%	9.09%
United-C	CY 2016			17.67%	17.34%		16.39%					26.43%
	10/01/2018–09/30/2019			15.33%	16.42%		17.00%					26.66%
	10/01/2019–09/30/2020			15.27%	15.89%		16.42%					25.84%
Vivida-M	CY 2016								15.76%			
	10/01/2018–09/30/2019								17.50%			
	10/01/2019–09/30/2020								19.61%			
Pre-Term Delivery Rate												
Aetna Better Health-C	CY 2016						9.31%	9.56%				9.33%
	10/01/2018–09/30/2019						12.93%	14.59%				9.92%
	10/01/2019–09/30/2020						14.72%	14.29%				10.82%
Community Care Plan-M	CY 2016										11.41%	
	10/01/2018–09/30/2019										13.77%	
	10/01/2019–09/30/2020										13.76%	
Humana-C	CY 2016	10.85%	9.73%	10.21%	10.88%	9.53%	9.31%	9.56%	8.62%	8.65%	11.41%	9.33%
	10/01/2018–09/30/2019	9.71%	12.92%	10.83%	9.72%	12.35%	11.82%	12.48%	10.49%	9.86%	12.02%	10.67%
	10/01/2019–09/30/2020	10.06%	10.84%	10.12%	9.22%	12.07%	11.00%	11.11%	10.47%	10.13%	12.70%	11.60%
Molina-C	CY 2016								8.62%			9.33%

Appendix D.

Plan Name	Measurement Period	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
	10/01/2018–09/30/2019								8.24%			9.30%
	10/01/2019–09/30/2020								8.85%			9.79%
Molina-S	CY 2016				10.88	9.53		9.56				
	10/01/2018–09/30/2019				13.75	15.53		14.29				
	10/01/2019–09/30/2020				12.25	17.65		16.57				
AmeriHealth-M	CY 2016									8.65%		9.33%
	10/01/2018–09/30/2019									10.83%		8.75%
	10/01/2019–09/30/2020									10.52%		10.10%
Simply-C**	CY 2016					9.53%	9.31%	9.56%			11.41%	9.33%
	10/01/2018–09/30/2019					12.29%	11.65%	12.16%			14.15%	11.65%
	10/01/2019–09/30/2020					12.34%	11.63%	12.24%			14.60%	11.44%
Clear Health-S**	CY 2016	10.85%	18.45%	17.67%	17.34%	16.87%	16.39%	17.10%	15.76%	18.00%	19.11%	26.43%
	10/01/2018–09/30/2019	28.57%	0.00%	10.00%	0.00%	25.00%	12.50%	8.00%	50.00%	7.69%	14.29%	24.32%
	10/01/2019–09/30/2020	12.50%	0.00%	11.11%	0.00%	22.22%	12.50%	20.69%	33.33%	5.88%	20.00%	32.43%
Staywell-C	CY 2016	10.85%	9.73%	10.21%	10.88%	9.53%	9.31%	9.56%	8.62%	8.65%		9.33%
	10/01/2018–09/30/2019	13.23%	11.17%	11.82%	11.57%	11.14%	11.63%	12.06%	10.78%	12.41%		12.06%
	10/01/2019–09/30/2020	13.74%	11.85%	11.20%	11.00%	11.11%	11.95%	12.08%	10.35%	11.33%		10.65%
Staywell-S	CY 2016	10.85%	9.73%	10.21%	10.88%	9.53%	9.31%	9.56%	8.62%	8.65%	11.41%	9.33%
	10/01/2018–09/30/2019	11.33%	11.54%	13.87%	18.92%	13.16%	17.34%	16.88%	14.69%	18.95%	21.43%	15.85%
	10/01/2019–09/30/2020	14.09%	11.15%	14.63%	16.99%	14.39%	17.28%	16.73%	14.96%	17.83%	19.52%	16.07%
Sunshine-C	CY 2016	10.85%	9.73%	10.21%	10.88%	9.53%	9.31%	9.56%	8.62%	8.65%	11.41%	9.33%
	10/01/2018–09/30/2019	14.89%	14.84%	8.99%	10.18%	11.56%	11.78%	9.93%	10.55%	11.34%	13.82%	10.79%
	10/01/2019–09/30/2020	13.26%	13.18%	9.26%	10.79%	10.45%	12.21%	9.74%	10.42%	11.85%	13.68%	11.13%
Sunshine-S-CW	CY 2016	10.85%	9.73%	10.21%	10.88%	9.53%	9.31%	9.56%	8.62%	8.65%	11.41%	9.33%
	10/01/2018–09/30/2019	NR	0.00%	12.50%	0.00%	30.00%	7.69%	7.14%	0.00%	10.00%	18.75%	15.00%
	10/01/2019–09/30/2020	0.00%	0.00%	12.50%	0.00%	20.00%	7.14%	8.33%	0.00%	8.33%	20.00%	22.73%
United-C	CY 2016			10.21%	10.88%		9.31%					9.33%
	10/01/2018–09/30/2019			12.31%	10.56%		14.43%					9.65%
	10/01/2019–09/30/2020			12.43%	10.79%		13.89%					10.97%

Plan Name	Measurement Period	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
Vivida-M	CY 2016								8.62%			
	10/01/2018–09/30/2019								8.75%			
	10/01/2019–09/30/2020								9.41%			
NAS per 1,000 Live Births												
Aetna Better Health-C	CY 2016						13.5	17				1.6
	10/01/2018–09/30/2019						10.6	18.52				0.99
	10/01/2019–09/30/2020						10.65	20.37				1.07
Community Care Plan-M	CY 2016										10.4	
	10/01/2018–09/30/2019										9.25	
	10/01/2019–09/30/2020										11.1	
Humana-C	CY 2016	28.9	17.4	30.7	42.3	44.1	13.5	17	27.1	12.9	10.4	1.6
	10/01/2018–09/30/2019	20.58	16.45	38.94	37.18	61.62	11.33	30.07	32.41	13.47	5.18	3.5
	10/01/2019–09/30/2020	18.4	14.15	36.83	26.34	59.96	12.33	29.82	37.28	13.47	7.18	4.07
Molina-C	CY 2016								27.1			1.6
	10/01/2018–09/30/2019								27.47			1.12
	10/01/2019–09/30/2020								15.84			3.14
Molina-S	CY 2016				42.3	44.1		17				
	10/01/2018–09/30/2019				NA	NA		NA				
	10/01/2019–09/30/2020				NA	NA		NA				
AmeriHealth-M	CY 2016									12.9		1.6
	10/01/2018–09/30/2019									10.92		1.38
	10/01/2019–09/30/2020									11.98		1.42
Simply-C**	CY 2016					44.1	13.5	17			10.4	1.6
	10/01/2018–09/30/2019					32.5	9.18	15.64			4.73	4.1
	10/01/2019–09/30/2020					30.26	10.21	15.42			4.46	3.3
Clear Health-S**	CY 2016	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	10/01/2018–09/30/2019	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	10/01/2019–09/30/2020	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Staywell-C	CY 2016	28.9	17.4	30.7	42.3	44.1	13.5	17	27.1	12.9		1.6

Appendix D.

Plan Name	Measurement Period	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
	10/01/2018–09/30/2019	9.06	10.81	21.63	22.59	50.97	10.37	16.74	19.89	30.99		2.85
	10/01/2019–09/30/2020	12.1	0	19.61	24.66	45.09	9.13	17.8	19.21	26.98		3.64
Staywell-S	CY 2016	28.9	17.4	30.7	42.3	44.1	13.5	17	27.1	12.9	10.4	1.6
	10/01/2018–09/30/2019	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	10/01/2019–09/30/2020	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Sunshine-C	CY 2016	28.9	17.4	30.7	42.3	44.1	13.5	17	27.1	12.9	10.4	1.6
	10/01/2018–09/30/2019	22.58	13.45	21.62	24.04	32.84	10.78	8.35	20.78	12.31	4.20	2.78
	10/01/2019–09/30/2020	30.36	16.13	22.65	24.00	29.49	13.46	8.28	20.56	12.65	4.25	2.87
Sunshine-S-CW	CY 2016	28.9	17.4	30.7	42.3	44.1	13.5	17	27.1	12.9	10.4	1.6
	10/01/2018–09/30/2019	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
	10/01/2019–09/30/2020	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
United-C	CY 2016			30.7	42.3		13.5					1.6
	10/01/2018–09/30/2019			25.55	33.64		13.1					2.57
	10/01/2019–09/30/2020			24.37	35.37		13.5					2.24
Vivida-M	CY 2016								27.1			
	10/01/2018–09/30/2019								31.4			
	10/01/2019–09/30/2020								32.11			

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

** Simply-C and Clear Health-S did not provide goals; therefore, HSAG could not assess whether these plans met their goals.

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

Plan Name	Measurement Period		Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
PPAs per 1,000 Enrollee Months													
Aetna Better Health-C	SFY 2015/2016							1.95	2.08				1.69
	10/01/2018–09/30/2019							1.9	2.26				1.29
	10/01/2019–09/30/2020							3.38	3.25				1.52
Community Care Plan-M	SFY 2015/2016											1.72	
	10/01/2018–09/30/2019											0.91	
	10/01/2019–09/30/2020											1.33	
Humana-C	SFY 2015/2016		1.64	1.88	2.06	2.08	2.2	1.99	2.16	1.93	2.07	1.74	1.94
	10/01/2018–09/30/2019		1.15	1.05	1.23	1.11	1.22	1.23	1.07	1.09	1.1	0.84	0.92
	10/01/2019–09/30/2020		1.98	2.17	2.44	2.17	2.64	1.59	2.31	2.03	1.59	1.33	1.47
Molina-C	SFY 2015/2016									1.93			1.94
	10/01/2018–09/30/2019									0.87			1.66
	10/01/2019–09/30/2020									0.92			1.96
Molina-S	SFY 2015/2016					1.81	2.06		2.08				
	10/01/2018–09/30/2019					4.71	4.49		5.59				
	10/01/2019–09/30/2020					5.36	5.44		6.9				
AmeriHealth-M	SFY 2015/2016										2.07		1.94
	10/01/2018–09/30/2019										1.01		1.13
	10/01/2019–09/30/2020										0.66		0.88
Simply-C**	SFY 2015/2016						2.06	1.95	2.08			1.72	1.69
	10/01/2018–09/30/2019						1.16	1.08	1.34			1.01	0.94
	10/01/2019–09/30/2020						1.71	1.41	2.29			1.49	1.34
Clear Health-S**	SFY 2015/2016		1.49	1.71	1.95					1.83	2.11		
	10/01/2018–09/30/2019		0.95	1.09	1.99	1.06	0.88	1.04	1.41	0.95	0.88	0.77	0.62
	10/01/2019–09/30/2020		1.85	1.14	2.09	1.74	1.98	1.34	3.26	1.28	1.83	1.31	1.00
Staywell-C	SFY 2015/2016		1.49	1.71	1.95	1.81	2.06	1.95	2.08	1.83	2.11	1.72	1.69
	10/01/2018–09/30/2019		0.74	1.25	1.28	1.2	1.16	1.18	1.12	1.06	1.02	NR	0.85
	10/01/2019–09/30/2020		1.57	1.6	1.77	1.57	1.52	1.55	1.45	1.29	1.6	NR	0.91

Plan Name	Measurement Period		Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
Staywell-S	SFY 2015/2016		1.49	1.71	1.95	1.81	2.06	1.95	2.08	1.83	2.11	1.72	1.69
	10/01/2018–09/30/2019		0.79	1.22	1.27	1.13	1.36	1.41	1.23	0.81	1.09	0.95	0.93
	10/01/2019–09/30/2020		2.07	2.71	2.4	2.22	2.85	2.42	3.12	2.11	2.01	1.93	1.36
Sunshine-C	SFY 2015/2016		1.49	1.71	1.95	1.81	2.06	1.95	2.08	1.83	2.11	1.72	1.69
	10/01/2018–09/30/2019		1.47	1.73	1.62	1.52	1.87	1.47	1.9	1.63	1.75	1.49	1.63
	10/01/2019–09/30/2020		3.8	4.09	3.87	3.05	4.41	3.58	4.03	3.7	3.51	2.79	4.5
Sunshine-S-CW	SFY 2015/2016		1.49	1.71	1.95	1.81	2.06	1.95	2.08	1.83	2.11	1.72	1.69
	10/01/2018–09/30/2019		0.4	0.43	1.59	1.04	0.51	0.46	0.96	0.99	0.41	0.46	0.52
	10/01/2019–09/30/2020		0.21	1.68	3.21	2.13	0.7	0.87	2.44	1.16	1.45	1.88	0.31
United-C	SFY 2015/2016				1.95	1.81		1.95					1.69
	10/01/2018–09/30/2019				1.59	1.36		1.66					1.19
	10/01/2019–09/30/2020				2.78	2.34		4.07					2.57
Vivida-M	SFY 2015/2016									1.83			
	10/01/2018–09/30/2019									1.11			
	10/01/2019–09/30/2020									0.56			
Florida Community Care***	CY 2019		74.12										
	CY 2020		74.58										
PPRs per 1,000 Hospital Admissions													
Aetna Better Health-C	SFY 2015/2016							83.17	86.2				89.54
	10/01/2018–09/30/2019							41.7	74.05				48.53
	10/01/2019–09/30/2020							58.71	87.06				68.47
Community Care Plan-M	SFY 2015/2016											93.13	
	10/01/2018–09/30/2019											60.76	
	10/01/2019–09/30/2020											84.49	
Humana-C	SFY 2015/2016		89.11	79.18	88.96	88.85	87.73	85.87	88.89	80.95	101.45	98.95	98.35
	10/01/2018–09/30/2019		54.06	28.91	71.43	45.21	50.2	47.33	53.61	48.66	63.12	57.31	62.89
	10/01/2019–09/30/2020		64.63	59.68	80.09	65.47	75.13	67.75	88.04	73.55	78.40	69.64	84.63

Plan Name	Measurement Period		Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
Molina-C	SFY 2015/2016									80.95			98.35
	10/01/2018–09/30/2019									58.67			55.68
	10/01/2019–09/30/2020									57.21			64.15
Molina-S	SFY 2015/2016					89.37	85.46		86.2				
	10/01/2018–09/30/2019					142.07	142.13		145.08				
	10/01/2019–09/30/2020					177.53	188.66		215.49				
AmeriHealth-M	SFY 2015/2016										94.81		89.54
	10/01/2018–09/30/2019										47.38		59.05
	10/01/2019–09/30/2020										59.54		87.5
Simply-C**	SFY 2015/2016						85.46	83.17	86.2			93.13	89.54
	10/1/2018–9/30/2019						56.7	53.43	69.08			54.57	52.34
	10/1/2019–9/30/2020						86.7	79.44	89.32			85.3	80.37
Clear Health-S**	SFY 2015/2016		94.57	77.27	89.97					76.88	94.81		
	10/01/2018–09/30/2019		98.03	77.39	110.86	59.64	88.61	86.62	87.18	49.95	86.44	103.6	92.6
	10/01/2019–09/30/2020		101.38	117.89	106.66	92.51	126.67	101.44	139.56	110.77	93.42	124.51	103.43
Staywell-C	SFY 2015/2016		94.57	77.27	89.97	89.37	85.46	83.17	86.2	76.88	94.81	93.13	89.54
	10/01/2018–09/30/2019		41.73	46.96	55.98	54.8	58.41	51.05	64.39	52.18	62.05	NR	65.93
	10/01/2019–09/30/2020		60.77	65.15	77.09	65.13	78.02	80	85.85	72.64	77.85	NR	70.89
Staywell-S	SFY 2015/2016		94.57	77.27	89.97	89.37	85.46	83.17	86.2	76.88	94.81	93.13	89.54
	10/01/2018–09/30/2019		75.54	69.22	74.44	79.04	88.34	83.45	96.27	78.21	86.6	103.84	91.43
	10/01/2019–09/30/2020		81.54	75.94	91.21	97.08	102.44	97.98	106.66	93.07	101.81	109.93	112.35
Sunshine-C	SFY 2015/2016		94.57	77.27	89.97	89.37	85.46	83.17	86.2	76.88	94.81	93.13	89.54
	10/01/2018–09/30/2019		43.08	46.95	53.03	50.92	46.65	49.89	54.5	40.72	55.25	55.46	52.39
	10/01/2019–09/30/2020		96.85	90.46	87.95	83.33	96.83	97.83	100.32	86.31	95.86	88.22	101.26
Sunshine-S-CW	SFY 2015/2016		94.57	77.27	89.97	89.37	85.46	83.17	86.2	76.88	94.81	93.13	89.54
	10/01/2018–09/30/2019		77.69	108.05	113.94	103.07	116.72	116.61	129.77	71.43	124.2	136.96	124.46
	10/01/2019–09/30/2020		250.19	101.12	164.29	139.29	156.45	148.08	162.87	148.6	135.18	155.48	176.14
United-C	SFY 2015/2016				89.97	89.37		83.17					89.54
	10/01/2018–09/30/2019				55.57	50.42		49.73					45.93

Plan Name	Measurement Period		Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
	10/01/2019–09/30/2020				86.38	81.83		95.01					89.97
Vivida-M	SFY 2015/2016									76.88			
	10/01/2018–09/30/2019									85.47			
	10/01/2019–09/30/2020									45.45			
Florida Community Care***	CY 2019		292.14										
	CY 2020		290.43										
PPVs per 1,000 Enrollee Months													
Aetna Better Health-C	SFY 2015/2016							25.76	26.19				19.51
	10/01/2018–09/30/2019							10.81	10.52				10.75
	10/01/2019–09/30/2020							8.15	7.93				7.43
Community Care Plan-M	SFY 2015/2016											23.46	
	10/01/2018–09/30/2019											10.11	
	10/01/2019–09/30/2020											5.79	
Humana-C	SFY 2015/2016		14.58	12.15	11.16	12.16	10.33	11.57	12.48	10.09	10.49	8.6	8.75
	10/01/2018–09/30/2019		13.29	9.95	9.46	9.36	8.19	10.03	9.69	8.81	8.66	10.27	8.78
	10/01/2019–09/30/2020		9.52	7.31	7.32	7.06	5.92	6.84	6.88	5.96	5.60	6.18	5.82
Molina-C	SFY 2015/2016									10.09			8.75
	10/1/2018–9/30/2019									10.54			11.17
	10/1/2019–9/30/2020									7.2			8.3
Molina-S	SFY 2015/2016					26.56	23.24		26.19				
	10/01/2018–09/30/2019					24.23	24.49		23.56				
	10/01/2019–09/30/2020					20.87	21.08		19.8				
AmeriHealth-M	SFY 2015/2016										23.77		19.51
	10/01/2018–09/30/2019										9.43		10
	10/01/2019–09/30/2020										25.95		27.61
Simply-C**	SFY 2015/2016						23.24	25.76	26.19			23.46	19.51
	10/01/2018–09/30/2019						10.05	10.29	10.66			10.83	8.83
	10/01/2019–09/30/2020						6.82	6.69	7.03			6.31	5.58

Plan Name	Measurement Period		Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
Clear Health-S**	SFY 2015/2016		30.98	26.12	24.76					22.4	23.77		
	10/01/2018–09/30/2019		15.65	12.52	13.3	11.15	11.21	13.5	11.81	8.76	12.57	14.27	11.26
	10/01/2019–09/30/2020		12.05	12.22	12.60	10.70	9.90	8.75	10.45	5.31	9.70	10.21	9.54
Staywell-C	SFY 2015/2016		30.98	26.12	24.76	26.56	23.24	25.76	26.19	22.4	23.77	23.46	19.51
	10/01/2018–09/30/2019		14.19	11.71	11.2	11.64	9.71	11.19	10.67	9.06	8.95	NR	9.55
	10/01/2019–09/30/2020		8.93	8.13	7.55	8.02	6,59	7.01	7.13	5.37	5.97	NR	5.57
Staywell-S	SFY 2015/2016		30.98	26.12	24.76	26.56	23.24	25.76	26.19	22.4	23.77	23.46	19.51
	10/01/2018–09/30/2019		19.22	14.36	14.45	14.17	15.88	15.74	15.35	13.05	16.1	17.73	12.71
	10/01/2019–09/30/2020		15.2	11.66	11.7	12.31	13.09	11.67	12.6	9.37	11.72	13.05	9.51
Sunshine-C	SFY 2015/2016		30.98	26.12	24.76	26.56	23.24	25.76	26.19	22.4	23.77	23.46	19.51
	10/01/2018–09/30/2019		11.55	12.25	10.24	11.09	8.26	9.64	10.14	8.58	8.97	10.17	8.39
	10/01/2019–09/30/2020		8.28	8.43	6.72	7.21	5.53	6.15	5.44	5.61	5.38	5.4	5.23
Sunshine-S-CW	SFY 2015/2016		30.98	26.12	24.76	26.56	23.24	25.76	26.19	22.4	23.77	23.46	19.51
	10/01/2018–09/30/2019		10.44	8.33	7.98	8.69	7.66	8.25	7.89	7.31	6.72	8.51	8.86
	10/01/2019–09/30/2020		6.73	5.4	5.65	5.93	5.43	5.41	4.63	5.06	4.47	4.87	4.73
United-C	SFY 2015/2016				24.76	26.56		25.76					19.51
	10/01/2018–09/30/2019				11.64	12.31		10.67					9.03
	10/01/2019–09/30/2020				8.08	8.36		7.41					5.67
Vivida-M	SFY 2015/2016									22.4			
	10/01/2018–09/30/2019									33.67			
	10/01/2019–09/30/2020									6.43			
Florida Community Care***	CY 2019		59.92										
	CY 2020		52.86										

* The performance indicator(s) rates documented in the table is reflective of the rates reported by the plans in the PIP submission and are indicated in green font when the goal was met, red font when the goal was not met, and blue font when a comparison with the goal could not be made.

** Simply-C and Clear Health-S did not provide goals; therefore, HSAG could not assess whether these plans met their goals.

***Florida Community Care reported CY 2019 and CY 2020 as the measurement periods. The plan calculated one cumulative rate and indicated it achieved approval from the Agency for the revised measurement periods and data reporting.

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

Plan Name	Measurement Period	Statewide
Preventable Dental ED Visits per 1,000 Enrollee Months		
DentaQuest	SFY 2016/2017	0.2584
	10/01/2018–09/30/2019	0.2454
	10/01/2019–09/30/2020	0.171
Liberty	SFY 2016/2017	0.2584
	10/01/2018–09/30/2019	0.2717
	10/01/2019–09/30/2020	0.189
MCNA	SFY 2016/2017	0.2584
	10/01/2018–09/30/2019	0.2294
	10/01/2019–09/30/2020	0.168

* *The remeasurement rates are indicated in green font when the goal was met and in red font when the goal was not met.*

For the *Reducing Potentially Preventable Dental-Related ED Visits* PIP, the three dental plans provided statewide remeasurement rates. All three plans met the goal rate for reducing preventable dental ED visits.

Improvement Strategies

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

Table D-5 displays the interventions as documented by the plans for the *Improving Birth Outcomes* PIP.[D-1]

Table D-5—Interventions Implemented/Planned for the *Improving Birth Outcomes* PIP

Plan Name	Interventions Implemented/Planned
Aetna-C	• Identify and educate OB/GYNs with high volume of primary C-sections. • Implement use of a C-section checklist with all network OB/GYNs. • Promote safe and appropriate use of 17P Makena (hydroxyprogesterone acetate) in pregnant women at risk of preterm labor and giving birth prematurely. • Promote prenatal visits. • Redesigned and redefined the Integrated Care Management program for pregnant women.

[D-1] Children Medical Services-S and Florida Community Care-L did not participate in the *Improving Birth Outcomes* PIP.

Plan Name	Interventions Implemented/Planned
	• Identify and engage pregnant women who have significant opiate use, opioid use disorder) or substance use disorder (SUD) in high-risk perinatal care management. • Neonatal Abstinence Care Management program.
AmeriHealth-M	• Healthy Start: AmeriHealth-M has a partnership with Healthy Start to refer all new moms and high-risk pregnant enrollees for assistance with community resources as well as connecting first time moms with Family Nurse Partnership program that focuses on first time moms at the enrollees' home. • Keys to your Care Maternity Texting/Two-Way Texting is an enrollee engagement program to encourage enrollees to make and keep doctor's appointments throughout their pregnancy and postpartum period. • Offer doula services to pregnant mothers. • In addition to educating enrollees on the importance of LARC, the health plan will also identify providers that work in LARC-approved facilities in regions 9 & 11 and educate providers on the availability of LARC unbundled payment. • AmeriHealth-M in collaboration with pharmacy vendor PerformRx will promote the use of progesterone treatment to help prevent premature births. This initiative also includes an at home program for administration of the Makena for enrollees who are high risk and meet criteria inclusive of non-compliance with attendance at OB appointments.
Community Care Plan-M	• The OB Care Management team receives a daily bed census report that is compiled from Broward Health, Memorial Healthcare System, and the Encounter Notification Service (ENS). The report includes the ED and IP utilizers and is analyzed daily to identify enrollees that indicate a potential pregnancy (e.g., threatened abortion) for outreach and enrollment into OB care coordination. • Obstetrical risk assessments are completed via phone utilizing a Health Risk Stratification Assessment Tool to identify the risk of a pregnant enrollee. • High-risk pregnant enrollees receive follow-ups with a designated registered nurse perinatal program manager at a frequency of every 4 to 6 weeks. • OB/GYNs who are in-network for six consecutive months, sign a pay for performance program agreement, and achieve the 75th percentile for given access and quality measures and the 60th percentile for the other measures during the measurement period will be paid at a Medicare rate. • A pregnant enrollee receives a $50 reward for obtaining a prenatal exam with an obstetrician during her first trimester and a postpartum exam with the obstetrician between three and seven weeks of the delivery date.
Humana-C	• Revised Health Risk Assessment (HRA) and Notification of Pregnancy form for identification of risk. • Enrollment into Moms First Case Management program and other programs to address psychosocial determinants of health. • Best Foot Forward Campaign: Call center outreach to enrollees that the other health plan staff have been unable to reach. • Verify, engage, and refer enrollees to medication-assisted treatment therapy. • Maternity Home Visiting/Remote Monitoring program.

Plan Name	Interventions Implemented/Planned
Molina-C	• OB/GYN Provider Profiling targets cost implications for providers with high C-section rates. Decreasing reimbursement rates for C-sections and increasing reimbursement rates for vaginal deliveries. • Enhanced methods to identify enrollees in the pregnant population utilizing multiple sources such as: claims data, pregnancy notification forms from providers, and panel roster. Outreach to new enrollees identified as pregnant includes initial telephonic outreach attempts. • Member Location Unit attempts to contact the enrollee as early as possible to coordinate prenatal care, complete prenatal risk assessments, and coordinate referral to any identified needs to improve birth outcomes. • Enhanced prior authorization review of IP admissions for deliveries to include review for elective early deliveries and planned C-sections to ensure medical necessity and appropriateness. This includes application of a policy to not approve or pay for elective early deliveries or non-medically appropriate primary C-sections. • Healthy Behaviors programs to include interventions and incentives to enrollees for meeting treatment milestones related to participation in prenatal substance use programs. • Identify enrollee needs for 17P therapy during pregnancy. • Continue including long-acting reversible contraceptive (LARC) education and coordination as part of the High-Risk OB program.
Molina-S (Molina-C reported separate interventions for their specialty population for this PIP)	• Continue to monitor the OB/perinatal specialists that treat enrollees with serious mental illness (SMI) and SUD. Encourage coordination between OB and behavioral health (BH) providers. • Intervention specialists meet with 10 providers a month in order to discuss HEDIS performance including timeliness of prenatal care trends. • Case management support and care coordination for existing comorbidities. • The High-Risk Maternity team tracks and trends pregnant enrollees with a history of SUD to increase number and frequency of screenings and counseling. • Offer the 17P program to those enrollees in need of progesterone therapy to lower preterm birth rates.
Simply-C (includes Clear Health-S)	• Identify and engage pregnant women in their first 20 to 24 weeks of gestation and who currently have substance abuse issues. • Gestational Diabetes Pilot: Home-delivered meals to high-risk enrollees with a history of preterm labor, preterm deliveries, and high blood pressure. • OB Quality Incentive Program offers incentives to OB providers to provide quality and efficient care, while keeping enrollees' healthcare needs primary.

Plan Name	Interventions Implemented/Planned
Staywell-C	• Partner with Healthy Start and their information technology vendor for continuous improvement of data exchange. • Enhance promotion and touch points with pregnant enrollees to use Healthy Rewards program following completion of prenatal & postpartum visits. • Produce a monthly pharmacy report of women of childbearing age (10 to 55 years) with prior fills of controlled substances to monitor future risk to pregnant women; targeted outreach to at-risk female enrollees with long-term use of controlled substances or high Morphine Equivalent Doses. • Participate in Florida Perinatal Quality Collaborative (FPQC) meetings at seven pilot hospitals to promote primary vaginal delivery. • Increase participation with "Access LARC" hospitals. • Engage provider relations staff to educate network OB providers regarding medication & counseling options for substance use and promote referrals to care management and MAT. • Promote use of 17P to reduce preterm births. • Investigate offering a provider payment incentive for reducing the rate of C-sections.
Sunshine-C (includes Sunshine-S-CW and Sunshine-S-SMI)	• Enroll pregnant mothers in Start Smart for Your Baby program. • Collaborate with Healthy Start Coalition and other community stakeholders to identify and engage pregnant mothers. • Implement Pay for Performance for obstetric providers. • Provider education on opioid use and Trauma Informed Care approach. • Use of telemedicine appointments with BH providers for pregnant enrollees with SUD.
United-C	• MMA Physician Incentive Program (MPIP). • Cesarean deliveries that are performed electively and do not include a high-risk diagnosis will be reimbursed at a lower amount. • Encourage OB providers to engage with the FPQC. • Partnership with March of Dimes on implementation of innovative supportive pregnancy care programs. • Provider incentive programs that reward providers for helping enrollees to become more engaged in their preventive health. • Collaboration with Healthy Start Coalition. • 17P/Makena Home Delivery program. • Healthy First Steps High Risk Case Management and Rewards program. • Pharmacy Management Solutions to identify pregnant women timely. • National Doula Network. • Brave Health: Provides telehealth enabled therapy and psychiatry, medication management, and support to high-risk enrollees. • Screening, Brief Intervention and Referral for Treatment Regarding Substance Use Disorders (SBIRT) Enhanced Provider Toolkit. • Maternity Episodes of Care: Episode/Bundle Payment program (value-based care) that pays for value and increases risk sharing. Rewards OB providers for achieving quality measures, increasing care coordination, and reducing cost. • Wellhop for Mom and Baby Pilot: Pregnant enrollees with similar due dates meet virtually for group learning and connection.

Plan Name	Interventions Implemented/Planned
Vivida-M	• Maternity Care Management program. • Implemented the Gold Card program. This program allows providers offering services to enrollees with high-risk pregnancies to bypass authorizations for certain services. • Encourage postnatal care, LARCs to reduce frequent pregnancies, Progestin (17P) therapy. • Substance abuse screen and treatment. • Family planning and preconception care for women who use opioids, including preconception services, pregnancy intention screening, and contraceptive counseling to prevent unintended pregnancy.

Table D-6 displays the interventions as documented by the plans for the *Reducing PPEs* PIP.[D-2]

Table D-6—Interventions Implemented/Planned for the *Reducing PPEs* PIP

Plan Name	Interventions Implemented/Planned
Aetna-C	• Initiate measures to increase access for all enrollees to primary care and BH services including telehealth and home physician visits. • Enroll enrollees with complex medical conditions (chronic obstructive pulmonary disease [COPD], diabetes, SMI, heart disease, congestive heart failure [CHF]) into intensive care management and include pharmacy, RNs, and community health workers in care management team. • Promote use of 24-hour nurse information line and 24-hour BH hotline, which are available for all enrollees. • Increase the number of PCPs and specialists in value-based arrangements which reward providers for extended and weekend hours and indirectly tie provider compensation to appropriate ED usage.
AmeriHealth-M	• For reducing PPAs, PPRs, and PPVs: – Value-based contracts. – Telemonitoring and mobile health coaching via the Vheda Health tool. This service is offered to enrollees diagnosed with poorly controlled diabetes mellitus or CHF. – Two-way texting campaign connects case managers with high-risk enrollees, allowing to initiate a conversation via a text message from their mobile device. • For reducing PPAs: – Predictive modeling proactive outreach approach. – Care management outreach by an RN case manager.

[D-2] Children Medical Services-S did not participate in *Reducing PPEs* PIP.

