



CHARLIE CRIST
GOVERNOR

HOLLY BENSON
SECRETARY

April 30, 2008

Policy Transmittal: HMO 08-05

RE: Nonreform Health Plan Performance Measures and FARS/CFARS Reporting

Dear Nonreform Health Plan:

The purpose of this policy transmittal is two-fold: (1) to provide notice that the Agency has modified the policy regarding Performance Measures, and (2) to provide notice that the Agency has revised the report submission requirements for Functional Assessment Rating Scale/ Children's Functional Assessment Rating Scale Reporting (FARS/CFARS) in the current Nonreform Medicaid Health Plan Model Contract.

Section VIII A. 3. c., of Attachment II of the Nonreform Medicaid Prepaid Health Plan Model contract, permits the Agency to add or remove reporting requirements with 30 days advance notice. This policy transmittal serves as notice that the Agency has revised the required Performance Measures to be submitted in accordance with specifications provided in this transmittal and its related attachments.

The Agency has selected 19 performance measures (PM) for Nonreform plans to report in Measurement Year 2 (January 1, 2008 – December 31, 2008). These performance measures will replace the performance measures outline in Section VIII A. 3.c. (6) of the 2006-2009 Nonreform Medicaid Prepaid Health Plan contract. The list of performance measures may be viewed in **Attachment A, Nonreform Medicaid Prepaid Health Plan Performance Measures**. Effective May 1, 2008, the performance measures report will be submitted to the Agency on an annual basis each July 1. It should be noted that this list does not represent a rotation schedule; rather, the measures shall be cumulative so that all 19 performance measures must be submitted to the Agency on July 1, 2009.

Attachment B, Nonreform Medicaid Prepaid Health Plan Reporting of Performance Measures to the Agency, provides detailed instructions on the collection and submission of the performance measures listed in Attachment A. For Measurement Year One, January 1, 2007, through December 31, 2007, the performance measure report that includes the 10 performance measures outlined in Attachment A is due to the Agency July 1, 2008. Measurement Year 2 captures data from January 1, 2008, through December 31, 2008. The report submission date for Measurement Year 2 that includes all 19 performance measures is July 1, 2009. Instructions for Measurement Year 3 performance measure report that includes data from January 1, 2009, through December 31, 2009, will be provided via a contract amendment to the Nonreform Medicaid Prepaid Health Plan contract and included in the 2009-2012 Nonreform Medicaid Prepaid Health Plan contract.



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Licensed HMOs must note that the performance measure reporting enacted by this policy transmittal does not replace the requirement for annual submission of HEDIS measures on October 1 to the Florida Center for Health Information and Policy Analysis for use in the HMO Report Card.

The Agency has also revised the report submission requirements for FARS and CFARS. Pursuant to Attachment II Section VI, Behavioral Health, Item C. 21, of the Nonreform Medicaid Prepaid Health Plan Contract, the Health Plans are required to reports FARS/CFARS scores to the Agency in the format specified in Attachment XII, Reporting Requirements, Item U. **Attachment C, Table 13 Functional Assessment Rating Scale/Children's Functional Assessment Rating Scale Reporting(FARS/CFARS)** contains the structure of this report to capture enrollee outcome scores with greater specificity and replaces the Table 13 in the current contract. This is effective for calendar year 2008. Reporting for January 1, 2008, through June 30, 2008, is due on August 15, 2008.

If you have any questions or require further clarification, please do not hesitate to contact your Health Systems Development contract manager at (850) 487-2355.

