Florida Agency for Health Care Administration

2007-2008 Report on Evaluation of Quality Strategies

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HSAG HEALTH SERVICES ADVISORY GROUP

1600 East Northern Avenue, Suite 100 ◆ Phoenix, AZ 85020

Phone 602.264.6382 ◆ Fax 602.241.0757

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Purpose of Report

As the external quality review organization (EQRO) for the State of Florida Medicaid managed care program, Health Services Advisory Group, Inc. (HSAG), prepared this report to assess the completeness of the Florida Medicaid Managed Care Quality Assessment & Improvement Strategies Annual Update 2007 (QAIS) developed by the Florida Agency for Health Care Administration (AHCA). Each state is required to have a written strategy for assessing and improving the quality of Medicaid managed care organization (MCO) and prepaid inpatient health plan (PIHP) services, according to the Balanced Budget Act of 1997 (BBA) and the Code of Federal Regulations (CFR), 42 CFR §438.202. In addition, HSAG recommended revisions to the QAIS to help further enhance and align the state's QAIS with federal regulations and improve the overall effectiveness of the QAIS.

Summary of Findings

The updated QAIS, or quality strategy, is consistent with the Centers for Medicare & Medicaid Services regulatory checklist elements in all areas except one, resulting in a document that appears to be almost entirely compliant with the requirements of 42 CFR §438.202. The QAIS provides a high level of detail regarding relevant contract provisions for each type of delivery system in a well-organized manner.

The QAIS appears to be in partial compliance with the BBA requirements for implementing a mechanism to ensure that race, ethnicity, and primary language information is collected consistently and provided to the contracted MCOs and PIHPs. The QAIS describes AHCA's substantial progress in implementing the technical infrastructure required to collect and distribute such data. Implementation of HSAG's 2007 recommendations to help AHCA achieve full compliance with BBA requirements requires substantial programming and system changes, and a work group composed of key staff members from the affected State agencies was formed in 2007 to address relevant issues. The State has competitively procured a new fiscal agent, EDS, to implement the new Florida Medicaid Management Information System (FMMIS) beginning in July 2008. The new FMMIS will improve the State's process and procedures for identifying the race, ethnicity, and primary language of MCO and PIHP enrollees, and improve the State's ability to provide the required data to the MCOs and PIHPs. Currently, as part of assisting beneficiaries with plan enrollment choices, the Medicaid reform choice counselor and the nonreform enrollment broker capture information from the beneficiary related to language preference and this information is forwarded to the health plans.

The QAIS carefully addresses the issues and recommendations made by HSAG in the June 2007 Report on Evaluation of AHCA's quality strategy. The QAIS update now:

- Includes details regarding the formal process and methods used for gathering input from enrollees and stakeholders on the QAIS.

- Describes two major managed care quality initiatives: a validation of all provider network files for MCOs and PIHPs operating under Florida's 1915(b) Managed Care waiver or 1115 Medicaid Reform waiver, and the proposed addition of a system in the Medicaid Reform Choice Counseling Program to allow choice counselors to use historical Medicaid pharmaceutical claims data to better assist beneficiaries in selecting a health plan that meets their current pharmaceutical needs.
- Includes a quality vision statement.
- Includes details regarding the process and methodology used to conduct the annual review of the effectiveness of the QAIS.
- Provides updated information on health information systems. The State contracted with Thomson Medstat in 2006 to develop a strategic plan for implementation of the Medicaid Encounter Data System (MEDS). Initial operation of MEDS was scheduled for March 2008. The quality strategy states that plans are required to provide a strategic plan that outlines steps to achieve system readiness for participation in MEDS, and that the State provides instructions and guidance. Health information systems requirements specified in MCO and PIHP contracts are outlined in detail.
- States the term of EQRO contract.

Several areas appear to be in compliance with the federal requirements but could be further enhanced:

- While the QAIS clearly states the goals and objectives of the quality strategy, the State should continue efforts to strengthen its continuous quality improvement program by translating these goals and objectives into quantified, measurable performance targets. The QAIS indicates that "the long-term goal…is to develop a model through the use of performance measure thresholds and benchmarks to move the entire Florida Medicaid managed care system toward higher quality."
- HSAG is working closely with AHCA to implement accurate and efficient methods for the evaluation of quality standards and file reviews, as well as effective approaches for reporting compliance evaluation results.
- As was the case in the initial quality strategy, the QAIS update defines "significant changes" to the quality strategy that will trigger stakeholder input as revisions to the numbers, types, or time frames of reporting, but does not address changes to other components of the quality strategy.
- Per CFR 438.360, in place of a Medicaid review by the state, its agent, or EQRO, states can use information obtained from a review by a national accrediting organization for the mandatory external quality review activities. Through this authority, states can deem National Committee for Quality Assurance (NCQA) standards as equivalent to state requirements or simply use the information obtained through accreditation surveys to streamline oversight. Regarding the avoidance of duplication of activities, the QAIS references HSAG's 2007 recommendation that prior to deeming any activities, the State use the NCQA Medicaid Managed Care Toolkit. The NCQA Medicaid Managed Care Crosswalk, contained within the Medicaid Managed Care Toolkit, provides a breakdown of how the federal requirements compare to NCQA standards and can be used to demonstrate areas of duplication. NCQA designed the crosswalk for states to use as a starting point for identifying how states can streamline managed care oversight, thereby preventing duplication of activities. The State should compare its regulatory or contractual

requirements to NCQA's standards to determine where it can streamline oversight or deem standards.

