Florida Agency for Health Care Administration

SFY 2013–2014 Annual Technical Report of External Quality Review Results

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HSAG HEALTH SERVICES ADVISORY GROUP

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Overview and Scope of the External Quality Review

The state fiscal year (SFY) 2013–2014 Annual Technical Report of External Quality Review Results, prepared for the Florida Agency for Health Care Administration (AHCA), is presented to comply with the Code of Federal Regulations (CFR) at 42 CFR 438.364. Health Services Advisory Group, Inc. (HSAG), is the external quality review organization (EQRO) for AHCA, the State agency responsible for the overall administration of Florida's Medicaid managed care program.

The Balanced Budget Act of 1997 (BBA) states that "each contract with a Medicaid managed care organization must provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible."[1]

This report describes how data from activities conducted in accordance with 42 CFR 438.352 and other quality activities were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care furnished to Medicaid enrollees by the Florida managed care organizations (MCOs).

This is the eighth year HSAG has produced the external quality review (EQR) report of results for the State of Florida. Report information does not disclose the identity of any individual, in accordance with 42 CFR 438.364(c).

HSAG's external quality review of the MCOs included directly performing two of the three federally mandated activities as set forth in 42 CFR 438.358—validation of performance measures and validation of performance improvement projects (PIPs). The third mandatory activity—evaluation of compliance with federal managed care standards—must be conducted once in a three-year period. AHCA completed the third year of a three-year review cycle in SFY 2011–2012 and chose not to perform compliance reviews in SFY 2013–2014. Other compliance review activities were conducted, however, and are described in Section 3 of this report.

In addition, the results of optional EQR and other quality activities performed during the year are included in this report, as follows:

- Encounter Data Validation (EDV) Study—performed by HSAG
- Overview of the Cultural Competency Focused Study currently in process—performed by HSAG
- Child Health Check-Up (CHCUP) participation rates—data obtained from AHCA

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Legislative Summary: Balanced Budget Act of 1997 Medicare and Medicaid Provisions.*

- Functional Assessment Rating Scale/Children's Functional Assessment Rating Scale (FARS/CFARS) results—data obtained from AHCA
- MCO accreditation outcomes—data obtained from AHCA

During the time period of the EQR review, the State was in the process of transitioning to a Statewide Medicaid Managed Care (SMMC) program. Due to this transition, which is discussed in more detail in Section 2 of the report, not all plan types were reviewed for all EQR activities.

This report includes the following for each EQR activity conducted:

- Objectives
- Technical methods of data collection and analysis
- A description of data obtained
- Conclusions drawn from the data

In addition, an assessment of the strengths and weaknesses of each MCO will be illustrated via individual MCO validation results and the MCO comparative information presented in this report. Where applicable, the report includes the status of improvement activities implemented by the MCOs and recommendations for improving the quality and timeliness of, and access to, healthcare services they provide.

The Centers for Medicare & Medicaid Services (CMS) has chosen the domains of quality, access, and timeliness as keys to evaluating the performance of MCOs. HSAG used the following definitions to evaluate and draw conclusions about the performance of the MCOs in each of these domains:

Quality

CMS defines quality in the EQR protocols, Version 2.0, September 2012,[2] as follows:

> Quality means the degree to which the managed care organization increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.

Timeliness

The National Committee for Quality Assurance (NCQA) defines timeliness relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to

[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction,* September 2012.

accommodate the clinical urgency of a situation."[3] NCQA further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MCO or prepaid inpatient health plan (PIHP)—e.g., processing expedited appeals and providing timely follow-up care.

Access

In the preamble to the BBA Rules and Regulations[4] CMS discusses access to and the availability of services to Medicaid enrollees as the degree to which MCOs and PIHPs implement the standards set forth by the state to ensure that all covered services are available to enrollees. Access includes the availability of an adequate and qualified provider network that reflects the needs and characteristics of the enrollees served by the MCO or PIHP.

Organizations Included in External Quality Review

During SFY 2013–2014, AHCA included its various MCO, PIHP, and PAHP (prepaid ambulatory health plan) model types within the scope of the EQR, as listed in Table 1-1.

AHCA is responsible for the administration of the Medicaid managed care program in Florida, and has delegated responsibility for monitoring the long-term care (LTC) plans to the Department of Elder Affairs (DOEA).