Sincerely,



Carlton D. Snipes

Deputy Secretary for Medicaid

CDS/pa

Enclosures

Attachment A

Nonreform Medicaid Prepaid Health Plan Performance Measures

Medicaid Nonreform Performance Measures		M.Y. 1 2007	M.Y. 2 2008	Comments
Plan Population Measures	1. Breast Cancer Screening – (BCS)		✓	
	2. Cervical Cancer Screening – (CCS)	✓		
	3. Childhood Immunization Status – (CIS)		✓	
	4. Well-Child Visits in the First 15 Months of Life – (W15)	✓		
	5. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life – (W34)	✓		
	6. Adolescent Well Care Visits – (AWC)	✓		
	7. Number of Enrollees Admitted to the State Mental Hospital		✓	Agency-Defined Measure
	8. Follow-Up after Hospitalization for Mental Illness – (FUH)	✓		
	9. Antidepressant Medication Management – (AMM)		✓	
	10. Use of Appropriate Medications for People with Asthma – (ASM)		✓	
	11. Controlling High Blood Pressure – (CBP)	✓		
	12. Comprehensive Diabetes Care – (CDC) – <i>Without Blood Pressure Measure</i>	✓		
	13. Adults Access to Preventive /Ambulatory Health Services – (AAP)		✓	
	14. Annual Dental Visits – (ADV)	✓		
	15. Prenatal and Postpartum Care – (PPC)	✓		Partial Prior Year Data Needed
	16. Frequency of Ongoing Prenatal Care – (FPC)		✓	Partial Prior Year Data Needed
	17. Ambulatory Care – (AMB)	✓		
	18. Readmission Rate		✓	Agency-Defined Measure
	19. Lead Screening in Children (LSC)		✓	
Cumulative Total Measures		10	19	

M.Y. 1 – Measurement Year 1 – Data collected January 1, 2007-December 31, 2007 due to the Agency July 1, 2008

M.Y. 2 – Measurement Year 2 – Data collected January 1, 2008-December 31, 2008 due to the Agency July 1, 2009

Attachment B

Nonreform Medicaid Prepaid Health Plan Reporting of Performance Measures to the Agency

As stipulated in the Nonreform Medicaid Prepaid Health Plan Contract, Section VIII.A.3.c., *the Health Plan shall collect data on patient outcome Performance Measures (PMs), as defined by the Healthcare Effectiveness Data and Information Set (HEDIS) or otherwise defined by the Agency and report the results of the measures to the Agency annually.*

Any Medicaid Nonreform Health Plan authorized to transact business in the state as of January 1 of the measurement year shall report Performance Measure (PM) data to the Agency for Health Care Administration (Agency). All data must be compiled and reported for each individual health plan.

Definitions:

Agency-Defined Performance Measure – These performance measures, not included in the HEDIS data set, have been determined by the Agency to be critical to the needs of the Medicaid population.

HEDIS – Healthcare Effectiveness Data and Information Set developed and published by the National Committee for Quality Assurance. HEDIS includes technical specifications for the calculation of the Performance Measures.

Hybrid Measure – A measure that requires the identification of a numerator using both administrative and medical record data. The denominator consists of a systematic sample of Enrollees drawn from the measure's eligible population.

Measurement Year – January 1 - December 31.

Report Year – The calendar year immediately following the Measurement Year.

1. The following Performance Measures Reporting Requirements chart provides the listing of measures to be reported by the Health Plan and the phase-in schedule encompassing the addition of the new measures. Measures 1 through 19 shall be collected and reported for all Enrollees. The Performance Measure (PM) report is due by July 1 after the Measurement Year being reported.
 - a. Measurement Year One captures January 1, 2007-December 31, 2007. The report submission date for Year Two is July 1, 2008.
 - b. Measurement Year Two captures January 1, 2008-December 31, 2008. The report submission date for Year Two is July 1, 2009.