Conclusions and Recommendations

HSAG commends AHCA for successfully updating a document that includes the various unique managed care plans and model types that service the Medicaid population in Florida. Further, AHCA has made substantial progress since its initial QAIS in developing plans to implement quality strategies, as evidenced by both the QAIS and the minutes of the Quality and Performance Standards Team meetings.

HSAG recommends that AHCA:

- Continue its focus on creating the necessary infrastructure and processes for the effective collection and distribution of race, ethnicity, and primary language data to achieve full compliance with BBA requirements.
- Consider expanding the definition of "significant changes" to the quality strategy that trigger stakeholder input to include changes such as those resulting from regulatory authorities, legislation at the state or federal level, and/or a change in membership demographics or the provider network of 50 percent or greater within one year.
- Compare its regulatory or contractual requirements to NCQA's standards to determine where it can streamline oversight or deem standards for those managed care programs that are NCQA accredited.
- Continue to work with HSAG to develop and implement performance standards and monitoring methodologies that will support continuous quality improvement efforts in order to enhance the quality of care provided to, and received by, Medicaid beneficiaries in Florida.

Background and Scope of External Quality Review (EQR) Activities

In June 2007, HSAG reported the results of its evaluation of Florida's initial QAIS, or quality strategy, to determine compliance with federal regulations and identify areas for improvement. In general, HSAG found the State's QAIS to be consistent with the Centers for Medicare & Medicaid Services (CMS) regulatory checklist elements, although HSAG noted that some additional details and information would further improve the document's alignment with federal expectations. HSAG reported that the State's QAIS provided a high level of detail regarding federal citations, waiver authority, and relevant contract provisions for each type of delivery system in a well-organized manner. HSAG identified five areas in need of further enhancement to better align Florida's QAIS with federal regulations and improve the overall effectiveness of the strategy.

HSAG compared the initial QAIS with the draft CMS Review List for State Quality Assessment & Improvement Strategies and the CMS State Quality Tool Kit for State Medicaid Agencies. In addition, HSAG's June 2007 Report on Evaluation of AHCA's quality strategy included a comprehensive review and summary of relevant "lessons learned" from 19 states and the District of Columbia.

The external quality review (EQR) activities conducted for this 2007–2008 Report on Evaluation of Quality Strategies include:

- An assessment of the level of compliance of the Florida Medicaid Managed Care Quality Assessment & Improvement Strategies Annual Update December 2007 (QAIS) with the requirements of 42 CFR §438.202, again using the CMS Review List for State Quality Assessment & Improvement Strategies. The QAIS addresses the State's MCO and PIHP contracts operated under Florida's approved 1115 Medicaid Reform Waiver, 1915(b) Medicaid Managed Care Waiver, and 1915(c) Nursing Home Diversion Waiver. Elements included in the QAIS also will apply to the MCO contracts being developed under the Florida Senior Care Waiver.
- Recommendations regarding potential revisions and improvements to Florida's QAIS.

Organization of Report

The Executive Summary (Section 1) presents the purpose of the report, a summary of findings, and conclusions and recommendations.

Section 2 provides an introduction to the report that includes the background and scope of EQR activities conducted and the organization of the report.

Section 3 describes the goals and objectives of the QAIS assessment, a description of data obtained and reviewed, and the methodology that HSAG used to produce findings and recommendations.

Section 4 presents key findings, strengths of the Florida Quality Strategy Plan, and conclusions and recommendations.

Appendix A is the Quality Strategy Review Tool that HSAG developed and used to conduct the assessment of the QAIS and to develop conclusions and recommendations.

3. Methodology for Conducting the Review

Goals and Objectives

The overall goal of the focused review of the Florida QAIS is to assess the completeness of the strategy with respect to the requirements specified in 42 CFR §483.202, which include:

- Having a written strategy for assessing and improving the quality of managed care services offered by all MCOs.
- Obtaining the input of recipients and other stakeholders to develop the strategy and make the strategy available for public comment before final adoption.
- Ensuring that MCOs comply with standards established by the State.
- Conducting periodic reviews to evaluate the effectiveness of the strategy, and updating the strategy periodically, as needed.
- Submitting to CMS a copy of the revised strategy whenever significant changes are made, and producing regular reports on the implementation and effectiveness of the strategies.

The objectives of the analysis were to identify strengths, limitations, and recommended improvements in the description of the QAIS.

Description of Data Obtained and Reviewed

HSAG obtained and reviewed the *Florida Medicaid Managed Care Quality Assessment & Improvement Strategies Annual Update December 2007* prepared by AHCA. Further, HSAG reviewed the Medicaid Reform Performance Measures section of the AHCA Web site, MyFlorida.com, and the minutes of the weekly Florida Quality and Performance Standards Team meetings held in 2007.

