

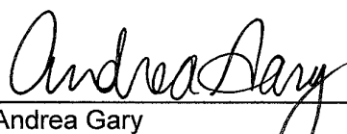


**CHILDREN'S MEDICAL SERVICES
MANAGED CARE PLAN
QUALITY IMPROVEMENT PLAN
FEBRUARY 2018**

UPDATE NO.	DATE ISSUED	MAJOR CHANGES
New Quality Improvement Plan	09/2004	
Revised Plan	07/2006	
Revised Plan	04/2007	
Revised Plan	07/2011	
Revised Plan	04/2012	
Revised Plan	07/2014	07/2014
Revised Plan	03/2015	
Revised Plan	05/2016	05/2016
Revised Plan	08/2017	
Revised Plan	02/2018	

Areas of responsibility include the Director, Office of CMS Plan & Specialty Programs, Director of CMS Plan Administration, Director of CMS Plan Operations & Specialty Programs. **Signatures below indicate the Quality Improvement Program has been approved for implementation as CMS Plan policies and procedures.**

Signature Block with Effective Date:



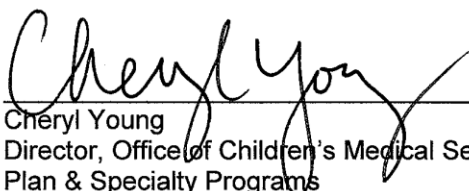
Andrea Gary
 Director of Children's Medical Services
 Plan Administration

2/13/2018
 Date



Kelli Stannard, RN, BSN
 Director of Children's Medical Services
 Plan Operations & Specialty Programs

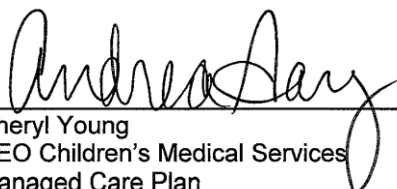
2/6/18
 Date



Cheryl Young
 Director, Office of Children's Medical Services
 Plan & Specialty Programs

2/21/18
 Date

Governing Body Approval:

for 
 Cheryl Young
 CEO Children's Medical Services
 Managed Care Plan
 Governing Body Representative

2/21/18
 Date

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INTRODUCTION

The Department of Health (DOH), Children's Medical Services Managed care Plan (CMS) provides comprehensive health care to children with special health care needs up to age 21 in Medicaid (Title XIX) and up to age 19 in KidCare (Title XXI). Children enrolled in CMS are provided with a medical home that links with a comprehensive array of specialty health care and community based services. A multi-disciplinary approach to the provision of services is used to meet the needs of the child and the family. This includes serving the cultural and linguistic needs of our enrollees.

MISSION

The scope and mission of the Quality Improvement Plan is to improve the quality of care to children with special health care needs by creating and maintaining a family-centered, coordinated, medically managed comprehensive system of care. The Quality Improvement (QI) Program's primary objective is to ensure that credentialed, qualified, and culturally sensitive providers at the appropriate services sites, which meet reasonable and established time and distance standards, render medically necessary services within the benefit structures of CMS. This goal is achieved through the development of a coordinated, integrated, and comprehensive program designed to improve the health status of CMS enrollees and includes coordination with CMS providers, both Integrated Care Systems (ICS) and CMS area offices to improve the continuity and quality of care. The Quality Improvement Program (QI Program) will monitor the structure, process, and outcomes of health care provided to CMS enrollees. The quality of health care delivered shall be improved by instituting and ensuring preventative health initiatives for all age and gender categories of enrollments, by establishing benchmarks, by implementing clinical guidelines, by sharing standards and information with the network providers, by measuring clinical outcomes and by a continuing educational process for both the enrollees and the providers. Findings from QI activities are shared on an ongoing basis with the CMS provider network and plan enrollees.

The CMS QI plan is committed to the monitoring and evaluation of quality and appropriateness of care provided to enrollees including, but not limited to, review of quality of care and service concerns, complaints and grievances, enrollee rights, adverse/critical events, enrollee safety and utilization management processes. CMS providers and enrollees are provided the opportunity to give input to the QI Plan through the annual satisfaction survey.

CMS has entered into a contractual relationship with two Integrated Care Systems (ICS) to provide comprehensive health care coverage to our enrollees: Community Care Plan (CCP) and Ped-I-Care.. CMS also incorporates 20 individual area offices throughout the state. These area offices house nurses and social workers who provide care coordination for each CMS enrollee. Thus, each ICS and each CMS area office play a significant role in the QI Program.

GOALS AND OBJECTIVES

The purpose of the CMS Quality Improvement (QI) Program is to develop a coordinated, integrated, comprehensive approach to the provision of care and services, to meet or exceed enrollee expectations, to measure outcomes and apply interventions that continue to improve the level of care and service provided to enrollees, and to continually monitor, evaluate and improve the quality of the health care services provided to enrollees.

A. PROGRAM GOALS

- Improve preventative care services and management of chronic conditions and complex health needs through monitoring and evaluating processes and identify areas that require improvement. The emphasis is on provider and CMS enrollee education. Standards are developed and performance is assessed against the clinical guidelines. Healthy Behavior Programs and Quality Enhancements are also monitored for improvement.
- Improve continuity and coordination of care through ongoing activities performed by Utilization Management, Care Coordination, Chronic Conditions/Disease Management, Provider Services, Enrollee Services, Claims Management, and Data Management.
- Improve appropriateness of care and foster safe practices through peer review, provider credentialing and re-credentialing, concurrent review, case management, chronic conditions/disease management, risk management, facility review and medical record review.
- Improve accessibility to and timeliness of care and service through the evaluation of enrollee grievances, satisfaction surveys, and internal and external processes (surveys, newsletters, and the establishment of guidelines communicated to enrollees and providers).
- Improve medical record documentation through the identification of areas that require improvement based on standards set by the Agency for Health Care Administration (AHCA), CMS, and professional practice guidelines. Emphasis is placed on providing educational feedback and resources to providers to improve the documentation process.
- Improve effectiveness of care and service through the review and analysis of medical resource utilization, chart review, and enrollee surveys.
- Improve provider education and communication through feedback via committees, provider surveys, newsletters, instructional letters, interviews, peer-referenced provider profiling, and provider manuals.
- Improve enrollee education and communication through surveys, educational sessions, and ongoing activities performed by care coordinators, chronic conditions/disease management, enrollee services, and utilization management.

- Assure validation of delegated services activities through direct monitoring and review of records, files and facilities, and ongoing analysis of submitted data and reports.
- Assure close monitoring of quality improvement and utilization management activities of delegates through ongoing analysis of submitted data and reports.
- Provide monitoring of records and evaluate processes to identify areas that require improvement. The focus is placed on provider and network education that will facilitate appropriateness of care and enrollee satisfaction.
- Provide monitoring and evaluation of non-clinical aspects of service with timely resolution of problems and improvement in processes.
- Assure ongoing and annual evaluation of the Quality Improvement Program and its activities to determine its effectiveness. To assess for improvement in the care and service provided to CMS enrollees.
- Assure CMS serves the cultural and linguistic needs of our population by educating CMS employees and providing CMS literature in appropriate translations for the population served.
- Assure that QI outcomes and findings are used in the revision of policies, scope of services provided, and improvement activities such as education.

B. PROGRAM OBJECTIVES

- To systematically and objectively monitor and evaluate access to care and the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes in service performance. This includes monitoring cultural and linguistic needs of our population as well as service availability and accessibility.
- To evaluate care and resolve identified problems related to professional standards of care.
- To utilize the peer review process in conjunction with our ICS's to evaluate clinical performance and network quality.
- To evaluate provider grievances and appeals.
- To evaluate enrollee grievances and appeals.
- To evaluate the outcomes of care using criteria developed by health care professionals.
- To implement procedures for taking effective remedial action if it is determined through this program that inappropriate or substandard care has been provided or that indicated contracted services were not provided.
- To document findings, conclusions, recommendations, actions taken and results of

actions taken throughout this program.