2. Reporting Instructions

- a. Beginning with Measurement Year One data, each Health Plan shall submit PM data no later than July 1 of the following year (Report Year).
- b. Data must be aggregated by Health Plan.
- c. For HEDIS and Agency-Defined PM there is no rotation schedule. Every PM is due to the agency by July 1 of the report year.
- d. Data must be reported for every required data field for each PM. However, when the denominator is less than 30, report "*" (asterisk) in the "rate" field. For these PMs, other than "rate" report all data elements, including the numerator and denominator.
- e. Extensions to the due date will be granted by the Agency for a maximum of 30 days from the due date in response to a written request signed by the chief executive officer or designee of the Health Plan. The request must be received prior to the due date and the delay must be due to unforeseen and unforeseeable factors beyond the control of the reporting Health Plan. Extensions shall not be granted to verbal requests.
- f. Each Health Plan shall submit indicator data in a text (ASCII) or Microsoft Excel file. The file name shall be in the format: PlanIDyyyy.txt or PlanIDyyyy.xls, where "PlanID" is the three-letter Health Plan identification code as assigned by the Agency and "yyyy" is the Measurement Year of the PM data
- g. Each Health Plan shall send indicator data by electronic mail to RPM@ahca.myflorida.com, or to the Agency's mailing address using a 3.5" diskette or CD as follows:

Agency for Health Care Administration
Attention: Medicaid Nonreform Performance Measures
2727 Mahan Drive, MS16
Tallahassee, Florida 32308
- h. Health Plans submitting indicator data using a diskette or CD must have an external label affixed with the following information:
 - (a) Text: "Medicaid Nonreform Performance Measure Data";
 - (b) The three-letter Health Plan identification code;
 - (c) Medicaid Nonreform Health Plan name;
 - (d) File name in the format PlanIDyyyy.txt or PlanIDyyyy.xls.

- i. Health Plans submitting indicator data using electronic mail shall include in the electronic mailing the following information:
 - (a) Text: "Medicaid Nonreform Performance Measure Data";
 - (b) The three-letter Health Plan identification code;
 - (c) Medicaid Nonreform Health Plan name;
 - (d) File name in the format PlanIDyyyy.txt or PlanIDyyyy.xls.

3. Data Specifications

Each Health Plan shall report the data elements described below for each of the required PMs. Report PM data in the following format with a space or tab between each data element (text files), or a single column for each data element (Excel files). Start a new line with each different PM:

- a. Health Plan Identification Number – The nine-digit Medicaid ID number that identifies the plan and county of operation, as assigned by the Agency for reporting purposes. Format: Nine digits.
- b. Measurement Year – The calendar year of the data. Format: Four digits.
- c. Performance Measure Identifier – The three character code of the PM as specified in the Performance Measures Reporting Requirements chart in parentheses after the PM name in Section XII, I. Format: Three characters.
- d. Data Collection Method – The source of data and approach used in gathering the data for all PMs as specified by HEDIS or Agency definitions. Format: One digit, as below:
 - 1. Administrative method – Enter "1".
 - 2. Hybrid method – Enter "2".
- e. Eligible Enrollee Population – The number meeting the criteria as specified by HEDIS or Agency definitions. Format: Number of digits required.
- f. Sample Size – Minimum required sample size as specified by HEDIS for HEDIS measures only. This data element is not required if the administrative method is used. Leave blank (zero-fill) if e. above is 1. Format: Number of digits required.
- g. Denominator – If the administrative method is used, eligible member population minus exclusions, if any, as specified by HEDIS or Agency definitions. If the hybrid method is used, the sample size is the denominator or as specified by HEDIS or Agency definitions. Format: Number of digits required.
- h. Numerator – Number of numerator events from all data sources as specified by HEDIS or Agency definitions. Format: Number of digits required.

- i. Rate – Numerator divided by denominator times 100.00.
 - j. Lower CI – Lower 95% confidence interval as specified by HEDIS. If the lower CI is less than zero, report 000.00. This statistic is to be calculated for all PMs.
 - k. Upper CI – Upper 95% confidence interval as specified by HEDIS. If the upper CI exceeds 100, report 100.00. This statistic is to be calculated for all PMs.
 - l. Format for Rate, Lower CI and Upper CI: Five digits with two decimal places required, right-justified. Zero-fill leading digits. Include decimal. Use the format: xxx.xx where x represents any digit and xxx is a value between 0 and 100.00.
4. The Number of Enrollees Admitted to State Mental Health Treatment Facilities, and the readmission rate shall be collected and submitted following the specifications listed below. All other Measurement Year One and Measurement Year Two measures shall be collected and submitted according to HEDIS specifications.

a. **Number of Enrollees Admitted to State Mental Health Treatment Facilities (MHF)**

The percentage of all Enrollees 18 years of age and older who receive a commitment order to a state mental health treatment facility within the measurement year.