Methodology

In March 2007, HSAG developed a Quality Strategy Review Tool to assess the completeness of AHCA's initial quality strategy against the draft CMS Review List for State Quality Assessment & Improvement Strategies. The components of the initial strategy were compared to the review list specifications. The completed tool organizes the analysis by topic, evaluates compliance and effectiveness, and documents observations and recommendations. HSAG again used the Quality Strategy Review Tool in May 2008 to assess the QAIS update.

Further, HSAG used experience in conducting EQR activities for other states in conducting the evaluation and making recommendations.

Key Findings

HSAG's focused review of the Florida QAIS update found that the strategy is consistent with the CMS regulatory checklist elements in all areas except one, resulting in a document that appears to be almost entirely compliant with the requirements of 42 CFR §438.202. As was the case with the initial quality strategy, the QAIS update provides a high level of detail regarding relevant contract provisions for each type of delivery system in a well-organized manner. AHCA should be commended for successfully updating a document that includes the various unique managed care plans and model types that service the Medicaid population. Further, AHCA has made substantial progress since its initial QAIS in developing plans to implement quality strategies, as evidenced by both the QAIS and the minutes of the Quality and Performance Standards Team meetings.

The QAIS appears to be in partial compliance with the BBA requirements for implementing a mechanism to ensure that race, ethnicity, and primary language information is collected consistently and provided to the contracted MCOs and PIHPs. The QAIS describes AHCA's substantial progress in implementing the technical infrastructure required to collect and distribute race, ethnicity, and primary language information, as further discussed in the "Strengths of the Florida Quality Strategy Plan" section below.

Several areas appear to be in compliance with the federal requirements but could be further enhanced:

- While the QAIS clearly states the goals and objectives of the quality strategy, the State should continue efforts to strengthen its continuous quality improvement program by translating these goals and objectives into quantified, measurable performance targets. The QAIS indicates that "the long-term goal…is to develop a model through the use of performance measure thresholds and benchmarks to move the entire Florida Medicaid managed care system toward higher quality." In 2008, the State will work with health maintenance organizations (HMOs) and provider service networks (PSNs) to adopt thresholds for HEDIS measures. 2008 will serve as a baseline-setting year. In future years, the State intends to use the methodology set forth in the Quality Improvement System for Managed Care (QISMC) to set individual goals for all plans, and incentives and consequences may then be applied. Also in 2008, with the assistance of HSAG, the State will develop standardized plan performance measures for prepaid mental health plans (PMHPs) and nursing home diversion plans (NHDPs). Measures will be finalized in 2008 and baselines will be established in 2009. Further, the State is scheduled to begin contracting with plans authorized under the Florida Senior Care Waiver in 2008, and will develop standardized plan performance measures with the assistance of HSAG.
- HSAG is working closely with AHCA to implement accurate and efficient methods for the evaluation of quality standards and file reviews, as well as effective approaches for reporting compliance evaluation results. Activities include outlining three basic methods for scoring and reporting the quality standards and file reviews conducted by the AHCA, and discussing ways

that compliance monitoring scores can be used to improve the delivery of safe, effective, timely, equitable, efficient, and person-centered care to beneficiaries.

- As was the case in the initial quality strategy, the QAIS update states the definition of "significant changes" to the strategy that will trigger stakeholder input as revisions to the numbers, types, or time frames of reporting, but it does not address changes in other components of the strategy.
- Per CFR 438.360, in place of a Medicaid review by the state, its agent or EQRO, states can use information obtained from a review by a national accrediting organization for the mandatory external quality review activities. Through this authority, states can deem NCQA standards as equivalent to state requirements or simply use the information obtained through accreditation surveys to streamline oversight. Regarding the avoidance of duplication of activities, the QAIS references HSAG's 2007 recommendation that prior to deeming any activities, the State use the NCQA Medicaid Managed Care Toolkit. The NCQA Medicaid Managed Care Crosswalk, contained within the Medicaid Managed Care Toolkit, provides a breakdown of how the federal requirements compare to NCQA standards and can be used to demonstrate areas of duplication. NCQA designed the crosswalk for states to use as a starting point for identifying how states can streamline managed care oversight, thereby preventing duplication of activities. The State should compare its regulatory or contractual requirements to NCQA's standards to determine where it can streamline oversight or deem standards.

Strengths of the Florida Quality Strategy Plan

The QAIS update carefully addresses the issues and recommendations that HSAG made in the June 2007 Report on Evaluation of AHCA's quality strategy. The QAIS update now:

- Includes details regarding the formal process and methods used for gathering input from enrollees and stakeholders on the QAIS. The strategy describes the background regarding obtaining input since 1995, and the formal process and methods used during 2006 and 2007 to gather input from enrollees and stakeholders on quality assessment and improvement standards in managed care. Further, the QAIS describes plans to improve and create a more formalized process for gathering input from enrollees and stakeholders by holding a series of public workshops specifically on the QAIS in 2008. The AHCA Web site, MyFlorida.com, states, "As part of Florida's Medicaid Reform initiative, the Agency sought to review and amend the performance measures historically required for HMOs contracting with the Agency to better assess the quality and effectiveness of health care services. Public input was sought and received from interested parties, including health care advocates, providers, and State of Florida sister agencies, culminating in the final list of adopted measures." The Web site provides links to documents distributed at public workshops held on October 6 and 26, 2006, and a compilation of stakeholder comments the agency received during the performance measures development process.
- Describes two major managed care quality initiatives: a validation of all provider network files for MCOs and PIHPs operating under Florida's 1915(b) Managed Care Waiver or 1115 Medicaid Reform Waiver, and the proposed addition of a system in the Medicaid Reform Choice Counseling Program to allow choice counselors to utilize historical Medicaid

pharmaceutical claims data to better assist beneficiaries in selecting a health plan that meets their current pharmaceutical needs.

