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February 20, 2014

Statewide Medicaid Managed Care (SMMC) Policy Transmittal

Policy Transmittal: 14-01

Applicable to:

Contract Type

☒ Comprehensive LTC Plan
☒ MMA HMO
☒ MMA PSN
☒ MMA Specialty Plan
☒ LTC Fee-for-Service PSN
☒ Children's Medical Services' Network

Re: Performance Measure and other Quality Management-related requirements

Dear Statewide Medicaid Managed Care Plans,

The purpose of this policy transmittal is to advise the statewide Medicaid managed care plans of changes and guidance related to performance measures and other quality management-related contract requirements.

Long-term Care Plans

Performance Measures

Attachment II, Exhibit II-B, Section VII. B.1.a is being amended to the following: The managed care plan shall collect and report the following performance measures, certified via qualified auditor.

	HEDIS/Agency-defined
1	Care for Older Adults (COA) – included components: advance care planning; medication review; and functional status assessment. Add age bands: 18 to 60 years as of December 31 of the measurement year* 61 to 65 years as of December 31 of the measurement year* 66 years and older as of December 31 of the measurement year
	Agency-defined
2	Required Record Documentation (RRD)
3	Face-to-Face Encounters (F2F)
4	Case Manager Training (CMT)
5	Timeliness of Services (TOS)
6	Prevalence of Antipsychotic Drug Use in Long-stay Dementia Residents

*Agency addition to HEDIS.

Please note that the Care for Older Adults measure is being amended to better meet the plans' contract requirements, and is thus becoming Agency-defined. The specifications for this measure will be included in the Agency's Performance Measure Specifications Manual.

For the Required Record Documentation measure, the Plan of Care/Primary Care Physician Participation component has been dropped. Specifications regarding the 701B Assessment component will be updated in the Agency's Performance Measure Specifications Manual.

For the Prevalence of Antipsychotic Drug Use in Long-stay Dementia Residents measure, plans will be notified when they are required to begin reporting this measure and will be provided with measure specifications.

The first Performance Measure Report is due to the Agency no later than **July 1, 2014**, covering the measurement period of calendar year 2013. Due to continuous enrollment requirements, several measures will not be reported for calendar year 2013. The measures that some plans should be able to report are:

- Face-to-Face Encounters (plans with at least three months of enrollment)
- Case Manager Training (plans with case managers employed 90 days or more as of December 31, 2013)
- Timeliness of Services (plans with at least one month of enrollment)

Performance Improvement Projects (PIPs)

Attachment II, Exhibit II-B, Section VII. C. is being amended to the following:

The Managed care Plan shall perform two (2) Agency-approved statewide performance improvement projects, one (1) clinical PIP and one (1) non-clinical PIP.

Please note that the collaborative PIP topic for the long-term care plans is Medication Review. The details for this indicator were sent to the plans by the External Quality Review Organization and the Agency during the fall of 2013. This is a clinical PIP, so each long-term care plan must select a non-clinical PIP. Long-term care plans must submit a proposed non-clinical PIP topic to their contract managers no later than Friday, **March 21, 2014**. PIP proposals (including

activities I through VI of the EQRO PIP validation form) for both the collaborative PIP and the non-clinical PIP are due to the Agency no later than **August 1, 2014**.

Enrollee Satisfaction Surveys

The Agency sent out a draft Enrollee Survey for Long-term Care Plans and draft Survey Administration Guidelines on August 2, 2013. The Agency revised the survey expectations and the survey tool for the first round of surveys in response to the feedback from the plans. The revised survey tool is enclosed with this policy transmittal. The Survey Administration Guidelines are being amended as follows:

1. Long-term Care Plans (LTC Plans) are required to contract with an Agency-approved independent survey vendor to administer the surveys. The minimum sample size is 1,700, with a target of 411 completed surveys. The survey should be administered according to the NCQA mixed mode protocol (mail with telephone follow-up).
2. The first round of surveys will be of LTC Plan members residing in the community. A simple random sample per NCQA protocol should be used.
3. To be included in the survey sample, enrollees must have been enrolled in the LTC plan for at least six months with no more than a 1-month gap in enrollment.
4. LTC Plans are required to use the core LTC Plan Enrollee Survey. If they would like to add questions to the survey, those questions may be added to the end of the core survey. Additional questions must be submitted to the Agency contract manager for review and approval prior to being included in the survey.
5. LTC Plans must submit an Excel file of the survey results (including the responses to each survey item for each respondent) as well as an Excel file report of the aggregate response rates for the plan for each survey item. Both of these files must be attested to by the plan's independent survey vendor and a plan attestation regarding the accuracy and completeness of the files must be submitted. The Agency will provide a report template for each of these two files.
6. The due dates for the LTC Plan Enrollee Survey Results reports will be as follows:
   a. The first report is due by **December 31, 2014**.
   b. The second report is due by **October 1, 2015**.
   c. The third report is due by **July 1, 2016**.
   d. Thereafter, reports are due by **July 1** of each contract year.