- To incorporate QI outcomes and findings in revision of policies, scope of services and improvement activities and education.

SCOPE OF THE QUALITY IMPROVEMENT PROGRAM

A. HEALTH PROMOTION ACTIVITIES

1. The Care Coordination staff will develop programs for enrollees identified as being at high risk for discontinuity of care or non-compliance with treatment.
2. The development of programs for pregnant enrollees.
3. The use of Health Risk Assessment tools and Acuity Tools.

B. QUALITY OF CARE MONITORING

The scope of the QI Program incorporates quality of care monitoring including:

1. Through our ICS, the generation of utilization reports for services provided by hospitals, emergency rooms, physician services, mental health facilities, home health agencies and durable medical equipment companies.
2. Through our ICS, facility audits and medical record reviews to monitor services provided by Primary Care Providers (PCP's), high volume specialists and enrollees who received Behavioral Health Services.
3. Monitoring practice guidelines through medical record reviews and utilization reports.
4. Through our ICS, the monitoring of high volume, high risk services based on a review of demographic and epidemiological distribution of enrollees.
5. Through our ICS, services reflecting acute and chronic care, including Home Health Services.
6. Continuity and coordination of care.
7. Over and underutilization of medical resources.
8. Enrollee and provider satisfaction surveys.
9. Grievance and appeals (non-claims) monitoring and analysis.
10. Compliance with practice guidelines including preventative health care guidelines.
11. Monitor, evaluate and improve the quality and appropriateness of care and services delivered (or the failure to provide care or deliver services) to enrollees through peer review, Performance Improvement Projects (PIPs), medical record

audits, performance measures, surveys, cultural competency plan, chronic conditions/disease management, safety, and related activities. Results of QI information is used in policy revision improvement activities, scope of services provided and education.

12. CMS uses QI activities that include methods for internal and external benchmarking to identify opportunities for improvement studies/initiatives that support the goals of the QI Program.

PROGRAM FOCUS AND STRUCTURE

The focus of CMS area offices is to assess quality performance improvement through an ongoing QI program that objectively and systematically monitors and evaluates access to care and the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes in service performance to its enrollees. The CMS QI program monitors, evaluates and improves the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to enrollees through peer review, PIPs, medical/case record audits, performance measures, surveys, and related activities. The CMS QI Program, through its Risk Management Program, is used to identify and track critical incidents and to review and analyze critical incidents to identify and address/eliminate potential and actual quality of care and/or health and safety issues. Formal internal quality assessments are performed in each area office to help identify problems or concerns to address improving the quality of services provided and results of these studies are reported quarterly and annually. Continuous Quality Improvement Plans (CQIP), if needed, will be formulated and included with the quarterly QI reports for the area offices. AHCA offers no incentives to CMS for any activities.

The structure of the CMS QI Program begins at the area office level. CMS incorporates 20 individual area offices throughout the state, all of which have their own local QI committee. The Area Office's QI committees report quarterly to the Central Office QI committee. The Central Office QI committee reports all quality improvement activities, including Risk Management and Utilization Management, to the Governing Body. This process ensures that QI activities are reported throughout the organization.

Each CMS area office follows the statewide QI process as outlined in this plan and establishes an area office QI Committee to oversee the internal performance improvement efforts. The Area Office QI Committee meets at a minimum, quarterly, to address issues affecting the area office's QI indicator results as well as staff, provider, office, and enrollee issues. If a quality indicator falls below the required programmatic threshold, a CQIP will be developed. CMS CQIPs will be reviewed by the Area Office QI Committee and are submitted to the Central Office QI Committee. This plan describes the activities to be taken by the area office to assure that comprehensive quality services are provided to CMS enrollees. If the CQIP is effective in improving performance, the plan will be continued each quarter. If an upward trend is not seen in the non-compliant quality indicator, the CQIP will be updated each quarter to document new strategies to be taken to address issues that have surfaced during the QI review process. Each Area Office QI Committee will report to the Central Office QI committee.

GOVERNING BODY

CMS's Governing Body will oversee and evaluate the QI program and the QI work plan at least annually. The role of CMS's Governing Body includes providing strategic direction to the QI program, as well as ensuring the Quality Improvement Plan (QI plan) is incorporated into operations throughout CMS. Area Office QI activities will monitor all operations including administrative, clinical and safety. This will be accomplished by the reporting of QI activities to the Central Office QI Committee who reports to the CMS Governing Body and Regional Management Staff. The Governing Body meets at least quarterly. Membership in the Governing Body includes, at a minimum, the CMS Director of the Office of Managed Care & Specialty Programs, Director of Managed Care Administration, Director of Managed Care Operations & Specialty Programs and the CMS Plan Medical Director. The CMS Central Office Quality and Practice Management Unit Director is responsible for reporting QI activities including Risk Management and Utilization Review information to the Governing Body. The Governing Body's responsibilities as related to CMS QI program include the following:

- Review and evaluation of the QI program description, QI work plans and the annual evaluation;
- Review of reports from the QI program delineating actions taken and improvements made;
- Ensuring that the QI program and work plan is implemented effectively and results in improvements in care and service;
- Ensuring links between QI and all benchmarking activities are communicated to management and the provider network;
- Ensuring results of satisfaction surveys are distributed to providers, members and other relevant committees and staff throughout CMS.

QUALITY IMPROVEMENT COMMITTEES

An effective improvement planning process requires input and participation from both management who execute new initiatives, and the staff who fulfill new initiatives, in addition to participation and/or input from Central Office staff.

CENTRAL OFFICE QUALITY IMPROVEMENT COMMITTEE

CMS has a Central Office QI program and committee. Committee representatives are selected to meet the needs of CMS and include representatives from the following: 1) Chair is the CMS Managed Care Plan Medical Director, 2) Director, Office of CMS Managed Care Plan & Specialty Programs, 3) Quality Review and Practice Management Unit Manager (Includes Risk Management), 4) Contract Management Unit Manager (Grievance/Appeal Coordinator), 5) Care Coordination/Area Office Nursing Consultant (Infection Control), 6) Utilization Management Nursing Consultant, 7) Provider Management Unit Manager (credentialing), 8) ICS Provider Relations Liaisons, 9) Fraud and Abuse Liaison (Compliance), 10) ICS Contract Managers (enrollee and provider satisfaction surveys and ICS monitoring) 11) Enrollee Advocate 12) CMS-K.I.D.S. Representative, 13) ICS Liaisons 14) Director CMS Managed Care Plan Administration, and 15) Director of CMS Managed Care Plan Operations & Specialty Programs. Individual staff members serve in multiple roles on the committee since they serve in multiple positions within

CMS. The resumes of QI program committee members will be made available to AHCA upon request.

Reports to the Central Office QI Committee are made on a regular and as needed basis to support the goals of the QI program. Reports from the following departments are used to evaluate medical necessity, continuity of care and to evaluate the quality and appropriateness of care provided and to improve the level of member satisfaction. These reports include, but are not limited to:

- Chronic Conditions/Disease Management, Healthy Behaviors Program
- Provider/Enrollee Services (includes satisfaction surveys and enrollee rights)
- Provider Credentialing/Recredentialing
- Utilization Management
- Risk Management (adverse events and patient safety)
- Grievance and Appeals
- Care Coordination/Performance Measures
- Employee Safety
- Fraud and Abuse
- ICS Reports regarding QI monitoring on behalf of CMS (includes PIPs)
- Area Office QI Activities
- AHCA Compliance and Coordination
- Review of Quality of Care and Service Concerns
- Any Non-clinical Aspects of Service with Timely Resolution
- Other Reports as Necessary

The CMS Central Office QI Committee meets on a quarterly basis. Committee responsibilities include the development and implementation of a written QI plan, which incorporates the strategic direction provided by the governing body. The CMS Central Office QI Committee reviews all quarterly and annual data from the Area Office QI Committees. The CMS Central Office QI Committee maintains minutes of all QI committee meetings. The minutes shall demonstrate resolution of items or items to be brought forward for discussions at the next meeting. Minutes will be made available to AHCA for review upon request.