As noted in Table 1-1 and as indicated throughout this report, health maintenance organizations (HMOs) and provider service networks (PSNs) are identified as either Reform or Non-Reform. Reform refers to the Medicaid Reform Pilot Program which AHCA implemented in July 2006, operating under an 1115 Research and Demonstration Waiver. Reform plans in the pilot program began providing services to Medicaid enrollees in two counties in September 2006, with expansion to three additional counties in September 2007. Reform plans operate as either HMOs or PSNs, but with some differences in benefits and requirements compared to HMOs and PSNs in Non-Reform counties. In December 2011, CMS approved extending the demonstration waiver through June 30, 2014. Table 1-1 describes all plan types that were reviewed during the EQR report period.

Table 1-1—MCO, PIHP, and PAHP Model Types Under External Quality Review

Model Type	MCO/PIHP /PAHP	Description of Services
Health maintenance organizations (HMOs)—Reform and Non-Reform	MCO	Prepaid, comprehensive physical and mental health services provided to enrollees
Provider service networks (PSNs)—Reform and Non-Reform	PIHP or MCO	Prepaid or fee-for-service, comprehensive physical and mental health services provided to enrollees

[3] National Committee for Quality Assurance. 2013 Standards and Guidelines for the Accreditation of Health Plans.
[4] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*, Vol. 67, No. 115, June 14, 2002.

Table 1-1—MCO, PIHP, and PAHP Model Types Under External Quality Review		
Model Type	**MCO/PIHP /PAHP**	**Description of Services**
Prepaid mental health plans (PMHPs)	PIHP	Prepaid mental health services provided to Medicaid enrollees who are not enrolled in an HMO or PSN
Child welfare prepaid mental health plan (CWPMHP)	PIHP	Prepaid mental health services provided to children and adolescents with open cases in Florida's Safe Families Network
Statewide inpatient psychiatric program health plans (SIPPs)	PIHP	Medicaid enrollees under the age of 18 years receiving mental health services in an intensive residential setting
Prepaid Dental Health Plans (PDHPs)	PAHP	Prepaid dental services for eligible children under the age of 21
Long-term Care Plans	PIHP	Prepaid long-term care services including nursing facility and home and community-based services

LTC plans were fully operational in March 2014. The timing of this implementation enabled HSAG to review these plans for performance measure validation (PMV) activities only.

For ease of reference, this report refers to the HMOs, PSNs, PMHPs, CWPMHP, SIPPs, PDHPs, and LTC plans as plans. For circumstances in which the activities or findings apply to one or more model types, but not to all, the report identifies the individual model types.

A comprehensive list of plan names, by plan type, is included as Appendix F.

Summary of Findings, Conclusions, and Recommendations

Review of Compliance With Access, Structure, and Operations Standards

AHCA completed the third year of a three-year compliance review cycle in SFY 2011–2012. Due to the transition to SMMC, AHCA chose not to perform compliance reviews in SFY 2013–2014. However, readiness reviews were conducted on all new plans. The Web-based Managed Care Survey Tool (MCST) that HSAG developed for the State the previous contract year will be used for upcoming compliance reviews. For these reviews AHCA may opt to take advantage of the federal non-duplication regulations that allow for deemed compliance based on accreditation of each health plan.

Validation of Performance Improvement Projects and Performance Measures

HMOs and PSNs

Performance Measures

Performance for the HMOs and PSNs continued to be strong in meeting the NCQA information systems (IS) standards. All PSNs and nearly all HMOs were compliant with all standards. Only one HMO for which noncompliance to the IS 6.0 standard resulted in an *NR* (*Not Reportable*) designation for the *Call Answer Timeliness* measure. For the other NCQA standards, not more than two HMOs were noncompliant and the impacts were very minimal. HMOs/PSNs were required to report 33 measures, grouped into six groups (i.e., Pediatric Care, Women's Care, Living With Illness, Access to Care, Use of Services, and Mental Health).

Measures under the **quality** domain included all Pediatric Care and Living With Illness measures, all Women's Care measures except two under *Prenatal and Postpartum Care*, and two Mental Health measures (*Antidepressant Medication Management* and *Mental Health Readmission Rate*).