Plan Name	Interventions Implemented/Planned
	– Medication adherence program: As part of the case management program for enrollees identified as high risk: the case manager will review the enrollee's medications via telephonic outreach. – The case managers conduct the social determinants of health during the initial assessment, which is completed via telephonic case management process. • For reducing PPRs: – Optum has an express access network of providers who have contractually agreed to see enrollees within five days of an appointment request. – Enhanced TOC; care coordination; community case management programs. • For reducing PPVs: – The ER Diversion Outreach program enlists a multi-facet approach with focus on intake, education, prevention, and interventional opportunities. The targeted population includes the top 400 ER utilizers and the top 400 ER cost enrollees identified through data mining and HIE data. – Express access to BH appointments via Optum express access network, which consists of providers who have contractually agreed to see enrollees within five days of an appointment request. – Telemedicine.
Community Care Plan-M	• Telemedicine: The health plan is working to design a policy and program that will enable access to telemedicine in care settings that meet the state requirements, for enrollees in need of care in which access to care is challenging due to limited providers, appointment availability, or where enrollee transportation issues exist. • LACE Initiative: The health plan utilizes the LACE tool to identify enrollees that are at high risk for readmission. LACE is defined as length of stay, acuity of the admission, comorbidities using the Charlson comorbidity index, and ED visits in the past 6 months. This tool is utilized on all enrollees who are admitted and placed on the ED/IP Bed Census for daily review and intervention by the Concierge Care Coordination team.
Florida Community Care-L	• Consistent and timely reassessments and person-centered care planning process that are shared with the provider. Care managers receive notification of hospitalizations through the HIE ENS, enrollees, providers and/or caregivers. Once notified, care managers will follow up while enrollee is in the hospital and after discharge to assess the enrollee's needs and update care plan. Care managers also provide assistance with provider appointments. • Network oversight and management related to routine and preventive care will consist of coordination with care managers and provider relation staff to communicate directly to providers that have not identified or coordinated care that results in poor or inadequate outcomes. Target lists of enrollees and their affiliated providers will be reviewed by care management leadership and provider relations leadership to develop intervention focus on both enrollee and provider education and improvement in outcomes. • FCC-L engaged with a medication therapy management (MTM) vendor to conduct comprehensive medication reviews for the enrollees.

Plan Name	Interventions Implemented/Planned
Humana-C	• For reducing PPAs: Enhance case management outreach and engagement to focus on enrollees with the top driver admission diagnoses CHF and COPD. • For reducing PPRs: – Enhance discharge planning, care transitions, and post discharge care coordination to focus on high-risk enrollees and top driver readmission diagnosis. Provide targeted post-discharge outreach calls and assessments to enrollees. – Provide outreach to enrollees during hospitalization (within one business day from determination) to conduct discharge planning. • For reducing PPVs: – Enhance enrollee ED visit education (mail, email, text) with focus on non-emergent high-utilizers and enrollees with top driver diagnosis in targeted regions. – Improve enrollee engagement by conducting outreach during ED visits. – Improve enrollee access to urgent care, telemedicine, and PCPs in targeted regions; enhance PCP education. • For reducing PPAs, PPRs, PPVs: Improve network providers' telehealth adoption by mitigating existing barriers.
Molina-C (includes Molina-S)	• Disease management and care coordination interventions using iPro predictive modeler for enrollee identification based on clinical risk and impact level along other identifiers. • An assigned case manager to provide education, care coordination, self-management teaching for enrollees identified with a chronic condition and two or more admissions for high volume PPA admission condition within a three-month period. • Value-based reimbursement contracting with PCPs to enhance focus on IP admission rates and reduce PPEs. • Disease management and care coordination interventions for the prevention of IP admissions for the top 10 conditions for PPA and PPR. The program will utilize a LACE score and other predictive modeling tools to indicate risk for hospital admission and identify target population. • Identify enrollees with one or more ED visit(s) for any period of time for any of the top 10 PPV conditions and evaluate the root cause of utilizing the ED versus PCP or urgent care. • Overall enrollee outreach and education to reinforce availability of alternatives to the ED including telehealth, urgent care centers, and Nurse Advice Line.
Simply-C (includes Clear Health-S)	• Enhanced the TOC program: The program's objective is to bridge the gap between the health plan and hospitals through the following process: – Pre-Cert notifies IP coordinators (ICs) of planned admissions. – IC provides pre-admission planning to enrollees and works with concurrent review nurse and hospital to determine enrollee transition needs. IC coordinates transition to skilled nursing facility, rehab, nursing home, and does discharge notification. – Discharge caller contacts enrollees within 24 to 72 hours post-discharge to coordinate discharge follow-up plans.

Plan Name	Interventions Implemented/Planned
	– TOC coordinator reviews discharge and triages for care management assignment daily. – TOC nurse visits enrollee within seven days and follows enrollee for 30 days post-discharge. • Telemonitoring programs aimed at enrollees with COPD, CHF, and diabetes. The plan contracts with First Quality Home Care, an organization that provides home healthcare services, to provide its enrollees with remote patient monitoring equipment. • Identify and engage asthma enrollees who are non-compliant with their medications and have no ED visits and/or hospital admissions in the fiscal year. • Improving ENS notification utilization by customized PPE alerts.
Staywell-C	• Promote use of Staywell's 24-hour Nurse Line & BH Crisis Line to triage enrollees for most appropriate place of service. • Ensure providers are educated about care management programs. • Engage and educate enrollees on our Disease Management programs. • Staywell-at-Home care managers will discuss and distribute nationally published, enrollee-driven action plans with red, yellow, and green status language to decrease hospital and ED visits, targeting at-risk enrollees with specific chronic conditions and to identify top PPV condition utilization to ensure enrollees are offered care management services. • For high-risk enrollees—increase referrals and engagement for biomonitoring support, making sure each enrollee's plan of care is inclusive of medication adherence, and customized to best meet the enrollee's needs. • Address enrollees' social determinants such as, cultural and linguistic concerns, food, housing, or transportation that may inhibit priority of their health or healthcare. • Promote new functionality of MyStaywell App for enrollees to easily access an in-network urgent care center near their home. • Clinical team of quality practice advisors, supported by medical directors, will meet with IPA groups and physicians to deliver enrollee specific data regarding high opportunity enrollees, distribute readmission data to enable direct interventions. • An Asthma Workgroup was created to develop an ED Diversion program through member education on self-management of their asthma. • Promote telehealth services. • Increase recruitment efforts with a goal of 10 percent increase of in contracted urgent care centers and then re-evaluate expansion efforts based on evaluation of capacity and PPE metrics. • Extended PCP office hours: Make extended office hours a contract requirement.
Sunshine-C (includes Sunshine-S-CW and Sunshine-S-SMI)	• For reducing PPAs: – Apply population management approach to identify enrollees for case management. – Increase use of telemedicine to improve access to specialty care for enrollees with chronic conditions in rural areas. • For reducing PPRs:

Plan Name	Interventions Implemented/Planned
	– Apply clinical programs on readmissions—Use daily IP census report to identify enrollees who may benefit from case management. – Apply clinical programs on readmissions including top readmit diagnoses of mental health. • For reducing PPVs: – Apply current ED diversion and other clinical programs to ED utilization. – Send ENS ADT data to PCPs to allow prompt follow-up post ED visits. – Implement 24/7 telemedicine program to increase access to urgent physician services outside of ED.
United-C	• Certified Peer Support Specialists: This program assigns a peer support specialist to enrollees with a mental health/substance abuse condition to help enrollees comply with their outpatient visits, medication, and navigate the system overall. • Event Notification System and Community Care: These two electronic systems will allow prompt identification of enrollees with IP admission. • Remote Patient Monitoring: Implement high-tech/high-touch home monitoring for enrollees with chronic conditions/or at risk of COPD, CHF, and diabetes. • Team MD: Pilot program in Region 4 to provide integrated primary care model, where the PCPs lead collaborative care teams. • Clinical Disease Management program: Enrollee education on proper ED utilization and home self-management practices. • Payment Methodology Changes: Use of low acuity diagnoses to drive payment methodology changes with particular focus on ED trends. • MTM program that targets enrollees with asthma/COPD, diabetes, and Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV) and who are not taking their medications. • PPE data sharing with providers. • 24/7 telephonic support. • High-Risk Patient Management (ACO program): This initiative will focus on high-risk patients who have not had an office visit in 90 days to schedule an in-office appointment. • Weekend End Tuck In Program (ACO program): This initiative will focus on reducing ED visits for non-emergent issues during the weekends.
Vivida-M	• Implementation of the Complex Care Management program for high-risk enrollees using stratification and predictive analytics, focusing on self-management. • Condition Care Management program for disease management using risk stratification and predictive analytics focusing on education. • Risk Stratification and Transition Care program implementation for enrollees at high risk for readmission. • Offer tobacco cessation to all enrollees that smoke.

Table D-7 displays the interventions as documented by the dental plans for the *Potentially Preventable Dental-Related ED Visits* PIP.

Table D-7—Interventions Implemented/Planned for the *Potentially Preventable Dental-Related ED Visits* PIP

Dental Plan Name	Interventions Implemented/Planned
DentaQuest-D	• Dental Home assignments. • DentaQuest identifies enrollees who have used the ED for any dental-related issues and outreaches to these enrollees to assist in finding a dentist or changing dental home. • DentaQuest case managers outreach to enrollees to help educate enrollees about their dental plan benefits and help reschedule a dental appointment.
Liberty-D	• Development and implementation of data sharing and joint care coordination agreements between prepaid dental and health plans to capture data associated with dental-related Potentially Preventable Visits (DPPVs) and include real-time notification. • CSR will connect enrollees having dental pain/discomfort with their dental home. If the CSR is unsuccessful, they will locate another facility to provide ED services. After-hours calls are handled by Liberty's 24/7 on-call staff dentists who can triage the enrollee's concern and assist the enrollee. • Use of value-based purchasing provider incentives. • Early Smiles program, in areas with the highest rates of PPVs, that allows Liberty to provide preventive dental services and help navigate children to a dental home through school-based partnerships and use of mobile dentistry outreach, education, and treatment in collaboration with County School Districts and the Florida Department of Education. • Text message outreach campaign to promote healthy behaviors.
MCNA-D	• Hygienist Helpline. • Care gap alerts to MSRs offer assistance with scheduling an appointment when an alert is triggered in the DentalTrac™ system during inbound calls that indicates the enrollee is overdue for a preventive dental visit. • Enrollee Pre-authorization Outbound Calls—MCNA's Care Connections Team conducts outbound calls to enrollees who have unused pre-authorization requests on file. • Provider Pre-authorization Outbound Calls—MCNA's Provider Relations team conducts outbound calls to provider offices with a high volume of unused pre-authorization requests and provides them with a list of enrollees. • Provider Portal Preventive Service Gaps—Real-time Early and Periodic Screening, Diagnostic and Treatment preventive dental service gaps visible to providers at the time of eligibility verification in MCNA's Provider Portal. • Targeted Provider Relations Outreach for Treatment Services—Targeted visits to dentists who, based on dental record review, have not completed documented treatment needs.

Appendix E. Plan-Specific Progress in Meeting EQRO Recommendations

Introduction

Regulations at §438.364 require an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity (described in §438.310[c][2]) has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. This appendix provides a summary of the follow-up actions per activity that the plans reported completing in response to HSAG's SFY 2020–2021 recommendations. Please note, content included in this section is presented verbatim as received from the plans and has not been edited or validated by HSAG.

Scoring

HSAG worked with the Agency to develop a methodology and rating system for the degree to which each plan addressed the prior year's EQR recommendations. In accordance with CMS guidance, HSAG used a three-point rating system. The plan's response to each EQRO recommendation was rated as *High*, *Medium,* or *Low* according to the criteria below.

High indicates *all* of the following:

- The plan implemented new initiatives or revised current initiatives that were applicable to the recommendation.
- Performance improvement directly attributable to the initiative was noted *or* if performance did not improve, the plan identified barriers that were specific to the initiative.
- The plan included a viable strategy for continued improvement or overcoming identified barriers.

A rating of *high* is indicated by the following graphic:

Medium indicates one or more of the following:

- The plan continued previous initiatives that were applicable to the recommendation.
- Performance improvement was noted that may or may not be directly attributable to the initiative.
- If performance did not improve, the plan identified barriers that may or may not be specific to the initiative.
- The plan included a viable strategy for continued improvement or overcoming barriers.

A rating of *medium* is indicated by the following graphic:

Low indicates one or more the following:

- The plan did not implement an initiative or the initiative was not applicable to the recommendation.
- No performance improvement was noted *and* the plan did not identify barriers that were specific to the initiative.
- The plan's strategy for continued improvement or overcoming identified barriers was not specific or viable.

A rating of *low* is indicated by the following graphic:

Plan Follow Up

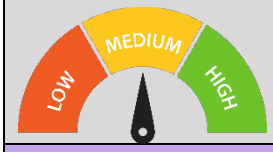
Comprehensive Plans

Aetna-C

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Access/Availability of Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine **why members do not consistently access preventive and ambulatory services**. Upon identification of a root cause, implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.
Response
a. Describe initiatives implemented based on recommendations: • Aetna Better Health of Florida identifies members who have not had an annual visit to primary care provider (PCP) and who had multiple emergency department (ED) visits and conducts telephone outreach to these members to help address barriers to care (change PCP, get transportation, etc.)
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • One month after launching this initiative, the rate for access to preventive/ambulatory care increased by more than 4 percentage points.
c. Identify any barriers to implementing initiatives: • Number of eligible members for this measure keeps inflating due to no Medicaid re-determination requirement (suspended during PHE): no one loses eligibility • Unable to reach members: no answer, wrong number, no current phone number • Members do not reply to voice mails requesting call back • Members fear "SPAM" calls and do not take the call • Ongoing impact of COVID: members did not seek preventive/maintenance care/ saw doctor when sick
d. Identify strategy for continued improvement or overcoming identified barriers: • When unable to reach the member, Aetna Better Health of Florida contact the member's PCP to verify contact info (phone number) and encourages the PCP to outreach the member directly • Working with phone services to ensure caller ID shows "Aetna"

Recommendations for Pediatric Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine **why child and adolescent members are not receiving all recommended vaccines**. Plans should consider if there are disparities within their populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve immunization rates.
Response
a. Describe initiatives implemented based on recommendations: • Collecting immunization records year-round • Identify children/adolescents falling behind in vaccinations • Conducts telephonic outreach to parents of children/adolescents in need of vaccination • Deliver Gap-in-Care reports to PCP/Peds listing 12-year olds (let's not wait until child turns 13 to get vaccinated) to enable provider to contact parent to schedule visit
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Child Immunizations -Combo 3 improved significantly from May2022 (62.38%) through Jul2022 (65.66%) just short of 50th percentile • Child Immunizations -Combo 10 improving slowly from May2022 (24.20%) through Jul2022 (24.99%) • Adolescent Immunizations – Combo 1 slow to improve; 31.32% in May2022 and 32.80% in Jul2022 • Adolescent Immunizations – Combo 2 also slow to improve; 68.50% in May2022 and 69.44% in Jul2022
c. Identify any barriers to implementing initiatives: • Providers are not required to provide vaccinations under Aetna contracts/providers do not stock/provider vaccinations • Parents not likely to go elsewhere (after PCP/Peds visits) for their child vaccination/inconvenience of having to go elsewhere for vaccination • Many parents refuse/decline child/adolescent vaccinations (i.e., HPV, Meningitis) • Unable to contact members (no phone number) to encourage vaccination/help with appointments • Ongoing impact of COVID: members did not seek preventive/maintenance care/ saw doctor when sick
d. Identify strategy for continued improvement or overcoming identified barriers: • Continue outreach efforts • Leaving voice mail messages on behalf of PCP/Peds to encourage call back/scheduling appointment • Use TXT/IVR messaging to educate/remind parents about needed vaccinations
HSAG Assessment 

Recommendations for Living With Illness Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why **members are not receiving timely recommended screenings for diabetes.**

Response
a. Describe initiatives implemented based on recommendations: • Identify members w/ gaps-in-care • Ongoing live telephonic outreach to members with gap-in-care to educate and assist w/ scheduling appointments • Outreach to member's PCP to encourage getting member in for care • Annual Eye Exam: new initiative launched in Jul2022 w/ eye care vendor: home exam for members who are home bound or challenged to go to eye doctor • Use TXT/IVR messaging and mailers to remind members about the recommended care
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Eye Exam: 22.05% in May2022, up to 26.76% in Jul2022 • BP Control: 35.79% in May2022, up to 40.16% in Jul2022 • HbA1c Control: 25.23% in May2022, up to 29.84% in Jul2022 • HbA1c Testing: 58.45% in May2022, up to 67.32% in Jul2022
c. Identify any barriers to implementing initiatives: • Unable to reach members: no answer, wrong number, no current phone number • Members do not reply to voice mails requesting call back • Members fear "SPAM" calls and do not take the call • Ongoing impact of COVID: members did not seek preventive/maintenance care/ saw doctor when sick; lifestyle changes – eating habits changed, poorer diabetes control • Telehealth does not capture BP measurements or HbA1c. Providers often forget to address BP or HbA1c during follow-up visits
d. Identify strategy for continued improvement or overcoming identified barriers: • Continue the existing initiatives • We anticipate the new initiative for home eye exam will generate a significant improvement
HSAG Assessment 
Recommendations for Behavioral Health Domain
HSAG recommended the following: • **Enhance communication and collaboration with hospitals** to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs. • Conduct a root cause analysis to determine **why members who access the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care** and establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, increase the use of telehealth services. • Conduct a root cause analysis or focus study to determine **why child and adolescent members with ongoing antipsychotic medication are not receiving regular metabolic testing**. • Upon identification of root causes, implement appropriate interventions to improve performance.
Response
a. Describe initiatives implemented based on recommendations: • Integrated behavioral health in-house effective 3/1/22

- Hired an 3rd Behavioral Health Liaison (BHL) in 2Q2022 to enhance existing telephonic outreach efforts to improve FUA 7-day rate (one BHL in each Region served)
- Partnering with providers/practices to educate about HEDIS requirements and encourage outreach to get members in for services
- BHLs work with hospitals with high volume of BH-related ED visits, to educate and encourage discharge staff to schedule the recommended follow-up appointments before releasing the member

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- The FUM measure has been meeting state defined goal historically
- Already at 5% in Jul2022 (2 percentage points below goal)

c. Identify any barriers to implementing initiatives:
- Tight turnaround time to schedule the recommended 7-day follow-up appointment
- Challenged to identify members with ED visits related to a BH diagnosis in daily census reports. Initial reason for ED visit may not be clear. This limits opportunity for outreach.
- Many providers do not have appointment availability (for new patients) in 7 days
- Facilities discharge members without scheduling the recommended appointments
- Some members decline/don't want help
- Parents of children/adolescents may not understand the importance of metabolic testing to monitor the effectiveness of antipsychotic medications.
- Additional inconvenience of having to take child/adolescent to lab (for blood draw) in addition to BH provider appointment
- Busy parents forget or are late to take their child/adolescent for labwork.

d. Identify strategy for continued improvement or overcoming identified barriers:
Continue interventions in place, especially live telephonic outreach to members and their BH providers to close gaps in care.

HSAG Assessment

Recommendations for LTC Program

HSAG recommended the following:

- **Continue to monitor rates over time to identify COVID-19 PHE rate impact**, ensuring lower quality and access to care is not driven by a non-PHE cause.

Response

a. Describe initiatives implemented based on recommendations:
- Educate LTC case managers on documentation to be captured in our CM application for maximize information needed for the LTC measures
- Perform ongoing audit of case management documentation to improve capture of information needed
- Educate LTC case managers to ask about inpatient admission/discharge information during each member or caregiver encounter

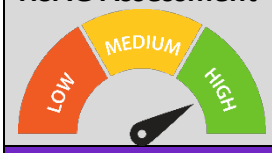
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- 3 of the 4 measures reported to AHCA in July 2022 exceeded the state defined goal and improved from prior year.

c. Identify any barriers to implementing initiatives:

- Face-to-face visits by LTC case managers were limited in 2021 due to COVID safety restrictions; making more challenging to complete some assessments
- Case managers are not notified timely when a member is hospitalized/discharged; challenging to capture the data needed for the post-discharge assessment measure (RAC)

d. Identify strategy for continued improvement or overcoming identified barriers:
- Continue the interventions in place

HSAG Assessment



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

Recommendations for Methodology

HSAG recommended the following:

- Report accurate annual PIP performance data in accordance with the Agency-defined specifications and approved methodology. The reported data should be comparable across all measurement periods.
- Address all validation feedback provided in the PIP Validation Tools. If not addressed, the corresponding evaluation element will be marked down in the PIP Validation Tool.

Response

a. Describe initiatives implemented based on recommendations:
- Verified and ensure our PIP meet the Agency-defined specifications and approved methodology
- The performance rates reported in our PIPs are comparable across all measurement periods
- We are addressing all validation feedback provider in the PIP Validation Tool in the PIP Summary Report being prepared for the upcoming submission (Oct 1, 2022)

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- No significant changes are needed to our approach to the PIP reporting

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

d. Identify strategy for continued improvement or overcoming identified barriers:
- Continue to follow the Agency-defined specifications and approved methodology, and follow the PIP reporting instructions and tools provided by HSAG
- Consult with HSAG as needed (technical call) for questions and clarifications needed to complete the annual PIP Summary Report.

HSAG Assessment

Recommendations for Interventions

HSAG recommended the following:

- Use active, evidence-based, innovative improvement strategies and interventions that have the potential to impact PIP performance indicator outcomes.
- Seek enrollee input in order to better understand enrollee-related barriers toward access to care.

- Collect intervention evaluation data frequently (weekly, biweekly, monthly, quarterly, etc.), unlike the annual performance indicator data. The intervention-specific evaluation data may help the plans identify significant clinical and programmatic improvement in outcomes.
- Evaluate the performance of each intervention and include the most current intervention evaluation data available at the time of the submission date.
- Provide adequate details about an intervention for the Agency and HSAG to better understand the intervention. For example, the plans should document how they will improve efforts to obtain real-time notifications from Florida's Encounter Notification System (ENS), and how the plans will use that data. For outreach interventions, the plans should include the mode and frequency of outreach.

Response

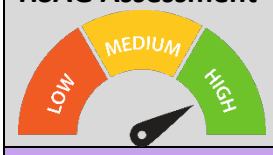
a. Describe initiatives implemented based on recommendations:
   - We use active, evidence-based, innovative improvement strategies and interventions that have the potential to impact PIP performance indicator outcomes.
   - We collect member input from our outreach calls and review member complaints/grievance data and satisfaction survey results to better understand member-related barriers to care
   - We collect and evaluate intervention data regularly, at a minimum quarterly and in many cases monthly.
   - We evaluate the performance of each intervention and document it in our annual PIP Summary Report submission.
   - We document how we use Florida's ENS system to drive our outreach interventions, specifically for the BH PIP.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - Refer to the performance improvement documented in the sections above

c. Identify any barriers to implementing initiatives:
   - Refer to the barriers documented in the sections above

d. Identify strategy for continued improvement or overcoming identified barriers:
   - Refer to the strategies documented in the sections above

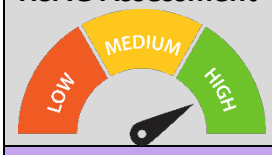
HSAG Assessment



Recommendations for Implementation

HSAG recommended the following:

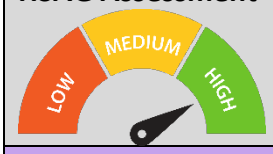
- Interventions deemed successful when tested on a small-scale using Plan-Do-Study-Act (PDSA) cycles should be ramped up and adopted plan-wide in order to impact the entire eligible population and realize improvement in the performance indicator rates.
- For unsuccessful interventions, the plans should make data-driven decisions to revise and continue the intervention or discontinue the intervention and revisit the causal-barrier analysis and implement new interventions.

Response
a. Describe initiatives implemented based on recommendations: • Our PIPs document how small-scale interventions are tested and adopted plan-wide/for the entire eligible membership when the intervention is deemed successful • We modify, discontinue and/or replace interventions deemed unsuccessful, based on data-driven decisions and review of causal barrier analysis
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Refer to the performance improvement documented in the sections above
c. Identify any barriers to implementing initiatives: • Refer to the barriers documented in the sections above
d. Identify strategy for continued improvement or overcoming identified barriers: • Refer to the strategies documented in the sections above
HSAG Assessment 
Recommendations for Analysis
HSAG recommended the following: • Use quality improvement science tools such as process mapping, failure modes and effects analysis, or key driver diagram to identify and prioritize barriers and opportunities for improvement. • Include an executive sponsor (e.g., medical director, chief medical officer, or chief executive officer) in their PIP team who takes responsibility for the success of the project and can work to remove institutional barriers when needed. • Include at a minimum one data analyst on the PIP team. Data mining and analysis are crucial components to justify topics and evaluate interventions.
Response
a. Describe initiatives implemented based on recommendations: • We use process mapping and key driver diagram in out PIPs to identify and prioritize barriers and opportunities for improvement • Our CMO and CEO are the executive sponsors of our PIPs and take responsibility for the success of these projects. They work with the Quality Management team to remove institutional barriers. • We have access to a team of data analysts for data mining and analysis of PIP data and interventions.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Refer to the performance improvement documented in the sections above
c. Identify any barriers to implementing initiatives: • Refer to the barriers documented in the sections above
d. Identify strategy for continued improvement or overcoming identified barriers: • Refer to the strategies documented in the sections above
HSAG Assessment 

Humana-C

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Pediatric Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine **why child and adolescent members are not receiving all recommended vaccines**. Plans should consider if there are disparities within their populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve immunization rates.
Response
a. Describe initiatives implemented based on recommendations: Close to 50% of the Florida MMA membership includes child and adolescent members. In our effort towards continued improvement of vaccination rates, Humana Healthy Horizons in Florida (FL HHH) Population Health Management (PHM) data monitoring strategies continuously inform new opportunities for analysis and intervention. Our program is designed to provide services and supporting information to our entire population, recognizing the member level of need, and tailoring our interventions systematically. Member education is continuous within all health tiers and includes direct to member messaging via social media, written communications, targeted community-based programs, and care management. Based on a root cause analysis of low child and adolescent immunization rates, FL HHH determined that guardians are not having children vaccinated via an annual child well-check visit as it is not required by Florida public schools. Moreover, disparities in child vaccinations were identified among families of color and those with Spanish as their preferred language. Based on this analysis, the following initiatives have been implemented: • Through the FL HHH case management program, parents/legal guardians of actively participating members are educated on the importance of annual vaccines as recommended by age group. • To particularly address low Hepatitis B immunization compliance among Spanish speaking members, a targeted text campaign to Spanish speaking members who are noncompliant with the Hepatitis B immunizations remains ongoing.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Based on the ongoing Hepatitis B text campaign, the language disparity goal to meet the 75th percentile for the HEDIS Hepatitis B immunizations among the FL HHH Spanish-speaking membership was met.
c. Identify any barriers to implementing initiatives: • Barriers to implementation of member/guardian education and outreach include the ability to contact and engage members due to inaccurate and/or incomplete contact information. • Parent/guardians demonstrate a perceived low risk for disease. • Limited availability of after-hours appointments may impact working parents/guardians' ability to attend appointments during the routine work/school day.
d. Identify strategy for continued improvement or overcoming identified barriers: • To continuously improve upon unable to contact members, FL HHH has deployed numerous methods to locate members through validation of demographic information obtained from claims, laboratory, clinical data, and the Health Information Exchange (HIE) along with external data sources. Outreach strategies include community-based, 2-way text and multi-channel communications across platforms to educate members on recommended vaccines, availability of transportation benefits, assistance with finding a Primary Care Provider (PCP), member rewards opportunities and health plan contact information.

HSAG Assessment



Recommendations for Women's Care Domain

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine **why female members are not receiving timely screenings**. Plans should consider if there are disparities within their populations that contributed to lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Conduct a root cause analysis or focus study to determine **why pregnant members are not obtaining prenatal care**.
- Upon identification of root causes, implement appropriate interventions to improve performance.

Response

a. Describe initiatives implemented based on recommendations:

In our effort towards continued improvement of women's health screenings and increasing prenatal care rates FL HHH Population Health Management (PHM) data monitoring strategies continuously inform new opportunities for analysis and intervention. Our program is designed to provide services and supporting information to our entire population, recognizing the member level of need, and tailoring our interventions systematically.

Based on a root cause analysis of general women's health screening and prenatal care non-compliance, FL HHH determined that many female plan members do not seek prenatal care until the second trimester and/or are unaware of potential consequences of not engaging with an obstetric provider earlier in the pregnancy. In terms of general women's care, many female plan members are unaware of needed screenings, such as breast or cervical cancer, as engagement with a gynecological provider is inconsistent. Moreover, disparities in both women's health screenings and prenatal care were identified among women with transportation needs and low health literacy. Based on these findings, the following initiatives have been implemented:

- Women's health education is continuous within all health tiers and includes direct to member messaging via social media, written communications, targeted community-based programs, and care management.
- FL HHH uses a preventive measure survey for all members enrolled in a care management program. Gaps in screenings are addressed and education is provided to members/guardians.
- System driven clinical alerts for screenings are in place and addressed by care managers for FL HHH members participating in case management programs.
- To improve upon early engagement in prenatal care, continued initiatives to support early identification of pregnancy include provider incentives for notification of pregnancy form completion, leveraging the HIE to identify women visiting the ER for pregnancy related concerns, authorization and claims notifications along with engagement with programs such as Healthy Start.
- Prenatal (PN) members are educated on the importance of routine prenatal appointments. All members have a preventive measure survey completed when enrolled in PN care management program and encouraged and incentivized to complete all recommended prenatal visits.

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

- As the above-described initiatives have been recently deployed, FL HHH will continue to evaluate the impact on women's care screenings and engagement in prenatal care.

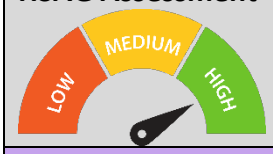
c. Identify any barriers to implementing initiatives:

- Barriers to implementation of member outreach/education include the ability to engage members due to inaccurate and/or incomplete contact information and member engagement in care management programs.
- Pregnant members are not alerted when Medicaid is active which can cause a delay in access to care.

d. Identify strategy for continued improvement or overcoming identified barriers:

- To continuously improve upon unable to contact barriers, FL HHH has deployed numerous methods to locate members through validation of demographic information obtained from claims, laboratory, clinical data, and the Health Information Exchange (HIE) along with external data sources.
- Outreach strategies include community-based, 2-way text, and multi-channel communications across platforms to educate members on recommended women's health screenings, availability of transportation benefits, assistance with finding a care provider, member reward opportunities and health plan contact information.
- To improve prenatal and postnatal engagement FL HHH has implemented a maternity 2-way texting platform to help pregnant members remain compliant with all maternal care visits.
- FL HHH is enhancing the member rewards program for 2023 to include a reward for attending prenatal and postpartum visits, pending Agency submission and approval.

HSAG Assessment



Recommendations for Living With Illness Domain

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why **members are not receiving timely recommended screenings for diabetes.**

Response

a. Describe initiatives implemented based on recommendations:

Based on a root cause analysis of screening non-compliance among members with diabetes, FL HHH determined that many members with diabetes do not see their primary care provider at a frequency consistent with timely diabetic screenings and/or have not been referred to and/or been seen by an endocrinologist. Based on these findings, the following initiatives have been implemented:

- All FL HHH members with diabetes have a preventive measures survey completed when enrolled in a care management program. Gaps in diabetic screenings are addressed and education is provided to member and/or guardian based on health literacy need.
- FL HHH continues to operate an Enhanced Care Management program for diabetes, which includes certified diabetic educators (CDE) engaging members in the management of their diabetes.

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

- Diabetic members enrolled in Enhanced Care Management have a 26% reduction in potentially preventable emergency room visits (PPV).

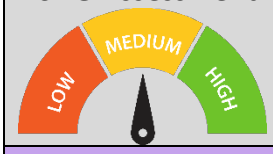
c. Identify any barriers to implementing initiatives:

- Barriers to implementation of member outreach/education include the ability to engage members due to inaccurate and/or incomplete contact information.
- Member knowledge around the importance of recommended screenings and perceived low risk of disease related complications are barriers in receptivity to recommendations.

d. Identify strategy for continued improvement or overcoming identified barriers:

- To continuously improve upon unable to contact barriers, FL HHH has deployed numerous methods to locate members through validation of demographic information obtained from claims, laboratory, clinical data, and the Health Information Exchange (HIE) along with external data sources.
- Multiple outreach campaign strategies to members include using 2-way text and multi-channel communications platform to educate members on recommended screenings, transportation benefits, assistance with finding a Primary Care Provider (PCP) or specialist, member reward opportunities, and health plan contact information for assistance.
- Continued routine member level reporting reviews with primary care physicians include detail related to various diabetic screenings (ex. HgbA1c testing and control, eye exams) and resources/tools available.