The Managed Care Plan shall submit to the Agency, in writing, **by April 7, 2014**, a proposal for survey administration and reporting that includes identification of the survey administrator/vendor; sampling methodology; administration protocol; analysis plan; and reporting description.

Managed Medical Assistance Plans

Performance Measures

Attachment II, Exhibit II-A, Section VII. B. is amended by replacing the current language with the following:

The Managed Care Plan shall collect and report the following performance measures, certified via qualified auditor.

HEDIS	
1	Adolescent Well Care Visits - (AWC)
2	Adults' Access to Preventive/Ambulatory Health Services - (AAP)
3	Annual Dental Visits - (ADV)
4	Antidepressant Medication Management - (AMM)
5	BMI Assessment – (ABA)
6	Breast Cancer Screening – (BCS)
7	Cervical Cancer Screening – (CCS)
8	Childhood Immunization Status – (CIS) – Combo 2 and 3
9	Comprehensive Diabetes Care – (CDC) · Hemoglobin A1c (HbA1c) testing · HbA1c poor control · HbA1c control (<8%) · Eye exam (retinal) performed · LDL-C screening · LDL-C control (<100 mg/dL) · Medical attention for nephropathy
10	Controlling High Blood Pressure – (CBP)
11	Follow-up Care for Children Prescribed ADHD Medication – (ADD)
12	Immunizations for Adolescents – (IMA)
13	Chlamydia Screening for Women – (CHL)
14	Prenatal and Postpartum Care – (PPC)
15	Use of Appropriate Medications for People With Asthma – (ASM)
16	Well-Child Visits in the First 15 Months of Life – (W15)
17	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life(W34)
18	Children and Adolescents' Access to Primary Care - (CAP)
19	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
20	Ambulatory Care - (AMB)
21	Lead Screening in Children – (LSC)
22	Annual Monitoring for Patients on Persistent Medications (MPM)
23	Plan All-Cause Readmissions (PCR)
Agency-Defined	
1	Mental Health Readmission Rate – (RER)
2	Transportation Timeliness (TRT)
3	Transportation Availability (TRA)
HEDIS & Agency-Defined	
1	Follow-Up after Hospitalization for Mental Illness – (FHM)
2	Prenatal Care Frequency (PCF)

Health Resources and Services Administration – HIV/AIDS Bureau	
1	CD4 Cell Count (CD4)
2	Viral Load Monitoring (VLM)
3	Antiretroviral Therapy (ART)
4	Viral Load Suppression (VLS)
CHIPRA Child Core Set/Child Health Check Up Report (CMS-416)	
1	Preventive Dental Services (PDENT)
2	Dental Treatment Services (TDENT)
3	Sealants (SEA)
CMS Adult Medicaid Core Set/Joint Commission	
1	Antenatal Steroids (ANT)
CAHPS Health Plan Survey	
1	Medical Assistance with Smoking and Tobacco Use Cessation

The first Performance Measure Report is due to the Agency no later than **July 1, 2015**, covering the measurement period of calendar year 2014. Measures should be collected based on the technical specifications for the measures, across the Statewide Medicaid Managed Care (SMMC) contract and the previous Managed Care Plan contract as applicable. For example, if someone has been in XYZ Health Plan for six months under the SMMC contract and for six months under the previous managed care contract, the person would meet the 12 months of continuous enrollment required for many performance measures. Due to calendar year 2014 being a transition year across contracts, performance measures will be collected and may be reported publicly by the Agency, but will be labeled as "transition year" measures and will not be subject to liquidated damages and sanctions related to where performance measure results fall relative to the National Medicaid Means and Percentiles (as published by the National Committee for Quality Assurance). Please note that liquidated damages and sanctions related to incomplete and/or inaccurate reporting will be in effect.

Beginning with the Performance Measure Report that is due to the Agency no later than **July 1, 2016**, covering the measurement period of calendar year 2015, all performance measure-related liquidated damages and sanctions will be in effect.

Performance Improvement Projects (PIPs)

Per Attachment II, Exhibit II-A, Section VII. C, the Managed Care Plan shall perform four (4) Agency-approved statewide performance improvement projects as specified below:

1. One (1) of the PIPs shall combine a focus on improving prenatal care and well-child visits in the first fifteen (15) months;

2. One (1) of the PIPs shall focus on preventive dental care for children;

3. One (1) of the PIPs shall be an administrative PIP focusing on a topic prior approved by the Agency; and

4. One (1) PIP shall be a choice of PIP in one of the following topic areas: population health issues (such as diabetes, hypertension and asthma) within a specific geographic area that have been identified as in need of improvement; integrating primary care and behavioral health; and reducing preventable readmissions.