- For the measures that contain AHCA performance targets, three measures, all under Pediatric Care (*Well-Child Visits in the First 14 Months of Life—4 Visits* and *5 Visits,* and *Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*), exceeded the performance targets for both Non-Reform and Reform HMOs/PSNs. Six Non-Reform statewide performance measures and seven Reform statewide performance measures exceeded their respective AHCA performance targets.
- Statewide performance by Non-Reform and Reform HMOs/PSNs was generally similar for most measures under the quality domain. Measures with performance differences greater than 5 percentage points included *Annual Dental Visit, Appropriate Testing for Children With Pharyngitis, Prenatal Care Frequency (> 81 Percent), Adult BMI Assessment, Use of Appropriate Medications for People with Asthma—51–64 Years*, *Mental Health Readmission Rate,* and all HIV-related measures. Non-Reform HMOs/PSNs performed better on *Prenatal Care Frequency* and *Adult BMI Assessment,* while Reform HMOs/PSNs performed better on all the other measures.
- Many of the quality measures showed statistically significant changes from the previous year. Both Reform and Non-Reform weighted averages for the *Immunizations for Adolescents* (all three indicators)*, Adult BMI Assessment, Breast Cancer Screening,* and *Highly Active Anti-Retroviral Treatment* measures reported statistically significant improvement. Non-Reform HMOs/PSNs had an additional six measures reporting statistically significant improvement and Reform HMOs/PSNs had an additional eight measures showing statistically significant improvement. Statistically significant decline was observed in weighted averages for both Non-Reform and Reform HMOs/PSNs. However, Reform HMOs/PSNs had only one weighted average in this domain with a significant decline in performance.

Measures under the **timeliness** domain included four Pediatric Care measures (*Lead Screening in Children*, *Childhood Immunization Status, Immunizations for Adolescents*, and *Follow-Up Care for Children Prescribed ADHD Medication*), one Women's Care measure (*Timeliness of Prenatal*

Care), and two Mental Health measures (*Follow-Up After Hospitalization for Mental Illness* and *Antidepressant Medication Management*).

- For measures that have AHCA performance targets, Non-Reform and Reform HMOs/PSNs each had two weighted averages exceeding AHCA performance targets. Statewide performance from both types met the target established for *Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*. Non-Reform weighted averages also exceeded AHCA's performance target for *Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase.* Reform weighted averages for the *Antidepressant Medication Management—Effective Continuation Phase Treatment* indicator exceeded the AHCA performance target.
- Statewide performance by Non-Reform and Reform HMOs/PSNs was similar except on the *Follow-Up after Hospitalization for Mental Illness* measure. For both indicators under this measure, Non-Reform statewide performance was at least 5 percentage points better than Reform performance.
- Most of the timeliness measures showed little change from the previous year. Statistically significant improvement from last year was noted on the *Immunizations for Adolescents* measure (all three indicators) for both Non-Reform and Reform HMOs/PSNs, and both indicators under *Follow-up Care for Children Prescribed ADHD Medication* for Non-Reform HMOs/PSNs. Statistically significant decline was observed in the *Follow-Up After Hospitalization for Mental Illness* measure (both indicators) for Non-Reform HMOs/PSNs. For Reform HMOs/PSNs, none of the timeliness measures demonstrated statistically significant decline.

Measures under the **access** domain included two Pediatric Care measures (*Annual Dental Visit* and *Follow-Up Care for Children Prescribed ADHD Medication),* two Women's Care measures (including two indicators under *Prenatal and Postpartum Care* and *Prenatal Care Frequency*), the *Ambulatory Care* Use of Services measure, and all measures in the Access to Care group.

- For measures with AHCA performance targets, two measures (*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* and *Call Answer Timeliness)* exceeded the performance targets for both Non-Reform and Reform HMOs/PSNs. Non-Reform statewide performance on the *Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase* indicator also exceeded the AHCA performance target.
- Statewide performance for Non-Reform and Reform HMOs/PSNs was similar on all but four measures. Reform HMOs/PSNs performed at least 5 percentage points better on *Annual Dental Visit* and *Adults' Access to Preventive/Ambulatory Health Services—65+ Years*. Conversely, Non-Reform HMOs/PSNs performed at least 5 percentage points better on *Prenatal Care Frequency >81 Percent* and *Transportation Timeliness*.
- Most of the access measures experienced statistically significant changes from the previous year. Significant improvements were noted for both Reform and Non-Reform weighted averages on *Call Answer Timeliness*, selected age groups for *Children and Adolescents' Access to Primary Care Practitioners* and *Adults' Access to Preventive/Ambulatory Health Services.* Non-Reform HMOs/PSNs also reported statistically significant improvement in *Follow-up Care for Children Prescribed ADHD Medication* and *Transportation Timeliness*. Reform HMOs/PSNs also reported statistically significant improvement on both *Call Abandonment* and

Annual Dental Visit measures. Both types reported significant decline in some measures, with Non-Reform statewide performance declining from the previous year on *Annual Dental Visit* and *Call Abandonment,* and Reform performance declining on *Transportation Timeliness*.