- Includes a quality vision statement: "The Agency ensures high quality health care is available to all Medicaid managed care beneficiaries. The Agency's quality strategies permeate the entire managed care system and move health plans toward appropriate clinical and administrative practices."
- Includes details regarding the process and methodology used to conduct the annual review of the effectiveness of the QAIS. The strategy describes the creation of the Quality and Performance Standards Team in March 2006, and the Continuous Improvement Team and the Access to Specialty Care Workgroup in 2007. Further, the QAIS describes two new major quality initiatives designed to address issues raised in numerous public forums. The long-term goal of the State is to develop a model through the use of performance measure thresholds and benchmarks to move the entire Florida Medicaid managed care system toward higher quality. The State's progress toward all MCOs and PIHPs operating within the parameters set forth for the model will serve as the evaluation of the success of the QAIS. The strategy also describes short-term goals regarding HEDIS threshold measures for health maintenance organizations (HMOs) and provider service networks (PSNs), and standardized plan performance measures for prepaid mental health plans, nursing home diversion plans, and Florida Senior Care Waiver plans.
- Provides updated information on health information systems. The State contracted with Thomson Medstat in 2006 to develop a strategic plan to implement a Medicaid Encounter Data System (MEDS), with the initial operation of MEDS scheduled for March 2008. The strategy states that the plans are required to provide a strategic plan that outlines steps to achieve system readiness for participation in MEDS, and that the State provides instructions and guidance. Health information systems requirements specified in MCO and PIHP contracts are outlined in detail.
- States the term of EQRO contract.
- Provides information on plans to address the collection and distribution of race, ethnicity, and primary language data. In 2007, HSAG conducted a review of the practices the State used at the time to identify race, ethnicity, and primary language. Overall, the review determined that the State was partially compliant with BBA requirements. The analysis resulted in nine recommendations described in the QAIS update. Implementation of recommendations will require programming and system changes, and a work group composed of key staff members from the affected State agencies was formed in 2007 to address relevant issues. The State has competitively procured a new fiscal agent, EDS, to implement the new Florida Medicaid Management Information System (FMMIS) beginning July 2008. The new FMMIS will improve the State's process and procedures for identifying the race, ethnicity, and primary language of MCO and PIHP enrollees, and improve the State's ability to provide the required enrollee race/ethnicity and primary language information to the MCOs and PIHPs. Currently, as part of assisting beneficiaries with plan enrollment choices, the Medicaid reform choice counselor and the nonreform enrollment broker capture information from the beneficiary related to language preference, and this information is forwarded to the health plans.

Conclusions and Recommendations

HSAG recommends that AHCA:

- Continue its focus on creating the necessary infrastructure and processes for the effective collection and distribution of race, ethnicity, and primary language data to achieve full compliance with BBA requirements.
- Consider expanding the definition of "significant changes" to the quality strategy that trigger stakeholder input, to include changes such as those resulting from legislated, State, federal, or other regulatory authority; and/or changes in membership demographics or provider network of 50 percent or greater within one year.
- Compare its regulatory or contractual requirements to NCQA's standards to determine where it can streamline oversight or deem standards for those managed care programs that are NCQA accredited.
- Continue to work with HSAG to develop and implement performance standards and monitoring methodologies that will support continuous quality improvement efforts in order to enhance the quality of care provided to, and received by, Medicaid beneficiaries in Florida.

State of Florida
Agency for Health Care Administration
Quality Strategy Review Tool—2007-2008

I. Process for Quality Strategy Development, Review, and Revision		
Topic (Numbers reflect CMS Review List for State QAIS; corresponding FL QAIS numbers are italicized in parentheses.)	**Compliance & Effectiveness**	**Observations and Recommendations**
I.A. (*I.A.*) A description of the process the state will use for the **development of the quality strategy**.	Describes the State's process to develop, review, and revise Florida Medicaid's QAIS, including amendments to the contracts of MCOs and the PIHP to include BBA-compliant requirements.	Appears to meet requirements.
I.B. (*I.B.*) A description of the formal process the state will use to obtain **beneficiary and stakeholder input** and public comment before final adoption in final.	Describes the background regarding obtaining input since 1995, and the formal process and methods used during 2006 and 2007 to gather input from enrollees and stakeholders on quality assessment and improvement standards in managed care. Describes plans to improve and create a more formalized process for gathering input from enrollees and stakeholders by holding a series of public workshops specifically on the QAIS in 2008.	Appears to meet requirements. Addresses 2007 recommendation, to include details regarding the formal process and methods used to gather input from enrollees and stakeholders on the QAIS. The AHCA Web site, MyFlorida.com, states, "As part of Florida's Medicaid Reform initiative, the Agency sought to review and amend the performance measures historically required for HMOs contracting with the Agency to better assess the quality and effectiveness of health care services. Public input was sought and received from interested parties, including health care advocate, providers, and State of Florida sister agencies, culminating in the final list of adopted measures." The Web site provides links to documents distributed at public work shops held on October 6 and 26, 2006, and a compilation of stakeholder comments the agency received during the performance measures development process.