The CMS QI Committee may, at times, find it necessary to select and direct a task force, committee, or other CMS activities to review areas of concern in the provision of health care services to enrollees. Any ad hoc committees will be appointed by the Quality and Practice Management Unit Director after discussion and approval from upper management. Any QI activities assigned to individual staff persons or ad hoc committees will include the selection of

time standards for completion. Ad hoc committees may also be appointed by the Director of CMS Plan Operations & Specialty Programs with consultation with the Quality and Practice Management Unit Director.

CMS Central Office QI activities involve each contracted ICS in reviewing for the quality and appropriateness of care and medical necessity provided to enrollees. Some members of the CMS Central Office QI Committee are also members of both of the contracted ICSs' QI Committees for oversight and review of enrollee services that are provided. Monitoring and evaluation of clinical, non-clinical, participating providers and service utilization is done by each ICS. The ICS QI committees include behavioral health practitioners and physicians that are from the provider network.

CMS uses multiple health management information systems to support the QI program. CMS QI Committee uses reports from CMS-K.I.D.S. (third party administrator), Care Coordination Module/Electronic Health Record, ICS reports, AHCA reports, Business Objects reports and Healthcare Effectiveness Data and Information Set (HEDIS) reporting to support the QI program. The QI program provides for review of QI indicators designated as such by AHCA and/or HEDIS measurement. Indicators are evaluated by the QI Committee. To support the goals of the QI program, the QI committee will evaluate the effectiveness of the performance indicators by comparing with the National HEDIS Medicaid Benchmark and/or benchmarks established by the External Quality Review Organization (EQRO) or AHCA annually.

All minutes of the CMS QI Committee are available to participating providers and QI activities are reported to the provider network, Area Offices, and CMS executive authority on an ongoing basis.

The CMS QI Plan is reviewed and evaluated annually by the Central Office QI Committee and the Governing Body. The annual QI evaluation will address CMS's organizational progress toward meeting the prior year's goals and objectives and the overall effectiveness of the program. The report is generated and reviewed, as appropriate, and reported at the Central Office QI committee and to the Governing Body. The annual report is used to determine QI monitoring initiatives for sustained improvement for the next year.

AREA OFFICE QUALITY IMPROVEMENT COMMITTEES

The Area Office QI Committees provide advice on issues based on approved CMS policies, procedures, and operational plans as it relates to quality improvement activities. The Area Office QI Committee has a good balance of representation of area office staff and meets quarterly, at a minimum, or more frequently if indicated. The Area Office QI Committee maintains minutes of all QI Committee meetings. Committee representation will include CMS area office staff from each major functional area in the office e.g. administration, nursing, fiscal, social services, clinic, specialty programs and clerical support staff.

Each area office will develop specific written criteria for staff participation on the committee. Members will be employed or familiar with CMS for a minimum of one (1) year and regular attendance and participation is required (see Area Office QI Committee Guidelines). Each area office will develop the business practices for their committee function in accordance with CMS policy and procedures.

The Area Office QI Committee provides oversight and review of the Area Office QI Performance Measures and, if needed, the CQIP at each quarterly meeting. Meetings will be scheduled each quarter prior to CQIP due dates. The group also serves as the lead committee to address

employee, client/family, and provider satisfaction issues, RM, QI, and UM issues at the local level. Committee members develop and implement plans to address changes in current office practices and serve as a resource for the Area Office staff for QI activities and during changes in operational practices. All area office QI activities will be based upon approved CMS policies, procedures, and operational plans.

The Area Office QI Committee will select a chairperson who will have an active role as a member of the Regional Management Team. The chairperson will submit Area Office QI committee recommendations to the Regional Management Team, who will then accept or reject recommendations. The Regional Management Team will subsequently provide the Area Office QI Committee with feedback on any action taken.

ACCOUNTABILITY

QUALITY AND PRACTICE MANAGEMENT UNIT DIRECTOR

The Quality and Practice Management Unit Director has the responsibility for the QI/UM/RM Programs and will ensure that the program functions to achieve its goals. Meetings will be held with the QI Consultant, UM Consultant, and Care Coordination Consultants to provide any needed oversight and direction to the programs.

QUALITY IMPROVEMENT CONSULTANT

The CMS QI Consultant oversees CMS's implementation of the QI Plan. In conjunction with the Quality and Practice Management Unit Director, he/she develops and obtains approval for the QI improvement survey tools, conducts training and conveys issues of integration and integrity of the data to appropriate areas of the organization. The QI consultant is responsible for the refinement of the QI Program and the development of the annual QI work plan and annual QI Program appraisal.

ROLE of the QI CONSULTANT:

1. To direct and review all QI activities for CMS.
2. To assure that QI activities take place where needed.
3. To review and suggest new and improved QI initiatives.
4. To direct in the review of focused concerns.
5. To report findings and recommendations to the appropriate committees.

Specific training about quality is provided to all staff serving in the QI Program. The training includes protocols developed by Centers for Medicare and Medicaid Services regarding quality.

PERFORMANCE MEASURES (PMs)

CMS must collect statewide data on enrollee PMs, as defined by AHCA and as specified in the Statewide Medicaid Managed Care Program (SMMC) Performance Measures Table found in the most current amendment of the AHCA contract No. FP031, the Managed Care Plan Report Guide and Performance Measures Specifications Manual.

CMS will collect and report additional PMs with respect to the applicable SMMC program as specified by AHCA.

CMS will report results of PMs to AHCA as specified in Section XIII, Reporting Requirements, and the Managed Care Plan Report Guide and Performance Measures Specifications Manual.

AHCA may add or remove PM requirements with sixty (60) days' advance notice.

CMS will submit performance measure data as specified by AHCA and in a manner and format prescribed by AHCA.

For the Annual Dental Visit performance measures, CMS will achieve the following rates by year:

- Calendar Year (CY) 2016: 45%
- CY 2017: 46%
- CY 2018: 47%
- CY 2019: 48%
- CY 2020: 49%

Failure to meet these rates may result in a corrective action plan as described in Attachment II of the AHCA contract FP031.

AHCA shall calculate the CMS Preventive Dental Services (PDENT), Dental Treatment Services (TDENT), and Sealants (SEA) measures using data that CMS reports in their CMS-416/CHCUP reports. CMS does not calculate and report on these measures as part of their annual performance measure submission.

WELL-CHILD VISIT PERFORMANCE MEASURES

Pursuant to s. 409.975(5), F.S., CMS will achieve a child health check-up (CHCUP) screening rate of at least eighty percent (80%) for the enrollees who are continuously enrolled for at least eight (8) months during the federal fiscal year (October 1-September 30). The screening compliance rate will be based on the CHCUP data reported by CMS in its CHCUP (CMS-416) and FL 80% Screening Report and/or supporting encounter data, and due to AHCA as specified in the AHCA Contract FP031. The data will be monitored by AHCA for accuracy. Any data reported by CMS that is found to be inaccurate shall be disallowed by AHCA, and AHCA will consider such findings as being in violation of the Contract. Failure to meet the eight percent (80%) screening rate may result in a corrective action plan.