Performance measure results suggested opportunities for improvement in almost all domains of care. HSAG recommended that improvement efforts be focused on 11 measures with calendar year (CY) 2013 rates below AHCA's performance targets by at least 10 percentage points. Five of these measures were found in the Women's Care domain; four in Pediatric Care; and one each in the Access to Care and Mental Health domains, respectively.

Performance Improvement Projects

For SFY 2013–2014, the percentage of HMO PIPs receiving an overall *Met* validation status declined. A *Met* validation status indicates that the reported results were valid and reliable and that improvement in outcomes was achieved, when applicable. Of the 62 PIPs validated, 23 (or 37 percent) received a *Met* validation status. This is a decrease from SFY 2012–2013, where 72 percent of PIPs validated received an overall *Met* validation status. The percentage of PSN PIPs receiving an overall *Met* validation status also declined, from 91 percent in SFY 2012–2013 to 33 percent.

For the collaborative PIP topic, *Well-Child Visits in the First 15 Months of Life—Six or More Visits,* which addressed aspects of **quality**, **timeliness**, and **access** to care, the Non-Reform plans performed better than the Reform plans in achieving statistically significant improvement. Eighty-five percent (11 of 13) of the Non-Reform HMOs with a remeasurement rate achieved statistically significant improvement over the baseline rate, while only 33 percent (two of six) of the Reform plans accomplished the same. Eight PSNs progressed to the point of assessing for statistically significant improvement, with only two (25 percent) demonstrating real change in study indicator outcomes.

For the non-collaborative PIP topics, which addressed various topics on **quality**, **access**, and **timeliness** of care, four out of 13 Non-Reform HMOs (31 percent) achieved statistically significant improvement over the baseline rate across all study indicators at the most recent remeasurement. Only one Reform HMO, Molina Healthcare of Florida, demonstrated statistically significant improvement from baseline to the current remeasurement across all study indicators. Of the eight PSNs reporting remeasurement data for non-collaborative PIP topics, six (75 percent) achieved statistically significant improvement over baseline.

The HMOs'/PSNs' biggest challenge was developing and implementing interventions that resulted in real change and improved outcomes. The new PIP validation scoring methodology, based more heavily on demonstrating statistically significant and sustained improvement in study indicators, more clearly reflected the need for further improvement among these plan types and all other plan types.

PMHPs/CWPMHP

Performance Measures

Based on SFY 2013–2014 PMV activities, HSAG found that the PMHPs and the CWPMHP continued to maintain their automated processes without significant changes in reporting performance measure rates. While issues were noted surrounding the rate calculation during the PMV, these issues were corrected, and the rates were revised and resubmitted before the end of the validation period, thereby rendering them reportable.

The PMHPs and the CWPMHP were required to report three measures. The *Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis—Mental Health Practitioner* and *Follow-up Within 30 Days of an Acute Care Discharge for a Mental Health Diagnosis—Mental Health Practitioner* measures belong to the timeliness domain. In CY 2013, at the statewide level, 44 percent and 63 percent of acute discharges were followed by a visit within seven days and 30 days, respectively. These rates represent a slight performance improvement from last year. Regarding the *Thirty-day Readmission Rate* measure (a measure under the quality domain), 24.45 percent of hospital discharges with a mental health diagnosis were followed by a readmission within 30 days after the discharge. Statewide performance for this measure showed a slight decline from last year. Since the PMHP/CWPMHP model will no longer exist under the SMMC program and these measures are required as part of Florida Medicaid's Managed Medical Assistance (MMA) measure reporting, HSAG recommends that service model or improvement strategies used by PMHPs/CWPMHP be shared with the MMA plans so that best practices can be adopted or continue to be used to improve care.