The PIPs identified as 1 and 2 above will be collaborative PIPs coordinated by the External Quality Review Organization (EQRO). The EQRO will put together proposed methodologies for the collaborative PIPs, which will be sent to the managed care plans for review. Once the proposed methodologies for the collaborative PIPs have been sent to the managed care plans, the Managed Care Plan has **two weeks** to submit feedback to the Agency and the EQRO on the methodologies.

Attachment II, Section C. 2 provides requirements for PIP proposals. This section states that within ninety (90) days after initial Contract execution, the Managed Care Plan shall submit to the Agency in writing, a proposal for each planned PIP. This requirement is amended to the following:

By **April 15, 2014**, the Managed Care Plan shall submit to the Agency, in writing:

- The Plan's proposed administrative PIP topic and its indicator(s);
- The Plan's proposed PIP topic and its indicator(s) from one of the following topic areas: population health issues within a specific geographic area that have been identified as in need of improvement; integrating primary care and behavioral health; and reducing preventable readmissions; and
- A brief summary of the baseline data that the plan will use for each indicator for each of the four proposed PIPs.

The Managed Care Plan shall submit to the Agency, in writing, a proposal for each planned PIP by **August 1, 2014**. This proposal must meet the requirements provided in Attachment II, Section C.2.

<u>Enrollee Satisfaction Surveys</u>

Attachment II, Exhibit II-A, Section VII.D.1 provides requirements related to Enrollee Satisfaction Surveys for Managed Medical Assistance Plans. These requirements are in addition to the Enrollee Satisfaction Survey requirements provided in Attachment II, Section VII.D.1. Please note the following requirements for the surveys whose results are due to the Agency by **July 1, 2015**:

- Managed Care Plans are required to use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey – Medicaid Survey 5.0.
- In addition to the core survey, managed care plans are required to include items MH1 through MH4 (related to Behavioral Health) and H.17 through H.20 (related to medical assistance with smoking and tobacco use cessation) from the CAHPS Health Plan Survey – Supplemental Items for the Adult Questionnaires.
- The Managed Care Plan shall submit to the Agency, in writing, **within 90 days of initial Contract execution**, a proposal for survey administration and reporting that includes identification of the survey administrator and evidence of NCQA certification as a

CAHPS survey vendor; sampling methodology; administration protocol; analysis plan; and reporting description.

Child Welfare Specialty Plan

Performance Measures

Attachment II, Exhibit II-C, Section VII.B.1.b is amended as follows:

The Specialty Plan shall collect and report the following additional performance measures:

CHIPRA Child Core Set	
1	HPV Vaccine for Female Adolescents – (HPV)
2	Medication Management for People with Asthma – (MMA)
3	Developmental Screening in the First Three Years of Life – (DEVSCR)
AHRQ-CMS CHIPRA National Collaboration for Innovation in Quality Measurement (NCINQ)	
1	Children on Higher than Recommended Doses of Antipsychotics (HRDPSY)
2	Use of Antipsychotics in Very Young Children (PSYVYC)
3	Use of Multiple Concurrent Antipsychotics in Children (CONPSY)

The Specialty Plan is not required to report the following Managed Medical Assistance Plan performance measures:

- Adults' Access to Preventive/Ambulatory Health Services
- Adult BMI Assessment
- Annual Monitoring for Patients on Persistent Medications
- Antidepressant Medication Management
- Breast Cancer Screening
- Cervical Cancer Screening
- Comprehensive Diabetes Care
- Controlling High Blood Pressure
- Plan All-Cause Readmissions

The NCINQ measures in the table above will not be required until these measures have been finalized and the technical specifications have been released.

HIV/AIDS Specialty Plan

Performance Measures

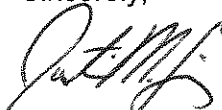
Attachment II, Exhibit II-C, Section VII.B.1.b is amended as follows:

The Specialty Plan shall collect and report the following additional performance measures, certified via qualified auditor:

	Health Resources and Services Administration – HIV/AIDS Bureau
1	Linkage to HIV Medical Care (HIVMC)
2	Housing Status (HOU)
3	HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis (STDCR)
4	Hepatitis C Screening (HEPC)

If you have questions regarding the information included in this policy transmittal, please contact your Agency contract manager. We appreciate the services you provide to Florida's Medicaid recipients.

Sincerely,



Justin M. Senior
Deputy Secretary for Medicaid

JMS/rl
Enclosure

Enrollee Survey for Long-term Care Plans

Survey Instructions

Answer each question by circling the letter to the left of your answer.

You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

a. Yes → **If Yes, go to #1 on page 1**
b. No

These questions ask you about care and services you have received in your Medicaid Long-term Care Plan.