CMS will adopt annual participation goals to achieve at least an eighty percent (80%) CHCUP participation rate, as required by the Centers for Medicare & Medicaid Services. This participation compliance rate will be based on the CHCUP data reported by CMS in its CHCUP (CMS-416) and FL 80% Screening Report (see above) and/or supporting encounter data. Upon implementation and notice by AHCA, CMS will submit additional data, as required by AHCA for its submission of the CMS-416, to the Centers for Medicare & Medicaid Services, within the schedule determined by AHCA. Any data reported by CMS that is found to be inaccurate shall be disallowed by AHCA, and AHCA will consider such findings as being in violation of the

Contract. Failure to meet the eight percent (80%) participation rate during a federal fiscal year may result in a corrective action plan in addition to the sanctions provided in the AHCA Contract FP031.

CMS will achieve a preventive dental services rate corresponding to the following schedule for those enrollees who are continuously eligible for CHCUP for ninety (90) continuous days. This rate will be based on the CHCUP data reported by CMS in its CHCUP (CMS-416) audited report and/or supporting encounter data and will be calculated by dividing line 12b by line 1b from the CHCUP report, excluding children under the age of one (1). Beginning with the report for federal fiscal year 2015-2016, failure to meet the following preventive dental services rates may result in a corrective action plan in addition to the sanctions provided in the AHCA Contract FP031.

- Federal Fiscal Year (FFY) 2015-2016 35%
- FFY 2016-2017 37%
- FFY 2017-2018 39%
- FFY 2018-2019 41%
- FFY 2019-2020 44%

CMS will achieve a dental treatment services rate corresponding to the following schedule for the enrollees who are continuously eligible for CHCUP for ninety (90) continuous days. This rate will be based on the CHCUP data reported by CMS in its CHCUP (CMS-416) audited report and/or supporting encounter data and shall be calculated by dividing line 12 c by line 1 b from the CHCUP report, excluding children under the age of one (1). Beginning with the report for federal fiscal year 2015-2016, failure to meet the following dental treatment service rates may result in a corrective action plan in addition to the sanctions as provided in the AHCA Contract FP031:

- FFY 2015-2016: 15%
- FFY 2016-2017: 17%
- FFY 2017-2018: 20%
- FFY 2018-2019: 21%
- FFY 2019-2020 23%

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

Each year by July 1, through our contracted vendor, CMS will have a report on performance measure data and a certification by a National Committee for Quality Assurance (NCQA) certified HEDIS auditor that the performance measure data reported for the previous calendar year are fairly and accurately presented. The report will be certified by the HEDIS auditor, and the auditor will certify the actual file submitted to AHCA. Extensions to the due date may be granted by AHCA for up to thirty (30) days and require a written request signed by the CMS CEO or designee. The request must be received by AHCA before the report due date and the delay must be due to unforeseen and unforeseeable factors beyond CMS's control. Extensions will not be granted on oral requests. This annual report of performance will be used by the QI committee to assist in determining monitoring initiatives and improvement efforts as appropriate based upon the analysis of this data.

A report, certification or other information required for PM reporting is incomplete when it does not contain all data required by AHCA or when it contains inaccurate data. A report that is

incomplete or contains inaccurate data will be considered deficient and each instance will be subject to administrative penalties pursuant to sanctions in the AHCA contract. 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 data or information that is not true or not accurate. A report that contains an “NR” due to bias for any or all measures by the HEDIS auditor, or is “false,” will be considered deficient and will be subject to administrative penalties pursuant to sanctions in the AHCA contract. AHCA may refer cases of inaccurate or “false” reports to its Bureau of Medicaid Program Integrity.

PUBLICATION OF PERFORMANCE MEASURES

CMS will publish results for HEDIS measures on the CMS website in a manner that allows recipients to reliably compare the performance of Managed Care Plans. CMS may meet this requirement by including information about the comparison of performance measures conducted by AHCA and providing a link to AHCA’s applicable website page.

PERFORMANCE TARGETS AND PENALTIES

CMS will meet AHCA-specified performance targets for all PMs. For HEDIS and AHCA-defined measures, AHCA will establish performance targets prior to execution of the contract with CMS. AHCA may change these targets and/or change the timeliness associated with meeting the targets. AHCA will make these changes with sixty (60) days’ advance notice to CMS.

If AHCA determines that CMS’s performance relative to the performance targets is not acceptable, AHCA may require CMS to submit a performance measure action plan (PMAP) within thirty (30) days after the notice of the determination in the format prescribed by AHCA. If CMS fails to provide a PMAP within the time and format specified by AHCA or fails to adhere to its own PMAP, AHCA may sanction CMS in accordance with the provisions of Section XI, Sanctions of the AHCA contract, and require CMS to submit reports to AHCA on the progress of all PMAPs.

If the AHCA-defined or HEDIS PMs indicate that CMS’s performance is not acceptable, AHCA may sanction CMS in accordance with the provisions of Section XI, Sanctions of the AHCA contract. When considering whether to impose specific sanctions, such as limiting enrollment activities or automatic assignments, AHCA may consider CMS’s cumulative performance on all quality and performance measures.

If CMS’s performance on AHCA-defined and HEDIS performance measures is not acceptable and CMS’s performance measure report is incomplete or contains inaccurate data, AHCA may sanction CMS in accordance with the provisions of Section XI, Sanctions of the AHCA contract. Acceptable performance under this section will be determined using the initial performance measure submission, due July 1, with its corresponding attestation of accuracy and completeness. In the event that CMS later determines the submission contained errors, AHCA may consider using the updated data for public reporting purposes. In that instance, the earliest submission will apply.

PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

Annually, by January 1 of each Contract year, AHCA will determine and notify CMS if there are changes in the number and types of PIPs that CMS will perform for the coming Contract year. CMS, through our contracted ICS’s, will perform four (4) AHCA-approved statewide performance improvement projects as specified below:

- One (1) of the PIPs will combine a focus on improving prenatal care and well-child visits in the first fifteen (15) months.
- One (1) of the PIPs will focus on preventive dental care for children.
- One (1) of the PIPs will be an administrative PIP focusing on a topic that has been prior approved by AHCA.
- One (1) PIP will be a choice of PIPs in one of the following topic areas: population health issues (such as diabetes, hypertension, and asthma) within a specific geographic area that has been identified as in need of improvement; integrating primary care and behavioral health; and reducing preventable readmissions.

All PIPs achieve, through ongoing measurements and intervention, significant improvement to the quality of care and service delivery, sustained over time, in areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Improvement will be measured through comparison of a baseline measurement and an initial re-measurement following application of an intervention. Change must be statistically significant at the ninety-five percent (95%) confidence level and must be sustained for a period of two (2) additional re-measurements.

Measurement periods and methodologies are submitted to AHCA for approval before initiation of the PIP. PIPs that have successfully achieved sustained improvement, as approved by AHCA, are considered complete and will not meet the requirement for one (1) of the number of PIPs required by AHCA, although CMS may wish to continue to monitor the performance indicator as part of its overall QI program. In this event, CMS selects a new PIP and submits it to AHCA for approval.

Each PIP will include a sample size sufficient to produce a statistically significant result. CMS PIP methodology complies with the most recent protocol set forth by the federal Centers for Medicare and Medicaid Services (CMS), Conducting Performance Improvement Projects, which is available on their website. Populations selected for the study under the PIP are specific to the AHCA Contract and will not include Medicaid recipients from other states, or enrollees from other DOH programs. CMS may contract with a separate entity for management of particular services but PIPs conducted by the separate entity will not include enrollees for other Managed Care Plans served by that entity.

PIP PROPOSALS

CMS submits to AHCA, in writing, a proposal for each planned PIP. Each PIP proposal will be submitted using the most recent version of the External Quality Review Organization (EQRO) PIP validation form. Instructions for using the form to submit PIP proposals and updates are available from AHCA. Activities 1 through 6 of the EQRO PIP validation form are addressed in the PIP proposal. In the event CMS elects to modify a portion of the PIP proposal after initial AHCA approval, a written request to do so will be submitted to AHCA.