Performance Improvement Projects

The PMHPs and CWPMHP demonstrated a substantial decline in the percentage of PIPs receiving an overall *Met* validation status in SFY 2013–2014, with 13 percent of the 24 PIPs validated achieving a *Met* status compared to 88 percent of the PIPs validated in SFY 2012–2013.

For the PMHPs'/CWPMHP collaborative PIP topic, *Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis*, which addressed the domains of **quality** and **timeliness** of care, all PMHPs/CWPMHP progressed to reporting a remeasurement period. Eleven of the 12 PMHPs/CWPMHP (92 percent) demonstrated statistically significant improvement over the baseline rate.

For the non-collaborative PIP topics, which aimed to improve various aspects related to quality, timeliness, and access to care, only two (20 percent) of the 10 PMHPs/CWPMHP that reported remeasurement data achieved statistically significant improvement over baseline across all study indicators. The lack of statistically significant improvement across all study indicators in the non-collaborative PIPs was an important contributor to the decline in the percentage of PMHP/CWPMHP PIPs that achieved an overall *Met* status through the new outcomes-focused PIP scoring methodology. Since the PMHP/CWPMHP model will no longer exist under the SMMC program, HSAG recommends that the conclusions and recommendations resulting from validation of the PMHP/CWPMHP PIPs be shared with the MMA plans to provide a foundation for ongoing performance improvement efforts.

LTC Plans

Performance Measures

This was the first year for the LTC plans to report performance measures to AHCA. For CY 2013, the LTC plans were required to report three measures (*Timeliness of Services, Case Manager Training*, and *Face-to-Face Encounters*). Based on Final Audit Report (FAR) reviews, HSAG found that not all LTC plan audits were conducted according to the NCQA HEDIS Compliance Audit policies and procedures. Nonetheless, HSAG's reviews of the LTC plans' data systems and processes used for calculating the required measures showed no major concerns. All seven LTC plans had dedicated and knowledgeable staff members working collaboratively to collect and process data relevant to measure calculation. All LTC plans also had adequate review and validation processes in place to ensure accurate and complete data for performance measure reporting.

All three measures required for LTC plan reporting belong to the **timeliness** domain. Statewide results showed that eight out of 10 case managers with at least three months of employment received training on the mandate to report abuse, neglect, and exploitation. At least seven out of 10 enrollees were visited by a case manager in person every three months. Additionally, at least seven out of 10 enrollees received services within three days of their enrollment. These first-year results, while fairly favorable, were characterized by wide rate variations among the LTC plans. HSAG recommended that all LTC plans and AHCA consider these rates as baseline performance from which investigation or intervention strategies can be developed to improve quality for future years. Since the *Case Manager Training* measure results showed that not all LTC plans reported rates of 100 percent, HSAG recommended that LTC plans reporting rates less than 100 percent should investigate the root cause of the noncompliance and assure proper and timely training for their case managers. Furthermore, although all performance measures were AHCA-defined measures and not HEDIS measures, HSAG agreed with AHCA that NCQA HEDIS Compliance Audit policies and procedures should be followed when auditing these measures. HSAG recommends that the FARs should include specific compliance findings related to each IS standard and a brief description for non-traditional data systems used for calculating the AHCA-defined measures.

Performance Improvement Projects

HSAG did not validate PIPs for LTC plans in SFY 2013–2014.

SIPPs

Performance Measures

HSAG did not validate performance measures for SIPPs in SFY 2013–2014.

Performance Improvement Projects

The SIPPs demonstrated a decline in the percentage of PIPs achieving an overall *Met* validation status in SFY 2013–2014. Of the 12 collaborative PIPs that were submitted and validated, only 25 percent received an overall *Met* validation status in SFY 2013–2014 compared to 50 percent in SFY 2012–2013.

For the collaborative PIP topic, *Seclusion and Restraints*, which addressed the **quality** of care domain, both study indicators are inverse indicators for which a lower rate is better. Eleven SIPPs reported remeasurement data for Study Indicator 1 (the rate of restraints used during the measurement year), while one SIPP reported only baseline data. Eight of the 11 SIPPs (73 percent) demonstrated statistically significant improvement from baseline to the most recent remeasurement period for Study Indicator 1. For Study Indicator 2 (the rate of seclusion used during the measurement year), 10 of the 12 SIPPs reported study indicators with remeasurement rates. The remaining two SIPPs maintained a rate of zero seclusions from baseline to the most recent remeasurement. Out of the 10 SIPPs reporting seclusion remeasurement rates, five (50 percent) demonstrated a statistically significant decrease in the seclusion rate from baseline.