I. Process for Quality Strategy Development, Review, and Revision		
Topic (Numbers reflect CMS Review List for State QAIS; corresponding FL QAIS numbers are italicized in parentheses.)	**Compliance & Effectiveness**	**Observations and Recommendations**
I.C. (*I.B, I.C., I.D., II.C*) A description of how and how often the State will conduct **periodic reviews of the effectiveness of the strategy**.	Describes the creation of the Quality and Performance Standards Team in March 2006, and the Continuous Improvement Team and the Access to Specialty Care Workgroup in 2007. Indicates that the State conducts an annual review of the effectiveness of the strategy in the fourth quarter of each calendar year following receipt of the EQRO report and the annual managed care program reporting. Describes two new major quality initiatives designed to address issues raised in numerous public forums. Indicates that the long-term goal of the State is to develop a model through the use of performance measure thresholds and benchmarks to move the entire Florida Medicaid managed care system toward higher quality. The State's progress toward all MCOs and PIHPs operating within the parameters set forth for the model will serve as the evaluation of the success of the QAIS. Also describes short-term goals regarding HEDIS threshold measures for HMOs and PSNs, and standardized plan performance measures for prepaid mental health plans, nursing home diversion plans, and Florida Senior Care Waiver plans.	Appears to meet requirements. Addresses 2007 recommendation to include details regarding the process and methodology used to conduct the annual review of the effectiveness of the QAIS.

I. Process for Quality Strategy Development, Review, and Revision		
Topic (Numbers reflect CMS Review List for State QAIS; corresponding FL QAIS numbers are italicized in parentheses.)	**Compliance & Effectiveness**	**Observations and Recommendations**
I.D. (*I.E.*) The state's definition of **"significant changes"** to strategy that will **trigger stakeholder input**.	States the definition of "significant changes" to strategy in terms of revisions to the numbers, types, or timeframes of ***reporting***. AHCA will determine when a change is "significant enough" for a stakeholder review.	As was the case in the initial quality strategy, describes changes in ***reporting only***, not changes in other components of ***strategy.*** HSAG recommends that AHCA consider expanding this definition to include changes such as those resulting from legislated, State, federal, or other regulatory authority; and/or change in membership demographics or provider network of 50 percent or greater within one year.
I.E. (*I.F.*) The state's timeframes for **updating the quality strategy**.	States the quality strategy will be updated annually.	Appears to meet requirements.

II. Managed Care Program Goals and Objectives		
Topic **(Numbers reflect CMS Review List for QAIS; corresponding FL QAIS numbers are italicized in parentheses.)**	**Compliance & Effectiveness**	**Observations and Recommendations**
II. (*II.A, II.B, II.C*) A description of the **goals and objectives of the state's managed care program**, including priorities, strategic partnerships, etc.	States both the vision and the goals/objectives of Florida Medicaid managed care programs. Identifies the State's priority as ensuring access to quality health care for managed care enrollees and utilizing strategic partnerships between the managed health care programs, the State, Florida's enrollment broker and the beneficiary to improve access, quality, and continuity of care. Describes the requirement that programs will, at a minimum and as applicable, be in compliance with all Federal state laws and regulations (specific examples are listed).	Appears to meet requirements.

III. Medicaid Contract Provisions		
Topic	**Compliance & Effectiveness**	**Observations and Recommendations**
III. (*III*) Either: 1) the provisions in the State's Medicaid MCO and PIHP contracts that incorporate the established standards for **access to care, structure and operations, and quality measurement and improvement**, or 2) a summary description of the contract provisions in its Medicaid MCO and PIHP contracts that incorporate the established standards for access to care, structure and operations, and quality measurement and improvement. If the State chooses the latter option, the description must be sufficiently detailed to offer a clear picture of the specific contract provisions.	Cites MCO and PIHP contract provisions requiring entities to be subject to annual, external, independent review of the quality outcomes, timeliness of, and access to, the services covered in accordance with 42 CFR §438.204. Describes the 11 activity categories for which the EQRO is responsible. Table 2 provides relevant contract provisions for each plan type. Not yet finalized for Florida Senior Care plans.	Appears to meet requirements.