ANNUAL PIP SUBMISSION

CMS submits ongoing PIPs annually by August 1 to AHCA for review and approval. CMS updates the EQRO PIP validation form in its annual submission to reflect CMS's progress. CMS is not required to transfer ongoing PIPs to a new, updated EQRO form. CMS submits the AHCA-

approved EQRO PIP validation form to the EQRO upon its request for validation. CMS will not make changes to the AHCA-approved PIP being submitted unless expressly permitted and approved by AHCA in writing.

EQRO VALIDATION

CMS PIPs are subject to review and validation by the EQRO. CMS will comply with any recommendations for improvement requested by the EQRO, subject to approval by AHCA.

INTEGRATED CARE SYSTEM PARTNERSHIPS

CMS contracts with two (2) ICSs to provide specified services to enrollees. The ICSs are responsible for QI activities including but not limited to provider satisfaction surveys, peer review activities, PIPs, PCP office surveys including the metrics for determining monitoring schedules, over and underutilization of services and medical/case record review. Both ICSs are responsible for a joint CMS/ICS QI Plan. CMS Central Office staff members participate on both ICS's QI Committees and filter information back to the Central Office QI Committee. The Central Office QI Committee has a liaison from both ICSs as members of the committee. Peer review activities will be used for the re-credentialing process for providers. Peer review activities for re-credentialing will include on-site visits, RM issues and enrollee satisfaction surveys.

SATISFACTION AND EXPERIENCE SURVEYS-ENROLLEE

CMS will contract with a qualified, AHCA-approved, National Committee for Quality Assurance (NCQA)-certified vendor to conduct annual enrollee satisfaction surveys required under the AHCA contract. AHCA will specify the survey requirements including survey specifications, applicable supplemental item sets and AHCA-defined survey items. Annually, by January 1 of each Contract year, AHCA will determine and notify CMS if there are changes in survey requirements.

CMS will submit to AHCA in writing, by the date specified by AHCA of each Contract year, a proposal for survey administration and reporting that includes identification of survey administration and reporting that includes identification of the survey administrator and evidence of NCQA certification as a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendor; sampling methodology; administration protocol; analysis plan; and reporting description. CMS will have its sample validated by a NCQA-certified HEDIS Auditor.

CMS will conduct an annual CAHPS survey for a time period specified by AHCA using the CAHPS Health Plan Survey-Medicaid Survey 5.0. In addition to the core survey, CMS will include items MH1 through MH4 (related to Behavioral Health) and H.17 and H.20 (related to medical assistance with smoking and tobacco use cessation) from the CAHPS Health Plan Survey-Supplemental Items for the Adult Questionnaires. Beginning with the 2017 reporting, CMS will include the following items in its Child CAHPS surveys:

1. How would you rate the number of doctors you had to choose from?

Response options: Excellent, Very Good, Good, Fair, Poor, No Experience

CMS will report its CAHPS survey results starting with the July 1 submission to the NCQA and AHCA. The submission to NCQA will be made by the NCQA deadline. By October 1 of each

Contract year, CMS will submit its CAHPS survey vendor's final report to AHCA, along with CMS's action plan to address the results of the CAHPS survey.

CMS will submit a corrective action plan, as required by AHCA, within sixty (60) days of the request from AHCA to address any deficiencies identified in the annual CAHPS survey.

CMS will use the results of the annual CAHPS survey to develop and implement plan-wide activities designed to improve enrollee satisfaction. Activities conducted by CMS pertaining to improving enrollee satisfaction resulting from the annual enrollee satisfaction survey will be reported to AHCA on a quarterly basis.

SATISFACTION AND EXPERIENCE SURVEYS-PROVIDER

CMS will conduct an annual Provider Satisfaction survey. CMS will submit a provider satisfaction survey plan (including tool and methodology) to AHCA for written approval annually. CMS will conduct the survey, and compile and analyze its survey results for submission annually by July 1.

The survey tool will utilize a four-point Likert scale and shall include the following domains:

- Provider relations and communications;
- Clinical management processes;
- Authorization processes including denials and appeals;
- Timeliness of claims payment and assistance with claims processing;
- Complaint resolution process; and
- Care coordination support.

CMS will provide the survey results to AHCA with an action plan to address the results of the Provider Satisfaction survey by July 1 of each Contract year.

PROVIDER-SPECIFIC PERFORMANCE MONITORING

Through our contracted ICSs, CMS will monitor the quality and performance of each participating provider. At the beginning of the Contract period, through our contracted ICSs, CMS will notify all participating providers of the metrics used by CMS for evaluating the provider's performance and determining continued participation in the network (see s. 409.975(3), F.S.).

PEER REVIEW

CMS, through our contracted ICSs, will have a peer review process that results in:

- Review of a provider's practice methods and patterns morbidity/mortality rates, and all grievances filed against the provider relating to medical treatment;
- Evaluation of the appropriateness of care rendered by providers;
- Implementation of corrective action(s) when CMS deems it necessary to do so;
- Development of policy recommendations to maintain or enhance the quality of care provided to enrollees;

- Reviews that include the appropriateness of diagnosis and subsequent treatment, maintenance of a provider's medical/case records, adherence to standards generally accepted by a provider's peers and the process and outcome of a provider's care;
- Appointment of a peer review committee, as a sub-committee to the CMS/ICS QI committee, to review provider performance when appropriate. The ICS medical director or a designee will chair the peer review committee. Its membership will be drawn from the provider network and include peers of the provider being reviewed;
- Receipt and review all written and oral allegations of inappropriate or aberrant service by a provider; and
- Education of enrollees and CMS staff about the peer review process, so that enrollees and the CMS staff can notify the peer review authority of situations or problems relating to providers.

MEDICAL/CASE RECORD REVIEW FOR PROVIDERS

CMS, through our contracted ICSs, has established and implemented a mechanism to ensure provider records meet established medical/case record standards. CMS, through our contracted ICSs, will conduct medical/case record reviews to ensure that enrollees are provided high quality health care that is documented according to established standards.

By June 1 of each Contract year, CMS will submit a written strategy for conducting medical/case record reviews for AHCA approval. The strategy will include, at a minimum;

- Designated staff to perform this duty;
- Process for establishing inter-rater reliability;
- Sampling methodology for case selection;
- The anticipated number of reviews by practice site (non-facility service providers such as home health agencies with multiple office locations serving the region);
- Record confidentiality and security;
- The tool that CMS, through the ICS, will use to review each site;
- Analysis and reporting; and
- How CMS will link the information compiled during the review to other CMS functions (e.g. QI, recertification, peer review).

CMS will conduct these reviews at all provider and facility provider sites (provider sites refers to service providers such as home health agencies with multiple office locations serving a region and facility provider sites refers to assisted living facilities, adult family care homes and adult foster care facility sites) that meet the criteria in Section VII, Provider-Specific Performance Monitoring, subsection E of the AHCA contract.

CMS will conduct medical/case record reviews of all provider sites with a pattern of complaints or poor quality outcomes.

The standards, which include all medical/case record documentation requirements addressed in the AHCA Contract, must be distributed to all providers.

INCIDENT REPORTING

CMS has developed and implemented an incident reporting and management system for critical/adverse events that negatively impact the health, safety, or welfare of enrollees. Adverse incidents may include events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing or major medication incidents. CMS identifies and tracks adverse incidents and reviews and analyzes each to identify and address/eliminate potential and actual quality of care and/or health and safety issues.

CMS requires participating and direct service providers to report adverse incidents to CMS through our contracted ICSs within forty-eight (48) hours of the incident.

CMS will not require provider submission of adverse incident reports from the following providers:

- Health Maintenance Organizations and Health Care Clinics reporting in accordance with s. 641.55, F.S.;
- Ambulatory Surgical Centers and Hospitals reporting in accordance with s. 395.0197, F.S.;
- Assisted Living Facilities reporting in accordance with s. 429.23, F.S.; and
- Nursing Facilities reporting in accordance with s. 394.459, F.S.