HSAG Assessment



Recommendations for Behavioral Health Domain

HSAG recommended the following:

- **Enhance communication and collaboration with hospitals** to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.
- Conduct a root cause analysis to determine **why members who access the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care** and establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, increase the use of telehealth services.
- Conduct a root cause analysis or focus study to determine **why child and adolescent members with ongoing antipsychotic medication are not receiving regular metabolic testing**.
- Upon identification of root causes, implement appropriate interventions to improve performance.

Response

a. Describe initiatives implemented based on recommendations:

Based on root cause analyses of behavioral health urgent care follow-up and antipsychotic medication management, FL HHH determined that not all behavioral health vendors use the Florida Encounter Notification Service (ENS) resulting in a delay in notification of behavioral health discharges for follow-up. In addition, lack of access and availability of behavioral health appointments for child and adolescent members creates difficulty in testing for medication management. Based on these determinations, the following initiatives have been implemented:

a. FL HHH has developed interventions to enhance efforts to obtain real-time hospital admission and emergency department visit notifications through Florida's HIE and increase follow-up visits with telehealth programs. These initiatives help facilitate timely outreach and follow-up care.
- To address barriers with child and adolescent members with ongoing antipsychotic medication, FL HHH shares information and actionable reporting data with behavioral health (BH) providers to support awareness of gaps in metabolic testing for members taking antipsychotic medication.

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

- Statistically significant performance improvement was achieved for the Follow-Up After Emergency Department Visit for Mental Illness (FUM) 7-day HEDIS measure in MY2021 when compared to the MY2019 baseline.
- Data evaluation is ongoing to determine performance improvement for 2022.

c. Identify any barriers to implementing initiatives:
- Gaps in post-discharge care management and outreach remain due to lack of receipt of discharge communication from the provider to set a member follow-up appointment within 7 days. Unable to contact members and appointment no shows continue to be a barrier in meeting 7 and 30 day follow-up measures.
- Lack of access and availability of follow-up appointments due to staffing shortages resulting from the COVID-19 pandemic. Some members are not linked to a BH provider impacting Access to Care.
- Metabolic screenings not captured in hospital claims data.

d. Identify strategy for continued improvement or overcoming identified barriers:

a. Continue to collaborate with providers to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings by leveraging all available resources to access accurate member contact information and timely notifications of ED visits, inpatient admissions, and discharges (HIE, Health Plan, inpatient and outpatient providers and BH utilization management team updates).

b. With support from Behavioral Health vendors, the Agency, and the Florida Behavioral Health Association we'll continue to educate facilities that are not utilizing the HIE, such as freestanding psychiatric facilities and Crisis Stabilization Units.

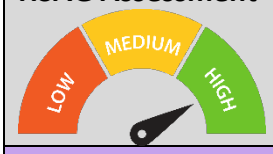
c. Continue to utilize direct feed HIE reports to obtain timely notifications of ED visits, inpatient admissions, and discharges and track success with member outreach to include in intervention outcome reporting.

d. Continue to educate and promote the use of telehealth providers.

e. Continue to educate providers on metabolic testing for members on antipsychotic medication and utilize member level reports identifying members that are missing this measure and obtain labs from hospital and/or BH provider.

- Continue to trend data quarterly to identify and mitigate barriers to ensure successful intervention progress and measure effectiveness on improvement in these areas.

HSAG Assessment



Recommendations for LTC Program

HSAG recommended the following:

- **Continue to monitor rates over time to identify COVID-19 PHE rate impact**, ensuring lower quality and access to care is not driven by a non-PHE cause.

Response

a. Describe initiatives implemented based on recommendations:

Humana Healthy Horizons LTSS Team continues to monitor rates to determine impacts of COVID-19 PHE to quality and access to care.

- In July 2021, the LTSS Transitions Team started tracking member's stated reason for transitioning to community, including COVID related reasons.
- Transition Coordinators have increased the reviews of institutionally placed members in an effort to improve timeliness of identifying possible community transitions.
- The LTSS Case Management team enhanced collaboration discussions with Care Coaches, Transition Coordinators, and members to center around the benefits of Assist Living versus Facility Skilled Nursing for those members deemed able to safely reside in a lower level of care.

- The fall risk assessment was enhanced in order to continue to identify and mitigate fall risk despite the transition to virtual/telephonic visits with members.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   a. In 2021, transitions from facilities to home decreased by 13.9% from 2020 but increased in 2022 by 4.5% from 2021. The 2022 rate is still a decrease of 10% from the 2020 rate.
   b. Our enhancements to the plan's member file system for screening increased by 4%.
   c. Fall risk assessment and care plan development remained consistent at the 98-99% threshold.

c. Identify any barriers to implementing initiatives:
   a. No barrier to fall risk screening, fall risk assessment, and fall risk care plan development identified at this time. Humana Healthy Horizons LTSS continues to utilize screening tools and education materials to members and representatives to assess and mitigate risk of falls.
   b. Contract negotiations with some facilities and home health agencies that impact the timely assumption of care for members has been identified as a barrier.

d. Identify strategy for continued improvement or overcoming identified barriers:
   - For fall risk measures, FL HHH will continue to employ the proven methods of screening, assessing, and care plan development used historically and will continue to monitor the Screening, Risk Assessment, and Plan of Care to Prevent Future Falls measure rate to identify additional opportunities that may exist.

HSAG Assessment

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

Recommendations for Methodology

HSAG recommended the following:

- Report accurate annual PIP performance data in accordance with the Agency-defined specifications and approved methodology. The reported data should be comparable across all measurement periods.
- Address all validation feedback provided in the PIP Validation Tools. If not addressed, the corresponding evaluation element will be marked down in the PIP Validation Tool.

Response

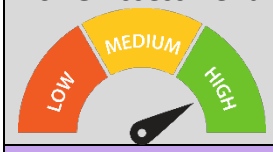
a. Describe initiatives implemented based on recommendations:
   - FL HHH follows all PIP instructions and guidance to ensure the reporting of PIP performance data is accurate, methodologically sound, and meets all State and Federal requirements.
   - FL HHH received a "Met" score for both the Behavioral Health and Transportation PIPs in the Final Validation Tools from HSAG in 2022. All PIP Validation Tool feedback that was provided by HSAG was addressed as appropriate and included in the PIP submission.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - FL HHH successfully executed PIP methodology that met all requirements and ensured that reported PIP results were accurate and capable of measuring improvement. The reported data was comparable across all measurement periods.
   - HSAG's validation determined that the PIP design (e.g., PIP question, population, PIP indicator(s), sampling techniques, and data collection methodology/processes) was based on sound methodological principles and could reliably measure outcomes.

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

d. Identify strategy for continued improvement or overcoming identified barriers:
- Continue to report PIP performance data in a methodologically sound manner, meeting all State and Federal requirements.
- Address any PIP Validation Tool feedback provided by HSAG and include responses in PIP submissions.

HSAG Assessment



Recommendations for Interventions

HSAG recommended the following:

- Use active, evidence-based, innovative improvement strategies and interventions that have the potential to impact PIP performance indicator outcomes.
- Seek enrollee input in order to better understand enrollee-related barriers toward access to care.
- Collect intervention evaluation data frequently (weekly, biweekly, monthly, quarterly, etc.), unlike the annual performance indicator data. The intervention-specific evaluation data may help the plans identify significant clinical and programmatic improvement in outcomes.
- Evaluate the performance of each intervention and include the most current intervention evaluation data available at the time of the submission date.
- Provide adequate details about an intervention for the Agency and HSAG to better understand the intervention. For example, the plans should document how they will improve efforts to obtain real-time notifications from Florida's Encounter Notification System (ENS), and how the plans will use that data. For outreach interventions, the plans should include the mode and frequency of outreach.

Response

a. Describe initiatives implemented based on recommendations:
- FL HHH uses active, evidence-based, innovative improvement strategies and interventions that have the potential to impact PIP performance indicator outcomes. Improvement strategies and intervention determinations are made collaboratively by key business areas through the review of PHM data, barrier analysis, identification of best practices, and potential impacts to study indicator compliance.
- Enrollee input is continuously evaluated to better understand enrollee-related barriers toward access to care. FL HHH collects qualitative and quantitative data from members through member satisfaction and experience surveys, case management interactions, member advisory committees, complaints, grievances, and appeals to identify barriers and opportunities to improve care access and the experience of care.
- Identification of significant clinical and programmatic improvement in outcomes of each intervention is determined through a monthly and quarterly systematic data collection process, analysis of data, and ongoing identification of barriers.
- The performance of each intervention is evaluated and the most current intervention evaluation data available is included in the PIP submission.

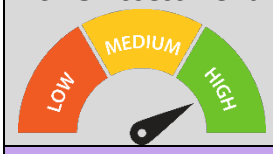
- Specific details about interventions are provided for the Agency and HSAG during routine PIP submission process as requested to better understand the interventions. This includes descriptions, process steps, and data collection methods.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Data driven interventions that are based on evidence-based innovative improvement strategies have positively impacted many of the PPE, Birth Outcomes, Behavioral Health, and Transportation PIP performance indicator outcomes.
- The monthly and quarterly systematic data collection process, analysis of data, the identification of barriers, and subsequent development of relevant interventions improved outcomes, quality, timeliness, and access to care provided to enrollees. This frequent data evaluation informs the need for process changes and/or data enhancements which result in an improved reporting accuracy and intervention measurement.
- The most current performance of each intervention was provided to the Agency and HSAG in the PIP submission for evaluation and validation feedback.

c. Identify any barriers to implementing initiatives:
- High volume of Unable to Contact members impacts the capability of collecting enrollee input.
- The COVID-19 pandemic caused delays in implementation of interventions and negatively impacted outcomes of measures that involve enrollee and provider engagement.

d. Identify strategy for continued improvement or overcoming identified barriers:
- FL HHH continues to deploy numerous methods to locate members through validation of demographic information obtained from claims, laboratory, clinical data, and the Health Information Exchange (HIE) along with external data sources and community-based outreach strategies.
- Barriers to access to care and member engagement that resulted from the COVID-19 pandemic continue to be monitored and addressed.

HSAG Assessment



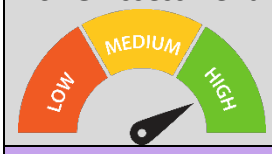
Recommendations for Implementation

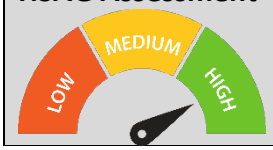
HSAG recommended the following:

- Interventions deemed successful when tested on a small-scale using Plan-Do-Study-Act (PDSA) cycles should be ramped up and adopted plan-wide in order to impact the entire eligible population and realize improvement in the performance indicator rates.
- For unsuccessful interventions, the plans should make data-driven decisions to revise and continue the intervention or discontinue the intervention and revisit the causal-barrier analysis and implement new interventions.

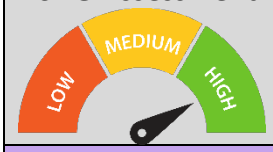
Response

a. Describe initiatives implemented based on recommendations:
- FL HHH implemented multiple regional pilots using PDSA cycles and are expanded to additional regions if deemed successful with the goal to impact the entire eligible population and realize improvement in the performance indicator rates.
- For unsuccessful interventions, FL HHH makes data-driven decisions to revise and continue interventions or discontinue interventions and revisit the causal-barrier analysis and implement new interventions. Key business areas meet on an ongoing basis to review and analyze intervention and

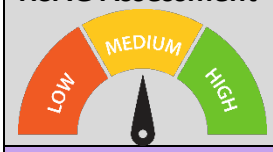
outcome data and determine improvement progress. Next steps are determined based on the progress evaluation and the need to address any implementation barriers that are identified.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Improved performance indicator rates were achieved for many study indicators for the PPE, Birth Outcomes, and Transportation PIPs. • Changes included modifications to the interventions to address additional or changed barriers, or the implementation of new interventions.
c. Identify any barriers to implementing initiatives: • No barriers were identified.
d. Identify strategy for continued improvement or overcoming identified barriers: • Continue to evaluate the success of regional pilots and expand plan-wide when deemed successful. • Continue to analyze intervention and outcome data routinely to determine improvement progress, identify barriers, and determine next steps of continuing, modifying, or discontinuing interventions.
HSAG Assessment 
Recommendations for Analysis
HSAG recommended the following: • Use quality improvement science tools such as process mapping, failure modes, and effects analysis, or key driver diagram to identify and prioritize barriers and opportunities for improvement. • Include an executive sponsor (e.g., medical director, chief medical officer, or chief executive officer) in their PIP team who takes responsibility for the success of the project and can work to remove institutional barriers when needed. • Include, at a minimum, one data analyst on the PIP team. Data mining and analysis are crucial components to justify topics and evaluate interventions.
Response
a. Describe initiatives implemented based on recommendations: • FL HHH completes a causal/barrier analysis annually for each PIP topic. Quality improvement science tools and processes utilized include failure modes, effects analysis, Plan-Do-Study-Act (PDSA) cycles, fishbone diagrams, brainstorming, and PHM data mining to continuously identify and prioritize barriers and opportunities for improvement. • Our executive sponsor is our Regional VP of Health Services, Dr. Traci Thompson, MD, MBA, CPE, who is included on the PIP team along with our Quality Improvement Director, Marisol Palau, who takes responsibility for the success of the projects and can work to remove institutional barriers when needed. • A minimum of one data analyst is included on the PIP team to ensure data mining and analysis are conducted to justify topics and evaluate interventions.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • FL HHH accurately identifies barriers, prioritizes identified barriers, and implements interventions that will impact the Study Indicators. • Quality Improvement Director participation on the PIP team ensured institutional barriers were addressed timely and this contributed to project success.

• Data analyst participation on the PIP team ensures our data mining and analysis are conducted to justify topics and evaluate interventions.
c. Identify any barriers to implementing initiatives: • No barriers were identified.
d. Identify strategy for continued improvement or overcoming identified barriers: • Continue to utilize Quality Improvement science tools to conduct an annual causal/barrier analysis to prioritize barriers and identify opportunities for improvement. • Continue to require the engagement of Executive Management and the Quality Improvement Director on the PIP team to ensure project success. • Continue to require data analysts' participation on the PIP team to conduct data mining and analysis to justify topics and evaluate interventions.
HSAG Assessment 

Molina-C and Molina-S

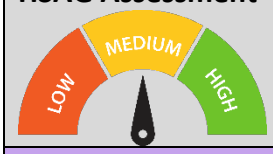
1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Access/Availability of Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine **why members do not consistently access preventive and ambulatory services**. Upon identification of a root cause, implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.
Response
a. Describe initiatives implemented based on recommendations: • Molina Healthcare will target AAP (Adult Access to Preventive/Ambulatory Health Services in all provider engagements and combine this specific measure with others that are over-lapping (e.g., AAP and Controlling Blood Pressure). • Implementation of Pay for Quality (P4Q) incentives for providers in Primary Care and Behavioral Health Services. Member incentives such as gift cards, and member support with outreach calls, My Home Doctor, transportation, and case management services.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable
c. Identify any barriers to implementing initiatives: • Lack of member contact information such as a phone number to outreach and assist them with education and appointment setting • The pandemic has affected several provider offices have reported the pandemic has caused staff shortages and the closure of some locations. Telehealth visits increased during the pandemic, but it does not meet the requirement for the well-visit and HEDIS Gap closure for AAP.
d. Identify strategy for continued improvement or overcoming identified barriers: • Molina Healthcare has recently contracted with an outside vendor for assistance with finding member contact information • Engagements have increased from 10 to 12 per month by each Quality Improvement Specialist. All providers will be given a monthly member missing services reports and continue to monitor month-over-month quality improvement to identify further opportunities to close AAP HEDIS gaps in care.
HSAG Assessment 
Recommendations for Women's Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine **why female members are not receiving timely screenings**. Plans should consider if there are disparities within their populations that contributed to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. • Conduct a root cause analysis or focus study to determine **why pregnant members are not obtaining prenatal care**. • Upon identification of root causes, implement appropriate interventions to improve performance.

Response
a. Describe initiatives implemented based on recommendations: • Provider Engagements- Increase Communication/Awareness/Collaboration with Provider groups via Engagements, letters and HEDIS tip sheets to make providers aware of PPC measure data and the Healthy Behaviors Program Member. Emphasis on identifying eligible members and encouraging members to participate in the Healthy Behavior program for completing PPC visits. • Call campaigns and other communications- make members aware of the importance of attending the PPC appointments and gift card program which includes providing assistance to members to set the appts, as necessary. Seek feedback from members to learn why they have not attended appts and address any barriers that may be revealed to improve the measure rates.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • For the SMI Line of business, the PPC prenatal compliance rates have shown an increase YOY of 20% in H23. For the MMA Line of business there is a 2% increase in PPC postpartum compliance rates from June to August.
c. Identify any barriers to implementing initiatives: • Lack of accurate phone numbers in some cases • Lack of adherence to scheduled appts. • No show rates • Housing instability • Transportation issues
d. Identify strategy for continued improvement or overcoming identified barriers: • Continue to enhance communication/awareness of importance of PPC visits through various media strategies and engagements with both provider groups and members. Address any new barriers that members or providers make us aware of. Provide assistance with Housing though HOME program and provide transportation support via case management • Continue to support and incentivize members to set appts with targeted call campaigns for prevention, screenings, and all women's measures. Offer gift cards to further incentivize members to keep appts. Utilize vendor to locate some additional phone numbers for our database.
HSAG Assessment 
Recommendations for Living With Illness Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why **members are not receiving timely recommended screenings for diabetes.**
Response
a. Describe initiatives implemented based on recommendations: • Molina Healthcare will conduct targeted calling campaigns specific to Comprehensive Diabetic Care and add quarterly drives for the providers with the highest priority as determined by quality performance reports • Provider and member education regarding the importance of A1c testing with results in a controlled range and retinal eye exam. Implementation of Pay for Quality incentives for providers and member incentives such as gift cards.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable
c. Identify any barriers to implementing initiatives: • Lack of member contact information such as a phone number • Not all providers perform A1c testing and retinal eye exam in their office and depend on the member to complete the referral for these services.
d. Identify strategy for continued improvement or overcoming identified barriers: • Molina Healthcare has recently contracted with an outside vendor for assistance with finding member contact information. • Provider education about eyecare vendor and laboratories contracted with Molina Healthcare for these services to be completed will be included in provider engagements.
HSAG Assessment 
Recommendations for Behavioral Health Domain
HSAG recommended the following: • **Enhance communication and collaboration with hospitals** to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs. • Conduct a root cause analysis to determine **why members with a new episode of AOD dependence are not accessing or receiving timely follow-up care** and establish potential performance improvement strategies and solutions. • Conduct a root cause analysis or focus study to determine **why child and adolescent members with ongoing antipsychotic medication are not receiving regular metabolic testing**. • Upon identification of root causes, implement appropriate interventions to improve performance.
Response
a. Describe initiatives implemented based on recommendations: • Molina Healthcare plan will improve efforts to obtain real-time hospital admission and emergency department visit notifications through Florida's Encounter Notification Service (ENS) to facilitate timely outreach to the member to schedule follow-up visits with primary care and BH health providers • Primary Care Physicians will continue to identify members through the Census Report to accommodate members within the seven-day window.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • FUH: Demonstrated 7% increase in performance from the past 2 quarters • FUA: Demonstrated 3% increase in performance from the past 2 quarters • FUM: Demonstrated 6% increase in performance from the past 2 quarters
c. Identify any barriers to implementing initiatives: • Member's lack of adherence to schedule appointments, demographic issues contacting 55% of members once discharged from facility. • Inconsistency of Hospitals to discharge members with a prior scheduled appointment.
d. Identify strategy for continued improvement or overcoming identified barriers: • MFL P4Q (Behavior Health Pay for Quality) program incentivizes BH health providers to invest in best practices and tools to effectively monitor member progress and collaborate with MFL and Primary Care Providers (PCPs) to support members in achieving their best possible health outcomes.

- Education to high utilizing Hospitals and Primary Care Physicians/ BH health providers

HSAG Assessment



Recommendations for LTC Program

HSAG recommended the following:

- **Continue to monitor rates over time to identify COVID-19 PHE rate impact**, ensuring lower quality and access to care is not driven by a non-PHE cause.

Response

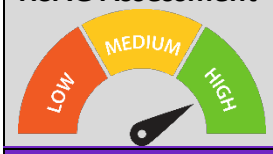
a. Describe initiatives implemented based on recommendations:
   - Telehealth visits to ensure continued communication and member engagement
   - Provided Caregiver support for those affected by Covid

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - Continued coordination and ensured member safety
   - Communication improvements as it relates to Providers and Case Management

c. Identify any barriers to implementing initiatives:
   - Assessment of member conditions

d. Identify strategy for continued improvement or overcoming identified barriers:
   - Development of "Covid Face to Face Assessment" to identify possible exposure risks for Member and Case Managers

HSAG Assessment



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

Recommendations for Methodology

HSAG recommended the following:

- Report accurate annual PIP performance data in accordance with the Agency-defined specifications and approved methodology. The reported data should be comparable across all measurement periods.
- Address all validation feedback provided in the PIP Validation Tools. If not addressed, the corresponding evaluation element will be marked down in the PIP Validation Tool.

Response

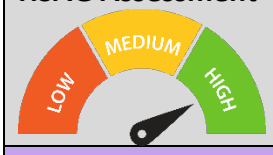
a. Describe initiatives implemented based on recommendations:
   - The utilization of various data sources including 3M data, predictive modeling, utilization reports to evaluate current performance and identify areas of opportunity. The health plan uses this data as a guide to plan new interventions and monitor existing interventions. 2 of the PIP's are based on Agency provided data and the remaining 2 PIP's data is comparable across all measurement periods in accordance with AHCA specifications
   - All validation feedback that has been provided in the PIP Validation tool has been reviewed to ensure all elements have been addressed.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - Not Applicable

c. Identify any barriers to implementing initiatives:
   - No current barriers related to data methodology or validation feedback.

d. Identify strategy for continued improvement or overcoming identified barriers:
   - We will continue to utilize various data sources to evaluate performance and identify areas of opportunity. In addition, once validation feedback has been received, we will continue to review and analyze results to address any concerns for the next submission.

HSAG Assessment



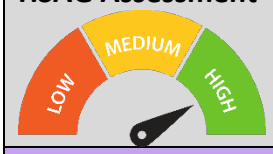
Recommendations for Interventions

HSAG recommended the following:

- Use active, evidence-based, innovative improvement strategies and interventions that have the potential to impact PIP performance indicator outcomes.
- Seek enrollee input in order to better understand enrollee-related barriers toward access to care.
- Collect intervention evaluation data frequently (weekly, biweekly, monthly, quarterly, etc.), unlike the annual performance indicator data. The intervention-specific evaluation data may help the plans identify significant clinical and programmatic improvement in outcomes.
- Evaluate the performance of each intervention and include the most current intervention evaluation data available at the time of the submission date.
- Provide adequate details about an intervention for the Agency and HSAG to better understand the intervention. For example, the plans should document how they will improve efforts to obtain real-time notifications from Florida's Encounter Notification System (ENS), and how the plans will use that data. For outreach interventions, the plans should include the mode and frequency of outreach.

Response

a. Describe initiatives implemented based on recommendations:
   - The health plan has put effort into creating innovative improvement strategies and interventions to impact our PIP performance outcomes. The utilization of various data sources including 3M data, predictive modeling, utilization reports to evaluate current performance and identify areas of opportunity. The health plan uses this data as a guide to plan new interventions and monitor existing interventions.
   - The Member Concierge Program committee was established in 2022 which created a strategic cross functional member and provider centric workgroup to research the root cause of high volume and repeat callers.
   - Intervention data was collected and evaluated quarterly and reported with the most recent PIP submission throughout Q3 2022. This gives Molina an opportunity to evaluate the performance of each intervention and identify significant improvements or barriers.
   - Molina will improve efforts to obtain real-time hospital admission and emergency department visit notifications through Florida's Encounter Notification Service (ENS). Community Connector team conducts telephonic outreach to assist members post ER visits with PCP follow up appointments and coordination of additional services as needed. to facilitate timely outreach to the members to schedule follow-up visits with primary care and BH health providers. Community Connectors assess members

by performing a Health Risk Assessment to determine if members need to enroll in Case Management for referral to Case Management program. Receipt of Hospital Census and Emergency Notification System (ENS) reports daily and twice a day, respectively. The plan requested an enhancement to the ENS Report consisting of notification to MFL as soon as any of the behavioral health codes are billed by the ED.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not Applicable
c. Identify any barriers to implementing initiatives: • Difficulty outreaching all identified members due to lack of current demographic information • Member lack of education regarding importance of follow-up appointments
d. Identify strategy for continued improvement or overcoming identified barriers: • Molina will continue to expand the ENS notifications to initiate outreach as soon as they are identified. This allows Molina's Community Connector team to conduct telephonic outreach and assist members post ER visits with PCP follow up appointments and coordination of additional services as needed.
HSAG Assessment 
Recommendations for Implementation
HSAG recommended the following: • Interventions deemed successful when tested on a small-scale using Plan-Do-Study-Act (PDSA) cycles should be ramped up and adopted plan-wide in order to impact the entire eligible population and realize improvement in the performance indicator rates. • For unsuccessful interventions, the plans should make data-driven decisions to revise and continue the intervention or discontinue the intervention and revisit the causal-barrier analysis and implement new interventions.
Response
a. Describe initiatives implemented based on recommendations: • The health plan has and will continue to align goals and measurements with those provided by the Agency in relation to the PIPs.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • Barriers have not been identified in relation to completing the health plan's PIPs.
d. Identify strategy for continued improvement or overcoming identified barriers: • Molina will continue to evaluate successful interventions and will be adopted plan wide as applicable.
HSAG Assessment 

Recommendations for Analysis
HSAG recommended the following: • Use quality improvement science tools such as process mapping, failure modes and effects analysis, or key driver diagram to identify and prioritize barriers and opportunities for improvement. • Include an executive sponsor (e.g., medical director, chief medical officer, or chief executive officer) in their PIP team who takes responsibility for the success of the project and can work to remove institutional barriers when needed. • Include at a minimum one data analyst on the PIP team. Data mining and analysis are crucial components to justify topics and evaluate interventions.
Response
a. Describe initiatives implemented based on recommendations: • Molina utilizes various quality improvement science tools to identify and prioritize barriers and opportunities for each of our PIP submissions, examples include: o NCQA Quality Compass o fishbone diagrams (cause-and-effect diagrams) o FMEA (Failure Mode and Effects Analysis) • The PIP team works closely with the AVP of Quality and Risk Management as well as our Chief Medical Officer. Utilizing the expertise and leadership we have from our executive sponsors we are able to collaborate with other departments to ensure barriers are resolved.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Molina continued to utilize various tools to break down all potential challenges across the various departments both internally and externally with for interventions. For example, during 2021, the Healthcare Services Department (HCS) continued to meet with Primary Care Physician groups to review measures' rates and discuss new and existing barriers that potentially hinder the compliance for the seven (7) day follow-up measures. Molina Healthcare will improve efforts to obtain real-time hospital admission and emergency department visit notifications through Florida's Encounter Notification Service (ENS) to facilitate timely outreach to the members to schedule follow-up visits with primary care and BH health providers.
c. Identify any barriers to implementing initiatives: • Not Applicable
d. Identify strategy for continued improvement or overcoming identified barriers: • Molina will continue to utilize improvement science-based tools to assess and prioritize any barriers or opportunities for improvement. We have and will continue to utilize our executive sponsors to help remove institutional barriers or provide feedback on PIP submissions.
HSAG Assessment 

Simply-C

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Access/Availability of Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine **why members do not consistently access preventive and ambulatory services**. Upon identification of a root cause, implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.
Response
a. Describe initiatives implemented based on recommendations: To address Adults' Access to Preventive/Ambulatory Health Services (AAP), Simply Healthcare Plans has implemented multiple initiatives including: o Conduct targeted clinic sessions. o Hold monthly collaborative meetings with priority groups to share and review data. o Conduct outreach to members with open care gaps. o Facilitate education about benefits in an effort to engage with their PCP and promote completion of preventive screenings. o Assist members in scheduling appointments and eliminate barriers to attending appointments. o Simply Healthcare Plans regularly identifies and engages the top 20 providers that have the largest number of AAP care gaps on a monthly basis. ▪ Simply Healthcare provides those groups with rates and member care gap lists as needed. o To educate and encourage members to use Telehealth, Simply Healthcare Plans has implemented the following initiatives: ▪ Live Health Online – ability for members to video chat with PCPs and Urgent Care doctors 24/7 ▪ Beacon Health Options – ability for members to video chat with Behavioral Health providers 24/7 ▪ Provider Education on Telehealth developed ▪ Covers all approved modalities ▪ Includes list of HEDIS measures which are eligible for provider gap closure through Telehealth services o Ongoing text campaigns tailored for AAP o Patient-Centered Medical Home (PCMH) Incentive Program • The plan conducted focus groups among BH providers to identify barriers impacting BH timely appointments and availability • The plan increased provider education towards appointment access and availability standards and requirements • The plan is conducting live and on-demand trainings to provider office staff and appointment schedulers to increase awareness and education towards appointment availability and alternate methods of access to care such as Telehealth, other providers, and alternate locations, expanding member awareness on access to care options when their provider is unavailable. • The plan conducts analysis of the quarterly appointment wait times report to identify non-compliance trends, outliers by provider type.

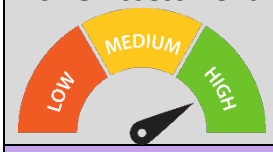
- Provider outreach to address access to care limitations and non-compliance reported in the Wait times report
- The plan incorporated dedicated workgroups focused on access to care issues and member complaints.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Simply Healthcare plans has seen an improvement in its AAP rates in spite of a significant increase in its membership which has impacted the measures denominators. In addition, due to the current PHE, the entire membership has met the continuous enrollment criteria.
- Enhanced communication between Provider Relations and the National Call Center in regards to member-related and access to care issues.
- Overall improvement in the plan's access to care rates.

c. Identify any barriers to implementing initiatives:
- Staff turnover in provider offices affecting education and awareness towards HEDIS measures.
- Provider schedules are often overbooked, impacting the availability for members to schedule appointments when needed.

d. Identify strategy for continued improvement or overcoming identified barriers:
- Continue to track all AAP initiatives on a monthly basis with key stakeholders to review and analyze intervention and outcome data in order to determine improvement progress.
- The plan has reinstated and has increased the frequency of its Enrollee Advisory Committees to better incorporate enrollee feedback.
- Continue to work with and educate our provider network.
- Continue current efforts towards improving appointment availability and stressing the importance internally and among the provider network.

HSAG Assessment



Recommendations for Women's Care Domain

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine **why female members are not receiving timely screenings**. Plans should consider if there are disparities within their populations that contributed to lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Conduct a root cause analysis or focus study to determine **why pregnant members are not obtaining prenatal care**.
- Upon identification of root causes, implement appropriate interventions to improve performance.

Response

a. Describe initiatives implemented based on recommendations:
- Encounter Notification System (ENS) SMART alerts developed to identify all pregnant women
  - The plan conducts outreach to all members identified in the ENS report to promote Doula services, provide education and assist with scheduling a prenatal appointment.
  - The plan will continue to address and mitigate any barriers linked to this intervention as part of its ongoing evaluation determine the impact of this initiative.
- OB Quality Incentive Program (OBQIP)
- Promote utilization of MAT and BH services
- Promote the use of Doula services through a partnership with a National Doula provider.

- Gestational Diabetes Program for High-Risk Members
- Early Identification of pregnant women
- Member education materials developed
- Provider Bulletins developed to address prenatal and postpartum benefits
- Healthy Rewards for Maternity
- Enrollee Advisory Committees targeting pregnant enrollees
- Promotion and use of the 'My Birth Matters' materials sent monthly to pregnant members
- Working with the Agency on implementing a universal Pregnancy Notification Form.
- Ongoing text campaigns targeting Prenatal and Postpartum visit compliance
- The plan is working with a new community-based partner in hosting baby showers that connect members with resources in their community

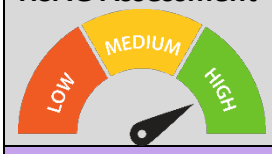
Taking Care of Baby and Me program:

My Advocate - components include HRA, educational info, reminder calls, and potential incentives. The program strives to improve birth outcomes by:

- Promoting preconception care
- Promoting prenatal care
- Increasing the number of prenatal care visits
- Reducing infant mortality
- Reducing premature births
- Reducing incidence of low birth weight
- Reducing Neonatal Intensive Care Unit (NICU) admissions and lengths of stay
- Improving identification of and access to treatment for perinatal depression
- Promoting education and access to treatment for smoking cessation and substance use disorders
- Improving access to and completion of postpartum care visits
- The program centers on achieving the earliest possible identification of and communication with a new or existing pregnant member, completing an assessment of the member's risk, and developing and enacting a collaborative plan of care for mother and her newborn. In general, the program also endeavors to increase the awareness of and advocates for the reproductive health of all members and the importance of well child Early Periodic Screening and Diagnostic Testing (EPSTD). This includes:
- Conducting problem-based comprehensive care planning that includes measurable goals and interventions tailored to the complexity level of the member as determined by the initial and ongoing assessments
- Coordinating care with PCPs, specialty providers, ancillary providers, and community resources
- Educating members on healthcare for themselves and their infants
- The Maternal Child Services model delivers a seamless, coordinated approach, offers a seamless, coordinated approach. From identification through care planning, trained staff seeks to improve the overall quality of life, functional status, and health outcomes for pregnant members and their newborns.