1. Our records show that you are now in [INSERT LTC PLAN NAME] long-term care plan. Is that right?
    a. Yes → **If Yes, go to #3**
    b. No
    c. Not sure

2. What is the name of your long-term care plan?

   Please print: ____

3. How long have you been enrolled in this long-term care plan?
    a. Less than 6 months
    b. At least 6 months but less than 1 year
    c. At least 1 year but less than 2 years
    d. At least 2 years

Your Long-term Care Plan

4. In the last 6 months, did you get information or help from your long-term care plan's customer service?
    a. Yes
    b. No → **If No, go to #7**

5. In the last 6 months, how often did your long-term care plan's customer service give you the information or help you needed?
    a. Never
    b. Sometimes
    c. Usually
    d. Always

6. In the last 6 months, how often did your long-term care plan's customer service staff treat you with courtesy and respect?
    a. Never
    b. Sometimes
    c. Usually
    d. Always

7. In the last 6 months, did your long-term care plan give you any forms to fill out?
    a. Yes
    b. No → **If No, go to #9**

8. In the last 6 months, how often were the forms from your long-term care plan easy to fill out?
    a. Never
    b. Sometimes
    c. Usually
    d. Always

9. Using any number from 0 to 10, where 0 is the worst long-term care plan and 10 is the best long-term care plan, what number would you use to rate your long-term care plan?
    a. 0 Worst long-term care plan
    b. 1
    c. 2
    d. 3
    e. 4
    f. 5
    g. 6
    h. 7
    i. 8
    j. 9
    k. 10 Best long-term care plan

Your Case Manager

10. Since you joined [PLAN NAME'S] long-term care plan, how often has it been easy to get in contact with your case manager?
    a. Never
    b. Sometimes
    c. Usually
    d. Always

11. Using any number from 0 to 10, where 0 is the worst case manager and 10 is the best case manager, what number would you use to rate your current case manager in [PLAN NAME's] long-term care plan?
    a. 0 Worst case manager
    b. 1
    c. 2
    d. 3
    e. 4
    f. 5
    g. 6
    h. 7

i. 8
j. 9
k. 10   Best case manager

Your Long-term Care Plan Services

12. Since you joined [PLAN NAME'S] long-term care plan, have you moved out of a nursing facility into the community?
    a. Yes
    b. No → **If No, go to #16**

13. Did someone from [PLAN NAME'S] long-term care plan contact you about the move?
    a. Yes
    b. No

14. Right after the move, did you miss any services you needed?
    a. Yes
    b. No → **If No, go to #16**
    c. Don't know → **If Don't know, go to #16**

15. Are the services you missed part of your care plan?
    a. Yes
    b. No
    c. Don't know

16. Where do you live right now?
    a. In a house/apartment
    b. In an Adult Family Care Home
    c. In an Assisted Living Facility
    d. Other

17. About how long have you lived there?
    a. Less than 1 month
    b. Between 1 month and 6 months
    c. Between 6 months and 1 year
    d. More than 1 year
    e. Not sure

18. Overall, how often are your long-term care services on time?
    a. Never
    b. Sometimes
    c. Usually
    d. Always

19. Using any number from 0 to 10, where 0 is the worst long-term care services and 10 is the best long-term care services, what number would you use to rate your long-term care services?
    a. 0 Worst long-term care services
    b. 1
    c. 2
    d. 3
    e. 4
    f. 5
    g. 6
    h. 7
    i. 8
    j. 9
    k. 10 Best long-term care services

About You

20. In general, how would you rate your overall health?
    a. Excellent
    b. Very Good
    c. Good
    d. Fair
    e. Poor

21. Since you enrolled in [PLAN NAME'S] long-term care plan, has your overall health improved?
    a. Yes, it has improved a lot.
    b. Yes, it has improved a little.
    c. No, it has not improved.

22. Since you enrolled in [PLAN NAME's] long-term care plan, has your quality of life improved?
    a. Yes, it has improved a lot.
    b. Yes, it has improved a little.
    c. No, it has not improved.

23. Did someone help you (the enrollee, the person to whom the survey was addressed) complete this survey?
    a. Yes → **If Yes, go to #24**
    b. No → **Thank you. Please return the completed survey in the postage-paid envelope.**

24. Who helped you (the enrollee) complete the survey?
    a. Case Manager
    b. Long-term Care Plan staff
    c. Child or grandchild
    d. Spouse
    e. Service Provider (for example, a home health aide)
    f. Legal guardian
    g. Other ______________________________

25. How did that person help you (the enrollee)? [Mark one or more]
    a. Read the questions to me
    b. Wrote down the answers I gave
    c. Answered the questions for me
    d. Translated the questions into my language
    e. Helped in some other way ______________________________

    ____

Thank you. Please return the completed survey in the postage-paid envelope.