Adverse incidents occurring in these licensed settings shall be reported in accordance with the facility's licensure requirements.

CMS will provide appropriate training and take corrective action as needed to ensure its staff, participating providers, and direct service providers comply with adverse incident reporting requirements. CMS accomplishes this for participating providers and direct service providers through our contracted ICSs.

CMS will immediately report to the Department of Children and Families Central Abuse Hotline any suspected abuse, neglect, and exploitation of enrollees immediately, in accordance with Section 39.201 and Chapter 415, Florida Statutes (F.S.).

Documentation related to the reporting of suspected abuse, neglect, or exploitation, including the reporting of such is kept in a file, separate from the enrollee's case file and is designated as confidential. Each area office will make these files available to AHCA upon request.

RISK MANAGEMENT

CMS maintains a Risk Management Program. CMS provides appropriate training and takes corrective action as needed to ensure staff complies with critical incident requirements. Through the ICSs, participating providers and direct service providers are educated regarding compliance with critical incident requirements. The Risk Management Committee for CMS is a part of the QI Committee and reports quarterly to the QI Committee.

Enrollee quality of care issues are reported to and a resolution coordinated with the CMS Quality and Practice Management Unit and the QI Committee at the Central Office.

CMS reports a summary of critical incidents to AHCA as specified in Section XIII of the AHCA Contract, Reporting Requirements, and the Managed Care Plan Report Guide and in a manner and format determined by AHCA.

CMS reports suspected unlicensed Assisted Living Facilities (ALF's) and Adult Family Care Homes (AFCH's) to AHCA and requires its providers to do the same pursuant to Chapter 408.812, F.S.

CMS has a reporting and management system for critical and adverse incidents that occur in all service delivery settings applicable to enrollees with MMA benefits.

For additional CMS Risk Management activities, please refer to the CMS Risk Management Plan.

ANNUAL MEDICAL/CASE RECORD AUDIT AND ONSITE MONITORING

CMS furnishes specific data requested in order for AHCA to conduct the medical/case record audit, including audit of the enrollee plan of care, provider credentialing records, service provider reimbursement records, contractor personnel records, and other documents and files as required under the AHCA Contract FP031-DOH CMS.

If the medical/case record audit and/or other document audits indicate that quality of care is not acceptable within the terms of the AHCA Contract, CMS will correct the problem immediately and may be required to submit a Corrective Action Plan (CAP) to address the problem. The CAP will be time limited based upon the nature of the deficiency. Regardless of a CAP, health and safety issues, and problems not corrected, will result in AHCA sanctioning CMS, in accordance with the provisions of Section XI, Sanctions of the AHCA contract, and may immediately terminate all enrollment activities and mandatory assignments, until the CMS Plan attains an acceptable level of quality of care as determined by AHCA.

PROGRAM OF ALL-INCLUSIVE CARE FOR CHILDREN (PACC)-SPECIFIC PERFORMANCE MONITORING

CMS will submit to AHCA on an annual basis, by August 15, a summary of the PACC QI activities and findings for each state fiscal year, as well as a summary on the status of any unresolved issues from the prior year. The summary will, at minimum, include the following:

- (a) Copies of quality improvement meeting minutes;
- (b) Any new PACC policies, procedures or clinical guidelines developed during the year, and any changes to existing policies, procedures, or clinical guidelines.
- (c) Results of any clinical records review conducted in the year for the PACC program.
- (d) Performance improvement plans developed or implemented for the PACC program as a result of complaints, grievances, adverse incidents, monitoring or quality improvement activities; and
- (e) Additional quality improvement initiatives for the PACC program that occurred during the year.

DOCUMENTATION REVIEW

An important component of assessing quality of care for CMS includes review of care coordination documentation. Assessments, care plans and notes will be reviewed each quarter to determine continuity of care, appropriate follow-up for care issues, and client/family involvement in the care coordination process. All area offices will review medical documentation in the Care Coordination Module (CCM) quarterly from the list of records provided by the CMS Central Office for Performance Measure Review. The results from the performance measurement review are utilized when completing QI performance evaluations of the care coordination staff for educational purposes to ensure the care coordination process is followed. The summary of this review will be reported to the Central Office QI Committee.

The chart documentation review consists of the following:

- Redetermination is completed within the prescribed time frame according to CMS policy.
- Yearly Education regarding the following is completed:
 1. Well Child Checkup;
 2. Immunizations;
 3. Disaster Planning;
 4. Healthy Weight and Counseling for Nutrition and Physical Activity; and
 5. Dental Care.
- Initial Care Plan is completed within 45 days of enrollment.
- Enrollees are assigned a CMS Care Coordinator within 30 days of enrollment.
- Youth transition is discussed yearly beginning at age 12.
- The Service Tracker is completed in the CCM.
- Acuity Level is listed on the properties pane in the CCM.
- Charting is consistent with the touch frequency indicated by the Acuity Level including assessment and care plan updates.
- Documentation exists that the Chronic Conditions/Disease Management Programs were discussed with the enrollee/family, if applicable.
- Documentation exists that the Healthy Behaviors Programs were discussed with the enrollee/family, if applicable.

Through the appropriate contracted ICS, CMS will monitor and evaluate primary care provider medical records to assess the continuity and coordination of care enrollees receive and assure compliance with regulatory standards and appropriateness of care.

EDUCATION AND TRAINING

There are six (6) components to the staff education and training program that facilitate quality improvement within CMS. Staff must be knowledgeable about the current Care Coordination Operational Plan, CMS Policy and Procedures, Customer Service, Risk Management, Cultural and Linguistic Needs and the Care Coordination Module/Electronic Health Record in order to achieve quality outcomes in care. Education as a result of findings from QI initiatives will be incorporated as needed.

Each Area Office will comply with the standardized “CMS Training and Education Requirements” that includes the following:

- **Care Coordination Operational Plan** - (All nurses and social workers) Staff will be provided with the operational plan and resources to ensure quality in performing the care coordination process initially and annually.
- **CMS Policy and Procedures** - Staff will be provided with resources to assist with appropriate care coordination activities and documentation of client information. Staff will know how to access all policies and procedures and operational plans.
- **Customer Service Training** - Perception of quality is closely linked to how customers feel they are treated. Satisfaction with the CMS program and services is enhanced as the staff understands expectations for dealing with clients and families. This is provided to staff during orientation and annually by DOH.
- **Risk Management Training** - Staff will be provided with initial and annual training regarding the reporting of adverse/critical incidents by each area office.
- **Cultural and Linguistic Training**- Staff will be provided with initial and annual training to work effectively with individuals and families from different cultural and ethnic backgrounds. Cultural and linguistic training provides equal access and quality health care to our enrollees.
- **Care Coordination Module/Electronic Health Record** - Staff will be provided with training information and technical assistance to ensure correct utilization of the system.

Each area office will identify individuals who have demonstrated proficiencies and skill and can provide support as a resource for staff. Each of the above six (6) trainings will be provided to all new staff (as applicable) during orientation, and as needed.

Additional state, federal and DOH trainings are required. Many of these are available in the ‘TRAIN’ system or may be provided by the area office. Completion of the required trainings, education and training plan is reported annually to the CMS Central Office Human Resources (HR) Liaison.