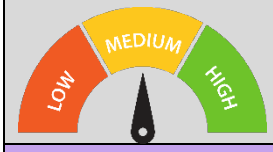
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- For PDSA PIP participants there has been an increase in the rate of prenatal screenings among pregnant members with prior BH/SUD
- 98% of all Doula participants had at least 1 prenatal visit during CY 2021 (Majority are high-risk pregnancies)
- Majority of provider groups participating in the OBQIP program show an improvement in C-section rates and Preterm Birth rates.

• The Gestational diabetes program has resulted in fewer NICU babies and improved health outcomes for Moms.
c. Identify any barriers to implementing initiatives: • Increase in the denominators has impacted the eligible population • Demographic challenges, lack of accurate data related to pregnancy status makes it challenging to identify and engage new enrollees in a timely manner. • For members with prior BH/SUD issues there is a potential gap in care among the OB/Provider, the plan, and a BH specialist.
d. Identify strategy for continued improvement or overcoming identified barriers: • Formally adopt current PDSA efforts and further expand promotion of Doula services.
HSAG Assessment 
Recommendations for Living With Illness Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why **members are not receiving timely recommended screenings for diabetes.**
Response
a. Describe initiatives implemented based on recommendations: • Collaborate with diabetic members who have a history of non-compliance and develop short-term and long-term goals • Verbal and/or written education provided to each member • Assistance with Durable Medical Equipment, Medical & BH appointments • Coordination of home health services • Monthly text campaigns for the Diabetic population • Clinic days for Diabetic members to complete their recommended eye exams • Clinic days to assist providers with scheduling members for their recommended appointments • Outreach Portal to schedule members' appointments • Monthly circulation of the GAPs in care reports to the Case Managers in order to target their assigned members • Dedicated Case Managers for specific Diabetic measures irrespective of case assignment • Provider Education on the importance of recommended screening
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Have seen a slight improvement in diabetic screenings for 2022. However, the plan is still tracking and analyzing outcome data on a monthly basis.
c. Identify any barriers to implementing initiatives: • Many diabetic enrollees have multiple comorbidities which makes it challenging when attempting to prioritize a sub-set of this population. As such, Simply Healthcare Plans enhanced its methods to better stratify and prioritize enrollees based on the acuity and value of their identified gaps in care.
d. Identify strategy for continued improvement or overcoming identified barriers: • Continue to track outcome data on a monthly basis and meet regularly with key stakeholders to review and analyze intervention and outcome data in order to determine improvement progress. Simply

Healthcare will also continue to obtain enrollee feedback to better understand the barriers and impact from an enrollee perspective.
- Continue to hire and obtain appropriate resources as needed.
- Dedicated clinic days targeting diabetic eye care

HSAG Assessment



Recommendations for Behavioral Health Domain

HSAG recommended the following:

- **Enhance communication and collaboration with hospitals** to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.
- Conduct a root cause analysis to determine **why members who access the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care** and establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, increase the use of telehealth services.
- Conduct a root cause analysis or focus study to determine why child and adolescent members with ongoing antipsychotic medication are not receiving regular metabolic testing.
- Upon identification of root causes, implement appropriate interventions to improve performance.

Response

a. Describe initiatives implemented based on recommendations:
- ENS Smart Alert for Behavioral Health created to better identify members with current or prior BH issues
  - The plan will continue to address and mitigate any barriers linked to this intervention as part of its ongoing evaluation determine the impact of this initiative.
- BH Telehealth Initiative
- The plan partnered with two Behavioral Health providers who agreed to perform the following:
  - Contact every member discharged from a Behavioral Health hospitalization within 24 hours and provide an immediate Telehealth BH visit which will address the FUH 7-Day population
  - Contact every member who visited an ED for Mental Illness, Alcohol and Other Drug Abuse or Dependence within 24 hours and provide an immediate Telehealth BH visit which will address the FUM and FUA 7-Day population
  - In addition, the plan did not want to miss the opportunity to impact a related PIP measure (FUH/FUM/FUA 30-Day sub measures) for those members who participate in the pilot. As such, each participant is contacted within 30 days of discharge from the Hospital/ED to schedule a BH Telehealth visit.
  - All members who participate and complete a TH visit are offered 1 week of free meals as a way to incentivize participation

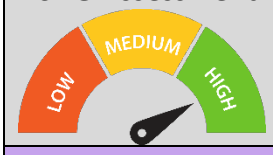
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Increased percentage of 7- and 30- day follow-up visits following a psychiatric ED/Hospital event.

c. Identify any barriers to implementing initiatives:
- Timely identification and engagement of members with SMI for a follow-up visit within 7 days of a psychiatric Hospital/ED event.

- COVID-19 Impact
  - It is difficult to ascertain the impact of COVID-19 on these rates. The overall impact of the pandemic on mental health, worsened by the apprehension over in-person visits and limited socialization has hindered the plan from potentially exceeding its annual goals for HEDIS

d. Identify strategy for continued improvement or overcoming identified barriers:
- The plan has seen positive results from this intervention and will continue to monitor and track utilization of the hospital and ED events for members who participate in these programs. The plan will use these data to evaluate this intervention for overall effectiveness and modify as needed. The plan has expanded these efforts in 2022 and updates will be provided regularly.

HSAG Assessment



Recommendations for LTC Program

HSAG recommended the following:

- **Continue to monitor rates over time to identify COVID-19 PHE rate impact**, ensuring lower quality and access to care is not driven by a non-PHE cause.

Response

a. Describe initiatives implemented based on recommendations:
- LTSS Successful Transition After Long-Term – a deep dive was conducted to determine reasons for not transitioning, these included severity of conditions, lack of family support, and member/representative not wanting to transition and limited financial resources. These members are on fixed incomes.
- Monthly assessments of nursing home members for possible transition.
- An additional Nursing Home manager and two team lead positions were added.
- Falls Part 2:
  - Quarterly file reviews conducted to track this measure.
  - Revision of fall risk assessment based on feedback from case managers and plan personnel.
  - Non-compliant cases are sent to case management for follow-up and coaching of case manager.
- The plan conducted live Falls Measures Training July 2022 and recorded the training for on-demand availability.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Falls Part 2: Rates increased from RY2021 to RY2022 by 13.27 percentage points.

c. Identify any barriers to implementing initiatives:
- Increase in membership over projected rates and CM attrition has resulted in continuous hiring of new CMs and their respective learning curves.
- National workforce shortages (Home health/ ALF staff) may affect a member's ability to transition from a facility.
- The conditions included in the Risk Adjustment Weight Table may not include the conditions most prevalent and debilitating in our LTC population.

d. Identify strategy for continued improvement or overcoming identified barriers:
- Falls 2: The plan sending email notifications of noncompliance to specific CM and their managers. This will enable a quicker response as well as consistent feedback.

- Update to contract to ensure increase in minimum wage paid by Medicaid providers to staff providing services to Medicaid members. Eff. 10/1/22
- Educational fund provided by plan to home health agency to provide tuition for home health aide certifications.

HSAG Assessment

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

Recommendations for Methodology

HSAG recommended the following:

- Report accurate annual PIP performance data in accordance with the Agency-defined specifications and approved methodology. The reported data should be comparable across all measurement periods.
- Address all validation feedback provided in the PIP Validation Tools. If not addressed, the corresponding evaluation element will be marked down in the PIP Validation Tool.
- Report accurate annual PIP performance data in accordance with the Agency-defined specifications and approved methodology. The reported data should be comparable across all measurement periods.

Response

a. Describe initiatives implemented based on recommendations:
   - Simply Healthcare Plans reports accurate annual PIP performance data in accordance with the Agency-defined specifications and approved methodology. The reported data is comparable across all measurement periods.
   - Simply Healthcare Plans addresses all validation feedback provided in the PIP Validation Tools.
   - Simply Healthcare Plans utilizes the PIP Completion Instructions while completing the HSAG PIP template.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - Simply Healthcare Plans is aligned with the Agency's defined reporting requirements and methodologies.
   - Simply Healthcare Plans received a "Met" score for all PIPs in the final validation from HSAG.

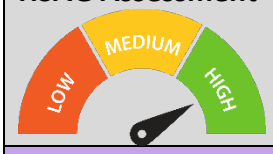
c. Identify any barriers to implementing initiatives:
   - There are no identified barriers at this time.

d. Identify strategy for continued improvement or overcoming identified barriers:
   - Simply Healthcare Plans will continue to work closely with the Agency and HSAG to ensure all documentation and reporting requirements are satisfied. This includes technical assistance calls with HSAG and the Agency when needed.

HSAG Assessment

Recommendations for Interventions
HSAG recommended the following: • Use active, evidence-based, innovative improvement strategies and interventions that have the potential to impact PIP performance indicator outcomes. • Seek enrollee input in order to better understand enrollee-related barriers toward access to care. • Collect intervention evaluation data frequently (weekly, biweekly, monthly, quarterly, etc.), unlike the annual performance indicator data. The intervention-specific evaluation data may help the plans identify significant clinical and programmatic improvement in outcomes. • Evaluate the performance of each intervention and include the most current intervention evaluation data available at the time of the submission date. • Provide adequate details about an intervention for the Agency and HSAG to better understand the intervention. For example, the plans should document how they will improve efforts to obtain real-time notifications from Florida's Encounter Notification System (ENS), and how the plans will use that data. For outreach interventions, the plans should include the mode and frequency of outreach.
Response
a. Describe initiatives implemented based on recommendations: • Simply Healthcare Plans has an established Quality Improvement process that uses the Plan-Do-Study-Act (PDSA) cycle to test and measure interventions. A formal process of barrier identification and prioritization and root-cause analysis provides the basic foundation for testing interventions. Data and interventions are reviewed regularly in multi-disciplinary work groups dedicated to each PIP. • For each PIP the plan has established a multi-disciplinary workgroup comprised of Simply Healthcare senior management, Medical Directors, Nursing staff, Quality Management, Business Intelligence, Finance, Provider Relations, Member Services and other relevant stakeholders. A formal quality improvement (QI) process is implemented, and all workgroup participants receive training on the QI process used during the workgroup meetings. • Enrollee input is collected through various methods such as Enrollee Advisory Committees, member-focused surveys, etc. This information is used to better understand enrollee-related barriers. • Intervention evaluation data is collected monthly. Each PIP intervention is evaluated in alignment with Agency and HSAG guidance and an update is provided in its annual PIP submissions. This includes providing the most current intervention evaluation data, statistical significance testing results, and any identified clinical and/or programmatic improvement in outcomes. • Simply Healthcare Plans included details for each of its interventions in the PIP Summary Forms that outline all steps taken as part of the PDSA process.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Innovative PIP interventions were implemented in early 2021 and 2022 and results for the majority of these interventions have been very positive. Interventions will continue to be tracked and trended monthly/quarterly to determine effectiveness.
c. Identify any barriers to implementing initiatives: • The Public Health Emergency has made it more difficult to meet with enrollees in-person and gain additional insight on enrollee-related barriers. However, the plan has restarted its Enrollee Advisory Committees.
d. Identify strategy for continued improvement or overcoming identified barriers: • Simply Healthcare Plans will continue to work closely with the Agency and HSAG to ensure all requirements for tracking and evaluating interventions are met. This includes technical assistance calls with HSAG and the Agency when needed.

HSAG Assessment



Recommendations for Implementation

HSAG recommended the following:

- Interventions deemed successful when tested on a small scale using Plan-Do-Study-Act (PDSA) cycles should be ramped up and adopted plan-wide in order to impact the entire eligible population and realize improvement in the performance indicator rates.
- For unsuccessful interventions, the plans should make data-driven decisions to revise and continue the intervention or discontinue the intervention and revisit the causal-barrier analysis and implement new interventions.

Response

a. Describe initiatives implemented based on recommendations:
   - Key stakeholders meet regularly to review and analyze intervention and outcome data and determine improvement progress. Next steps are determined based on the progress evaluation and the need to address any implementation barriers that are identified. Changes may include modifications to the interventions to address additional or changed barriers, or the implementation of new interventions.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - For those interventions deemed successful via the PDSA cycle, the plan did adopt those efforts plan-wide in order to impact the entire eligible population and realize improvement in overall performance indicator rates.

c. Identify any barriers to implementing initiatives:
   - Certain programmatic changes/enhancements in data-driven processes were required before adopting small-scale tests plan-wide. These barriers have been successfully addressed and additional detail can be found in the plan's annual PIP Summary forms.

d. Identify strategy for continued improvement or overcoming identified barriers:
   - Continue to track outcome data monthly and meet regularly with key stakeholders to review and analyze intervention and outcome data in order to determine improvement progress.

HSAG Assessment

Recommendations for Analysis

HSAG recommended the following:

- Use quality improvement science tools such as process mapping, failure modes and effects analysis, or key driver diagram to identify and prioritize barriers and opportunities for improvement.
- Include an executive sponsor (e.g., medical director, chief medical officer, or chief executive officer) in their PIP team who takes responsibility for the success of the project and can work to remove institutional barriers when needed.

- Include at a minimum one data analyst on the PIP team. Data mining and analysis are crucial components to justify topics and evaluate interventions.

Response

a. Describe initiatives implemented based on recommendations:

- Simply Healthcare Plans utilizes quality improvement science tools (i.e. process mapping, key driver diagrams, etc.) and includes these tools as part of its annual PIP submissions.
- A Medical Director is assigned to each PIP workgroup who takes the clinical lead and responsibility for the project.
- In addition to Business Intelligence, at least one data analyst is assigned to each workgroup.

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

- Through the above mentioned quality improvement tools, the plan is able to more accurately identify root-causes and effectively implement improvement strategies that result in real and sustained improvement.

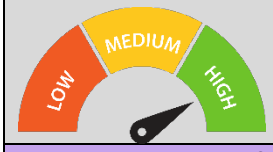
c. Identify any barriers to implementing initiatives:

- There are no identified barriers at this time.

d. Identify strategy for continued improvement or overcoming identified barriers:

- Continue to meet with key stakeholders regularly and review the progress and effectiveness of each intervention using quality improvement tools and methodologies in alignment with the Agency and HSAG.

HSAG Assessment



Recommendations for Pediatric Care Domain

HSAG recommended the following:

Conduct a root cause analysis or focus study to determine **why child members are not receiving all recommended vaccines**. Plans should consider if there are disparities within their populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve immunization rates.

Response

a. Describe initiatives implemented based on recommendations:

Member Focused Efforts

- Direct-to-Member Outreach (text, Interactive Voice Response (IVR), email, social media)
  - Direct-to-member outreach
    - Back to School Readiness events (June 1st – September 1st)
    - Flu Season and Immunization Drive-Ups
    - Appointment scheduling assistance with PCP
    - Promoting education and access to incentives as part of the Benefits page and Patients portal
  - Clinic Sessions
    - Targeted outreach encouraging all recommended vaccinations
    - Clinic session attendees incentivized for attendance/closing care gap during session

- **Provider Education and Collaboration**
  - Provider Bulletins
    - Updated annually per guidance on coding & reimbursement rates
    - Distributed to PCPs and Specialists via fax
    - Email & Provider website postings completed
  - Data Sharing
    - The plan sends providers lists of members in their panel who are due for a vaccination within 120 days
  - Cobranding opportunities to their patients for education about schedule of preventive visit and immunizations
  - Pharmacy Communications
  - Clinic Session Collaboration
    - Worked with Providers to host specific clinic days for pediatric vaccinations
    - Provider Flu Trainings conducted
      - ➢ CMEs/CEUs are offered to participants

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- The plan has seen an increase of 2.43% when comparing September 2021 to September 2022. In addition, there has been an increase of 7.21% when comparing 2021 final rates vs 2020 final rates.

c. Identify any barriers to implementing initiatives:

COVID-19 Impact:

a. It is difficult to ascertain the impact of COVID-19 on these rates. The overall impact of the pandemic, worsened by the apprehension over in-person visits and limited socialization has hindered the plan from further improving its rates of immunizations/vaccines.

d. Identify strategy for continued improvement or overcoming identified barriers:
- The plan has seen positive results from these efforts and will continue to meet with key stakeholders monthly to review the progress and effectiveness of each intervention using quality improvement tools and methodologies in alignment with the Agency and HSAG.

HSAG Assessment

Sunshine-C

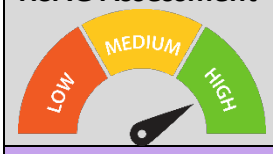
1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Access/Availability of Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine **why members do not consistently access preventive and ambulatory services**. Upon identification of a root cause, implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.
Response
a. Describe initiatives implemented based on recommendations: • Sunshine Health conducted a focus study to identify challenges and opportunities to increase member utilization of preventive and ambulatory services
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Results will be evaluated after the performance year has ended
c. Identify any barriers to implementing initiatives: • Younger adults who are healthy don't see importance of preventive care • Bad phone numbers and unanswered calls • High member no-show rates when appointments are made
d. Identify strategy for continued improvement or overcoming identified barriers: • Implemented 24/7 telemedicine program to increase access to physician services • Sunshine Health continues to work on expanding network access to Urgent Care and Minute Clinics • The Provider Relations team stresses importance of focusing on members without primary care physician visits at all monthly meetings • Patient Care Advocates call members to schedule preventative visits for their assigned primary care providers • CM assists with scheduling medical appointments, as appropriate • Sunshine Health utilized MyHealthDirect to enhance scheduling efforts
HSAG Assessment NA, intervention in progress.
Recommendations for Pediatric Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine **why child and adolescent members are not receiving all recommended vaccines**. Plans should consider if there are disparities within their populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve immunization rates.
Response
a. Describe initiatives implemented based on recommendations: • Partnering with Pfizer to send co-branded educational communications to members • Resuming initiatives paused because of COVID (in-person Provider visits by the Quality Practice Advisors [QPAs], Case Manager [CM] in-home visits, etc.) while not newly implemented, will help improve these rates • Rolled out a Concierge Team at the beginning of 2022, some of this team's responsibility is calling members non-compliant for these care-gaps, helping them schedule appointments

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Results will be evaluated after the performance year has ended

c. Identify any barriers to implementing initiatives:
- Data issues delayed the rolling out of the Primary Care Provider (PCP) incentive program
- Delays in recruiting and hiring of new staff
- Provider care-gap data was not available October 2021-June 2022
- Provider office closures, or short staffing issues, related to the pandemic, impacted member's access to care
- Members/caregivers state they have limited/no time to devote to getting vaccines and they are concerned about seeking care due to desire to limit potential exposure to COVID-19

d. Identify strategy for continued improvement or overcoming identified barriers:
- Continue member and provider education efforts
- Data monitoring (monthly monitoring of rates, monitoring of the performance of PCPs, and appointments scheduled by the out-reach team)
- Data issues that impacted the deployment of the care-gap reports and incentive programs have been corrected

HSAG Assessment



Recommendations for Women's Care Domain

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine **why female members are not receiving timely screenings**. Plans should consider if there are disparities within their populations that contributed to lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Conduct a root cause analysis or focus study to determine **why pregnant members are not obtaining prenatal and postpartum care**.
- Upon identification of root causes, implement appropriate interventions to improve performance.

Response

a. Describe initiatives implemented based on recommendations:
- Sunshine Health conducted a focus study that revealed the following reasons why female members are not receiving chlamydia (CHL) screenings:
  - A common misunderstanding with CHL screening is that it's not only for women who are "sexually active" but also for those that have been dispensed a contraceptive service/birth control (and may not actually be sexually active); providers may be missing these members and not screening them yearly
  - For members that are not yet receiving pap smears, some providers may not understand that the CHL screening can be done via urine screening, which also closes the care gap
  - Younger members decline chlamydia screening because they do not want their parent or guardian to find out that a sexually transmitted infection/disease (STI/STD) screening was completed
- Sunshine Health conducted a focus study that revealed the following reasons why female members are not receiving timely prenatal and postpartum care:

- When members come in for a "confirmation of pregnancy" some providers are not coding for the positive pregnancy test; they then have the member come back later for a full "initial OB exam" and its outside of the first trimester
- Many members don't know they are pregnant or hide pregnancy from their parent/guardian and are late to prenatal care
- For postpartum care, members often don't return for postpartum visits because they are overwhelmed with seeking specialist care for their chronic complex condition(s)

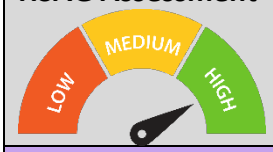
- Initiatives planned and implemented to address root causes include:
  - Utilization of obstetrician (OB) Care Gap Reports to conduct targeted member and provider education
  - Incentive program for OBs was implemented, incentivizing OBs for each CHL & prenatal and postpartum care (PPC) care gap they close.
  - Rolled out a Concierge Team at the beginning of 2022, some of this team's responsibility is calling members non-compliant for these care-gaps, helping them schedule appointments
- Resuming initiatives paused because of COVID (in-person Provider visits by the Quality Practice Advisors, CM in-home visits, etc.) while not newly implemented, will help improve these rates

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Results will be evaluated after the performance year has ended

c. Identify any barriers to implementing initiatives:
- Members state they have limited/no time to devote to going to the doctor and they are concerned about seeking care due to desire to limit potential exposure to COVID-19
- Provider office closures, or short staffing issues, related to the pandemic, impacted members access to care
- The plan experienced data issues, which resulted in care-gap data not being available to PCPs for a 6-month period (October 2021-June 2022) and OBs not receiving care-gap data for approximately a year

d. Identify strategy for continued improvement or overcoming identified barriers:
- Continue member and provider education efforts
- Data issues that impacted the deployment of the care-gap reports and incentive programs have been corrected
- Expand the OB groups being worked by the OB QPAs
- Roll out the OB Incentive Program earlier in the year
- Expand usage of the Concierge Team
- Data monitoring (monthly monitoring of rates, monitoring of the performance of OBs in the OB QPA program, and appointments scheduled by the out-reach team)

HSAG Assessment



Recommendations for Living With Illness Domain

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why **members are not receiving timely recommended screenings for diabetes.**

Response

a. Describe initiatives implemented based on recommendations:

- Sunshine Health requested member feedback during regular case management and patient care advocate outreach

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Results will be evaluated after the performance year has ended

c. Identify any barriers to implementing initiatives:
- Members state they have limited/no time to devote to screenings and they are concerned about seeking care due to desire to limit potential exposure to COVID-19
- The plan experienced data issues, which resulted in care-gap data not being available to PCPs for a 6-month period (October 2021-June 2022)

d. Identify strategy for continued improvement or overcoming identified barriers:
- Continue member and provider education efforts
- Data issues that impacted the deployment of the care-gap reports and incentive programs have been corrected
- Developing Endocrinologist (Endo) care-gap reports
- Developing an Endo incentive program, incentivizing them for each CDC gap they close
- Implementing, in 2023, an Endo Quality Practice Advisor who will deliver the Endo care-gaps to the larger groups, and will provide education on how to close the care-gaps and will educate them on the incentive program
- Data monitoring (monthly monitoring of rates and performance monitoring of PCPs and Endocrinologists)

HSAG Assessment

Recommendations for Behavioral Health Domain

HSAG recommended the following:

- **Enhance communication and collaboration with hospitals** to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.
- Lead a program-wide focus group that includes members and key community stakeholders to **identify barriers/facilitators to members accessing follow-up care after hospitalization for mental illness or AOD abuse**.
- Conduct a root cause analysis or focus study to determine **why child and adolescent members with ongoing antipsychotic medication are not receiving regular metabolic testing**.
- Upon identification of root causes, implement appropriate interventions to improve performance.
- Evaluate the impact of the COVID-19 PHE and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.

Response

a. Describe initiatives implemented based on recommendations:
- The plan hired more case managers to assist with communication and collaboration with hospitals
- We requested member feedback during regular case management outreach. Reasons why members are not remaining on antidepressant medication include:
  - Members are concerned about the perceived stigma associated with taking antidepressants
  - Members stop taking antidepressants when they feel better
  - Members cannot tolerate the side effects

- Some members didn't want to admit they needed something to help them feel normal
- Family thinks the member needs to 'snap out of it' and deal with things on their own
- Some members didn't want a medication to define them
- Some members didn't feel the medication was needed

- Sunshine Health conducted a focus study of members in the 7-Day Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) denominator. Preliminary results reveal members are resistant to follow up care for various reasons (i.e., refusal, not a perceived problem by the family, member readmitted).
- We are developing behavioral health (BH) provider care-gap reports (available Quarter 4)
- Continue to expand telehealth services
- Updated CM trainings to include telehealth as an option during member outreach and education
- Sunshine Health continues to promote telehealth services to facilitate community handoffs, follow-up care, and medication monitoring

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Results will be evaluated after the performance year has ended.

c. Identify any barriers to implementing initiatives:
- Members state they have limited/no time to devote to services and they are concerned about seeking care due to desire to limit potential exposure to COVID-19
- Provider office and pharmacy closures, or short staffing issues, related to the pandemic, impacted access to care
- The plan experienced data issues, which resulted in care-gap data not being available for a 6-month period (October 2021-June 2022)

d. Identify strategy for continued improvement or overcoming identified barriers:
- Continue member and provider education efforts
- BH QPA will deliver BH care-gap reports to the larger BH groups
- Developing a BH provider incentive program, which will be rolled out in 2023
- Data monitoring (monthly monitoring of rates and performance monitoring of providers)

HSAG Assessment

(Results pending but plan showed high degree of response.)

Recommendations for LTC Program

HSAG recommended the following:

- **Continue to monitor rates over time to identify COVID-19 PHE rate impact**, ensuring lower quality and access to care is not driven by a non-PHE cause.

Response

a. Describe initiatives implemented based on recommendations:
- During the on-going Public Health Emergency, Sunshine Health LTC Case Managers continued to educate members about how they can elect to have telephonic/virtual visits with assigned case manager instead of a face-to-face visit should they have safety concerns related to COVID infection exposure
- Sunshine Health LTC conducted a statewide realignment of Care Coordinators and membership to meet the needs of the population based on geographical location, special requirements for facilities COVID screening requirements, and member preference for face-to face versus virtual/telephonic visits due to prioritizing health safety and wellness

- The plan conducted a refresher training for all Care Coordinators on the importance of assisting members in creating a solid back up/contingency plan in the event the home health provider is unable to provide services due to staff shortage

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Results will be evaluated after the performance year has ended

c. Identify any barriers to implementing initiatives:
- Lack of available home health aides due to staffing shortages related to COVID, agency salary and staffing constraints, and other health care business related issues

d. Identify strategy for continued improvement or overcoming identified barriers:
- Sunshine Health recognized the need to make improvements to our Person-Centered Care Plan. The improvements included updating the goal sections to include the member's perception of progress towards their personal goals, added contact phone numbers for member's home and community-based service providers and Primary Care Physician, and added an area to differentiate the distinct reason for the care plan review, such as significant change, etc.
- Work with other health plans and AHCA on strategies to improve pay for home health aides

HSAG Assessment

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

Recommendations for Methodology

HSAG recommended the following:

- Report accurate annual PIP performance data in accordance with the Agency-defined specifications and approved methodology. The reported data should be comparable across all measurement periods.
- Address all validation feedback provided in the PIP Validation Tools. If not addressed, the corresponding evaluation element will be marked down in the PIP Validation Tool.

Response

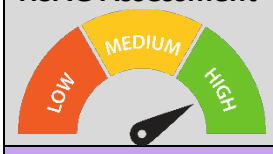
a. Describe initiatives implemented based on recommendations:
- Sunshine Health already had processes in place that align with the recommendations
  - We will continue to report accurate data that is comparable across all measurement periods in accordance with the Agency-defined specifications and approved methodology
  - Sunshine Health designated a performance improvement project (PIP) manager last year to ensure validation feedback is addressed

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Sunshine Health performed well on the PIPs:
  - All 4 PIPs earned a 'Met' validation status
  - All 4 PIPs earned a score of 100% for critical elements
  - 3 of 4 PIPs earned a score of 100% for evaluation elements (1 PIP received a score of 94%)

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

d. Identify strategy for continued improvement or overcoming identified barriers:
- Continue current process

HSAG Assessment



Recommendations for Interventions

HSAG recommended the following:

- Use active, evidence-based, innovative improvement strategies and interventions that have the potential to impact PIP performance indicator outcomes.
- Seek enrollee input in order to better understand enrollee-related barriers toward access to care.
- Collect intervention evaluation data frequently (weekly, biweekly, monthly, quarterly, etc.), unlike the annual performance indicator data. The intervention-specific evaluation data may help the plans identify significant clinical and programmatic improvement in outcomes.
- Evaluate the performance of each intervention and include the most current intervention evaluation data available at the time of the submission date.
- Provide adequate details about an intervention for the Agency and HSAG to better understand the intervention. For example, the plans should document how they will improve efforts to obtain real-time notifications from Florida's Encounter Notification System (ENS), and how the plans will use that data. For outreach interventions, the plans should include the mode and frequency of outreach.

Response

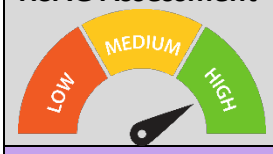
a. Describe initiatives implemented based on recommendations:
   - Sunshine Health already had processes in place that align with most of the recommendations
     - Sunshine Health continues to utilize and evaluate improvement strategies and interventions that have the potential to impact PIP performance indicator outcomes
     - We continue to seek member feedback regarding barriers to accessing care during regular case management outreach and during consumer advisory board meetings
     - We will continue to collect intervention evaluation data frequently
     - We will continue to evaluate the performance of each intervention and include the most current intervention evaluation data available at the time of the submission date
   - Sunshine Health incorporated additional details about interventions with prior inquiries to facilitate Agency and HSAG understanding of the intervention

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - Sunshine Health performed well on the PIPs:
     - All 4 PIPs earned a 'Met' validation status
     - All 4 PIPs earned a score of 100% for critical elements
     - 3 of 4 PIPs earned a score of 100% for evaluation elements (1 PIP received a score of 94%)

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

d. Identify strategy for continued improvement or overcoming identified barriers:
   - Continue current process

HSAG Assessment



Recommendations for Implementation

HSAG recommended the following:

- Interventions deemed successful when tested on a small-scale using Plan-Do-Study-Act (PDSA) cycles should be ramped up and adopted plan-wide in order to impact the entire eligible population and realize improvement in the performance indicator rates.
- For unsuccessful interventions, the plans should make data-driven decisions to revise and continue the intervention or discontinue the intervention and revisit the causal-barrier analysis and implement new interventions.

Response

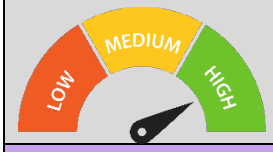
a. Describe initiatives implemented based on recommendations:
   - Sunshine Health already had processes in place that align with the recommendations
     - PDSA cycle successful interventions are adopted plan-wide
     - Data-driven decisions are made to revise and continue or discontinue unsuccessful interventions

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - Sunshine Health performed well on the PIPs:
     - All 4 PIPs earned a 'Met' validation status
     - All 4 PIPs earned a score of 100% for critical elements
     - 3 of 4 PIPs earned a score of 100% for evaluation elements (1 PIP received a score of 94%)

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

d. Identify strategy for continued improvement or overcoming identified barriers:
   - Continue current process

HSAG Assessment



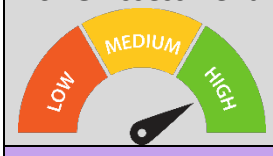
Recommendations for Analysis

HSAG recommended the following:

- Use quality improvement science tools such as process mapping, failure modes and effects analysis, or key driver diagram to identify and prioritize barriers and opportunities for improvement.
- Include an executive sponsor (e.g., medical director, chief medical officer, or chief executive officer) in their PIP team who takes responsibility for the success of the project and can work to remove institutional barriers when needed.
- Include at a minimum one data analyst on the PIP team. Data mining and analysis are crucial components to justify topics and evaluate interventions.