Opportunities for improvement continue to exist for the SIPPs to achieve statistically significant study indicator changes and improved enrollee outcomes. Since the SIPP model will no longer exist under the SMMC program, HSAG recommends that the conclusions and recommendations resulting from validation of the SIPP PIPs be shared with the MMA plans to provide a foundation for ongoing performance improvement efforts.

PDHPs

Performance Measures

AHCA required the two contracted PDHPs to report four performance measures, one of which was the HEDIS *Annual Dental Visit* measure. Although the PDHPs had adequate time to prepare for the NCQA HEDIS Compliance Audit, HSAG continued to find varying interpretations of how the three non-HEDIS measures were calculated by the two PDHPs. As such, HSAG was only able to agree with the auditors' findings regarding the audit designation for the *Annual Dental Visit* measure.

Aggregate performance from both Miami-Dade County region and the statewide region on the *Annual Dental Visit* measure showed that less than four in 10 enrollees (37.04 percent) received at least one dental visit during CY 2013. The PDHPs' aggregate performance was at least 20 percentage points below AHCA's performance target. Since the *Annual Dental Visit* measure is both a **quality** and **access** measure, PDHPs have opportunities for improvement on this measure. As dental performance measures will be reported by the MMA plans under the SMMC program, HSAG recommended that AHCA initiate early discussions with the MMA plans about the non-HEDIS measures and delineate the specifications and reporting requirements before the annual compliance audit. At the time of finalizing this report, AHCA has indicated that due to these concerns, the AHCA-defined dental measures have been dropped and that the MMA plans are required to report on CHCUP dental measures instead.

Performance Improvement Projects

SFY 2013–2014 was the first year that PDHPs submitted PIPs for validation. Each of the two PDHPs submitted two plan-selected PIP topics for validation for a total of four PIPs. Two of the PIPs focused on improving the rate of annual dental visits, which represents **access** to, and **timeliness** of, care domains. The other two PIPs focused on member and/or provider satisfaction, which addressed the **quality** of care domain. Only one of the PDHP PIPs progressed to the point of

reporting remeasurement data, and this PIP demonstrated a statistically significant decline between baseline and the first remeasurement. None of the four PIPs received a *Met* validation status. Based on their validation performance, the PDHPs demonstrated a need for additional training and have opportunities for improvement in all three stages of the PIP process. Since the PDHP model will no longer exist under the SMMC program, HSAG recommends that the conclusions and recommendations resulting from validation of the PDHP PIPs be shared with the MMA plans to provide a foundation for ongoing performance improvement efforts.

Encounter Data Validation

Accurate and complete encounter data are critical to the success of any managed care program. State Medicaid agencies rely on the quality of encounter data submissions from contracted plans in order to monitor and improve the quality of care; establish performance measure rates; generate accurate and reliable reports; and obtain utilization and cost information. The completeness and accuracy of these data are essential to the state's overall management and oversight of its Medicaid managed care program and in demonstrating the state's responsibility and stewardship.

During SFY 2013–2014, AHCA contracted with HSAG to conduct an EDV study. The goal of the study was to examine the extent to which encounters submitted to AHCA by its contracted managed care plans, PMHPs, and PDHPs (collectively referred to as plans) are complete and accurate.

Encounter Data Completeness and Reasonableness

Findings from the evaluation of the volume of submitted encounters showed a wide range of variation among plans for physician and pharmacy encounters, while inpatient, outpatient, and dental showed minimal variation among all plans.

Based on analyses of the key encounter data fields, HSAG found that most encounters submitted to AHCA's encounter data system contained reasonable and accurate values. While some fields exhibited minor data issues (e.g., *Billing Provider ID*, *Rendering Provider ID*, *Referring Provider ID*, and *Prescribing Provider ID*), the majority of the critical data fields contained accurate and reasonable values.

Moreover, during HSAG's processing of the data, several data anomalies associated with AHCA's extraction of the data were identified that affected the integrity of the assignments of specific encounters to a specific plan. Investigation of the submitted data showed that, for a subset of encounters, the *Provider Submitter ID* indicated a different plan than the enrollee's assigned plan (i.e., *Recipient PMP Provider ID* field). The majority of the anomalies were related to encounters associated with the PDHPs and the PMHPs.