AREA OFFICE REVIEWS

External quality reviews will be conducted by CMS Central Office staff annually or more often if necessary. The purpose of the Area Office Review is to ensure adherence to the CMS QI Process Plan, CMS policies and procedures and operational plans which in turn impact the quality of care

being provided to enrollees. This is accomplished through on-site and webinar reviews. The area office review includes analysis of QI data and review of the following:

- CMS Area Office Quarterly Reports
- CMS Area Office Annual Reports
- Continuous Quality Improvement Plans
- Exposure Control Plan
- Occupational Safety and Health Administration (OSHA) Compliance
- Security Plan
- Review of the Care Coordination Module/Electronic Health Record for conducting audits
- Observation of an Area Office Quality Improvement meeting or review of the minutes
- Review of compliance with performance measures

Central Office staff will provide a schedule for the area office reviews at the start of each new fiscal year in an effort to provide the regions with sufficient notice for planning purposes. A written confirmation letter will be sent at least thirty (30) days in advance. This will include the scheduled date and will designate the quarter to be evaluated.

At the conclusion of on-site visits, the findings will be discussed during an exit interview with the Regional Management Team and Area Office QI Chairperson. The on-site review for performance measures will also be reported to the Central Office QI Committee. Findings from Area Office reviews will be evaluated to determine future QI monitoring activities.

For additional information on area office reviews and performance measures, refer to the CMS policy and procedure, CMS Area Office Oversight and Performance Measures (HCMSP 145-021).

CENTRAL OFFICE REPORTS

Findings from both on-site and desk/electronic reviews will be detailed in the exit review. This exit review will include recommendations and expected time frames for response.

REPORT DUE DATES

Each Area Office sends QI data according to the following schedules:

QUARTER	TIME PERIOD	REPORT DUE	CQIP DUE
Qtr. 1	Jul 1 – Sep 30	Nov 15 th	Nov 30 th
Qtr. 2	Oct 1 – Dec 31	Feb 15 th	Feb 28 th
Qtr. 3	Jan 1 – Mar 31	May 15 th	May 30 th
Qtr. 4	Apr 1 – Jun 30	Aug 15 ^{th*}	Aug 30 th

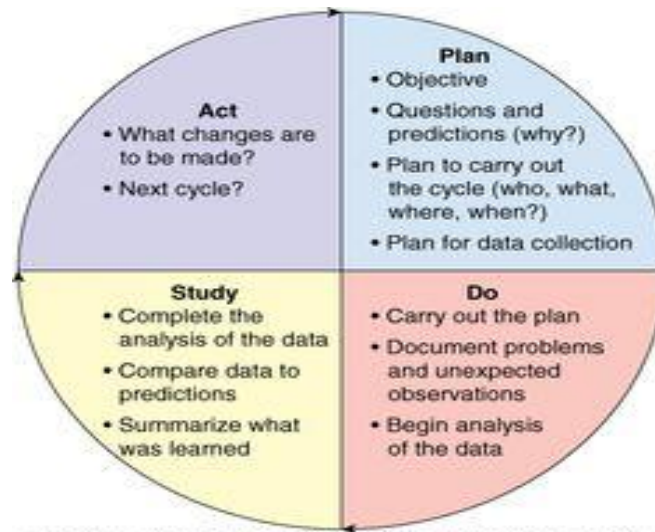
**CMS Quarterly & Annual Report Due*

SUBMISSION OF LATE REPORTS

If the area office has unforeseen circumstances that prevents timely data submission, the Central Office Quality and Practice Management Director is contacted prior to the report submission date. Extensions may be granted on a case by case basis.

CONTINUOUS QUALITY IMPROVEMENT PLAN (PDSA) PROCESS

The “Cycle of Continuous Quality Improvement” is exemplified in the:



Source: McKean S, Ross JJ, Drexler DD, Brofman DO, Ginsberg JS: Principles and Practice of Hospital Medicine: www.accessmedicine.com

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The philosophy is to continuously improve quality by utilizing four key processes:

- **Plan** - design or review the process components to improve results
- **Do** - implement the plan and measure its performance
- **Study** - assess the measurements and report the results
- **Act** - decide on changes which are needed to improve the process

Providing continuous QI initiatives will serve to break down barriers between departments, provide accountability and responsibility, demonstrate the effectiveness of the implementation plans, and assist in providing a program of continuous education and self-improvement in the area office.

CONTINUOUS QUALITY IMPROVEMENT PLAN (CQIP)

The CQIP is based upon the CMS QI initiative to develop, implement and report on statewide program performance measures. The purpose of the CQIP is to demonstrate continuous QI by:

1. Documenting areas that are found to be below the statewide standard (Problem Resolution);
2. Identifying the root cause - is there a process problem or another causative factor;
3. Determining a corrective plan of action (Improvement Approach and Strategy); and
4. Evaluating the implemented action.

The CQIP is the development of a current plan of action for improving deficiencies identified during the data collection review process. Once the root cause has been determined and a plan has been developed and implemented, the effectiveness of corrective action(s) must be evaluated during the next quarterly data collection review process. The evaluation of the effectiveness of corrective action(s) will be documented in the subsequent quarterly CQIP.

If the performances for an indicator decline or remains stagnate, the corrective action plan will be revisited to determine if the correct root cause was identified and determine if an alternative action should be developed. Once the deficient performance measure meets the statewide standard, this is documented in the evaluation section of the CQIP and no further CQIP is required for that indicator as long as the performance remains at or above the standard.

REQUIREMENTS FOR A CQIP

A CQIP will be required quarterly for each performance measure indicator that falls below the established programmatic thresholds:

- **CMS Quarterly Reports** – The compliance standards vary depending upon the performance measure. If an indicator falls below the established programmatic thresholds on the performance indicators, a CQIP is required. If an intervention demonstrates effectiveness, the CQIP continues until compliance is achieved. If the CQIP fails to demonstrate an upward trend in the indicator, a new CQIP would need to be developed for that indicator.
- **CMS Annual Reports** – A CQIP is not required for deficiencies on these reports. Central Office will make recommendations for needed improvements.

INSTRUCTIONS FOR SUBMITTING A CQIP

Each area office will formulate and electronically submit a CQIP based on the results of the quarterly performance measures review outcomes, if needed. CQIPs will be reviewed by the Central Office QI Committee. Implementation and submission of the CQIP are due within two (2) weeks following the submission of the performance measures quarterly reports for all CMS program areas.

The Central Office QI Committee will review the appropriate CQIP and provide feedback to the area office.

LATE SUBMISSION OF A CQIP

CQIPs are due two (2) weeks following the submission of the data collection quarterly report. If unforeseen circumstances prohibit the area office from submitting the CQIP on time, the Director of Quality and Practice Management at the Central Office is notified. An extension may be granted on a case by case basis. If a CQIP is not submitted by the area office, the Regional Management Team will be notified and this will be noted in the Quality and Practice Management Area Office Review Report and the Central Office QI Committee meeting minutes.

COMPLETING A CQIP

The following is an explanation of the documentation required on the CQIP form:

- **Name** - Select the name of the area office;
- **Reviewer** - Record the name of the person facilitating the CQIP development process;
- **Date** - Select the date the CQIP;
- **Program** - Indicate the appropriate program (CMS MMA or CMS Title XXI);

- **Reporting Period** - Select the fiscal year and indicate the appropriate quarter being reported;
- **Performance Measure** - Identify the performance measure(s) that were below the statewide standard with the performance measure and abbreviation (example: Performance Measure-ADV);
- **Root Cause** - Identify, verify, and analyze root causes. Identify what the root cause is or the reason why the measure was below the compliance standard;
- **Plan** - Specify the planned intervention to resolve or correct the deficit. Define the process;
- **Implementation Plan** - Develop an implementation plan that specifically identifies the steps/actions to be taken to improve the performance for that measure;
- **Responsible Person** - Identify the person(s) responsible that will facilitate the corrective action for this process;
- **Evaluation Due Date** - The date of evaluation will be the end of the next quarter at which time the plan will be re-evaluated. If the plan was effective in improving the performance but did not achieve the indicator's standard, this plan should be continued and the new achievement date will be the end of the following quarter. If the corrective action did not improve performance from the previous quarter, the Area Office QI Committee will reassess and modify the plan; and
- **Evaluation** - Assess the effectiveness of the Implementation Plan and identify how the proposed corrective action will be evaluated and subsequently, if the action(s) were successful. Revise the plan as necessary based on the evaluation. Standardize successful countermeasures.