Ages: Eighteen years of age and older as of December 31 of the measurement year.

Data Collection Method: Administrative data, based on provider reporting. No sampling allowed.

Enrollment: No minimum or continuous period of enrollment is required. Include all eligible Enrollees during the measurement year, regardless of period of enrollment.

Calculation: Results will be expressed as a percentage rate:

Denominator: Number of enrollees with a mental health diagnosis during the measurement year or the year prior to the measurement year.

"Mental health diagnosis" is defined from the following list of ICD-9-CM codes. Codes can be a principal diagnosis or any secondary diagnosis:

290 - 290.43; 293 - 298.9; 300 - 301.9; 302.7, 306.51 - 312.4; 312.81 through 314.9; 315.3, 315.31, 315.5, 315.8, and 315.9.

Numerator: Number of Enrollees for whom a commitment order was signed during the measurement year.

Exclusions:

- Enrollees for whom the commitment process has been initiated but who have not yet received an order for placement;
- Enrollees who are awaiting transport and whose order was reported in an earlier reporting period;
- New enrollees whose commitment process was in progress prior to enrollment in the Health Plan.

- b. **Readmission Rate:** The percentage of enrollees who were hospitalized for a mental health diagnosis and were discharged to the community from an acute care facility and were readmitted for a mental health diagnosis within 30 days.

Denominator: Enrollees who were discharged to the community from an acute care facility (inpatient or crisis stabilization unit) who had a discharge diagnosis of ICD-9-CM codes 290.0 through 290.43, 293.0 through 298.9, 300.00 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9) who were continuously enrolled for 30 days following discharge.

Exclusions: enrollees who died, or enrollees whose discharges were followed by readmission or direct transfer to a Statewide Inpatient Psychiatric Program (SIPP), a readmission or direct transfer to a Department of Juvenile Justice or Child Welfare Behavioral Health Overlay Service facilities, members who receive Florida Assertive Community Treatment services, and members who are admitted to hospice, nursing facilities, state mental health facilities, correctional institutions and hospice programs within the 30 days after discharge.

Age/Gender: N/A

Enrollment Requirement: Continuously enrolled for 30 days following discharge.

Numerator

Readmission to an acute care facility (inpatient or crisis stabilization unit) with a diagnosis of ICD-9-CM codes 290.0 through 290.43, 293.0 through 298.9, 300.00 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9) within 30 days of discharge.

5. Data Certification

- a. By July 1 of each year, the Health Plan shall deliver to the Agency a certification by an independent auditor that the PM data reported for the previous year (Measurement Year) have been fairly and accurately presented. This certification should accompany the PM data.
- b. The Health Plan shall submit and attest to the accuracy and completeness of data from all subcontracted entities, including, but not limited to, behavioral health managed care organizations, disease management organizations and laboratories as described in Section XII, A., of the Nonreform Medicaid Prepaid Health Plan Model Contract. In no instance will separate, direct submission of data to the Agency from such entities be permitted.

6. Data Validation

- a. As specified in Section VIII, A.1.e., the Health Plan shall cooperate with the Agency and the External Quality Review Organization (EQRO). The Agency will set methodology and standards for Quality Improvement with advice from the EQRO.
- b. Each Health Plan shall participate in the EQRO's performance measures validation process according to CMS protocol.
- c. Any Health Plan failing to participate with the external EQRO PM validation process will be deemed non-compliant.

7. Report Deficiencies

- a. A report, certification, or other information required for PM reporting is incomplete when it does not contain all data required by the Agency or when it contains inaccurate data. A report or certification is "false" if done or made with the knowledge of the preparer or a superior of the preparer that it contains information or data that is not true or not accurate.
- b. A Health Plan that refuses to file, fails to timely file, or files a false or incomplete report or a report that cannot be certified, validated, or excludes other information required to be filed may be subject to administrative penalties pursuant to Section XIV., Sanctions, of the Nonreform Medicaid Prepaid Health Plan Model Contract.