Information System Review

As state Medicaid agencies increasingly use encounter data submitted by their contracted plans, the quality of these data becomes paramount. Depending on each plan's contractual arrangements with their providers, the completeness and accuracy of transactional data submitted to the state may vary.

While plan encounter data submission requirements/manuals, regular feedback in terms of encounter rejection reports, and performance standards in encounter submission can be effective in managing the quality of the encounters received from the plans, there are other factors that affect the quality of these data.

To measure the completeness and accuracy of the data, HSAG developed several questionnaires designed to yield information on the plans' and AHCA's information systems. Although most of the questions in the plan and AHCA questionnaires relate to policies, procedures, and specific approaches to handling various stages of claims and encounter processing, the questions were developed to provide a supplemental understanding of how each organization's unique processes might affect the quality of the encounter data submitted to AHCA by the plans. The questionnaires were intended to provide additional insight into quantitative results generated from the comparative claims analyses. In cases where data anomalies were identified in quantitative results, plan responses could be used to try to identify the root cause for the data discrepancies. Since results from the desk review of plan and AHCA questionnaires were not intended to be an independent study of each entity's processes, they are best viewed as a building block to explore process-oriented opportunities for improvement in the completeness and quality of submitted encounters.

In general, each plan has its own policies and procedures; levels of automation; and processes for receiving, validating, and processing claims and encounters from its providers. It also appears that each plan has a process of extracting claims and encounters from either their claims systems or data warehouses to prepare the encounter files for submission to AHCA, as well as processes for receiving data submission feedback from AHCA (e.g., issues identified in the response files are investigated and researched). Third-party claims, including Medicare crossover claims, generally account for a very small percentage of overall claims processing, and plans do not consider the submission of these claims to AHCA to be a major challenge. Many of the challenges cited by the plans are instead related to discrepancies created by accurate and timely provider registration and mapping to AHCA's database. These issues appear to pose significant challenges to the plans, especially for encounters rejected by AHCA for these reasons.

Medical Record Review

Encounter Data Completeness

Based on the cases sampled for medical record review, HSAG found that the encounters submitted to AHCA were generally supported by documentation in enrollees' medical records. Across the sampled plans, 86.2 percent of the dates of service identified in the electronic encounter data were supported by enrollees' medical records. Moreover, 79.1 percent of diagnosis codes and 78.0 percent of procedure codes identified in the electronic encounter data were found in enrollees' medical records. These findings suggest a moderate level of completeness of key data elements in AHCA's electronic encounter data when compared to documentation in enrollees' medical records.

However, while encounters submitted to AHCA by the plans were generally supported by the medical records, not all services documented in the medical records were submitted to AHCA (i.e., encounter data omission). For instance, 23.8 percent of the diagnosis codes and 21.0 percent of the procedure codes documented in the enrollees' medical records were missing from the electronic

encounter data. This finding represents an opportunity to improve the completeness of AHCA's encounter data by increasing the percentage of diagnosis and procedure codes submitted to the encounter data system to better align with what is found in the medical records.

Results from the medical record omission and encounter data omission analyses highlight existing discrepancies in the completeness of AHCA's encounter data. Although the discrepancies were not extensive, the results suggest that in CY 2012, some services rendered to enrollees were not incorporated into AHCA's encounter data system.

Additionally, during the procurement of medical records, it was identified that encounter data completeness was likely affected by the way plans approach the submission of adjusted encounters to AHCA. For many of the cases associated with unmatched encounters[5], plans were unable to, or had difficulty with, procuring the medical records since they were frequently for services for which the plan was not responsible. Sometimes when an encounter is adjusted at the plan level, those adjustments are not submitted to AHCA, leading to discrepancies within the encounter data. This finding also suggests that eligibility verification was not in place when encounters were processed prior to submission to AHCA.

Encounter Data Accuracy

In general, when key data elements (i.e., diagnosis codes, procedure codes, and procedure code modifiers) were present in the encounter data submitted to AHCA, and evaluated separately at each individual data element, they were found to be coded accurately. Among the codes that were evaluated, 90.6 percent of diagnosis codes, 86.9 percent of procedure codes, and 87.5 percent of procedure code modifiers identified in the encounter data were supported by medical record documentation. These findings suggested that less than 15 percent of the diagnosis codes, procedure codes, and procedure code modifiers in AHCA's encounter data were inaccurate. For both diagnosis and procedure codes, the majority of errors resulted from the use of inappropriate codes when compared to national coding standards.