AUXILIARY AIDS AND LIMITED ENGLISH PROFICIENCY

The QI program follows the CMS policy and procedure, Auxiliary Aids, and Limited English Proficiency, HCMSP 145-018. This program is monitored by the CMS Central Office HR Liaison within the Central Office. Annual reports are submitted to the QI program regarding compliance for the Central Office and Area Offices regarding yearly training requirements. The Area Offices are monitored using the yearly education monitoring tool. Area Offices are responsible for orienting employees on the process for accessing language line, interpreters, and culturally appropriate literature for enrollees.

CONFIDENTIALITY

CMS is committed to assuring that confidentiality is maintained with all documentation produced as a result of the QI process and that the documents are in compliance with legal requirements and regulatory standards. Members of all committees will be required to sign an attendance sheet with a confidentiality statement at each meeting. CMS will ensure the Health Insurance Portability and Accountability Act (HIPAA) requirements are met, and whenever possible data with identification fields removed will be used for QI activities.

QUALITY IMPROVEMENT INITIATIVES

All CMS QI initiatives were developed using significant indicators that are necessary for our Managed Medical Assistance (MMA) contract with AHCA, required by state or federal regulations and provide an impact on our quality and appropriateness of care provided to enrollees. All QI indicators have identified:

- Expected performance goals for the area of each QI indicator,
- Data that will be collected in order to determine the current performance level,
- Evidence of data collection,
- Any problem areas and indicated the frequency, severity, and the source of the problem in the CQIP, and
- A method for comparison of each quarter's performance goal to the previous quarter's performance goal.

CMS will maintain a written QI Plan and shall make the QI Plan available to AHCA as requested.

ACCREDITATION

Pursuant to s. 409.967(2)(f)3., Florida Statutes (F.S.), CMS Plan will be accredited by a nationally recognized accrediting body and shall maintain accreditation throughout the life of the AHCA contract. CMS will authorize its accrediting body to provide AHCA with a copy of its most recent accreditation review in accordance with 42 CFR 438.332.

CMS Plan is currently accredited by Accreditation Association for Ambulatory Health Care (AAAHC).

If CMS subcontracts with a Managed Behavioral Health Organization (MBHO) for the provision of behavioral health services, the MBHO must be accredited by a recognized national accreditation organization in accordance with the AHCA Contract FP031. All MBHO's must undergo reaccreditation not less than once every three (3) years. Each ICS will monitor the MBHO for current accreditation and reaccreditation.

Both CMS ICSs contract with Concordia Behavioral Health. Concordia is accredited by AAAHC and National Committee for Quality Assurance (NCQA).

AREA OFFICE QUALITY IMPROVEMENT GUIDELINES

The Area Office QI Committee is comprised of staff from all areas of CMS operations and provides the area office with guidance based upon approved CMS policies and procedures and operational plans on issues related to the implementation of CMS programmatic and CMS policies and procedures. Oversight and review of the area office performance measures and CQIPs, if necessary, are completed at each quarterly meeting. The group also serves as the lead committee to address employee, client/family, and provider satisfaction issues at the local level.

- Each Area Office QI Committee will develop written business practices for functioning and will maintain this information for review.
- Membership on the Area Office QI Committee is comprised of staff from all areas of CMS operations. There may be multiple staff members in the workgroup from the same discipline to allow for absences and the inability of staff to attend every meeting.
- Each area office will develop specific criteria for staff participation in the Area Office QI Committee and maintain this information for review.
- Area Office QI Committee membership needs will be evaluated at least annually and any time a member vacancy occurs and will be reflected in the QI committee minutes.
- It is recommended that membership terms are a minimum of two years; however, members may remain on the committee for a longer period of time.
- Membership is voluntary and will be approved by the employee's supervisor. Candidates for membership may be recommended and asked to join if there is a vacancy in a particular area.
- Members will decide prior to the end of the fiscal year if they wish to continue to participate and notify the chairperson of their decision.
- Members will have worked with or been affiliated with CMS for a minimum of one year prior to participation on the workgroup, if possible.
- Regular attendance and participation is expected. Frequent absences from meetings will result in member replacement.
- Area office staff will be notified of available vacancies in the group. If an employee is interested in participating, they must obtain approval from their supervisor.
- Voting participants are appointed members of the core group.
- Ad-hoc, non-voting participants and guests may be invited to attend meetings to provide the workgroup with information and input on specific issues.
- Meetings will be conducted quarterly or more frequently if needed and may be held via video conferencing. Sign-in sheets, agenda and committee minutes for each meeting will be maintained and available for review by the Central Office or AHCA.
- Each Area Office QI Committee will have a chairperson selected by the Regional Management Team.

AREA OFFICE QUALITY IMPROVEMENT COMMITTEE CHAIRPERSON GUIDELINES

Each Regional Management Team will select a chairperson for the Area Office QI Committee. The Chairperson will direct and facilitate the QI activities according to the QI process. Responsibilities will include the following:

- Ensures QI activities are performed in each area office which includes data collection and reporting and the development of CQIPs if indicated.
- Establish and organize the Area Office QI Committee ensuring the established guidelines are followed.
- Plan and chair the quarterly Area Office Quality Improvement Committee meetings.
- Summarize the Performance Measure Reports for the workgroup and the Regional Management team for review.
- Assumes a lead role in identifying causes for non-compliance and issues while identifying strategies and establishing processes to improve the quality of care for enrollees and improve satisfaction for providers and staff.
- Participate as a member of the Regional Management Team.
- Submits Area Office QI Committee recommendations to the Regional Management Team.
- The Area Office QI Chairperson will be a clinical staff member.

CMS AREA OFFICE QUARTERLY REPORTS

For specific, detailed information regarding quarterly performance measures, refer to the following documents:

- Performance Measurements Care Coordination Desk Reference (most current edition)
- CMS Performance Measures for Care Coordination, HCMSP 145-117
- CMS Area Office Oversight and Performance Measures, HCMSP 145-021

For the quarter, a percentage of the charts will be Title XIX, a percentage of the charts will be Title XXI and a percentage of the charts, if possible, will be Safety Net. If there are no Safety Net enrollees in an office, please review additional Title XXI charts. The percentage of charts for each office will be determined using an algorithm based upon the statewide and area office census of the desired population for each performance measure.

CMS, through our ICSs, contract with Carenet, a nurse help line that is available 24 hours per day, 7 days per week. CMS, through our ICSs, monitors monthly statistics from each ICS Carenet service and the following are reported to the QI Committee on a quarterly basis:

- Total # of calls
- Type of call (enrollment or clinical)
- Date of Area Office Notification if a clinical call
- Triage Reports sent to the Area Offices with twenty-four (24) hours of the clinical call

Each Area Office monitors the care coordination enrollee follow-up to the Carenet line within two (2) working days of the call, if the call was for a clinical issue. The Area Office will report this data on a quarterly basis along with the following:

- Documentation of a follow-up call in the CCM with both the family and the PCP;
- In the CCM, note type is “Care Coordination” and the note title is “Carenet”;
- In the note, there is documentation that the PCP was notified of the triage call to Carenet, if the call indicated the need for follow-up by the PCP or if the enrollee was directed to seek emergency care; and
- The Triage Call Report was scanned and indexed in the Electronic Health Record according to CMS policy and procedure.

Refer to the CMS policies, CMS After Hours Triage (Carenet), HCMSP 145-115 and CMS Medical Records Scanning and Indexing, HCMSP 145-502.

UTILIZATION MANAGEMENT (UM)

For UM provisions, please refer to the CMS Utilization Management Plan, most recent version.