IV. State Standards for Access to Care		
Topic	**Compliance & Effectiveness**	**Observations and Recommendations**
IV.A. (*III*) A summary description of the state standards for access to care with reference as applicable to the details included in the MCO/PIHP contract; the standards must be at least as stringent as those specified in §§438.206-438.210 including—		
A.1 (*A.1.a-h*) Availability of Services a) Maintains and monitors a network of appropriate providers. b) Provides female enrollees with direct access to a women's health specialist. c) Provides for a second opinion from a qualified health care professional. d) Must provide necessary services that are not available in the network. e) Requires out of network providers to coordinate with the MCO or PIHP with respect to payment. f) Demonstrates that providers are credentialed. g) Timely access to care. h) Cultural considerations.	Describes requirements for MCOs and PIHPs regarding the eight elements of Availability of Services. Tables 3-10 provide relevant contract provisions for each plan type. Not yet finalized for Florida Senior Care plans.	Appears to meet requirements.
A.2. (*A.2.a-b*) Assurances of Adequate Capacity and Services a) Offers an appropriate range of preventative, primary care, and specialty services. b) Maintains a network of providers that is sufficient in number, mix, and geographic distribution.	Describes requirements for MCOs and PIHPs regarding the two elements of Assurances of Adequate Capacity and Services. Tables 11-12 provide relevant contract provisions for each plan type. Not yet finalized for Florida Senior Care plans.	Appears to meet requirements.

IV. State Standards for Access to Care		
Topic	**Compliance & Effectiveness**	**Observations and Recommendations**
A.3. (*A.3.a-e*) Coordination and Continuity of Care a) Ensure that each enrollee has an ongoing source of primary care. b) Coordinate all services that the enrollee receives. c) Share identification and assessment information to prevent duplication of services for individuals with special health care needs. d) Protect the enrollee's privacy in the process of coordinating care. e) Additional services for persons with special health care needs, including: i. Identification; ii. Assessment; iii. Treatment plans, and iv. Direct access to specialists.	Describes requirements for MCOs and PIHPs regarding the five elements of Coordination and Continuity of Care. Tables 13-17 provide relevant contract provisions for each plan type. Not yet finalized for Florida Senior Care plans.	Appears to meet requirements.
A.4. (*A.4.a-d*) Coverage and Authorization of Services a) Identify, define, and specify the amount, duration and scope of each service that the MCO and PIHP is required to offer. b) Specify what constitutes "medically necessary services." c) That the MCO, PIHP, or PAHP have in place and follow written policies and procedures for authorization of services. d) That any decision to deny a service be made by an appropriate health care professional.	Describes requirements for MCOs and PIHPs regarding the four elements of Coverage and Authorization of Services. Tables 18-21 provide relevant contract provisions for each plan type. Not yet finalized for Florida Senior Care plans.	Appears to meet requirements.
B. Detailed information related to the access to care standards, including—		

IV. State Standards for Access to Care		
Topic	**Compliance & Effectiveness**	**Observations and Recommendations**
(*B.1*) Identification of mechanisms the State uses to **identify persons with special health care needs** to MCOs and PIHPs.	Describes requirements for MCOs and PIHPs regarding mechanisms to identify persons with special health care needs and provide case management. Table 22 provides relevant contract provisions for each plan type. Not yet finalized for Florida Senior Care plans.	Appears to meet requirements.
(*B.2*) Identification of standards the State uses to determine the extent to which **treatment plans** are required to be produced by MCOs, PIHPs, and PAHPs for individuals with **special health care needs**.	Describes requirements for MCOs and PIHPs regarding identification standards used to determine the extent to which treatment plans are required to be produced for persons with special health care needs. Table 23 provides relevant contract provisions for each plan type. Not yet finalized for Florida Senior Care plans.	Appears to meet requirements.

V. State Standards for Structure and Operations		
Topic	**Compliance & Effectiveness**	**Observations and Recommendations**
V.A. (*IV.A.1-8*) A summary description of the state standards for **structure and operations** with reference as applicable to the details included in the MCO/PIHP contract; the standards must be at least as stringent as those specified in §§438.214-438.230 including— 1. Provider selection (Each State must establish a uniform credentialing and recredentialing policy) 2. Enrollee information. 3. Confidentiality. 4. Enrollment and disenrollment. 5. Grievance system. 6. Subcontractural relationship and delegation—oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor.	Describes requirements for MCOs and PIHPs regarding state standards for structure and operations for the six elements. Tables 24-29 provide relevant contract provisions for each plan type. Not yet finalized for Florida Senior Care plans.	Appears to meet requirements.
V.B. (*IV.B*) Detailed information related to the structure and operation standards, including— 1. State procedures for the review of the records of MCO and PIHP **grievances and appeals**, and for identifying and resolving systemic problems.	Describes requirements for MCOs and PIHPs regarding state procedures for the review of the records of MCO and PIHP grievances and appeals, and for identifying and resolving systemic problems. Table 28 provides relevant contract provisions for each plan type. Not yet finalized for Florida Senior Care plans.	Appears to meet requirements.