Response
a. Describe initiatives implemented based on recommendations: • Sunshine Health already had processes in place that align with the recommendations o We will continue to use quality improvement science tools to identify and prioritize barriers and opportunities for improvement o We have an executive sponsor on the PIP team that takes responsibility for the success of the project and works to remove institutional barriers when needed • We will continue to include several data analysts on the PIP team
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Sunshine Health performed well on the PIPs: o All 4 PIPs earned a 'Met' validation status o All 4 PIPs earned a score of 100% for critical elements o 3 of 4 PIPs earned a score of 100% for evaluation elements (1 PIP received a score of 94%)
c. Identify any barriers to implementing initiatives: • None identified
d. Identify strategy for continued improvement or overcoming identified barriers: • Continue current process
HSAG Assessment 

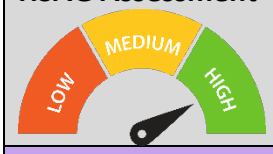
Sunshine-S-CW and Sunshine-S-SMI

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Pediatric Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine **why adolescent members are not receiving all recommended vaccines**. Plans should consider if there are disparities within their populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve immunization rates.
Response
a. Describe initiatives implemented based on recommendations: • Partnering with Pfizer to send co-branded educational communications to members • Resuming initiatives paused because of COVID (in-person Provider visits by the Quality Practice Advisors [QPAs], Case Manager [CM] in-home visits, etc.) while not newly implemented, will help improve these rates • Rolled out a Concierge Team at the beginning of 2022, some of this team's responsibility is calling members non-compliant for these care-gaps, helping them schedule appointments
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Results will be evaluated after the performance year has ended
c. Identify any barriers to implementing initiatives: • Data issues delayed the rolling out of the Primary Care Provider (PCP) incentive program • Delays in recruiting and hiring of new staff • Provider care-gap data was not available October 2021-June 2022 • Provider office closures, or short staffing issues, related to the pandemic, impacted member's access to care • Members/caregivers state they have limited/no time to devote to getting vaccines and they are concerned about seeking care due to desire to limit potential exposure to COVID-19
d. Identify strategy for continued improvement or overcoming identified barriers: • Continue member and provider education efforts • Data monitoring (monthly monitoring of rates, monitoring of the performance of PCPs, and appointments scheduled by the out-reach team) • Data issues that impacted the deployment of the care-gap reports and incentive programs have been corrected
HSAG Assessment 
Recommendations for Women's Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine **why pregnant members are not receiving timely prenatal and postpartum care**. • Upon identification of root causes, implement appropriate interventions to improve performance.

Response
a. Describe initiatives implemented based on recommendations: • Sunshine Health conducted a focus study that revealed the following reasons why female members are not receiving chlamydia (CHL) screenings: o A common misunderstanding with CHL screening is that it's not only for women who are "sexually active" but also for those that have been dispensed a contraceptive service/birth control (and may not actually be sexually active); providers may be missing these members and not screening them yearly o For members that are not yet receiving pap smears, some providers may not understand that the CHL screening can be done via urine screening, which also closes the care gap o Younger members decline chlamydia screening because they do not want their parent or guardian to find out that a sexually transmitted infection/disease (STI/STD) screening was completed • Sunshine Health conducted a focus study that revealed the following reasons why female members are not receiving timely prenatal and postpartum care: o When members come in for a "confirmation of pregnancy" some providers are not coding for the positive pregnancy test; they then have the member come back later for a full "initial OB exam" and its outside of the first trimester o Many members don't know they are pregnant or hide pregnancy from their parent/guardian and are late to prenatal care o For postpartum care, members often don't return for postpartum visits because they are overwhelmed with seeking specialist care for their chronic complex condition(s) • Initiatives planned and implemented to address root causes include: o Utilization of obstetrician (OB) Care Gap Reports to conduct targeted member and provider education o Incentive program for OBs was implemented, incentivizing OBs for each CHL & prenatal and postpartum care (PPC) care gap they close. o Rolled out a Concierge Team at the beginning of 2022, some of this team's responsibility is calling members non-compliant for these care-gaps, helping them schedule appointments • Resuming initiatives paused because of COVID (in-person Provider visits by the Quality Practice Advisors, CM in-home visits, etc.) while not newly implemented, will help improve these rates
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Results will be evaluated after the performance year has ended
c. Identify any barriers to implementing initiatives: • Members state they have limited/no time to devote to going to the doctor and they are concerned about seeking care due to desire to limit potential exposure to COVID-19 • Provider office closures, or short staffing issues, related to the pandemic, impacted members access to care • The plan experienced data issues, which resulted in care-gap data not being available to PCPs for a 6-month period (October 2021-June 2022) and OBs not receiving care-gap data for approximately a year
d. Identify strategy for continued improvement or overcoming identified barriers: • Continue member and provider education efforts • Data issues that impacted the deployment of the care-gap reports and incentive programs have been corrected • Expand the OB groups being worked by the OB QPAs • Roll out the OB Incentive Program earlier in the year • Expand usage of the Concierge Team

- Data monitoring (monthly monitoring of rates, monitoring of the performance of OBs in the OB QPA program, and appointments scheduled by the out-reach team)

HSAG Assessment



Recommendations for Living With Illness Domain

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why **members are not receiving timely recommended screenings for diabetes.**
- Conduct a root cause analysis or focus study to determine **why members are not quitting tobacco use**. Consider conducting a focus group to identify barriers that members are experiencing in quitting.

Response

a. Describe initiatives implemented based on recommendations:
- Sunshine Health requested member and caregiver feedback during regular case management and patient care advocate outreach

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Results will be evaluated after the performance year has ended

c. Identify any barriers to implementing initiatives:
- Members state they have limited/no time to devote to screenings and they are concerned about seeking care due to desire to limit potential exposure to COVID-19
- The plan experienced data issues, which resulted in care-gap data not being available to PCPs for a 6-month period (October 2021-June 2022)
- Members do not want to quit smoking, they smoke socially with friends, and some use it as a way to stay thin

d. Identify strategy for continued improvement or overcoming identified barriers:
- Continue member and provider education efforts
- Data issues that impacted the deployment of the care-gap reports and incentive programs have been corrected
- Developing Endocrinologist (Endo) care-gap reports
- Developing an Endo incentive program, incentivizing them for each CDC gap they close
- Implementing, in 2023, an Endo Quality Practice Advisor who will deliver the Endo care-gaps to the larger groups, and will provide education on how to close the care-gaps and will educate them on the incentive program
- Data monitoring (monthly monitoring of rates and performance monitoring of PCPs and Endocrinologists)
- Sunshine Health joined AHCA's Cancer Screening Initiative; tobacco cessation is one focus

HSAG Assessment

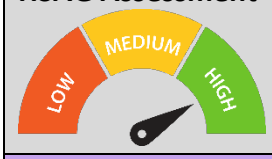
Recommendations for Behavioral Health Domain
HSAG recommended the following: • **Enhance communication and collaboration with hospitals** to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs. • Lead a program-wide focus group that includes members and key community stakeholders to identify barriers/facilitators to determine **why members who access the ED for AOD abuse or dependence are not accessing or receiving timely follow-up care** and establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, increase the use of telehealth services. • Conduct a root cause analysis or focus study to determine **why child and adolescent members with ongoing antipsychotic medication are not receiving regular metabolic testing**. • Upon identification of root causes, implement appropriate interventions to improve performance. • Evaluate the impact of the COVID-19 PHE and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.
Response
a. Describe initiatives implemented based on recommendations: • The plan hired more case managers to assist with communication and collaboration with hospitals • We requested member feedback during regular case management outreach. Reasons why members are not remaining on antidepressant medication include: o Members are concerned about the perceived stigma associated with taking antidepressants o Members stop taking antidepressants when they feel better o Members cannot tolerate the side effects o Some members didn't want to admit they needed something to help them feel normal o Family thinks the member needs to 'snap out of it' and deal with things on their own o Some members didn't want a medication to define them o Some members didn't feel the medication was needed • Sunshine Health conducted a focus study of members in the 7-Day Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) denominator. Preliminary results reveal members are resistant to follow up care for various reasons (i.e., refusal, not a perceived problem by the family, member readmitted). • We are developing behavioral health (BH) provider care-gap reports (available Quarter 4) • Continue to expand telehealth services • Updated CM trainings to include telehealth as an option during member outreach and education • Sunshine Health continues to promote telehealth services to facilitate community handoffs, follow-up care, and medication monitoring
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Results will be evaluated after the performance year has ended.
c. Identify any barriers to implementing initiatives: • Members state they have limited/no time to devote to services and they are concerned about seeking care due to desire to limit potential exposure to COVID-19 • Provider office and pharmacy closures, or short staffing issues, related to the pandemic, impacted access to care • The plan experienced data issues, which resulted in care-gap data not being available for a 6-month period (October 2021-June 2022)
d. Identify strategy for continued improvement or overcoming identified barriers: • Continue member and provider education efforts

- BH QPA will deliver BH care-gap reports to the larger BH groups
- Developing a BH provider incentive program, which will be rolled out in 2023
- Data monitoring (monthly monitoring of rates and performance monitoring of providers)

HSAG Assessment

(Results pending but plan showed high degree of response.)

United-C

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Access/Availability of Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine **why enrollees do not consistently access preventive and ambulatory services**. Upon identification of a root cause, implement appropriate interventions to improve performance. If the COVID-19 PHE was a factor, HSAG recommends working with enrollees to increase the use of telehealth services, when appropriate.
Response
a. Describe initiatives implemented based on recommendations: UHCCP FL conducted a review of enrollees in the Adult Access to Preventive and Ambulatory Services (AAP) measure for compliance history (single and multi-year), cohort volume by age range, and co-morbid conditions. Specifically: • Acceptance and abstraction of supplemental data via Practice Assist (Provider portal), an effort to capture medical record data not otherwise closed via a claim. • Provider incentive (pay for performance) on AAP per gap closure (instituted July 1st) for Providers with largest volume of non-compliant enrollees. • HouseCalls, a home visiting and telehealth program, for select enrollees with 2-year history of non-compliance in AAP. • Enrollee Outreach calls to select cohort of enrollees with co-morbidities (diabetes, high blood pressure). • IVR Telephonic Outreach for AAP, Diabetes Care, and Women's Health.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None noted – too early to evaluate, need initiatives to mature to demonstrate influence on AAP rate and to allow time for claims runout.
c. Identify any barriers to implementing initiatives: • Hard to reach enrollees - ~30% of enrollees with no phone number, history of non-compliance (some with multi-year non-compliance), insufficient Provider workflows and staffing necessary to mine data (supplemental data requires effort from the Provider).
d. Identify strategy for continued improvement or overcoming identified barriers: • Continued monitoring and evaluation of current tactics and workflows.
HSAG Assessment  (Results pending but plan showed high degree of response.)
Recommendations for Pediatric Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine **why child and adolescent enrollees are not receiving all recommended vaccines**. Plans should consider if there are disparities within their populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve immunization rates.
Response
a. Describe initiatives implemented based on recommendations:

The following is noted in the American Academy of Pediatrics, "PEDIATRICS" publication Volume 150, Issue 3 September 2022:
"Our findings underscore the important role of Pediatricians in addressing parents' concerns about childhood vaccines, as they are highly trusted by parents about vaccinations and can address vaccine hesitancy."

United Healthcare has implemented initiatives that engage with our Pediatric Providers aimed at bringing child and adolescent enrollees up to date for recommended vaccines. Regions 3 and 4 have been identified as having lower immunizations rates. Specifically:

- An initiative to engage enrollees assigned to Providers in Regions 3 and 4 that are due or coming due for both the Well Child Visit (WCV) and Immunizations for Adolescents (IMA) measures, will be targeted for telephone outreach. Agents will assist by educating the enrollee/guardian on the importance of well visits and then facilitate scheduling appointments by contacting the enrollee's PCP with the enrollee/guardian on the call. Participating Providers have been engaged to schedule appointments and bring the enrollees up to date with well visits and immunizations as quickly as possible. Enrollees between 11 and 13 years of age due for vaccines are specifically targeted.
- An initiative to engage Providers in bringing young children up to date in the Childhood Immunization Services (CIS) measure has also been implemented. On a monthly basis, Providers receive an email with a specific report of their assigned enrollees that are due or coming due for childhood vaccinations. Through monthly virtual meetings with UnitedHealthcare Quality staff, Providers are requested and encouraged to prioritize performing outreach to these enrollees and educated on the importance of the reminder/recall process to identify and contact the parent/guardian of children due and overdue for vaccinations.

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

- Performance improvement for this initiative will be tracked by a weekly report specifying the enrollees scheduled, Provider, date and time of appointments and appointments verified as kept within 30 days of outreach.
- Performance improvement for this measure will be tracked through bi-monthly Childhood Immunization Series (CIS) and Immunizations for Adolescents (IMA) rates.

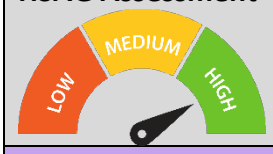
c. Identify any barriers to implementing initiatives:

- Lack of telephone contact information for enrollees.
- Florida school entrance for grades 7-12 requires only Tdap. Meningococcal and Human Papillomavirus vaccines are not required, which could result in lower vaccination rates for these recommended vaccines.
- Florida Department of Health Vaccine-Preventable Disease Surveillance Report August 2022 -- http://www.floridahealth.gov/VPD. "The proportion of children aged 4–18 years with new REs (religious exemptions) are increasing each month. Statewide, the estimated prevalence of REs among children aged 4–18 years old is 4.7% with individual counties ranging from 0.8– 10.4%. In August 2021, the statewide prevalence was 4.0% and the prevalence has gradually increased each month since."
- Florida Department of Education - Home Education in Florida 2021-22 School Year Annual Report-- Established by the Florida Legislature as a school choice option in 1985. Home education is defined in Section 1002.01, Florida Statutes (F.S.), as "the sequentially progressive instruction of a student directed by his or her parent." For the 2021-22 school year, the numbers provided by the districts indicate that 104,961 families and 152,109 students participated in home education programs. In the last five years, the total number of students in home education has increased by 62,292 or 69% over the 89,817 students reported in 2017-18. Children enrolled in home education are not required to have proof of vaccination.
- American Academy of Pediatrics, "PEDIATRICS" publication Volume 150, Issue 3, September 2022. "The proportion of parents concerned about the safety and side effects of routine childhood vaccines increased significantly between April 2020 and March 2022."

d. Identify strategy for continued improvement or overcoming identified barriers:

- UnitedHealthcare is introducing a new workflow management tool that will better enable Providers to manage patient care opportunities.

HSAG Assessment



Recommendations for Women's Care Domain

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine **why female enrollees are not receiving timely screenings**. Plans should consider if there are disparities within their populations that contributed to lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Conduct a root cause analysis or focus study to determine **why pregnant enrollees are not obtaining prenatal and postpartum care**.
- Upon identification of root causes, implement appropriate interventions to improve performance.

Response

a. Describe initiatives implemented based on recommendations:

- UHCCP FL has a defined process for identifying pregnant women within our enrollees who need to have ongoing prenatal and post-partum care. When enrollees join UHCCP FL, enrollees are outreached within 60 days to complete a Health Risk Assessment (HRA).
- Screenings – Secondary to COVID, and as cited by national data, screening rates were significantly impacted by the pandemic. In addition, several women left the workforce due to the pandemic, moving to coverage under Medicaid and, as a result, our denominators for Breast Cancer Screening (BCS) and Cervical Cancer Screening (CCS) doubled.
- Acceptance and abstraction of supplemental data via Practice Assist (Provider portal), an effort to capture medical record data not otherwise closed via a claim and to account for multi-year look back periods for both BCS and CCS for women new to Medicaid.
- Securing connection to select Electronic Medical Record (EMR) for a data feed on select HEDIS® measures, including BCS and CCS.
- Provider incentive (pay for performance) on BCS and CCS gap closure.
- IVR Telephonic Outreach for Adults' Access to Preventive/Ambulatory Care, Diabetes Care, and Women's Health.
- Live Calling for AAP, Diabetes Care, and Cervical Cancer Screening.
- Prenatal and Postpartum UnitedHealthcare Community & State plan's data demonstrated a significant lower rate of timeliness of prenatal visits among Black enrollees than any other ethnic group. Based on the scientific literature and internal data analysis UHCCP FL decided to focus on addressing race/ethnicity disparities in the "Timeliness to Prenatal Care (PPC-TOPC) HEDIS® as part of our Health Equity commitment.
- As of 2022, all Black and Indigenous People of Color (BIPOC) enrollees who fall into the rising risk category are automatically referred for Case Management services with Healthy First Steps (HFS) program.
- As of 2022, the Doula program has been expanded for rising risk pregnancy BIPOC enrollees who automatically meet the criteria for access to culturally sensitive services and benefits.
- As of 2022, UHCCP FL Enrollee Services and social worker Case Managers complete a Maternity Initial Risk Evaluation (MIRE) on new pregnant enrollees. Additionally, RN Case Managers can complete the Health Risk Assessment (HRA) evaluation and/or the MIRE. This allows Case Managers to be aware of race and ethnicity of pregnant enrollees. In addition to the MIRE and HRA, trimester assessments are completed on every high and rising risk enrollee. This includes any of the BIPOC population (either rising or high risk) to receive an

initial maternity evaluation and trimester assessments to ensure that enrollees are thoroughly educated and informed about resources and benefits offered.

- IVR Telephonic Outreach for AAP, Diabetes Care, and Women's Health.
- Live Calling for AAP, Diabetes Care, and CCS.
- Provider incentive (pay for performance) on PPC HEDIS® measures.
- UHCCP FL has revised the Healthy First Steps Maternity Program to include:
  - Additional staff to support a community-based program, where enrollees and Providers can engage with HFS staff regarding education and information on the importance of early identification of pregnant enrollees and the importance of prenatal and post-partum care.
  - Healthy First Steps CM program has extended the Case Management duration from 2 months to 12 months post-delivery, to ensure that enrollees are receiving post-partum education, connected to resources necessary after delivery, and education for well-baby visits and vaccinations.
  - Incentives for OB Risk Assessment Form submissions to assist in identifying our high-risk pregnant enrollees earlier in their pregnancy to ensure they are connected to resources and prenatal care timely.
  - Expanded Doula benefits to all high-risk pregnant enrollees to provide support and education during the prenatal and post-partum periods, along with support during labor and delivery.
  - Implemented CareAngel, expanded outreach via an Artificial Intelligence (AI) virtual assistant for enrollees with at risk pregnancies. CareAngel will deliver 28-week and 36-week Maternity Risk Trimester assessments (depending on gestational age upon enrollment) and 2 outreaches to follow-up on postpartum care.

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

- There has been a significant month over month increase in OB Risk Assessment Forms received by Providers after the implementation of the incentive and ongoing Provider outreach and education. Approximately 80% of submitted OBRAFs have qualified for incentive payment, and a combined 60% of OBRAFs resulted in a high risk/risking risk pregnancy.
- There is visible increase in post-partum visit confirmation for our high-risk enrollees in our HFS CM program through August 2022 with 347 PP visits confirmed compared to 403 for all of 2021.

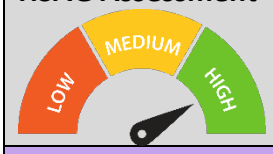
c. Identify any barriers to implementing initiatives:

- Ongoing barrier is the "Unable to Reach" population due to missing contact information when enrolled in Medicaid program.
- Screenings - Hard to reach enrollees, BCS, and CCS are often not managed by the PCP; specifically, insufficient Provider workflows and staffing necessary to mine data (supplemental data requires effort from the Provider).

d. Identify strategy for continued improvement or overcoming identified barriers:

- Continue to outreach and educate OB/GYN Providers about timely OBRAF submissions and incentives, and about UHCCP FL maternity supportive services.

HSAG Assessment



Recommendations for Living With Illness Domain

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why **enrollees are not receiving timely recommended screenings for diabetes.**

- Conduct a root cause analysis or focus study to determine **why enrollees are not quitting tobacco use**. Consider conducting a focus grou**p** to identify barriers that enrollees are experiencing in quitting.

Response – "Enrollees are not receiving timely recommended screenings for diabetes."

a. Describe initiatives implemented based on recommendations:
   - Diabetes – Secondary to COVID, and as cited by national data, screening rates were significantly impacted by the pandemic.
   - Acceptance and abstraction of supplemental data via Practice Assist (Provider portal), an effort to capture medical record data not otherwise closed via a claim and to account for the look back period of Comprehensive Diabetes Care – Eye Exam (CDC-eye).
   - Enrollee Outreach calls to select cohort of enrollees with co-morbidities (diabetes, high blood pressure).
   - IVR Telephonic Outreach for AAP, Diabetes Care, and Women's Health.
   - Live Calling for AAP, Diabetes Care, and CCS.
   - Provider incentive (pay for performance) on all CDC HEDIS® measures.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - Diabetes - None noted – too early to evaluate, need for initiatives to mature to demonstrate influence on AAP rate and to allow time for claims runout.

c. Identify any barriers to implementing initiatives:
   - Diabetes - Hard to reach enrollees - ~30% of enrollees with no phone number, history of non-compliance (some with multi-year non-compliance), insufficient Provider workflows and staffing necessary to data mine (supplemental data requires effort from the Provider).

d. Identify strategy for continued improvement or overcoming identified barriers:
   - Diabetes - Continued monitoring and evaluation of current tactics and workflows.

HSAG Assessment

Response – "Why enrollees are not quitting tobacco use."

a. Describe initiatives implemented based on recommendations:
   - UHCCP FL has a Tobacco Cessation program under the state required program, Healthy Behaviors. The Tobacco Cessation program is a telephonic Health Coach designed to help enrollees identify, prioritize unhealthy behaviors, and set personalized goals that focus on positive, healthy change in behavior.
   - This program focuses on long - term behavior change through the Prochaska/DiClemente Transtheoretical Stages of Change and the ASM (Awareness, Skill-building, and Maintenance/Motivational Interviewing) model for behavior change. Our Health Coach solution guides enrollees through the three phases of change process: awareness, skill-building, and maintenance.
   - The Health Coaches completes a Tobacco Cessation assessment with the enrollees after obtaining their consent to participate. The enrollees set a goal and a plan of care is generated. Subsequently, a series of coaching sessions are implemented to provide education, skills, and strategies for a successful outcome.
   - Health Coaches also coordinate with the enrollees' medical Provider for ongoing supervision of recommended interventions. Enrollees are provided with community resources and support group to help them sustain their goal to quit smoking and/or using tobacco products.
   - Targeted enrollees with diagnosis of smoking and/or using tobacco products are sent a Healthy Behaviors mailer to educate and encourage them to join the program.
   - Nicotine replacement therapy and other interventions through coordination with primary care or appropriate specialists who knows the enrollee's health status are significant to the program to ensure that interventions

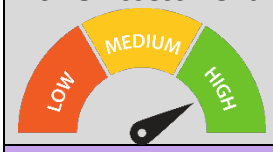
are medically approved and appropriate to each enrollee. Nicotine replacement therapy can be obtained through Over the Counter program or through the enrollees' pharmacy benefits.
- Enrollees receive rewards multiple times throughout their enrollment in the program until they successfully achieve their goal to quit smoking.
- Case Managers from Medical Case Management, Disease Management and Healthy First Steps are aware of the program and refer appropriate enrollees.
- There is also coordination with our remote patient monitoring vendor who also refer enrollees to the program
- External Providers are educated on the program which includes how to refer enrollees who could benefit from the program through Provider boot camps and online self-paced learning.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- In 2021, a total of 185 enrollees joined the Tobacco Cessation program. Twenty-eight enrollees quit smoking, 49 enrollees reduced smoking, and 37 enrollees used medication such as a smoking patch to quit smoking. There was a 39% increase of enrollees participating from year 2020 to 2021.

c. Identify any barriers to implementing initiatives:
- Many enrollees have been unable to be reached due to a disconnected phone or simply not returning calls despite multiple calls from the Health Coaches.

d. Identify strategy for continued improvement or overcoming identified barriers:
- Continue with educating and encouraging Case Managers, vendors, and Providers to refer appropriate enrollees to the program.
- Reevaluate program periodically and modify process as needed.

HSAG Assessment



Recommendations for Behavioral Health Domain

HSAG recommended the following:

- **Enhance communication and collaboration with hospitals** to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for enrollees with behavioral health needs.
- **Conduct a root cause analysis** to determine **why enrollees with a new episode of AOD dependence are not accessing or receiving timely follow-up care** and establish potential performance improvement strategies and solutions.
- **Lead a program-wide focus group** that includes enrollees and key community stakeholders to identify barriers/facilitators to enrollees accessing follow-up care after hospitalization for mental illness.
- **Conduct a root cause analysis** or focus study to determine **why child and adolescent enrollees with ongoing antipsychotic medication are not receiving regular metabolic testing**.
- Upon identification of root causes, implement appropriate interventions to improve performance.
- Evaluate the impact of the COVID-19 PHE and enrollee use of telehealth services to **determine best practices or opportunities to improve access that may be reproduceable**.

Response

a. Describe initiatives implemented based on recommendations:
- UHCCP FL initiated and held meetings with hospital clinical leadership and discharge planning teams to discuss transition of care, identify follow-up appointment access and availability, explore reintegration of field visits by Optum Behavioral Health Advocates post-pandemic, and provided education on resources available to patients. Several fact sheet flyers were developed and provided to facilities to educate on

qualified aftercare appointments for the follow-up HEDIS® measures including inpatient level of care discharges and emergency room discharges.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- There has been some improvement in follow-up HEDIS® measures. For the Follow-Up After Hospitalization for Mental Illness 7-Day Follow-Up Total, the MY 2022 prospective data rate increased to 28.55% in which is trending higher than the final rate for 2021 (27.03%).

c. Identify any barriers to implementing initiatives:
- Access to timely follow-care has been a challenge in Florida. Data from Encounter Notification Service (ENS) has not been accurate or complete.

d. Identify strategy for continued improvement or overcoming identified barriers:

UHCCP FL has continued to educate both internal Care Advocates and Providers about telehealth options for enrollees to receive aftercare follow-up care. Additionally, we are meeting monthly with Encounter Notification Service (ENS) to identify barriers and ways to improve the accuracy of the notifications from emergency room admissions.

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

a. Describe initiatives implemented based on recommendations:
- UHCCP FL conducted a root cause analysis on the Initiation of AOD Treatment and Engagement of AOD Treatment which noted a trend in PCPs diagnosing enrollees with a new AOD diagnosis. The IET root cause analysis indicated that many PCPs are diagnosing enrollees with an AOD but not ensuring SUD treatment is being initiated within 14 days of the diagnosis. UHCCP FL has been educating PCPs on Screening, Brief Intervention, and Referral to Treatment (SBIRT) and providing resources around appropriate referrals to care. Additionally, a 3-Part On-Demand Series HEDIS® training has been provided to PCPs with a specific segment on SUD measures. PCPs have the opportunity to earn free CEUs to improve awareness of the need for enrollees to be referred to SUD treatment.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- UHCCP FL is continuing to monitor claims data for improvement and trends. The final rate for Initiation of Alcohol and Other Drug Dependence Treatment Initiation Total (IETI) in 2021 was 36.28%. As of September 1, 2022, the MY 2022 prospective rate is trending higher at 42.91%.

c. Identify any barriers to implementing initiatives:
- Substance abuse confidentiality regulations are one barrier to timely follow-up care. Title 42 of the Code of Federal Regulations prevents the sharing of SUD diagnosis information without written consent. Obtaining written consent is challenging due to lack of accurate contact information on enrollees, enrollees not responding to outreach, and there is significant difficulty with Health Plan ability to obtain written consent in a timely manner to impact the short window of time on SUD treatment needed to improve the specific HEDIS® measure. Also, while many Providers are making referrals and setting up subsequent SUD treatment for enrollees, some enrollees lack motivation for treatment and may be in denial they have a substance use issue. Therefore, they are not following through with initiating treatment or remaining engaged in treatment.

d. Identify strategy for continued improvement or overcoming identified barriers:
- UHCCP FL is working with the care advocacy team to ensure use of the ENS Prompt Portal to identify possible alternative phone numbers for enrollees so that they can be reached to assist in aftercare appointments. Educating PCPs about enrollees who may be discharging from an emergency room visit for substance use disorders and need follow-up care, referral to other resources, and exploring peer support services are other interventions taking place for continued improvement.

Lead a program-wide focus group that includes enrollees and key community stakeholders to identify barriers/facilitators to enrollees accessing follow-up care after hospitalization for mental illness.

a. Describe initiatives implemented based on recommendations:

- Findings from meetings with outpatient BH Providers helped to guide data analysis to confirm some of the barriers the Providers highlighted regarding barriers to treating enrollees discharging from inpatient level of care or the emergency room. This included the high percentage of involuntary inpatient admissions (under Florida's Baker Act); in these cases, patients may be less likely to attend timely follow-up appointments. Additional themes explored in the data analysis included:

1. Identifying inpatient facilities with lower percentages of follow-ups;
2. Identifying enrollees who fall in the denominator(s) multiple times within the same year and year-over-year (i.e., have repeated hospitalizations and/or ED visits);
3. Differences in compliance by line of business (Comprehensive vs. Medicaid),
4. The most frequent billing codes used for coding follow-up visits;
5. Which types of Providers more frequently complete follow-up visits;
6. Identifying Providers not coding follow-up visits with the correct service codes or who are not using BH ICD10 codes as the primary diagnosis for a follow-up visit (missed opportunities); and
7. Impact of COVID19 in enrollee ED visits, inpatient admissions, and follow-ups.

This comprehensive analysis allowed for a more thorough analysis and development of a targeted improvement strategy for 2021. Using workgroup feedback, a fishbone diagram was drafted by the project lead, categorizing barriers into five enrollee groups (noted below). Enrollees of the workgroup made recommendations and changes to finalize the diagram to prioritize barriers and determine strategies to implement for improvement in the HEDIS® measures.

Enrollee Groups

1. Enrollee is not connected with their PCP
2. High percentage of involuntary inpatient admissions (via the Baker Act); enrollee believes they do not need care (FUH)
3. Enrollee is not motivated to go to appointment.
4. ER visits related to alcohol use; enrollee believes they do not need care (FUA)
5. One-time events (one time use of AOD), enrollee not likely to follow-up (FUA)

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

There has been some improvement in follow-up HEDIS® measures in 2022. For the Follow-Up After Hospitalization for Mental Illness 7-Day Follow-Up Total, MY 2022 prospective rate increased to 28.55% in 2022 which is trending higher than the final rate for 2021 (27.03%).

c. Identify any barriers to implementing initiatives:

- The top five barriers in order of priority for each category identified in the analysis included:

Health Plan

1. Receives incomplete data from the Encounter Notification System (ENS).
2. Delayed event notification to internal clinical platforms.
3. Missing enrollee contact information.
4. Limited outpatient resources (discharge planning).
5. Low telephonic enrollee reach.
6. Unable to share substance abuser diagnoses with Providers per federal and state law (FUA).

Behavioral Health Providers

1. Only a few BH Providers receive event notifications.
2. Limited appointments within 7 days.
3. Follow-up visit billed incorrectly (does not close gap as defined by HEDIS® Technical Specifications).
4. Do not provide walk-in appointments (long waits for enrollees).

Primary Care Provider (PCP)

1. Only a few PCPs receive event notifications.
2. Provider does not screen for BH conditions or focuses only on primary care conditions.
3. Primary diagnosis not coded as BH (does not close gap as defined by HEDIS Technical Specifications).
4. Behavioral health and primary care poorly integrated within large Providers/health systems.
5. Do not receive substance abuse event notifications (diagnosis suppressed in compliance with Title 42 of the Code of Federal Regulations, FUA).

Emergency Department/Inpatient Facility

1. ED is not educating enrollees about 7 day follow up appointments.
2. ED is not scheduling follow-up appointments.
3. Inconsistent collaboration between Health Plan and ED on follow-up care.
4. Inpatient facility does not provide walk-in appointments.

d. Identify strategy for continued improvement or overcoming identified barriers:
UHCCP FL's Quality Department used the CMS Quality Assurance and Performance Improvement (QAPI) PIP Prioritization Worksheet to support the barriers prioritization process. Based on findings from the above analysis, a prioritization worksheet captured each barrier category to develop strategies including providing hospitals and enrollees telehealth options for appointment access, utilization management and care coordination teams engaging in daily communication regarding discharges to assist in timelier outreach to patients to assist in timely follow-up care, enhancing communication and collaboration with hospitals, development of fact sheet flyers on FUH, FUM, and FUA HEDIS® measures that have been provided to facilities and outpatient Providers to educate on qualified aftercare appointments and importance of timely follow-up. Provider education on claims coding has also been implemented to ensure the primary diagnosis is coded as BH or SUD to close the gap as defined by HEDIS Technical Specifications. Behavioral Health toolkits and screenings have been provided to Providers that are available on www.Providerexpress.com to assist Providers in screening for BH or SUD conditions. Education on Screening, Brief Intervention, and Referral to Treatment (SBIRT) has been a focus for the past few years in the Provider Information Expo held annually through UHCCP FL for Providers as well as in Provider meetings held monthly by UHCCP FL. A monthly meeting with ENS takes place to identify barriers and ways the notifications from emergency room admissions are more accurate.