Attachment C

Table 13 FUNCTIONAL ASSESSMENT RATING SCALE/CHILDREN'S FUNCTIONAL ASSESSMENT RATING SCALE (FARS/CFARS) Reporting

Table 13 FUNCTIONAL ASSESSMENT RATING SCALE/CHILDREN'S FUNCTIONAL ASSESSMENT RATING SCALE Reporting				
O***YY06.txt (January through June, due August 15) OR O***YY12.txt (July through December, due February 15)				
Data Element Name	Length	Start Column	End Column	Description
Recipient Identification Number	9	1	9	9-Digit Medicaid Identification Number of Enrollee.
Recipient Date of Birth	10	10	19	Enrollee's date of birth in CCYMMDD format, e.g., 20010101.
Recipient Name First	15	20	35	Enrollee's first name.
Recipient Name Last	15	36	50	Enrollee's last name.
Provider Identification Number	9	51	59	9-Digit Medicaid Plan Identification Number.
Contractor Identification Number	10	60	70	10-digit Federal Tax Identification Number or National Provider Identifier (NPI) of the provider conducting the assessment.
Contract Number	5	71	76	Up to 5-digit alphanumeric number of the Department of Children and Families contract responsible for serving the enrollee being evaluated through FUNCTIONAL ASSESSMENT RATING SCALE or CHILDREN'S FUNCTIONAL ASSESSMENT RATING SCALE. If the provider does not have a contract, enter "00000".
Assessment Type	1	77	77	1-digit code to designate the type of functional assessment that was done, i.e., "F" = FUNCTIONAL ASSESSMENT RATING SCALE or "C" = CHILDREN'S FUNCTIONAL ASSESSMENT RATING SCALE
Assessment Purpose	1	78	78	1-digit code to designate the purpose for doing the assessment, i.e., "1" = Initial assessment at time of admission into provider agency; "2" = every 6-month after admission, or "3" = assessment at time of discharge from provider agency
Assessment Date	8	79	86	Date of assessment in CCYMMDD format, e.g., 20060812.

Data Element Name	Length	Start Column	End Column	Description
Disability Score	2	87	88	Sum of the assessment scores for all the scales in the Disability domain.
Emotionality Score	2	89	90	Sum of the assessment score for all the scales in the Emotionality domain.
Relationship Score	2	91	92	Sum of the assessment score for all the scales in the Relationships domain.
Safety Score	2	93	94	Sum of the assessment score for all the scales in the Personal Safety domain.
Overall Assessment Score	3	95	97	Sum of all domain scores.

The definitions of FUNCTIONAL ASSESSMENT RATING SCALE and CHILDREN'S FUNCTIONAL ASSESSMENT RATING SCALE domains and related functional scales and subscales for each domain are available on the following Florida Mental Health Institute web site: <http://outcomes.fmhi.usf.edu>. For example, the following are domains and functional scales for FUNCTIONAL ASSESSMENT RATING SCALE and CHILDREN'S FUNCTIONAL ASSESSMENT RATING SCALE:

Domains	Functional Scales	FARS	CFARS
Disability	Hyper Affect	✓	
	Thought Process	✓	✓
	Cognitive Performance	✓	
	Medical/Physical	✓	✓
	Activity of Daily Living	✓	✓
	Ability to Care for Self	✓	
Emotionality	Depression	✓	✓
	Anxiety	✓	✓
	Traumatic Stress	✓	✓
Relationships	Interpersonal Relations	✓	✓
	Family Relations	✓	
	Family Environment	✓	
	Socio-Legal	✓	
	Work or School	✓	✓
	Danger to Others	✓	✓
	Hyper Activity		✓
	Cognitive Performance		✓
	Behavior in Home Setting		✓
Personal Safety	Substance Use	✓	✓
	Danger to Self	✓	✓
	Security Management Needs	✓	✓
	Socio-Legal		✓