VI. State Standards for Quality Measurement		
Topic	**Compliance & Effectiveness**	**Observations and Recommendations**
VI.A. A summary description of the state standards for **quality measurement and improvement** with reference as applicable to the details included in the MCO/PIHP contract; the standards must be at least as stringent as those specified in §§438.236-438.242 including—		
A.1 (*A.1*) Practice guidelines a) Based on valid and reliable clinical evidence. b) Consider the needs of MCO's, PIHP's, and PAHP's enrollees. c) Adopted in consultation with contracting health care professionals. d) Reviewed and updated as appropriate.	Describes requirements for MCOs and PIHPs regarding the four elements of practice guidelines. Table 30 provides relevant contract provisions for each plan type. Not yet finalized for Florida Senior Care plans.	Appears to meet requirements.
A.2 (*A.2*) Quality assessment and performance improvement program a) Conduct performance improvement projects. b) Submit performance measurement data. c) Have in effect mechanisms to detect both overutilization and underutilization of services. d) Have in effect mechanisms to assess quality and appropriateness of care to enrollees. e) Measure performance and/or report performance data to the State. f) Report the status and results of each project to the State as requested. g) State must review at least annually, the impact and effectiveness of each MCO's and PIHP's quality assessment and performance improvement program.	Describes requirements for MCOs and PIHPs regarding the seven elements of the quality assessment and performance improvement program. Tables 31-32 provide relevant contract provisions for each plan type. Not yet finalized for Florida Senior Care plans.	Appears to meet requirements.

VI. State Standards for Quality Measurement		
Topic	**Compliance & Effectiveness**	**Observations and Recommendations**
A.3 (*A.3.A-J*) Health Information Systems a) Collect data on enrollee and provider characteristics as specified by the State. b) Ensure the data received from providers is accurate and complete. c) Make all collected data available to the State and upon request to CMS.	Describes requirements that plans comply with reporting requirements established by the state and specified in the plan's contract, and certification of data as provided in 42 CFR 438.606. The State contracted with Thomson Medstat in 2006 to develop a strategic plan for implementation of Medicaid Encounter Data System (MEDS); initial operation of MEDS scheduled for March 2008. Plans are required to provide a strategic plan that outlines steps to achieve system readiness for participation in MEDS. The state provides instructions and guidance. Health information systems requirements specified in MCO and PIHP contracts are outlined in detail. Table 33 provides relevant contract provisions for each plan type. Not yet finalized for Florida Senior Care plans. Tables 34-35 provides summary list of MCO and PIHP reports (by level of analysis, frequency, and submission media) required by state contracts.	Appears to meet requirements.
VI.B. Detailed information related to the quality measurement and improvement standards, including—		
B.1. (*B.1.*) A description of the methods and timeframes to assess the quality and appropriateness of care and services to all Medicaid beneficiaries.	Describes requirements for mechanisms to identify, assess, and ensure the existence of a treatment plan for individuals with special health care needs, and for evaluation of health risk assessment for all enrollees. State requires plans to implement a process for receiving and considering provider and enrollee input. Table 36 provides relevant contract provisions for each plan type. Not yet finalized for Florida Senior Care plans.	Appears to meet requirements.

VI. State Standards for Quality Measurement		
Topic	**Compliance & Effectiveness**	**Observations and Recommendations**
B.2. (*B.2*) An identification of the populations the State will consider when determining individuals with special health care needs.	Lists populations and definitions.	Appears to meet requirements.
B.3. (*B.3*) The state standards for the identification and assessment of individuals with special health care needs.	Describes requirements for mechanisms that include evaluation of health risk assessments, claims data, and, if available, CPT/ICD-9 codes for identifying, assessing, and ensuring the existence of a treatment plan for individuals with special health care needs. Table 37 provides relevant contract provisions for each plan type. Not yet finalized for Florida Senior Care plans.	Appears to meet requirements.
B.4. (*B.4*) Procedures the state will use to separately assess the **quality and appropriateness of care** and services furnished under the State's MCO and PIHP contracts to all Medicaid enrollees and to individuals with **special health care needs**.	Describes Florida's procedures to conduct on-site surveys and desk reviews. Table 38 provides relevant contract provisions for each plan type. Not yet finalized for Florida Senior Care plans.	Appears to meet requirements.
B.5. (*B.5*) A description of the state's **information system(s)** and how these systems support the initial and ongoing operation and review of the State's quality strategy; for example, a description of how the state intends to use its MMIS and any other system to monitor quality, produce reports on performance indicators, collect data on different quality measures, etc.	Describes plans for development, installation and initial operation of MEDS, and requirement that plans provide system readiness strategic plan during FY2005-2006. Plans are required to be prepared to meet all system requirements, to submit encounter data, and to conform to the technical enhancements required by the state for full participation in MEDS to begin March 2008. Table 33 provides relevant contract provisions for each plan type. Not yet finalized for Florida Senior Care plans.	Appears to meet requirements.

VII. State Monitoring and Evaluation and Medicaid Contract Provisions		
Topic	**Compliance & Effectiveness**	**Observations and Recommendations**
VII. (*VI*) A description of how the state will regularly **monitor and evaluate MCO and PIHP compliance** with the State-established standards for access to care, structure and operations, and quality measurement and improvement; this may include for example, a description of the types of reviews the state will perform, how often it will monitor these standards, and how the results of the State's efforts will be reported.	Describes specific mechanisms used by the State. Table 38 provides relevant contract provisions for each plan type. Not yet finalized for Florida Senior Care plans.	Appears to meet requirements.
VII.A. (*III and VI.A*) Arrangements for external quality reviews A description of the state's arrangements for an annual, independent external quality review of the timeliness, outcomes, and accessibility of the services covered under each MCO and PIHP contract. This section should include a broad description of the scope of the contract (e.g., calculating HEDIS measures or designing performance improvement projects), including the term of the contract.	*FL QAIS VI.A* describes 11 categories of activities included in contract with HSAG as Florida's EQRO. *FL QAIS III* describes the term of the State's contract with HSAG.	Appears to meet requirements. Addresses 2007 recommendation to state the term of EQRO contract.