Conduct a root cause analysis or focus study to determine why child and adolescent enrollees with ongoing antipsychotic medication are not receiving regular metabolic testing.

a. Describe initiatives implemented based on recommendations:
UHCCP FL conducted a root cause analysis which included data analysis as well as Provider feedback. The data analysis identified which prescribers of the antipsychotic medications had enrollees who had not received metabolic testing. UHCCP FL outreached to these Providers to educate on the importance of metabolic testing and timeframe metabolic testing recommended. Our Quality team worked with physician staff to put alerts on charts for patients who had not yet received metabolic testing for the year.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- There was improvement in metabolic testing rates in 2021 after outreach and education was completed per the HEDIS® rates prior to outreach compared to post outreach; this is being continued in 2022.

c. Identify any barriers to implementing initiatives:

- Inaccurate phone numbers and incorrect practice information with UHCCP FL made it difficult to reach Providers to educate about the metabolic HEDIS® measures. Some Providers had moved to other locations and had different phone numbers than what is listed in the network. This delayed the process. Another barrier seen from the root cause analysis showed some Providers are not ordering both the HbA1c and LDL test

d. Identify strategy for continued improvement or overcoming identified barriers:

- Strategies include identification and update of inaccurate phone numbers for Providers and education on the importance or ordering both HbA1c and the LDL test for this measure.
- Upon identification of root causes, implement appropriate interventions to improve performance.

Evaluate the impact of the COVID-19 PHE and enrollee use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.

a. Describe initiatives implemented based on recommendations:

- UHCCP FL has been evaluating the impact of COVID-19 PHE and enrollee use of telehealth since early 2020. Data over time has demonstrated a significant rise in telehealth services at the beginning of the pandemic in early 2020, and it has remained steady in both 2021 and thus far in 2022 for the number of telehealth services month over month. We have continued to educate inpatient Providers about the availability of Providers rendering telehealth options for post-discharge care, including the addition of new telehealth Providers available. Our Care Advocacy teams have also received education on new telehealth Providers available to connect enrollees to care. As part of our Provider education efforts, we are advising Providers that telehealth appointments can be utilized to close HEDIS® measure gaps that require timely post IP or ED appointments.

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

- For the Follow-Up After Hospitalization for Mental Illness 7-Day Follow-Up Total, the MY prospective rate increased to 28.55% in 2022. This rate is not final but is trending higher than the final rate for 2021 (27.03%). This is also higher performance compared to September 2021 rate (25.67%). Brave Health, one telehealth Provider for UHCCP FL has worked closely with us and due to their availability and access to telehealth appointments, provides data monthly on the number of referrals and enrollees enrolled with them for outpatient appointments. In 2022 alone, there have been 460 referrals made to Brave Health by UHCCP FL or referring facilities in Florida with an average of 66% opt in rate for telehealth services.

c. Identify any barriers to implementing initiatives:

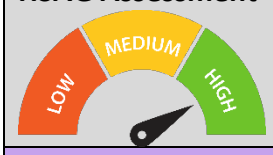
- Inability to reach enrollees post-discharge in order to connect to care due to enrollees not answering their phone, not having a phone, or incorrect phone numbers is a barrier. Some enrollees also prefer face-to-face care rather than telehealth appointments. Substance abuse confidentiality regulations are another barrier to timely follow-up care. Title 42 of the Code of Federal Regulations prevents the sharing of SUD diagnosis information without written consent. Obtaining written consent if difficult due to lack of accurate contact information on enrollees, enrollees not responding to outreach, and there is significant difficulty with Health Plan ability to obtain written consent in a timely manner to impact the short window of time on SUD treatment needed to improve the specific HEDIS® measure. Also, data from Encounter Notification Service (ENS) has not been accurate. Brave Health has provided information on potential barriers including incorrect telephone numbers or email addresses of enrollees being referred by facilities for aftercare appointments as well as education from the facilities on the services Brave Health offers and how the process works to get an appointment.

d. Identify strategy for continued improvement or overcoming identified barriers:

- A monthly meeting with ENS takes place to identify barriers and ways the notifications from emergency room admissions are more accurate. UHCCP FL is working with the care advocacy team to ensure use of the

HIE Iprompt portal to identify possible alternative phone numbers for enrollees so that they can be reached to assist in aftercare appointments. Brave Health has suggested offering educational one-pagers and/or tablets to enrollees while they are in the hospital to assist enrollees with completing required forms prior to discharge to expedite the follow-up appointment process.

HSAG Assessment



Recommendations for LTC Program

HSAG recommended the following:

- **Continue to monitor rates over time to identify COVID-19 PHE rate impact**, ensuring lower quality and access to care is not driven by a non-PHE cause.

  "The statewide average for the LTSS Minimizing Institutional Length of Stay measure declined more than 21 percentage points, and the statewide average for the LTSS Successful Transition After Long-Term Institutional Stay measure declined more than 11 percentage points from RY 2020 to RY 2021."

Response

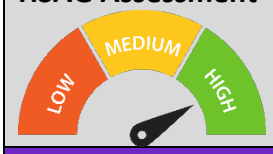
a. Describe initiatives implemented based on recommendations:
   - UHCCP FL continues to monitor the rates for short-term and long-term stays in an institution. The RY 2022 data continues to show this trend due to the impact of COVID-19. We implemented a weekly case conference to monitor enrollees discharged from the hospital to an institutional setting. Our short-term stay continued a downward trend and decreased by 8% while our long-term stay trend increased 5%.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - UHCCP FL attributes the 5% increase in successful transition to the community after long-term institutional stay to the pandemic. We saw an increased interest to leave the nursing home due to the pandemic.

c. Identify any barriers to implementing initiatives:
   - At the height of the pandemic, it was difficult to communicate with nursing homes. Since returning to the field in October 2021 that has abated.

d. Identify strategy for continued improvement or overcoming identified barriers:
   - UHCCP FL continues to conduct weekly case conference to monitor enrollees discharged from the hospital to an Institutional setting.

HSAG Assessment



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

Recommendations for Methodology

HSAG recommended the following:

- Report accurate annual PIP performance data in accordance with the Agency-defined specifications and approved methodology. The reported data should be comparable across all measurement periods.

- Address all validation feedback provided in the PIP Validation Tools. If not addressed, the corresponding evaluation element will be marked down in the PIP Validation Tool.

Response

a. Describe initiatives implemented based on recommendations:

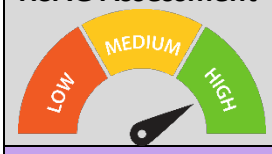
- UHCCP FL implements processes to ensure our data is accurate and in accordance with Agency-defined specifications and approved methodologies (HEDIS). Any identified changes in HEDIS or AHCA methodologies are reviewed every year to ensure data is comparable across all measurements. Due to a change in vendors (transportation) or transition in contracts (changes in regions served by UHCCP FL) some of the MY rates are not 100% comparable. UHCCP FL has made note of this barrier in previous annual submissions (impact on internal validity and comparability).
- The Quality Improvement Manager reviews the EQRO validation tool and ensures that EQRO recommendations are address in the annual PIP submission.

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

c. Identify any barriers to implementing initiatives:
NA

d. Identify strategy for continued improvement or overcoming identified barriers:
NA

HSAG Assessment



Recommendations for Interventions

HSAG recommended the following:

- Use active, evidence-based, innovative improvement strategies and interventions that have the potential to impact PIP performance indicator outcomes.
- Seek enrollee input in order to better understand enrollee-related barriers toward access to care.
- Collect intervention evaluation data frequently (weekly, biweekly, monthly, quarterly, etc.), unlike the annual performance indicator data. The intervention-specific evaluation data may help the plans identify significant clinical and programmatic improvement in outcomes.
- Evaluate the performance of each intervention and include the most current intervention evaluation data available at the time of the submission date.
- Provide adequate details about an intervention for the Agency and HSAG to better understand the intervention. For example, the plans should document how they will improve efforts to obtain real-time notifications from Florida's Encounter Notification System (ENS), and how the plans will use that data. For outreach interventions, the plans should include the mode and frequency of outreach.

Response

a. Describe initiatives implemented based on recommendations:

- UHCCP FL implemented evidence-based, innovative strategies and interventions that have impacted PIP performance indicators.
- UHCCP FL seeks input from members to better understand enrollee-related barriers regarding access to care in the quarterly MMA Advisory Committee (MAC). The Committee was established in 2021.

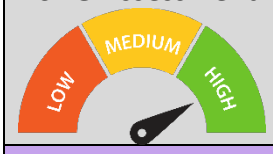
- Initiatives are tracked on a monthly and quarterly basis via process metrics to capture success in impacting clinical/programmatic outcomes. Interventions or processes are modified based on evaluation results (if needed).
- The effectiveness of programs to impact performance metrics is evaluated every year. Quality improvement strategies and interventions are modified based on evaluation results. The most recent evaluation data is included in the PIP annual submission.
- UHCCP FL includes detailed interventions in the annual PIP submission form and updates activities every year if any changes have been made.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- UHCCP FL observed improvement in some performance metrics across PIPs for the 2021 reporting year (2022 submissions). For example, UHCCP FL observed improvement, meeting contractual goals, in primary c-section rates in regions 3 and 4; pre-term deliveries in regions 4 and 11, and NAS rates in region 3, 4 and 6. UHCCP FL also observed improvement, meeting contractual goals, in PPAs in regions 4 and 11; PPRs in regions 4, 6 and 11 and PPVs in all regions. Although targets were not met for the metrics under the Behavioral and Transportation PIP, improvements were observed in some of the metrics.
- UHCCP FL also observed improvement in various new activities/processes implemented internally. Some examples include, but not limited to, increased in SBIRT utilization by OB/GYN Providers (SBIRT claims monitoring; improved ENS notifications after adding a new flag to daily BH notification report, and increased submission of Obstetrical Risk Assessment Form (OBRAFs) by OB/GYN Providers.

c. Identify any barriers to implementing initiatives:
- Low member participation in the MMA Advisory Committee continues to be a barrier.

d. Identify strategy for continued improvement or overcoming identified barriers:
- UHCCP FL is working in collaboration with Community Organization to help engage Medicaid member in conversations around access of care.

HSAG Assessment



Recommendations for Implementation

HSAG recommended the following:

- Interventions deemed successful when tested on a small-scale using Plan-Do-Study-Act (PDSA) cycles should be ramped up and adopted plan-wide to impact the entire eligible population and realize improvement in the performance indicator rates.
- For unsuccessful interventions, the plans should make data-driven decisions to revise and continue the intervention or discontinue the intervention and revisit the causal-barrier analysis and implement new interventions.

Response

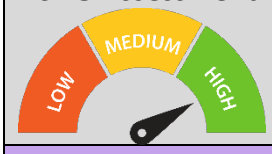
a. Describe initiatives implemented based on recommendations:
- UHCCP FL implemented small scale interventions using the PDSA cycle method for some of the PIPs.
- UHCCP FL made decisions to continue or discontinue interventions based on results of PDSA.
- For unsuccessful interventions UHCCP FL revisit the causal-barriers analysis to identify a new intervention.

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

c. Identify any barriers to implementing initiatives:
NA

d. Identify strategy for continued improvement or overcoming identified barriers:
NA

HSAG Assessment



Recommendations for Analysis

HSAG recommended the following:

- Use quality improvement science tools such as process mapping, failure modes and effects analysis, or key driver diagram to identify and prioritize barriers and opportunities for improvement.
- Include an executive sponsor (e.g., medical director, chief medical officer, or chief executive officer) in their PIP team who takes responsibility for the success of the project and can work to remove institutional barriers when needed.
- Include at a minimum one data analyst on the PIP team. Data mining and analysis are crucial components to justify topics and evaluate interventions.

Response

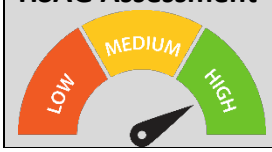
a. Describe initiatives implemented based on recommendations:
- UHCCP FL implements quality improvement science tools to identify and prioritize barriers and opportunities for improvement. UHCCP FL identified a new quality improvement tool, the Prioritization Worksheet for Performance Improvement Projects, from the Quality Assurance/Performance Improvement (QAPI) approach published by the American Health Care Association. This tool was identified to better fit better the prioritization process for PIPs.
- UHCCP FL Chief Medical Officer (CMO), participates in monthly workgroup meeting and fully engages in quality improvement process, programs implementation, and works to remove institutional barriers when needed.
- UHCCP FL has included a Data Analyst to support programs evaluation and data mining required for each PIP.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- The Prioritization Worksheet PIPs has allowed for easier conversations with SMEs in the barrier's prioritization process.

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

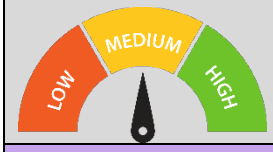
d. Identify strategy for continued improvement or overcoming identified barriers:
- NA

HSAG Assessment



Specialty Plans

Children's Medical Services-S

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Pediatric Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine **why child and adolescent members are not receiving all recommended vaccines**. Plans should consider if there are disparities within their populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve immunization rates.
Response
a. Describe initiatives implemented based on recommendations: • Partnering with Pfizer to send co-branded educational communications to members • Resuming initiatives paused because of COVID (in-person Provider visits by the Quality Practice Advisors [QPAs], Care Manager [CM] in-home visits, etc.) while not newly implemented, will help improve these rates • Rolled out a Concierge Team at the beginning of 2022, some of this team's responsibility is calling members non-compliant for these care-gaps, helping them schedule appointments
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Results will be evaluated after the performance year has ended
c. Identify any barriers to implementing initiatives: • Data issues delayed the rolling out of the Primary Care Provider (PCP) incentive program • Delays in recruiting and hiring of new staff • Provider care-gap data was not available October 2021-June 2022 • Provider office closures, or short staffing issues, related to the pandemic, impacted member's access to care • All members on the plan have complex medical and/or behavioral health conditions. Members and caregivers are focused on care related the member's condition/illness, voice having limited/no time to devote to preventive care, and are concerned about seeking preventive care due to desire to limit potential exposure to COVID-19
d. Identify strategy for continued improvement or overcoming identified barriers: • Continue member and provider education efforts • Data monitoring (monthly monitoring of rates, monitoring of the performance of PCPs, and appointments scheduled by the out-reach team) • Data issues that impacted the deployment of the care-gap reports and incentive programs have been corrected
HSAG Assessment 
Recommendations for Women's Care Domain
HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine **why female members are not receiving timely chlamydia screenings**. Plans should consider if there are disparities within their populations that contributed to lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Conduct a root cause analysis or focus study to determine **why pregnant members are not receiving timely prenatal and postpartum care**.
- Upon identification of root causes, implement appropriate interventions to improve performance.

Response

a. Describe initiatives implemented based on recommendations:
   - CMS Health Plan conducted a focus study that revealed the following reasons why female members are not receiving chlamydia (CHL) screenings:
     - A common misunderstanding with CHL screening is that it's not only for women who are "sexually active" but also for those that have been dispensed a contraceptive service/birth control (and may not actually be sexually active); providers may be missing these members and not screening them yearly
     - For members that are not yet receiving pap smears, some providers may not understand that the CHL screening can be done via urine screening, which also closes the care gap
     - Younger members decline chlamydia screening because they do not want their parent or guardian to find out that a sexually transmitted infection/disease (STI/STD) screening was completed
   - CMS Health Plan conducted a focus study that revealed the following reasons why female members are not receiving timely prenatal and postpartum care:
     - When members come in for a "confirmation of pregnancy" some providers are not coding for the positive pregnancy test; they then have the member come back later for a full "initial OB exam" and its outside of the first trimester
     - Many members don't know they are pregnant or hide pregnancy from their parent/guardian and are late to prenatal care
     - For postpartum care, members often don't return for postpartum visits because they are overwhelmed with seeking specialist care for their chronic complex condition(s)
   - Initiatives planned and implemented to address root causes include:
     - Utilization of obstetrician (OB) Care Gap Reports to conduct targeted member and provider education
     - Incentive program for OBs was implemented, incentivizing OBs for each CHL & prenatal and postpartum care (PPC) care gap they close.
     - Rolled out a Concierge Team at the beginning of 2022, some of this team's responsibility is calling members non-compliant for these care-gaps, helping them schedule appointments
     - Resuming initiatives paused because of COVID (in-person Provider visits by the Quality Practice Advisors, CM in-home visits, etc.) while not newly implemented, will help improve these rates

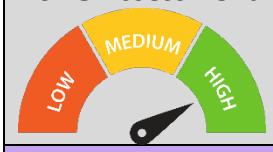
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - Results will be evaluated after the performance year has ended

c. Identify any barriers to implementing initiatives:
   - All members on the plan have complex medical and/or behavioral health conditions. Members and caregivers are focused on care related the member's condition/illness, voice having limited/no time to for additional appointments, and they are concerned about seeking care due to desire to limit potential exposure to COVID-19
   - Provider office closures, or short staffing issues, related to the pandemic, impacted members access to care

- The plan experienced data issues, which resulted in care-gap data not being available to PCPs for a 6-month period (October 2021-June 2022) and OBs not receiving care-gap data for approximately a year

d. Identify strategy for continued improvement or overcoming identified barriers:
- Continue member and provider education efforts
- Data issues that impacted the deployment of the care-gap reports and incentive programs have been corrected.
- Expand the OB groups being worked by the OB QPAs
- Roll out the OB Incentive Program earlier in the year
- Expand usage of the Concierge Team
- Data monitoring (monthly monitoring of rates, monitoring of the performance of OBs in the OB QPA program, and appointments scheduled by the out-reach team)

HSAG Assessment



Recommendations for Living With Illness Domain

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why **members are not receiving timely recommended screenings for diabetes.**

Response

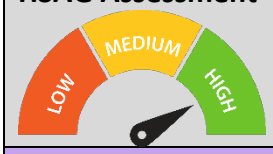
a. Describe initiatives implemented based on recommendations:
- CMS Health Plan requested member feedback during regular care management outreach
- Developed younger age band comprehensive diabetes care (CDC) HEDIS reporting

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Results will be evaluated after the performance year has ended

c. Identify any barriers to implementing initiatives:
- All members on the plan have complex medical and/or behavioral health conditions. Members and caregivers are focused on care related the member's condition/illness (not screenings), voice having limited/no time to devote to screenings, and they are concerned about seeking care due to desire to limit potential exposure to COVID-19
- The plan experienced data issues, which resulted in care-gap data not being available to PCPs for a 6-month period (October 2021-June 2022)

d. Identify strategy for continued improvement or overcoming identified barriers:
- Continue member and provider education efforts
- Data issues that impacted the deployment of the care-gap reports and incentive programs have been corrected
- Developing Endocrinologist (Endo) care-gap reports
- Developing an Endo incentive program, incentivizing them for each CDC gap they close
- Implementing, in 2023, an Endo Quality Practice Advisor who will deliver the Endo care-gaps to the larger groups, and will provide education on how to close the care-gaps and will educate them on the incentive program
- Data monitoring (monthly monitoring of rates and performance monitoring of PCPs and Endocrinologists)

HSAG Assessment



Recommendations for Behavioral Health Domain

HSAG recommended the following:

- **Enhance communication and collaboration with hospitals** to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.
- Lead a program-wide focus group that includes members and key community stakeholders **to identify barriers/facilitators for members who access the ED for AOD abuse or dependence follow-up care**.
- Conduct a root cause analysis or focus **study to determine why members are not remaining on their antidepressant medication**.
- Upon identification of root causes, implement appropriate interventions to improve performance.
- Evaluate the impact of the COVID-19 PHE and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.

Response

a. Describe initiatives implemented based on recommendations:
   - The plan hired more care managers to assist with communication and collaboration with hospitals
   - We requested member feedback during regular care management outreach. Reasons why members are not remaining on antidepressant medication include:
     - Members/families are concerned about the perceived stigma associated with taking antidepressants
     - Members stop taking antidepressants when they feel better
     - Members cannot tolerate the side effects
     - Some members didn't want to admit they needed something to help them feel normal
     - Family thinks the member needs to 'snap out of it' and deal with things on their own
     - Some members didn't want a medication to define them
     - Some members/families didn't feel the medication was needed
   - CMS Health Plan conducted a focus study of members in the 7-Day Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) denominator. Of the members reviewed, 93.18% had appropriate outreach from the assigned care manager. Of the members outreached, 43.9% members were able to be reached but were resistant to follow up care for various reasons (i.e., refusal, not a perceived problem by the family, member readmitted).
   - We are developing behavioral health (BH) provider care-gap reports (available Quarter 4)
   - Continue to expand telehealth services
   - Updated CM trainings to include telehealth as an option during member outreach and education
   - CMS Health Plan continues to promote telehealth services to facilitate community handoffs, follow-up care, and medication monitoring

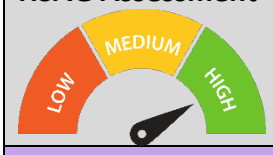
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - Results will be evaluated after the performance year has ended.

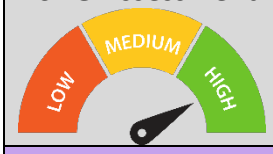
c. Identify any barriers to implementing initiatives:
   - All members on the plan have complex medical and/or behavioral health conditions. Members and caregivers are focused on care related the member's condition/illness, voice having limited/no time to

devote to additional appointments (especially for conditions they don't acknowledge as a problem), and they are concerned about going to the pharmacy due to desire to limit potential exposure to COVID-19
- Provider office and pharmacy closures, or short staffing issues, related to the pandemic, impacted members access to care
- The plan experienced data issues, which resulted in care-gap data not being available for a 6-month period (October 2021-June 2022)

d. Identify strategy for continued improvement or overcoming identified barriers:
- Continue member and provider education efforts
- BH QPA will deliver BH care-gap reports to the larger BH groups
- Developing a BH provider incentive program, which will be rolled out in 2023
- Data monitoring (monthly monitoring of rates and performance monitoring of providers)

HSAG Assessment

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendations for Methodology
HSAG recommended the following: • Report accurate annual PIP performance data in accordance with the Agency-defined specifications and approved methodology. The reported data should be comparable across all measurement periods. • Address all validation feedback provided in the PIP Validation Tools. If not addressed, the corresponding evaluation element will be marked down in the PIP Validation Tool.
Response
a. Describe initiatives implemented based on recommendations: • CMS Health Plan already had processes in place that align with the recommendations o We will continue to report accurate data that is comparable across all measurement periods in accordance with the Agency-defined specifications and approved methodology o CMS Health Plan designated a performance improvement project (PIP) manager last year to ensure validation feedback is addressed
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • CMS Health Plan performed well on the PIPs: o All 4 PIPs earned a 'Met' validation status o All 4 PIPs earned a score of 100% for critical elements o 3 of 4 PIPs earned a score of 100% for evaluation elements (1 PIP received a score of 95% due to the increased indicator rate for Remeasurement 1 not being statistically significant)
c. Identify any barriers to implementing initiatives: • None identified.
d. Identify strategy for continued improvement or overcoming identified barriers: • Continue current process
HSAG Assessment 
Recommendations for Interventions
HSAG recommended the following: • Use active, evidence-based, innovative improvement strategies and interventions that have the potential to impact PIP performance indicator outcomes. • Seek enrollee input in order to better understand enrollee-related barriers toward access to care. • Collect intervention evaluation data frequently (weekly, biweekly, monthly, quarterly, etc.), unlike the annual performance indicator data. The intervention-specific evaluation data may help the plans identify significant clinical and programmatic improvement in outcomes. • Evaluate the performance of each intervention and include the most current intervention evaluation data available at the time of the submission date. • Provide adequate details about an intervention for the Agency and HSAG to better understand the intervention. For example, the plans should document how they will improve efforts to obtain real-time notifications from Florida's Encounter Notification System (ENS), and how the plans will use that data. For outreach interventions, the plans should include the mode and frequency of outreach.

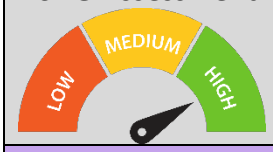
Response
a. Describe initiatives implemented based on recommendations: • CMS Health Plan already had processes in place that align with most of the recommendations o CMS Health Plan continues to utilize and evaluate improvement strategies and interventions that have the potential to impact PIP performance indicator outcomes o We continue to seek member feedback regarding barriers to accessing care during regular care management outreach and during consumer advisory board meetings o We will continue to collect intervention evaluation data frequently o We will continue to evaluate the performance of each intervention and include the most current intervention evaluation data available at the time of the submission date • CMS Health Plan incorporated additional details about interventions with prior inquiries to facilitate Agency and HSAG understanding of the intervention
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • CMS Health Plan performed well on the PIPs: o All 4 PIPs earned a 'Met' validation status o All 4 PIPs earned a score of 100% for critical elements o 3 of 4 PIPs earned a score of 100% for evaluation elements (1 PIP received a score of 95% due to the increased indicator rate for Remeasurement 1 not being statistically significant)
c. Identify any barriers to implementing initiatives: • None identified
d. Identify strategy for continued improvement or overcoming identified barriers: • Continue current process
HSAG Assessment 
Recommendations for Implementation
HSAG recommended the following: • Interventions deemed successful when tested on a small scale using Plan-Do-Study-Act (PDSA) cycles should be ramped up and adopted plan-wide in order to impact the entire eligible population and realize improvement in the performance indicator rates. • For unsuccessful interventions, the plans should make data-driven decisions to revise and continue the intervention or discontinue the intervention and revisit the causal-barrier analysis and implement new interventions.
Response
a. Describe initiatives implemented based on recommendations: • CMS Health Plan already had processes in place that align with the recommendations o PDSA cycle successful interventions are adopted plan-wide o Data-driven decisions are made to revise and continue or discontinue unsuccessful interventions
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • CMS Health Plan performed well on the PIPs:

- All 4 PIPs earned a 'Met' validation status
- All 4 PIPs earned a score of 100% for critical elements
- 3 of 4 PIPs earned a score of 100% for evaluation elements (1 PIP received a score of 95% due to the increased indicator rate for Remeasurement 1 not being statistically significant)

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

d. Identify strategy for continued improvement or overcoming identified barriers:
- Continue current process

HSAG Assessment



Recommendations for Analysis

HSAG recommended the following:

- Use quality improvement science tools such as process mapping, failure modes and effects analysis, or key driver diagram to identify and prioritize barriers and opportunities for improvement.
- Include an executive sponsor (e.g., medical director, chief medical officer, or chief executive officer) in their PIP team who takes responsibility for the success of the project and can work to remove institutional barriers when needed.
- Include at a minimum one data analyst on the PIP team. Data mining and analysis are crucial components to justify topics and evaluate interventions.

Response

a. Describe initiatives implemented based on recommendations:
- CMS Health Plan already had processes in place that align with the recommendations
  - We will continue to use quality improvement science tools to identify and prioritize barriers and opportunities for improvement
  - We have an executive sponsor on the PIP team that takes responsibility for the success of the project and works to remove institutional barriers when needed
  - We will continue to include several data analysts on the PIP team

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- CMS Health Plan performed well on the PIPs:
  - All 4 PIPs earned a 'Met' validation status
  - All 4 PIPs earned a score of 100% for critical elements
  - 3 of 4 PIPs earned a score of 100% for evaluation elements (1 PIP received a score of 95% due to the increased indicator rate for Remeasurement 1 not being statistically significant)

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

d. Identify strategy for continued improvement or overcoming identified barriers:
- Continue current process

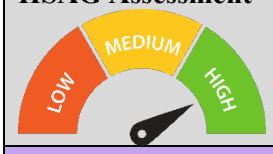
HSAG Assessment

Clear Health-S

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Women's Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine **why female members are not receiving timely cervical and breast cancer screenings**. Plans should consider if there are disparities within their populations that contributed to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. • Conduct a root cause analysis or focus study to determine **why pregnant members are not receiving timely prenatal and postpartum care prenatal care**. • Upon identification of root causes, implement appropriate interventions to improve performance.
Response
a. Describe initiatives implemented based on recommendations: • Encounter Notification System (ENS) SMART alerts developed to identify all pregnant women o The plan conducts outreach to all members identified in the ENS report to promote Doula services, provide education and assist with scheduling a prenatal appointment. o The plan will continue to address and mitigate any barriers linked to this intervention as part of its ongoing evaluation determine the impact of this initiative. • OB Quality Incentive Program (OBQIP) • Promote utilization of MAT and BH services • Promote the use of Doula services through a partnership with a National Doula provider. • Gestational Diabetes Program for High-Risk Members • Early Identification of pregnant women • Member education materials developed • Provider Bulletins developed to address prenatal and postpartum benefits • Healthy Rewards for Maternity • Enrollee Advisory Committees targeting pregnant enrollees • Promotion and use of the 'My Birth Matters' materials sent monthly to pregnant members • Working with the Agency on implementing a universal Pregnancy Notification Form. • Ongoing text campaigns targeting Prenatal and Postpartum visit compliance • The plan is working with a new community-based partner in hosting baby showers that connect members with resources in their community **Taking Care of Baby and Me program:** My Advocate - components include HRA, educational info, reminder calls, and potential incentives. The program strives to improve birth outcomes by: • Promoting preconception care • Promoting prenatal care • Increasing the number of prenatal care visits • Reducing infant mortality • Reducing premature births • Reducing incidence of low birth weight • Reducing Neonatal Intensive Care Unit (NICU) admissions and lengths of stay

• Improving identification of and access to treatment for perinatal depression • Promoting education and access to treatment for smoking cessation and substance use disorders • Improving access to and completion of postpartum care visits • The program centers on achieving the earliest possible identification of and communication with a new or existing pregnant member, completing an assessment of the member's risk, and developing and enacting a collaborative plan of care for mother and her newborn. In general, the program also endeavors to increase the awareness of and advocates for the reproductive health of all members and the importance of well child Early Periodic Screening and Diagnostic Testing (EPSTD). This includes: • Conducting problem-based comprehensive care planning that includes measurable goals and interventions tailored to the complexity level of the member as determined by the initial and ongoing assessments • Coordinating care with PCPs, specialty providers, ancillary providers, and community resources • Educating members on healthcare for themselves and their infants • The Maternal Child Services model delivers a seamless, coordinated approach, offers a seamless, coordinated approach. From identification through care planning, trained staff seeks to improve the overall quality of life, functional status, and health outcomes for pregnant members and their newborns.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • For PDSA PIP participants there has been an increase in the rate of prenatal screenings among pregnant members with prior BH/SUD • 98% of all Doula participants had at least 1 prenatal visit during CY 2021 (Majority are high-risk pregnancies) • Majority of provider groups participating in the OBQIP program show an improvement in C-section rates and Preterm Birth rates. • The Gestational diabetes program has resulted in fewer NICU babies and improved health outcomes for Moms.
c. Identify any barriers to implementing initiatives: • Increase in the denominators has impacted the eligible population • New enrollees with a lack of prenatal compliance makes it difficult to identify and track some pregnant members. • For members with prior BH/SUD issues there is a potential gap in care among the OB/Provider, the plan, and a BH specialist. For Cervical and Breast Cancer screenings: • Difficulty in reaching the members • Difficulty engaging providers to complete the screenings as a part of the annual visit • Some providers see themselves as specialists for HIV and not as responsible for overall care • Some providers with availability may not be willing to see members who are not assigned to them
d. Identify strategy for continued improvement or overcoming identified barriers: • Formally adopt current PDSA efforts and further expand promotion of Doula services. For Cervical and Breast Cancer screenings: • Working with Human Resources to ensure the plan has appropriate resources in place • Completing face-to-face outreach where possible for members who are difficult to reach/engage • Coordinating with providers with mobile access to complete the tests irrespective of PCP registration

HSAG Assessment



Recommendations for Living With Illness Domain

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why **members are not receiving timely recommended screenings for diabetes.**

Response

a. Describe initiatives implemented based on recommendations:
- Collaborate with diabetic members who have a history of non-compliance and develop short-term and long-term goals
- Verbal and/or written education provided to each member
- Assistance with Durable Medical Equipment, Medical & BH appointments
- Coordination of home health services
- Monthly text campaigns for the Diabetic population
- Clinic days for Diabetic members to complete their recommended eye exams
- Clinic days to assist providers with scheduling members for their recommended appointments
- Outreach Portal to schedule members' appointments
- Monthly circulation of the GAPs in care reports to the Case Managers in order to target their assigned members
- Dedicated Case Managers for specific Diabetic measures irrespective of case assignment
- Provider Education on importance of screening

b. Identify any noted performance improvement because of initiatives implemented (if applicable):
- Have seen a slight improvement in diabetic screenings for 2022. However, the plan is still tracking and analyzing outcome data monthly.

c. Identify any barriers to implementing initiatives:
- Many diabetic enrollees have multiple comorbidities which makes it challenging when attempting to prioritize a sub-set of this population. As such, Simply Healthcare Plans enhanced its methods to better stratify and prioritize enrollees based on the acuity and value of their identified gaps in care.

d. Identify strategy for continued improvement or overcoming identified barriers:
- Continue to track outcome data monthly and meet regularly with key stakeholders to review and analyze intervention and outcome data in order to determine improvement progress. Simply Healthcare will also continue to obtain enrollee feedback to better understand the barriers and impact from an enrollee perspective.
- Continue to hire and obtain appropriate resources as needed.
- Dedicated clinic days targeting diabetic eye care

HSAG Assessment: HSAG has determined that the plan has addressed the recommendations in the prior year's annual technical report.

