Florida Medicaid

Draft Comprehensive Quality Strategy

2014 Update

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

III. ESTABLISHING PERFORMANCE AND QUALITY MEASURES

Quality Measures for the 1915 (c) Waiver

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

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

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

Appendix C---Participants-Qualified Providers
Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services
Percentage of all new managed care plans that satisfy waiver service provider qualifications prior to delivery of services.
Percentage of licensed subcontractors, by type, within managed care plans' provider networks evaluated by the managed care plan that meet service provider qualifications prior to delivering services.
Percentage of licensed subcontractors, by type, within managed care plan's provider networks evaluated by the managed care plan that meet service provider qualifications continuously.
Percentage of managed care plans continually qualified as program providers on an annual basis.
Sub-Assurance: The State monitors non-licensed/non-certified service providers to assure adherence to waiver requirements.
Percentage of non-licensed/non-certified service providers, by type, within the managed care plan network satisfying waiver service provider qualifications prior to the delivery of services.
Percentage of non-licensed/non-certified service providers, by type, within the managed care plan network satisfying waiver service provider qualifications continually.
Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.
Percentage of subcontractors with staff mandated to report abuse, neglect and exploitation, verified by managed care plan that staff have received the appropriate training.
Percentage of case managers or subcontracted case managers satisfying abuse, neglect and exploitation, and Alzheimer's disease and dementia training requirements.
Appendix D---Participant-Centered Planning and Service Delivery
Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.
Percentage of enrollees with care plans meeting all assessed needs and risks.

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

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

PERFORMANCE MEASURES – HEDIS and other LTC measures

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

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

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

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

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

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