VII. State Monitoring and Evaluation and Medicaid Contract Provisions		
Topic	**Compliance & Effectiveness**	**Observations and Recommendations**
VII.B. (*VI.B*) Nonduplication of mandatory external quality review activity A description of the standards and activities that will be monitored through the use of Medicare or private accreditation review information and an explanation of the rationale for why the State review would be duplicative of review activity already performed.	Indicates requirement that the EQRO identify and describe the standards and activities that will be monitored through the use of Medicare or private accreditation reviews to avoid duplication and streamline the EQR process. Table 2 provides relevant contract provisions for each plan type. Not yet finalized for Florida Senior Care plans.	The December 2007 QAIS Annual Update indicates that in 2007, HSAG recommended, prior to deeming any activities, that the State use the NCQA Medicaid Managed Care Toolkit. The tool kit was developed by NCQA to compare NCQA accreditation standards to the Federal Medicaid managed care requirements that fall under the mandatory EQRO activities. The crosswalk is designed for states to use as a starting point for identifying how managed care oversight can be streamlined, thereby preventing duplication of activities. HSAG recommended in 2007 that AHCA complete a crosswalk for each plan type operated by Florida Medicaid, and now recommends that AHCA report progress toward completing these tools.

VIII. Procedures for Race, Ethnicity, and Primary Language		
Topic	**Compliance & Effectiveness**	**Observations and Recommendations**
A. (*VII*) A description of how the state identifies the race, ethnicity, and primary spoken language of each Medicaid MCO and PIHP enrollee and how it will provide this information on each Medicaid enrollee to the MCO and/or PIHP at the time of enrollment.	Indicates that the State's primary procedure during FY 2006-2007 for identification of race, ethnicity, and primary spoken language of Medicaid MCO and PIHP enrollees is through the most recent census data provided by the U.S. Census Bureau. Further, AHCA relies on U.S. Census Bureau information on the ethnicity and primary language spoken for beneficiaries receiving Supplemental Security Income. Finally, the State identification system of race, ethnicity, and primary categories is based on the U.S. Census Bureau categories and definitions.	In 2007, HSAG conducted a review of the current practices the State used to identify race, ethnicity, and primary language. Overall, the review determined that the State was partially compliant with BBA requirements. The analysis resulted in nine recommendations described in the December 2007 QAIS Annual Update. Implementation of recommendations will require programming and system changes. A work group composed of key staff members from the affected State agencies was formed in 2007 to address issues. The State has competitively procured a new fiscal agent, EDS, to implement the new Florida Medicaid Management Information System (FMMIS) beginning July 2008. The new FMMIS will improve the State's process and procedures for identifying the race, ethnicity, and primary language of MCO and PIHP enrollees, and improve the State's ability to provide the required enrollee race/ethnicity and primary language information to the MCOs and PIHPs. As part of assisting beneficiaries with plan enrollment choices, the Medicaid reform choice counselor and the nonreform enrollment broker capture information from the beneficiary related to ethnicity and language preference. The State is analyzing the accuracy of the information and the feasibility of making this information available to the plans. HSAG recommends the continuation of these efforts to achieve the goal of full compliance with BBA requirements.
B. (*VII*) A description of the state's efforts to collect information on ethnicity and primary language spoken for any beneficiaries receiving Supplemental Security Income, as this information is not available from the Social Security Administration.		
C. (*VII*) An identification of the State's race, ethnicity, and primary language categories, including a description of how it defines and categorizes "ethnicity."		

IX. National Performance Measures and Levels		
Topic	**Compliance & Effectiveness**	**Observations and Recommendations**
IX. (*VIII*) For MCOs and PIHPs, the performance measures and levels developed by CMS in consultation with States and other relevant stakeholders. (Note: at this time no performance measures and levels have been developed. At the point CMS undertakes their development; the States will be consulted in each phase of the development process, including the specification of the level of information to be included in the State's quality strategy.)	MCO and PIHP contracts specify that if CMS specifies PIPs, the plan will participate and this will count toward the State-approved quality-of-care projects. Further, contracts specify the diagrams and specify steps for monitoring PIPs. Table 32 provides relevant contract provisions for each plan type. Not yet finalized for Florida Senior Care plans.	Appears to meet requirements.

X. Intermediate Sanctions for MCOs in Support of Quality Strategy		
Topic	**Compliance & Effectiveness**	**Observations and Recommendations**
X. (*IX*) For MCOs only, a description of how the state uses intermediate sanctions in support of its quality strategy. These sanctions must, at a minimum, meet the requirements specified in 42 CFR 438 Subpart I. The State's description should specify its methodology for using sanctions as a vehicle for addressing identified quality of care problems.	Describes specific sanctions and methodology for using sanctions. Table 39 provides relevant contract provisions for each plan type. Not yet finalized for Florida Senior Care plans.	Appears to meet requirements.