Recommendations for Behavioral Health Domain

HSAG recommended the following:

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

- Conduct a root cause analysis to determine **why members who access the ED for mental illness are not accessing or receiving timely follow-up care** and establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, increase the use of telehealth services.
- Upon identification of root causes, implement appropriate interventions to improve performance.
- Evaluate the impact of the COVID-19 PHE and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.

Response

a. Describe initiatives implemented based on recommendations:
   - ENS Smart Alert for Behavioral Health created to better identify members with current or prior BH issues
     - The plan will continue to address and mitigate any barriers linked to this intervention as part of its ongoing evaluation determine the impact of this initiative.
   - BH Telehealth Initiative
   - The plan partnered with two Behavioral Health providers who agreed to perform the following:
     - Contact every member discharged from a Behavioral Health hospitalization within 24 hours and provide an immediate Telehealth BH visit which will address the FUH 7-Day population
     - Contact every member who visited an ED for Mental Illness, Alcohol and Other Drug Abuse or Dependence within 24 hours and provide an immediate Telehealth BH visit which will address the FUM and FUA 7-Day population
     - In addition, the plan did not want to miss the opportunity to impact a related PIP measure (FUH/FUM/FUA 30-Day sub measures) for those members who participate in the pilot. As such, each participant is contacted within 30 days of discharge from the Hospital/ED to schedule a BH Telehealth visit.
     - All members who participate and complete a TH visit are offered 1 week of free meals as a way to incentivize participation

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - Increased percentage of 7- and 30- day follow-up visits following a psychiatric ED/Hospital event.

c. Identify any barriers to implementing initiatives:
   - Timely identification and engagement of members with SMI for a follow-up visit within 7 days of a psychiatric Hospital/ED event.
   - COVID-19 Impact
   - It is difficult to ascertain the impact of COVID-19 on these rates. The overall impact of the pandemic on mental health, worsened by the apprehension over in-person visits and limited socialization has hindered the plan from potentially exceeding its annual goals for HEDIS

d. Identify strategy for continued improvement or overcoming identified barriers:
   - The plan has seen positive results from this intervention and will continue to monitor and track utilization of the hospital and ED events for members who participate in these programs. The plan will use these data to evaluate this intervention for overall effectiveness and modify as needed. The plan has expanded these efforts in 2022 and updates will be provided regularly.

HSAG Assessment

Managed Medical Assistance Plans

AmeriHealth-M

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Women's Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine **why female members are not receiving timely breast cancer screenings**. Plans should consider if there are disparities within their populations that contributed to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. • Upon identification of root causes, implement appropriate interventions to improve performance.
Response
a. Describe initiatives implemented based on recommendations: • Domain workgroups were developed to focus on measures. A Women's Health Domain workgroup has been convened to focus on these members. • Secret shopper activities were performed with providers to determine if appointment availability is an issue. The findings indicate this is not an issue for members at this time. • Focused outreach has been implemented with members in areas of high rates of non-compliance. Current focus is on members with good contact information and are Spanish speaking. Community Health Navigator is conducting focused outreach to assist in answering questions and scheduling appointments. • Member outreach is in place for members whereby they receive a monthly text message reminding them of their service. The message changes each month but focuses on the measure until the member becomes compliant or opts out of the program. • Researching mobile mammography capabilities as they relate to the AHCA restrictions. • ACFL is working to implement a two-way texting campaign to reach members in the way they prefer to communicate. • Healthy Behaviors member incentive programs are in place as an added incentive for member to complete services. Providing information to providers on Quality calls to encourage members to participate as there has not been a high adherence rate.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • HEDIS interim rates suggest the plan is performing the same as the previous year. ACFL monitors these rates closely and is working to identify ways to impact the measure further.
c. Identify any barriers to implementing initiatives: • AHCA restrictions on mobile mammography. Feedback was solicited from the agency indicating mobile partnerships can only exist with providers already contracted with the plan. This is a limited capacity.
d. Identify strategy for continued improvement or overcoming identified barriers: • Currently looking to partner with contracted facilities to engage members for mobile mammography. Working with a contact at the facility to address any barriers for members and develop a strong strategy to meet the needs of the members.

HSAG Assessment

Recommendations for Living With Illness Domain

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why **members are not receiving timely recommended screenings for diabetes.**

Response

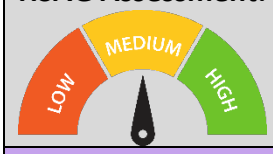
a. Describe initiatives implemented based on recommendations:
   - Domain workgroups were developed to focus on measures. A Diabetes Domain workgroup has been convened to focus on these members.
   - Member Advisory Committee is being utilized to recruit diabetic members. Members will be encouraged to share their barriers to access care.
   - Working with providers to encourage the use of Retinal Imaging as opposed to dilated eye exams. Intent is to reduce barriers for members who may need assistance with transportation if dilation is required.
   - Member outreach is in place for members whereby they receive a monthly text message reminding them of their service. The message changes each month but focuses on the measure until the member becomes compliant or opts out of the program.
   - Two-way texting campaigns in place to reach members with more complex health conditions. Case managers are able to communicate with members over a texting platform to reach them as they prefer.
   - Healthy Behaviors member incentive programs are in place as an added incentive for member to complete services. Providing information to providers on Quality calls to encourage members to participate as there has not been a high adherence rate.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - HEDIS interim rates indicate the rates for the Comprehensive Diabetic Care members are trending slightly lower than the previous year at the same time.

c. Identify any barriers to implementing initiatives:
   - Members are not remaining engaged with case managers
   - Members requiring someone to transport them to appointments if eye dilation is required

d. Identify strategy for continued improvement or overcoming identified barriers:
   - Collaborating with providers who are offering the retinal imaging option for members.
   - Exploring options of developing social media content to share with members to increase engagement in short educational videos.

HSAG Assessment:



Recommendations for Behavioral Health Domain

HSAG recommended the following:

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

- Lead a program-wide focus group that includes members and key community stakeholders to identify barriers/facilitators **why members who access the ED for mental illness are not accessing or receiving timely follow-up care** and establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, increase the use of telehealth services.
- Conduct a root cause analysis or focus study to determine **why child and adolescent members with ongoing antipsychotic medication are not receiving regular metabolic testing**.
- Upon identification of root causes, implement appropriate interventions to improve performance.
- Evaluate the impact of the COVID-19 PHE and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.

Response

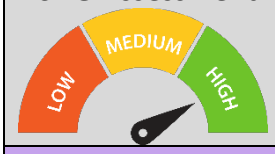
a. Describe initiatives implemented based on recommendations:
   - Domain workgroups were developed to focus on measures. A Behavioral Health Domain workgroup has been convened to focus on these members.
   - High volume providers have been targeted for focused education. Meetings have been convened with the providers to discuss strategy, members' needs and ensure appropriate contact information is available.
   - Brave Health has been contracted to work with members for the seven (7) day follow up requirements. Monitoring of the outcomes from these programs with Brave Health are ongoing.
   - PerformRX conducts outreach to members and providers regarding medication adherence issues.
     - AMM, SSA, and SSD measures include Pharmacist reviewing members records to address medication adherence issues. The Pharmacist can interact with the member, or the provider based on need.
     - APM: The pharmacist reviews and addresses all issues relating to metabolic monitoring and the use of concurrent antipsychotic medication. The pharmacist will also address Gaps in Care identified by PerformPRO. Gaps in Care are proprietary algorithms designed to identify gaps in evidence-based therapy.
   - Healthy Behaviors member incentive programs are in place as an added incentive for member to complete services. Providing information to providers on Quality calls to encourage members to participate as there has not been a high adherence rate.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - HEDIS interim rates indicate the rates for the behavioral health members are trending slightly lower than the previous year at the same time.

c. Identify any barriers to implementing initiatives:
   - Short turnaround time for identifying members and getting them into an appointment.

d. Identify strategy for continued improvement or overcoming identified barriers:
   - Strong focus on partnering with high volume facilities to address barriers as they develop.

HSAG Assessment:

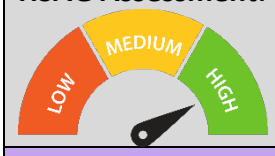
2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendations for Methodology
HSAG recommended the following: • Report accurate annual PIP performance data in accordance with the Agency-defined specifications and approved methodology. The reported data should be comparable across all measurement periods. • Address all validation feedback provided in the PIP Validation Tools. If not addressed, the corresponding evaluation element will be marked down in the PIP Validation Tool.
Response
a. Describe initiatives implemented based on recommendations: • Internal reviews of documents to ensure all elements are addressed based on feedback received.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Fewer items have required re-work.
c. Identify any barriers to implementing initiatives: • This process increases the amount of time required to complete submissions.
d. Identify strategy for continued improvement or overcoming identified barriers: • Continuous quality improvement strategies are in place to review documents with Subject Matter Expert's to ensure information is accurate and timely.
HSAG Assessment: 
Recommendations for Interventions
HSAG recommended the following: • Use active, evidence-based, innovative improvement strategies and interventions that have the potential to impact PIP performance indicator outcomes. • Seek enrollee input in order to better understand enrollee-related barriers toward access to care. • Collect intervention evaluation data frequently (weekly, biweekly, monthly, quarterly, etc.), unlike the annual performance indicator data. The intervention-specific evaluation data may help the plans identify significant clinical and programmatic improvement in outcomes. • Evaluate the performance of each intervention and include the most current intervention evaluation data available at the time of the submission date. • Provide adequate details about an intervention for the Agency and HSAG to better understand the intervention. For example, the plans should document how they will improve efforts to obtain real-time notifications from Florida's Encounter Notification System (ENS), and how the plans will use that data. For outreach interventions, the plans should include the mode and frequency of outreach.
Response
a. Describe initiatives implemented based on recommendations: • PIP workgroups have been developed including various SME's from the organization. • SME's attend the meeting and provide updates on the interventions in place and discuss the impact of these interventions.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Neonatal Abstinence Syndrome (NAS) measure has met the goal in Region 9.
- PPE PIP: All three metrics met target for both regions.

c. Identify any barriers to implementing initiatives:
- Some of the previous interventions were implemented without a clear vision on how to measure.

d. Identify strategy for continued improvement or overcoming identified barriers:
- Identifying data sources to measure the outcomes of the interventions.

HSAG Assessment:



Recommendations for Implementation

HSAG recommended the following:

- Interventions deemed successful when tested on a small scale using Plan-Do-Study-Act (PDSA) cycles should be ramped up and adopted plan-wide in order to impact the entire eligible population and realize improvement in the performance indicator rates.
- For unsuccessful interventions, the plans should make data-driven decisions to revise and continue the intervention or discontinue the intervention and revisit the causal-barrier analysis and implement new interventions.

Response

a. Describe initiatives implemented based on recommendations:
- Piloting a small-scale intervention of focused outreach to members in need of Adult Access Preventative Care and Breast Cancer Screening screenings.
- Working to partner with provider for a clinic day activity.
- Developing a two-way texting strategy to engage with members as they prefer.
- MDLive is now active with the plan providing members with a telehealth option.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Nothing significant noted at this time.

c. Identify any barriers to implementing initiatives:
- Members are hesitant to answer the phone. Those who do answer are not interested in allowing ACFL to assist in appointment scheduling.

d. Identify strategy for continued improvement or overcoming identified barriers:
- Implementing two-way texting campaign to engage with members in the way they prefer,
- Member Advisory Committee is a forum for members to share barriers they have with their care. This information is used to review processes and make changes as needed.
- Ongoing meetings with high volume providers to assess interest in partnering on clinic days.

HSAG Assessment:

Recommendations for Analysis
HSAG recommended the following: • Use quality improvement science tools such as process mapping, failure modes and effects analysis, or key driver diagram to identify and prioritize barriers and opportunities for improvement. • Include an executive sponsor (e.g., medical director, chief medical officer, or chief executive officer) in their PIP team who takes responsibility for the success of the project and can work to remove institutional barriers when needed. • Include at a minimum one data analyst on the PIP team. Data mining and analysis are crucial components to justify topics and evaluate interventions.
Response
a. Describe initiatives implemented based on recommendations: • ACFL's Chief Medical Officer participates in the PIP workgroups in place for the plan. • CMO is a champion specifically for the PPE PIP. The CMO meets with providers to review the 3M data supporting the PPE • Barrier analysis conducted for PIP's to determine if there were changes in the barriers.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • AFCL met the targets for all three PPE metrics (PPV, PPR, and PPA) in both regions 9 and 11 for 2021.
c. Identify any barriers to implementing initiatives: • No barriers at this time.
d. Identify strategy for continued improvement or overcoming identified barriers: • Consistent meetings are scheduled to review the PIP, identify current interventions, evaluate interventions and determine if new interventions are needed.
HSAG Assessment 

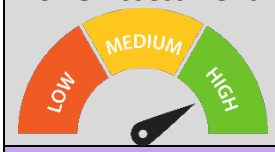
Vivida-M

Due to the upcoming acquisition by Simply, the Agency advised that Vivida was not required to submit a response to the prior year EQR recommendations.

Community Care Plan-M

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Pediatric Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine **why child and adolescent members are not receiving all recommended vaccines**. Plans should consider if there are disparities within their populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, implement appropriate interventions to improve immunization rates.
Response
• Analysis showed for Adolescent Immunizations: o No differences in results by gender, language preferred, or race/ethnicity. o Parents refusing meningococcal vaccine due to confusion with MMR vaccine controversy. o Parents refusing HPV vaccine or not bringing child back for 2nd or 3rd in series. o Providers starting HPV series too close to 13th birthday. • Analysis showed for Childhood Immunizations: o No difference by gender, language preferred, or race/ethnicity. o Religious Exemption is 3.3% in Broward compared to 2.9% statewide. o Anti-vaccine sentiment rising in Florida overall. Broward has lowest vaccination rates in Florida – dropped from 94% in 2020 to 44% in 2021. o Identified 10 medium to large practices that were giving 3 DTap and 3 Prevnar instead of the required 4 each. a. Describe initiatives implemented based on recommendations: o Text messaging to all households that are deficient in completion of shots/annual well visit. o List of enrollees that need to get caught out before turning 2 or 13 years old sent to providers monthly. o Education to providers about starting HPV at 11 years of age. o Sponsor of Vaccinate Broward each year with Memorial Healthcare System and Broward Health.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Current Combo 3 rate for 2-year-old is 60.98% with 4 months left in year, 3.74 points below final last year. • Current Combo 2 rate for 13-year-old is 31.83%, 1.82 points below final rate last year
c. Identify any barriers to implementing initiatives: (See Attachment A) • COVID-19 pandemic – turn out for Vaccinate Broward was lower than expected. Vaccinate Broward is a one-day county wide event (up to ten sites) for vaccination catch-up. • Religious Exemption is 3.3% in Broward compared to 2.9% statewide. • Anti-vaccine sentiment rising in Florida overall. Broward has the lowest vaccination rates in Florida – dropped from 94% in 2020 to 44% in 2021. • Parent/guardian limiting vaccines given at one time creating a missed opportunity to finish a series (i.e., 3 rotavirus vaccines before age 6 months)
d. Identify strategy for continued improvement or overcoming identified barriers: • Continue to send practice specific rates and monthly list of enrollees needing to complete series prior to birthday. • Continue monthly Well Child Visit reminder lists to providers – to encourage enrollee outreach from their established primary care provider.

HSAG Assessment



Recommendations for Women's Care Domain

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine **why female members are not receiving timely screenings**. Plans should consider if there are disparities within their populations that contributed to lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Upon identification of root causes, implement appropriate interventions to improve performance.

Response

a. Describe initiatives implemented based on recommendations:
   - Conducted analysis of compliance with breast and cervical cancer screening by race/ethnicity and language.
   - Breast Cancer Screening: Women ages 60+ were less likely to complete a mammogram. Spanish language preferred also showed a higher non-compliance.
   - Cervical Cancer Screening: Women post child-bearing years completed the exam less than women ages 20-39. There were no overt differences in compliance based on race or preferred language.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - Breast Cancer Screening MY 2022 is 52.09 as of August which is slightly higher than yearend MY2021.
   - Cervical Cancer Screening: not available

c. Identify any barriers to implementing initiatives:
   - Breast Cancer Screening: Identifying and targeting Spanish language preferred enrollees with correct education in their Spanish dialect.

d. Identify strategy for continued improvement or overcoming identified barriers:
   a. Breast Cancer Screening:
      - Posts on social media.
      - Text campaign.
      - Education through Community Resource Center personnel/website.
   - Cervical Cancer Screening:
      - Reminders to women post child-bearing years.

HSAG Assessment

Recommendations for Living With Illness Domain

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why **members are not receiving timely recommended screenings for diabetes**.

Response

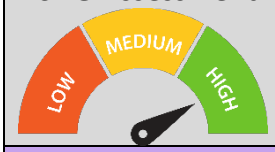
a. Describe initiatives implemented based on recommendations:
- Conducted analysis of diabetic enrollees and compliance with hemoglobin A1c testing and retinal examination by race/ethnicity and language.
  - Hemoglobin A1c: Age was a factor in completing testing for enrollees 18-29 years old. Low compliance in both working and older enrollees was due to telehealth visits (member not receiving lab order in person), having to leave the house to go to a lab, and labs open by appointment only in 2020 and early 2021.
  - Retinal Examination: Younger enrollees did not complete the examination. Race/Ethnicity was not a factor. Overall, in meetings with providers, increase use of telehealth by primary care provider, enrollee reports 'no eye problems', Broward County lock down of non-essential services in 2020 and into 2021 were barriers to closing care gap.
- Implemented:
  - Suggestion to large clinics to purchase point of care hemoglobin A1c test kits.
  - Implemented residential retinal screening program with eye care vendor.
  - Vision vendor opened facility in north central part of Broward County by appointment for screening.
  - Expanded in clinic program (2 cameras in place) to a sickle cell clinic.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Residential retinal screening program captured 86 screenings versus 24 in primary care clinic.

c. Identify any barriers to implementing initiatives:
- Facilities in north Broward County have declined working with eye care vendor for in clinic cameras.

d. Identify strategy for continued improvement or overcoming identified barriers:
- Continue residential screening program and begin early in next MY.
- Attempt expansion of cameras in clinics program to north Broward County.

HSAG Assessment



Recommendations for Behavioral Health Domain

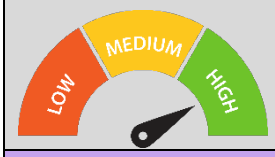
HSAG recommended the following:

- **Enhance communication and collaboration with hospitals** to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.
- Conduct a root cause analysis and lead a program-wide focus group that includes members and key community stakeholders to identify barriers/facilitators for **members who access the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care** and establish potential performance improvement strategies and solutions. If the COVID-19 PHE was a factor, increase the use of telehealth services.
- Conduct a root cause analysis or focus study to determine **why members are not remaining on their antidepressant medication**. Upon identification of a root cause, implement appropriate interventions to improve performance.
- Upon identification of root causes, implement appropriate interventions to improve performance.
- Evaluate the impact of the COVID-19 PHE and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable.

Response

Analysis showed:
• ED for Mental Illness or AOD abuse or dependence: Behavioral staff insight showed:
  ○ Enrollee does not feel they have a problem or need treatment, denial.
  ○ Homelessness, using drugs/alcohol as coping mechanism.
  ○ Stigma or shame particularly with mental illness.
  ○ Not ready to stop using.
• Antidepressant Medication Continuation Phase: phone outreach by CCP pharmacy department to enrollees on antidepressants and close to end of continuation phase date. Person to person interviewing found that:
  ○ Stated they did not have depression.
  ○ Filled but did not start the medication.
  ○ Stopped because of side effects.
  ○ Became pregnant.
  ○ Prescribed for an upsetting life event – short episodic use.
a. Initiatives implemented:
  ○ Brought behavioral health in house in 2020.
  ○ Contracted with, known to health plan, behavioral health medical director.
  ○ Implemented daily Behavioral Health Huddles to discuss inpatient and ED admissions.
  ○ Contracted with behavioral health hospital to receive timely data on admissions.
  ○ Working with two behavioral health community resources to improve data capture of follow up visits.
  ○ Implemented phone outreach to enrollees on antidepressants to educate and encourage continued use and to coordinate with antidepressant prescriber.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Follow up after ED visit for mental illness (30 day) current year to date rate is 37.50% (30.09 points higher than MY20 and 5.68 points than MY21). • Follow up after ED visit for Substance Use Disorder 7-day current rate is 19.44% and 30 day is 27.78% which is higher that year end MY21: 3.92% for both 7 day and 30 day follow up. • Antidepressant Medication Continuation Phase: current MY22 rate is 55.56% which is 1.71 points higher than MY21.
c. Identify any barriers to implementing initiatives: • Nature of addiction and mental illness – difficult to engage enrollee. • One hospital has not agreed to share data timely.
d. Identify strategy for continued improvement or overcoming identified barriers: • Continue talks with inpatient facilities to secure timely data on ED use. • Continue Huddles and review of ED and inpatient admissions. • Continue pharmacy outreach to enrollees to educate on antidepressant use and to encourage continuation.
HSAG Assessment 

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendations for Methodology
HSAG recommended the following: • Report accurate annual PIP performance data in accordance with the Agency-defined specifications and approved methodology. The reported data should be comparable across all measurement periods. • Address all validation feedback provided in the PIP Validation Tools. If not addressed, the corresponding evaluation element will be marked down in the PIP Validation Tool.
Response
a. Describe initiatives implemented based on recommendations: • Updated the PIPs methodology: goals, benchmarks, and results based on feedback.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Meeting target rate for all 3 PPE metrics (PPA, PPR, PPV) • Decreased NAS per 1000 deliveries from 11.10 per thousand in FFY 2020 to 3.52 per thousand in FFY 2021 • Although it did not meet target rate, decreased preterm deliveries from 13.76% in FFY 2020 to 11.95% in FFY 2021
c. Identify any barriers to implementing initiatives: • CCP does not know of pregnancy until presentation for delivery.
d. Identify strategy for continued improvement or overcoming identified barriers: • Use of ENS and CCP Daily Bed Census to identify members who are pregnant, could have a PPE, or a BH condition.
HSAG Assessment 
Recommendations for Interventions
HSAG recommended the following: • Use active, evidence-based, innovative improvement strategies and interventions that have the potential to impact PIP performance indicator outcomes. • Seek enrollee input in order to better understand enrollee-related barriers toward access to care. • Collect intervention evaluation data frequently (weekly, biweekly, monthly, quarterly, etc.), unlike the annual performance indicator data. The intervention-specific evaluation data may help the plans identify significant clinical and programmatic improvement in outcomes. • Evaluate the performance of each intervention and include the most current intervention evaluation data available at the time of the submission date. • Provide adequate details about an intervention for the Agency and HSAG to better understand the intervention. For example, the plans should document how they will improve efforts to obtain real-time notifications from Florida's Encounter Notification System (ENS), and how the plans will use that data. For outreach interventions, the plans should include the mode and frequency of outreach.
Response
a. Describe initiatives implemented based on recommendations:

- Updated the BH and Transportation PIP. Completed PDSAs on two BH interventions and updated FMEA.
- Completed Cycle #3 of Transportation PDSA and included monitoring of vendor.
- Birth Outcomes: Updated PDSAs with top high-risk conditions, identification of high-risk pregnancies, and providers that are meeting MPIP.,
- Data is collected monthly for BH, PPE and Transportation and daily for Birth Outcomes. All data is loaded into an Operational Dashboard for viewing and request for action by Executive Team.
- Implemented collaboration Community Resources (Henderson and Chrysalis) and with Fort Lauderdale Hospital (Admissions and Discharge data).

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Will have by end of the year

c. Identify any barriers to implementing initiatives:
- Outreached to two BH inpatient hospitals – still in negotiations.
- Two BH community resources are now sharing data about admissions and discharges – daily/weekly.

d. Identify strategy for continued improvement or overcoming identified barriers:
- Continue to pursue consistent data sharing with BH hospitals.

HSAG Assessment

Recommendations for Implementation

HSAG recommended the following:

- Interventions deemed successful when tested on a small scale using Plan-Do-Study-Act (PDSA) cycles should be ramped up and adopted plan-wide in order to impact the entire eligible population and realize improvement in the performance indicator rates.
- For unsuccessful interventions, the plans should make data-driven decisions to revise and continue the intervention or discontinue the intervention and revisit the causal-barrier analysis and implement new interventions.

Response

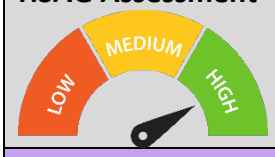
a. Describe initiatives implemented based on recommendations:
- CCP is a small health plan in one county. We have tested and implemented, if successful, on the whole population.
- PPE: discontinued LACE initiative; added Bed Census Initiative.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- BH Priority #3 Cycle #2 9.43 percentage point increase in total number of BH Cases managed inhouse.
- Transportation Cycle #3 showed 93.33% compliance. Increase of 6.49 percentage points from Cycle #1 testing period.
- PPE PDSA–: Demonstrated a decrease (from 19.67% to 8.33%) in ED visits per thousand in members with a Blueberry Pediatrics claim over the past two quarters.
- PPE PDSA-Readmission: Successfully reached for follow up call within 7 days and 15 days post discharge from inpatient admission. From 1st measurement 7 day increased from 19.72% to 20.02% and 15 day increased from 23.45% to 26.4%.

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

d. Identify strategy for continued improvement or overcoming identified barriers:
- BH: Continue daily Huddles with BH medical director in attendance; continue outreach to stakeholders to identify all enrollees admitted to inpatient or seen in an ER and in need of behavioral health services.
- Transportation: Continue monthly monitoring of compliance. Issue CAP when below goal for 3 consecutive months.
- PPR: Continue follow up calls post discharge to resolve enrollee needs.
- PPV: Continue Blueberry Telemedicine outreach and enrollment into program.
- Continue Bed Census Review to capture ED and inpatient admission so that case managers can intervene quickly with care coordination with primary care provider.
- Birth Outcomes: Continue use of Bed Census to identify pregnancies early and be able to assess the enrollee for risk to be able to best coordinate care.

HSAG Assessment



Recommendations for Analysis

HSAG recommended the following:

- Use quality improvement science tools such as process mapping, failure modes and effects analysis, or key driver diagram to identify and prioritize barriers and opportunities for improvement.
- Include an executive sponsor (e.g., medical director, chief medical officer, or chief executive officer) in their PIP team who takes responsibility for the success of the project and can work to remove institutional barriers when needed.
- Include at a minimum one data analyst on the PIP team. Data mining and analysis are crucial components to justify topics and evaluate interventions.

Response

a. Describe initiatives implemented based on recommendations:
- BH – Added additional language to team attendees with role in Step VIII. Updated FMEA (NBD202210PIPMHb) tool to re-prioritize based on current data. Updated PDSA on Priority 1 with Cycle #2 data (NBD202210PIPMHc). Created PDSAs on Priority 2 and Priority 3 with Cycle #1 data. (NBD202210PIPMHd and NBD202210PIPMHe).
- Transportation – completed Cycle #3 testing of continued monitoring and resolution of CAP.
- PPE-outcomes based on enrollees who utilized telemedicine services.
- Birth Outcomes- continued PDSA cycles for enrollee incentive, MPIP, Bed Census, and risk stratification.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- BH Priority #3 Cycle #2 9.43 percentage point increase in total number of BH Cases managed in house.
- Transportation Cycle #3 showed 93.33% compliance. Increase of 6.49 percentage points from Cycle #1 testing period.

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

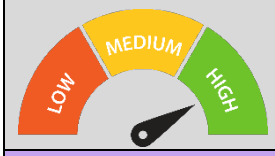
d. Identify strategy for continued improvement or overcoming identified barriers:
- BH: Continue daily Huddles with BH medical director in attendance; continue outreach to stakeholders to identify all enrollees admitted to inpatient or seen in an ER and in need of behavioral health services.
- Transportation: Continue monthly monitoring of compliance. Issue CAP when 3 months are below compliance.
- Birth Outcomes: Continue daily monitoring. If new trend in birth outcomes arise, implement new initiatives to improve rates.
- PPEs: Continue monthly monitoring. If new trend arises, implement new initiatives to combat increase in PPE.

HSAG Assessment

Long Term Care Plus Plans

Florida Community Care-L

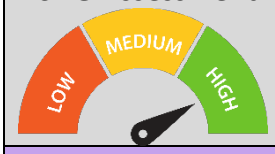
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for LTC Program
HSAG recommended the following: • **Continue to monitor rates over time to identify COVID-19 PHE rate impact**, ensuring lower quality and access to care is not driven by a non-PHE cause.
Response
a. Describe initiatives implemented based on recommendations: • During the Covid PHE from April 2020 – March 2021, FCC developed a specific COVID assessment which was used by the Care Managers for tracking, trending, and ensuring the proper support was received. • Since March 2021, FCC has implemented a daily dashboard for each Care Manager based on the utilization of the Encounter Notification Service (ENS) data. The Care Managers receive an alert when the enrollee is admitted with COVID, and the follow-up protocol is initiated including the COVID-19 assessment.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Enrollees are more forthcoming with providing the Care Managers with COVID-19 diagnoses as the fear factor has lessened. • ENS notifications are being accessed daily and assessments and follow-ups are timelier due to the dashboard. Non-PHE diagnoses are also identified.
c. Identify any barriers to implementing initiatives: • Incomplete data received through ENS.
d. Identify strategy for continued improvement or overcoming identified barriers: • FCC Care Managers will continue to track, trend, and assist with appointments and transportation. • FCC Care Managers outreach to facilities, providers, and caregivers when ENS data is incomplete.
HSAG Assessment 
3. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendations for Methodology
HSAG recommended the following: • Report accurate annual PIP performance data in accordance with the Agency-defined specifications and approved methodology. The reported data should be comparable across all measurement periods. • Address all validation feedback provided in the PIP Validation Tools. If not addressed, the corresponding evaluation element will be marked down in the PIP Validation Tool. • Report accurate annual PIP performance data in accordance with the Agency-defined specifications and approved methodology. The reported data should be comparable across all measurement periods.

• Florida Community Care-L reported transportation vendor-specific data. HSAG provided feedback that the plan should provide a comprehensive rate in the next submission.
Response
a. Describe initiatives implemented based on recommendations: • FCC followed the recommended guidelines and provided a comprehensive rate in the transportation PIP. • All validation feedback from the validation tool were addressed in the latest PIP submission. • No new initiatives were implemented based on the HSAG recommendations summarized above.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not Applicable
c. Identify any barriers to implementing initiatives: • Not Applicable
d. Identify strategy for continued improvement or overcoming identified barriers: • Not Applicable
HSAG Assessment 
Recommendations for Interventions
HSAG recommended the following: • Use active, evidence-based, innovative improvement strategies and interventions that have the potential to impact PIP performance indicator outcomes. • Seek enrollee input in order to better understand enrollee-related barriers toward access to care. • Collect intervention evaluation data frequently (weekly, biweekly, monthly, quarterly, etc.), unlike the annual performance indicator data. The intervention-specific evaluation data may help the plans identify significant clinical and programmatic improvement in outcomes. • Evaluate the performance of each intervention and include the most current intervention evaluation data available at the time of the submission date. • Provide adequate details about an intervention for the Agency and HSAG to better understand the intervention. For example, the plans should document how they will improve efforts to obtain real-time notifications from Florida's ENS, and how the plans will use that data. For outreach interventions, the plans should include the mode and frequency of outreach.
Response
a. Describe initiatives implemented based on recommendations: • Real-time enrollee satisfaction survey was implemented during this period. Data were collected weekly. The mode of contact was outbound telephone calls after receiving transportation services.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • One 90-day cycle was completed. Results reveal primary cause of dissatisfaction was the transportation provider's late pick-ups. The intervention is to share the data with the transportation vendor.
c. Identify any barriers to implementing initiatives:

- There were no barriers when implementing the real-time enrollee satisfaction survey. FCC does not anticipate any barriers to working with our transportation vendor.

d. Identify strategy for continued improvement or overcoming identified barriers:
- Additional 90-day cycles, data analysis, and intervention with the transportation vendor.

HSAG Assessment



Recommendations for Implementation

HSAG recommended the following:

- Interventions deemed successful when tested on a small-scale using Plan-Do-Study-Act (PDSA) cycles should be ramped up and adopted plan-wide in order to impact the entire eligible population and realize improvement in the performance indicator rates.
- For unsuccessful interventions, the plans should make data-driven decisions to revise and continue the intervention or discontinue the intervention and revisit the causal-barrier analysis and implement new interventions.

Response

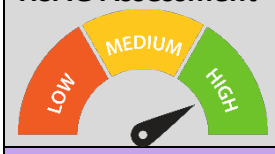
a. Describe initiatives implemented based on recommendations:
- The centralization of telehealth referrals for Behavioral Health (BH) 7-day follow-up was discontinued due to the low number of completed 7day appointments. A new resource was identified with BH experience to assess enrollee preferences for 7day appointments.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- The modified intervention started in August. Data is being collected and analyzed.

c. Identify any barriers to implementing initiatives:
- In general enrollees are not amenable to telehealth services or BH follow-up.
- Some enrollees that are willing to engage with telehealth are technologically challenged.

d. Identify strategy for continued improvement or overcoming identified barriers:
- The FCC BH nurse accesses the enrollee and schedules the 7day follow-up per enrollee's preferred modalities.

HSAG Assessment



Recommendations for Analysis

HSAG recommended the following:

- Use quality improvements science tools such as process mapping, failure modes, and effects analysis, or key driver diagrams to identify and prioritize barriers and opportunities for improvement.
- Include an executive sponsor (e.g., medical director, chief medical officer, or chief executive officer) in their PIP team who takes responsibility for the success of the project and can work to remove institutional barriers when needed.

• Include at a minimum one data analyst on the PIP team. Data mining and analysis are crucial components to justify topics and evaluate interventions.
Response
a. Describe initiatives implemented based on recommendations: • FCC utilizes the fishbone diagram to determine the root causes of the issue to help with improvement strategies. • FCC's Chief Medical Officer oversees the initiatives and ensures that the project is successful. • Our VP of Actuarial Services and Director of Reporting is pivotal to the PIPs by providing and analyzing the data that is reported.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable
c. Identify any barriers to implementing initiatives: • None
d. Identify strategy for continued improvement or overcoming identified barriers: • All fishbone diagrams were revisited, and barriers were reprioritized.
HSAG Assessment 

Dental Plans

DentaQuest-D

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

HSAG recommended the following:
• The statewide average for the following measure indicators declined more than 5 percentage points from RY 2020 to RY 2021:
  ○ *Annual Dental Visits—Total*
  ○ *Topical Fluoride for Children at Elevated Caries Risk—Total*
  ○ *Oral Evaluation—Total*
  ○ *Follow-Up After ED Visits for Dental Caries in Children—30 Day Follow-Up—Total*
  ○ *Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk—Total*
  ○ *Follow-Up After Dental-Related ED Visits*
The dental plans should continue to monitor their rates over time to identify public health emergency (PHE) rate impact, ensuring lower access to dental care is not driven by a non-PHE cause, and adopt QI strategies to improve rates. If access to care is the reason for lower rates, the plans should also evaluate their networks to ensure enough providers are available for services for members.

Response
a. Describe initiatives implemented based on recommendations: • We monitor utilization rates continuously and continue to see most if not all of the decreased utilization in 2020 through early 2022 has been due to impacts of the PHE. However, recent inflationary pressure on provider office overhead in 2022 is starting to cause a rebalance of patient mix to offset the higher overhead. DQ is investing in provider offices to increase office capacity and access for Medicaid members
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • None identified; although low dental rates are impacting the ability to recruit and retain providers
d. Identify strategy for continued improvement or overcoming identified barriers: • Continue to monitor and will develop strategies as needed
HSAG Assessment 
2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendations for Methodology
HSAG recommended the following: • For the *Coordination of Transportation Services With the SMMC Plans PIP*, the PIP performance indicator data reported by DentaQuest were not in accordance with the Agency-defined specifications. The dental

plan must seek technical assistance from the Agency and/or HSAG prior to the annual PIP submission due date rather than documenting the issues in the PIP Submission Form and not reporting data.

- Address all validation feedback provided in the PIP Validation Tools. If not addressed, the corresponding evaluation element will be marked down in the PIP Validation Tool.

Response

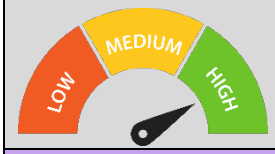
a. Describe initiatives implemented based on recommendations:
   - Transportation PIP Performance Indicator two was re-baselined according to HSAG recommendations.
   - Validation feedback will be addressed in subsequent PIP submissions.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - N/A: No initiative implemented since this was related to a data collection issue and subsequent performance indicator re-baseline.

c. Identify any barriers to implementing initiatives:
   - N/A: No initiative implemented since this was related to a data collection issue and subsequent performance indicator re-baseline.

d. Identify strategy for continued improvement or overcoming identified barriers:
   - N/A: No initiative implemented since this was related to a data collection issue and subsequent performance indicator re-baseline.

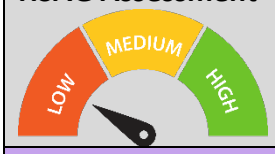
HSAG Assessment



Recommendations for Interventions

HSAG recommended the following:

- For the *Preventive Dental Services for Children PIP*, there was a decline or no improvement in the PIP performance indicator rate, despite the intervention evaluation data-driven evidence of clinically significant or programmatically significant improvement in PIP outcomes. In addition to offering telehealth appointments, the dental plan should consider addressing other social determinants of health that prevent the enrollees from seeking preventive dental care. Additionally, the interventions determined as successful during the Plan-Do-Study-Act (PDSA) cycles should be expanded to the entire eligible population served by the dental plan to impact the plan-wide rate.
- Seek enrollee input in order to better understand enrollee-related barriers toward access to care.
- Collect intervention evaluation data frequently (weekly, biweekly, monthly, quarterly, etc.), unlike the annual performance indicator data. The intervention-specific evaluation data may help the plans identify significant clinical and programmatic improvement in outcomes.
- Evaluate the performance of each intervention and include the most current intervention evaluation data available at the time of the submission date.
- Provide adequate details about an intervention for the Agency and HSAG to better understand the intervention. For example, the plans should document how they will improve efforts to obtain real-time notifications from Florida's Encounter Notification System (ENS), and how the plans will use that data. For outreach interventions, the plans should include the mode and frequency of outreach.

Response
a. Describe initiatives implemented based on recommendations: • Monthly PIP meetings, monitor strategies
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • n/a
c. Identify any barriers to implementing initiatives: • Raised issue of data sharing with agency, no changes implemented
d. Identify strategy for continued improvement or overcoming identified barriers: • Continue monitoring
HSAG Assessment 
Recommendations for Implementation
HSAG recommended the following: • Interventions deemed successful when tested on a small scale using Plan-Do-Study-Act (PDSA) cycles should be ramped up and adopted plan-wide in order to impact the entire eligible population and realize improvement in the performance indicator rates. • For unsuccessful interventions, the plans should make data-driven decisions to revise and continue the intervention or discontinue the intervention and revisit the causal-barrier analysis and implement new interventions.
Response
a. Describe initiatives implemented based on recommendations: • Committee in place, initiatives implemented
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A due to public health emergency
c. Identify any barriers to implementing initiatives: • Public health emergency
d. Identify strategy for continued improvement or overcoming identified barriers: • Successful interventions will be ramped up and causal barrier analysis will be revisited to implement new interventions.
HSAG Assessment NA
Recommendations for Analysis
HSAG recommended the following: • Use quality improvement science tools such as process mapping, failure modes and effects analysis, or key driver diagram to identify and prioritize barriers and opportunities for improvement. • Include an executive sponsor (e.g., medical director, chief medical officer, or chief executive officer) in their PIP team who takes responsibility for the success of the project and can work to remove institutional barriers when needed. • Include at a minimum one data analyst on the PIP team. Data mining and analysis are crucial components to justify topics and evaluate interventions.

Response
a. Describe initiatives implemented based on recommendations: • Continue to use quality improvement tools; research and develop new outcomes
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • n/a due to public health emergency
c. Identify any barriers to implementing initiatives: • None at this time – Public Health Emergency
d. Identify strategy for continued improvement or overcoming identified barriers: • Successful interventions will be ramped up and causal barrier analysis will be revisited to implement new interventions.
HSAG Assessment NA

Liberty-D

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

HSAG recommended the following:
• The statewide average for the following measure indicators declined more than 5 percentage points from RY 2020 to RY 2021:
  ○ *Annual Dental Visits—Total*
  ○ *Topical Fluoride for Children at Elevated Caries Risk—Total*
  ○ *Oral Evaluation—Total*
  ○ *Follow-Up After ED Visits for Dental Caries in Children—30 Day Follow-Up—Total*
  ○ *Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk—Total*
  ○ *Follow-Up After Dental-Related ED Visits*
The dental plans should continue to monitor their rates over time to identify public health emergency (PHE) rate impact, ensuring lower access to dental care is not driven by a non-PHE cause, and adopt QI strategies to improve rates. If access to care is the reason for lower rates, the plans should also evaluate their networks to ensure enough providers are available for services for members.

Response
a. Describe initiatives implemented based on recommendations: • LIBERTY actively monitors access to care barriers through monthly and quarterly geo-access reports, call center data, and member complaint and grievance data to ensure that utilization of services is not impacted by access issues. The Provider Relations team also reviews all out of network denials to identify leads. The local network manager calls or visits offices to present the contracting and Credentialing material to avoid further claims denials. • We use our new Asynchronous Teledentistry program to engage members, triage their caries risk, and navigate them to a dental home. The program offers members the opportunity to engage a LIBERTY dental clinician through our proprietary, secure application. Unlike Synchronous Teledentistry that occurs in "real time," our Asynchronous program offers members the convenience of initiating a visit at a time that is convenient to them, even if it is outside business hours. Using the survey and images submitted, LIBERTY's clinical team triages the member's risk level and provides follow-up engagement. We offer a nominal member incentive for participation in the program. • LIBERTY was successful in contracting with a periodontist and prosthodontist who have never participated in the Medicaid program. • LIBERTY implemented a P-DENT pay-for-performance program to incentivize providers to outreach to under-utilizing enrollees in Florida. Providers were paid a bonus in addition to their contracted fee when performing eligible services. • LIBERTY implemented a HEDIS ADV pay-for performance program to incentivize providers to outreach to under-utilizing enrollees in Florida. Providers were paid a bonus in addition to their contracted fee when performing eligible services. • To encourage the appropriate, medically necessary use of dental sealants in Florida, LIBERTY designed a multi-pronged strategy identifying under-utilizing providers, and then counseled and educated them through one-on-one outreach. • The Dental Wellness Team partners with local providers to perform oral health education, and to conduct child screenings and fluoride varnish application. The team identifies children who are high-risk (with active dental disease) and navigates them to a dental provider for an in-office visit.

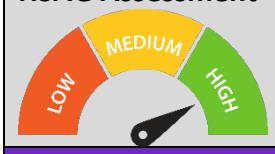
- LIBERTY has a dedicated outreach team within Member Services to reach out to new enrollees to complete the enrollee's OHRA, educate the enrollee regarding their dental home, and schedule an appointment for the member.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- After one intervention that was focused on targeting under-utilizing providers, one provider increased their sealant rate from 22 in 2019 to 189 in 2021 and with 249 YTD in 2022.
- In 2022, LIBERTY's dental wellness team in collaboration with local providers, performed over 3200 oral screenings and applied over 2600 fluoride varnish applications
- In RY 2022, LIBERTY was able to showcase an 11.50% increase in the Annual Dental Visits measure when compared to RY 2021.

c. Identify any barriers to implementing initiatives:
- The COVID-19 Pandemic had a significant impact on the dental delivery system. All non-essential services were prohibited by Executive Order in 2020. Once the non-essential services prohibition was lifted, dental providers were still not authorized to perform non-essential services unless providers had PPE. There was a national PPE shortage, which impacted Florida providers' ability to provide services. The COVID Pandemic continues to impact utilization to this day. See Milliman documentation provided in support of the 2021, 2022, and 2023 rate setting processes.
- Certain Florida Counties (located in Regions 2, 8, 11) are lacking certain specialties. This barrier may create access to care issues for enrollees in these regions.
- Inaccurate enrollee demographic data negatively impacts successful outreach to targeted enrollees.

d. Identify strategy for continued improvement or overcoming identified barriers:
- LIBERTY conducts active recruitment and network development. These efforts specifically target and encourage non-Medicaid providers to enroll with Florida Medicaid and help facilitate growth within the FL Medicaid network.
- LIBERTY's Dental Wellness Team in collaboration with Florida's Department of Health performs mobile dental services in various regions across Florida. Efforts from these teams typically include application of fluoride varnish, sealant placement, oral exams, and educational visits.
- LIBERTY performs outreach to partner SMMC plans to try to obtain updated enrollee demographic information. In addition, LIBERTY updates demographic information retrieved through ENS data files and through enrollee contact with the LIBERTY Member Service Department. Updated information is stored in our internal Management Information System (MIS).
- LIBERTY has a dedicated outreach team within Member Services to reach out to new enrollees to perform the OHRA, educate on the enrollee's dental home, and schedule an appointment for the member.

HSAG Assessment



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

Recommendations for Methodology

HSAG recommended the following:

- For the *Coordination of Transportation Services With the SMMC Plans* PIP, the PIP performance indicator data reported by Liberty were not in accordance with the Agency-defined specifications. The dental plan must seek technical assistance from the Agency and/or HSAG prior to the annual PIP submission due date rather than documenting the issues in the PIP Submission Form and not reporting data.

- Address all validation feedback provided in the PIP Validation Tools. If not addressed, the corresponding evaluation element will be marked down in the PIP Validation Tool.

Response

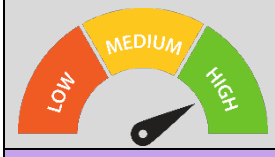
a. Describe initiatives implemented based on recommendations:
   - In March 2021, LIBERTY scheduled a technical assistance call with HSAG representatives Anchal Gupta and Kim Elliot regarding the Agency-defined specifications for the Coordination of Transportation Services PIP. HSAG educated LIBERTY and confirmed that the denominator for both indicators should be same and should reflect all the transportation requests that were received by the dental plan. The PIP focuses on whether the requests that were received by the dental plan were coordinated, whether the enrollee was referred to the SMMC plan/or the transportation vendor, whether the plan contacted the enrollee to ensure that the transportation was scheduled, and whether the enrollee was notified.
   - HSAG also trained LIBERTY on how to report statistical significance via GraphPad and through various tests, such as fisher's exact or chi square.
   - With HSAG guidance, LIBERTY was able to correct the report and data in the most recent submission, and do not anticipate any issues on future submissions.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - LIBERTY's 2022 PIP submission was completed in accordance with agency defined specifications, included statistical significance tests/validation, and addressed all feedback from the prior submissions.

c. Identify any barriers to implementing initiatives:
   - NA

d. Identify strategy for continued improvement or overcoming identified barriers:
   - LIBERTY will seek technical assistance from HSAG/AHCA prior to all future annual PIP submissions, when suitable.

HSAG Assessment



Recommendations for Interventions

HSAG recommended the following:

- For the *Preventive Dental Services for Children* PIP, there was a decline or no improvement in the PIP performance indicator rate, despite the intervention evaluation data-driven evidence of clinically significant or programmatically significant improvement in PIP outcomes. In addition to offering telehealth appointments, the dental plan should consider addressing other social determinants of health that prevent the enrollees from seeking preventive dental care. Additionally, the interventions determined as successful during the Plan-Do-Study-Act (PDSA) cycles should be expanded to the entire eligible population served by the dental plan to impact the plan-wide rate.
- Seek enrollee input in order to better understand enrollee-related barriers toward access to care.
- Collect intervention evaluation data frequently (weekly, biweekly, monthly, quarterly, etc.), unlike the annual performance indicator data. The intervention-specific evaluation data may help the plans identify significant clinical and programmatic improvement in outcomes.
- Evaluate the performance of each intervention and include the most current intervention evaluation data available at the time of the submission date.

- Provide adequate details about an intervention for the Agency and HSAG to better understand the intervention. For example, the plans should document how they will improve efforts to obtain real-time notifications from Florida's Encounter Notification System (ENS), and how the plans will use that data. For outreach interventions, the plans should include the mode and frequency of outreach.

Response

a. Describe initiatives implemented based on recommendations:

- Once COVID restrictions were lifted after the initial Public Health Emergency (PHE) period, LIBERTY's outreach team re-engaged at community events to educate enrollees on dental carries and impact on their overall health, and where possible, performing exams, sealants, and fluoride treatments.
- Pay for performance provider bonus initiatives were deemed successful and rolled out to entire eligible populations.
- Enrollee input from member complaint and grievance data is used to assess access issues.
- Information from Community Smiles data on social determinants of health (SDOH) impacting members, and an update to the Oral Health Risk Assessment (OHRA) to include access risks/needs were implemented to allow us to expand enrollee direct input.
- LIBERTY has been expanding tools and resources to allow for more frequent reporting and analysis of the various interventions. Starting in Q4 2022, all intervention data will be monitored and reported at least quarterly, which will allow us to include most current performance evaluation data at the time of submission moving forward.
- LIBERTY currently obtains real-time data from the ENS system, which is used to perform outreach and care coordination. LIBERTY also added real-time input from OHRA submissions and Teledental appointments to capture oral health risks or barriers to care. These risks and barriers are routed to Case Managers within the Case Management Department who perform outreach and help coordinate an appointment.

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

- N/A

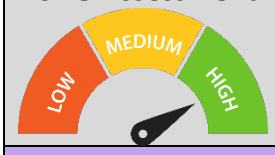
c. Identify any barriers to implementing initiatives:

- The COVID-19 Pandemic had a significant impact on the dental delivery system. All non-essential services were prohibited by Executive Order in 2020. Once the non-essential services prohibition was lifted, dental providers were still not authorized to perform non-essential services unless providers had PPE. There was a national PPE shortage, which impacted Florida providers' ability to provide services. The COVID Pandemic continues to impact utilization to this day. See Milliman documentation provided in support of the 2021, 2022, and 2023 rate setting processes.
- Outdated member demographic information continues to be a leading barrier to implementing various initiatives.

d. Identify strategy for continued improvement or overcoming identified barriers:

- LIBERTY has implemented several initiatives to help with obtaining, sharing, and storing updated member demographic information, as collected in real time.
- LIBERTY has created new positions that will have roles dedicated to enrollee outreach and follow-up initiatives. These positions are currently in the recruitment stage and are anticipated to be filled sometime in Q4 2022.

HSAG Assessment



Recommendations for Implementation

HSAG recommended the following:

- Interventions deemed successful when tested on a small scale using Plan-Do-Study-Act (PDSA) cycles should be ramped up and adopted plan-wide in order to impact the entire eligible population and realize improvement in the performance indicator rates.
- For unsuccessful interventions, the plans should make data-driven decisions to revise and continue the intervention or discontinue the intervention and revisit the causal-barrier analysis and implement new interventions.

Response

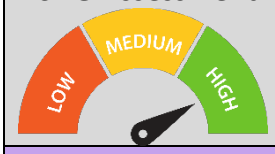
a. Describe initiatives implemented based on recommendations:
   - LIBERTY continually tracks the results of existing interventions to evaluate the results every remeasurement period. Results from each evaluation shows if LIBERTY will need to pivot, revise, or retire an existing intervention. For LIBERTY's most recent submission, LIBERTY made several enhancements that either improved the method of outreach or type of outreach conducted to the identified population. New interventions were also added and documented that focused on healthy behaviors as well as pay for performance provider incentive programs. These interventions will continue to be tracked and reported on each subsequent annual submission.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
   - LIBERTY's Healthy Behavior Program intervention was designed to address lack of parental education and cooperation in preventive dental care for their child. The intervention was identified as successful, in terms of the high rate of preventive utilization rates for those who enrolled in the Program. However, LIBERTY modified its intervention strategy to focus on increasing the volume of members enrolled in the Program. Results from Q4 2021 to Present show 652 new enrollees in the Program.

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

d. Identify strategy for continued improvement or overcoming identified barriers:
   - N/A

HSAG Assessment



Recommendations for Analysis

HSAG recommended the following:

- Use quality improvement science tools such as process mapping, failure modes and effects analysis, or key driver diagram to identify and prioritize barriers and opportunities for improvement.

- Include an executive sponsor (e.g., medical director, chief medical officer, or chief executive officer) in their PIP team who takes responsibility for the success of the project and can work to remove institutional barriers when needed.
- Include at a minimum one data analyst on the PIP team. Data mining and analysis are crucial components to justify topics and evaluate interventions.

Response

a. Describe initiatives implemented based on recommendations:
   - For both 2021 and 2022 submissions, LIBERTY has continued to utilize quality improvement science tools including a combination of failure mode and effects analysis, key driver diagrams, and barrier analysis within each submission to help change focus or direction depending on intervention results. Additionally, Dr. Rosa Roldan has been LIBERTY's key executive sponsor of the PIP team who reviews, provides clinical guidance, and assess overall PIP success. LIBERTY also has a team of data analysts from our Quality Improvement Team to assess and aggregate data related to each PIP topic and generate intervention success.
   - LIBERTY will share additional supporting quality improvement science tools that were utilized and will include all documented internal and external team members involved for future submissions.

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

c. Identify any barriers to implementing initiatives:
   - LIBERTY noted that on the PIP submission form, there is currently no field or section to document all internal and external team members involved within the PIP process. By having this section, LIBERTY could list all applicable team members, executive sponsors, and any external partners relevant to the PIP.

d. Identify strategy for continued improvement or overcoming identified barriers:
   - LIBERTY will include the requested additional documentation as an appendix in lieu of an updated submission template.

HSAG Assessment

MCNA-D

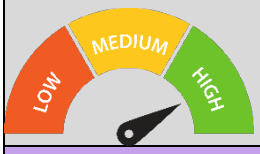
1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

HSAG recommended the following:
• The statewide average for the following measure indicators declined more than 5 percentage points from RY 2020 to RY 2021:
  ○ *Annual Dental Visits—Total*
  ○ *Topical Fluoride for Children at Elevated Caries Risk—Total*
  ○ *Oral Evaluation—Total*
  ○ *Follow-Up After ED Visits for Dental Caries in Children—30 Day Follow-Up—Total*
  ○ *Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk—Total*
  ○ *Follow-Up After Dental-Related ED Visits*
The dental plans should continue to monitor their rates over time to identify public health emergency (PHE) rate impact, ensuring lower access to dental care is not driven by a non-PHE cause, and adopt QI strategies to improve rates. If access to care is the reason for lower rates, the plans should also evaluate their networks to ensure enough providers are available for services for members.

Response
a. Describe initiatives implemented based on recommendations: • Overall, MCNA's performance measure (PM) rates continued to decline due the ongoing impacts of COVID-19 including the Delta variant that caused members to be hesitant to visit their dentist for routine preventive care. MCNA monitors its PMs on a weekly, monthly, and quarterly basis and the VP of Dental Management and Quality Improvement as well as the VP of Network Development and Provider Engagement meet daily to discuss network adequacy to ensure there are enough providers available to our members.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • There are no barriers.
d. Identify strategy for continued improvement or overcoming identified barriers: • MCNA will continue to monitor its PMs and network of providers to ensure there are no barriers to accessing dental care.
HSAG Assessment 
2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendations for Methodology
HSAG recommended the following: • Address all validation feedback provided in the PIP Validation Tools. If not addressed, the corresponding evaluation element will be marked down in the PIP Validation Tool.

Response
a. Describe initiatives implemented based on recommendations: • MCNA addressed all validation feedback provided in the PIP Validation Tools in the annual submission.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • N/A
d. Identify strategy for continued improvement or overcoming identified barriers: • MCNA will continue to address all validation feedback provided in the PIP Validation Tools.

HSAG Assessment



Recommendations for Interventions
HSAG recommended the following: • For the *Preventive Dental Services for Children* PIP, there was a decline or no improvement in the PIP performance indicator rate, despite the intervention evaluation data-driven evidence of clinically significant or programmatically significant improvement in PIP outcomes. In addition to offering telehealth appointments, the dental plan should consider addressing other social determinants of health that prevent the enrollees from seeking preventive dental care. Additionally, the interventions determined as successful during the Plan-Do-Study-Act (PDSA) cycles should be expanded to the entire eligible population served by the dental plan to impact the plan-wide rate. • Seek enrollee input in order to better understand enrollee-related barriers toward access to care. • Collect intervention evaluation data frequently (weekly, biweekly, monthly, quarterly, etc.), unlike the annual performance indicator data. The intervention-specific evaluation data may help the plans identify significant clinical and programmatic improvement in outcomes. • Evaluate the performance of each intervention and include the most current intervention evaluation data available at the time of the submission date. • Provide adequate details about an intervention for the Agency and HSAG to better understand the intervention. For example, the plans should document how they will improve efforts to obtain real-time notifications from Florida's Encounter Notification System (ENS), and how the plans will use that data. For outreach interventions, the plans should include the mode and frequency of outreach.

Response
a. Describe initiatives implemented based on recommendations: • MCNA's preventive dental services rate declined due the ongoing impacts of COVID-19 including the Delta variant that has caused members to be hesitant to visit their dentist for routine preventive care. To address social determinants of health (SDOH), MCNA has updated its oral health risk assessment form to include SDOH in order to facilitate targeted outreach to the member. Additionally, all interventions that were deemed successful during the PDSA cycles were expanded to the entire population and those that were not successful were documented as discontinued. • MCNA's Member Advocate Outreach Specialists (MAOS) obtain member feedback on barriers to care

via community outreach events as well as via incoming and outbound calls. The member's barriers are captured and reported within the PIP form and revisited at least annually.

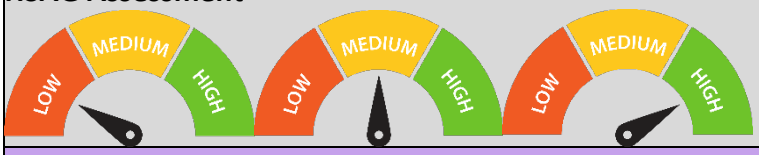
- Intervention data is collected weekly wherein the VP of Data Analytics refreshes PowerBi with intervention outcomes every Wednesday. This ensures that the most current intervention evaluation data is available and reported on the PIP form.
- On the last annual submission, MCNA included the mode and frequency of outreach for each of the interventions listed.

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

c. Identify any barriers to implementing initiatives:
- There are no barriers.

d. Identify strategy for continued improvement or overcoming identified barriers:
- MCNA will continue to develop new interventions to increase preventive utilization and educate our members that the dental office is a "safe" place. MCNA's MAOS will also continue to obtain feedback from members at outreach events and via inbound/outbound calls. Intervention data will also continue to be refreshed weekly for the most up to date outcomes and lastly, MCNA will continue to include the mode and frequency of improvement strategies.

HSAG Assessment



Recommendations for Implementation

HSAG recommended the following:

- Interventions deemed successful when tested on a small scale using Plan-Do-Study-Act (PDSA) cycles should be ramped up and adopted plan-wide in order to impact the entire eligible population and realize improvement in the performance indicator rates.
- For unsuccessful interventions, the plans should make data-driven decisions to revise and continue the intervention or discontinue the intervention and revisit the causal-barrier analysis and implement new interventions.

Response

a. Describe initiatives implemented based on recommendations:
- Those interventions that were determined to be successful on a small scale using PDSA cycles were adopted plan-wide and those that were not successful, were documented as discontinued on the PIP form. The causal-barrier analysis was revisited and documented accordingly within the PIP form.

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

c. Identify any barriers to implementing initiatives:
- There were no barriers.

d. Identify strategy for continued improvement or overcoming identified barriers:
- MCNA will continue to adopt successful interventions plan-wide and revise or discontinue those are deemed not successful.

HSAG Assessment

Recommendations for Analysis

HSAG recommended the following:

- Use quality improvement science tools such as process mapping, failure modes and effects analysis, or key driver diagram to identify and prioritize barriers and opportunities for improvement.
- Include an executive sponsor (e.g., medical director, chief medical officer, or chief executive officer) in their PIP team who takes responsibility for the success of the project and can work to remove institutional barriers when needed.
- Include at a minimum one data analyst on the PIP team. Data mining and analysis are crucial components to justify topics and evaluate interventions.

Response

a. Describe initiatives implemented based on recommendations:

- MCNA utilizes a fishbone diagram, however, a key driver diagram will be used in the next cycle to identify and prioritize barriers and opportunities for improvement.

- MCNA's Chief Dental Officer currently serves as our "executive sponsor" and is integral to our PIP team. He also chairs our quarterly Quality Improvement Committee (QIC) meetings where our PIP results and any barriers are presented.
- MCNA's PIP team is inclusive of the VP of Data Analytics who is responsible for data mining and analysis.

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

- N/A

c. Identify any barriers to implementing initiatives:

- There were no barriers.

d. Identify strategy for continued improvement or overcoming identified barriers:

- MCNA will continue with the Chief Dental Officer and VP of Data Analytics as part of its PIP team and incorporate quality improvement science tools such as the key driver diagram.

HSAG Assessment

Appendix F. EQR Technical Report Requirements

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

Table F-1—EQR Technical Report Elements

	Required Elements	Page Number
1	The state submitted its EQR technical report by April 30.	NA
2	All eligible Medicaid and CHIP plans are included in the report.	Appendix A
3	Required elements are included in the report:	
3a	Describe the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity.	7, 118, 124
3b	An assessment of the **strengths and weaknesses of each MCO, PIHP, PAHP and PCCM entity** with respect to (a) quality, (b) timeliness, and (c) access to the healthcare services furnished by each MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR §438.310[c][2]) furnished to Medicaid and/or CHIP beneficiaries. Contain specific recommendations for improvement of identified weaknesses.	Sections 3-5, Appendix C
3c	Describe how the state can **target goals and objectives in the quality strategy**, under 42 CFR §438.340, to better support improvement in the quality, timeliness, and access to healthcare services furnished to Medicaid and/or CHIP enrollees.	12-14
3d	Recommends improvements to the quality of healthcare services furnished by each MCO.	Sections 3-5, Appendix C
3e	Provides state-level recommendations for performance improvement.	12-14, 41, 66-73, 106-107
3f	Ensures methodologically appropriate, comparative information about all MCOs.	Sections 2-5, Appendix D
3g	Assesses the degree to which each MCO has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR.	Appendix E
4	Validation of PIPs: A description of **PIP interventions** associated with each state-required PIP topic for the current EQR review cycle, and the following for the validation of PIPs: **objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.**	

	Required Elements	Page Number
4a	**Interventions.**	87-92, 93, 100-101
4b	• **Objectives.**	120
4c	• **Technical methods of data collection and analysis.**	78, 120
4d	• **Description of data obtained.**	78, 121
4e	• **Conclusions drawn from the data.**	9-11, 12-14, 102-103, Appendix D
5	Validation of performance measures: A description of **objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.**	
5a	• **Objectives.**	42
5b	• **Technical methods of data collection and analysis.**	118-120
5c	• **Description of data obtained.**	118-120
5d	• **Conclusions drawn from the data.**	9-11, 12-14, 66-73, Appendix D
6	**Review for compliance:** 42 CFR §438.358(b)(1)(iii) (cross-referenced in CHIP regulations at 42 CFR §457.1250[a]) requires the technical report include information **on a review, conducted within the previous three-year period**, to determine each MCO's, PIHP's, PAHP's or PCCM's compliance with the standards set forth in Subpart D and the QAPI requirements described in 42 CFR §438.330. Additional information that needs to be included for compliance is listed below:	
6a	• **Objectives.**	114
6b	• **Technical methods of data collection and analysis.**	114-116
6c	• **Description of data obtained.**	116
6d	• **Conclusions drawn from the data.**	41
7	**Each remaining activity** included in the technical report must include a **description of the activity** and the following information:	
7a	• **Objectives.**	123
7b	• **Technical methods of data collection and analysis.**	124-126
7c	• **Description of data obtained.**	124-126
7d	• **Conclusions drawn from the data.**	106-107