Moreover, only one-third of those cases in medical record agreement accurately represented all three data elements (i.e., diagnosis code, procedure code, and procedure code modifier) when compared to enrollees' medical records. The overall accuracy findings indicated that there was at least one inaccurate data element for two-thirds of the dates of service reviewed in this study.

[5] Unmatched encounters represent those encounters where encounters attributed to a plan were associated with enrollees not enrolled with that plan at the time the service was rendered.

Background

The BBA, Public Law 105-33, requires that states ensure that a qualified EQRO perform an annual review of each contracted MCO and PIHP, as specified in 42 CFR 438.350. The BBA further specifies that the EQR activities be conducted in a manner consistent with the protocols established under 438.352 by CMS. The BBA identifies the scope of the EQR, including mandatory and optional activities.

History and Current Status of Florida Medicaid Managed Care and Demographics

The Florida Medicaid program was created in 1970. The program has evolved throughout its history and is progressively moving toward managed care throughout the State. Key events in the history of Florida's Medicaid program and the movement toward managed care are listed below.

- In 1984, the Health Care Financing Administration (HCFA) selected Florida as one of five states to receive a grant to implement a demonstration program. Eligible Medicaid recipients were provided with the opportunity to enroll in Medicaid HMOs in some parts of the State.
- In January 1990, HCFA approved the State's original 1915(b) waiver which enabled the State to implement the Medicaid Physician Access System (MediPass), designed as a managed care alternative for Florida Medicaid recipients.
- Over time, the 1915(b) waiver evolved into a variety of managed care plans including MCOs, Primary Care Case Management (PCCM) programs, PIHPs, and Prepaid Ambulatory Health Plans (PAHPs).
- In 2006, an 1115 research and demonstration waiver enabled the State to initiate Medicaid Reform in two geographic areas of the State. In December 2011, CMS approved Florida's three-year waiver extension request, extending the demonstration through June 30, 2014.
- In 2011, the Florida legislature passed legislation to expand managed care in the Florida Medicaid program. This legislation created the Statewide Medicaid Managed Care (SMMC) program with two components: the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) program.
- On June 14, 2013, CMS approved an amendment to the State's 1115(a) demonstration waiver, which included approval of the SMMC program.
- Seven managed care plans were selected to provide services for the LTC program, which consolidated five home and community-based services programs into a single managed LTC and home and community-based services waiver. The LTC program was implemented on a regional basis, with the first regions enrolling on August 1, 2013, and the final regions enrolling on March 1, 2014.
- Fourteen managed care plans and six specialty plans were selected to provide services for the MMA program. Plans were phased in from May 2014 through August 2014.

The demographics of the Florida Medicaid population (excluding the fee-for-service population) as of January 2015 were as follows:

- Approximately 2.8 million were enrolled in an MMA plan (includes specialty plans)
- Approximately 85,000 were enrolled in the LTC program plans

The State's Quality Strategy

The State's 2013–2014 Revised Comprehensive Quality Strategy (CQS) is an updated version of the State's previous Quality Assessment and Improvement Strategy (QAIS) and was expanded to include a Long-term Care Program Quality Strategy. The CQS "…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."[6]

The goals and objectives of Florida's Medicaid managed care programs are:

- To promote quality standards of healthcare within managed care programs by monitoring internal/external processes for improvement opportunities and to assist the managed care plans with the implementation of strategies for improvement.
- To ensure access to quality healthcare through contract compliance within all managed care programs in the most cost-effective manner.
- To promote the appropriate utilization of services within acceptable standards of medical practice.
- To coordinate quality management activities within the State as well as with external customers.
- To comply with State and federal regulatory requirements through the development and monitoring of quality improvement policies and procedures.

To meet CMS requirements and State goals, AHCA contracted with HSAG to conduct EQR mandatory and optional activities for SFY 2013–2014. The assessment of these activities and recommendations that follow, as discussed in Section 3 of this report, are an integral component of AHCA's quality strategy. These recommendations are used to continually improve quality of care to Medicaid enrollees in Florida.

One of the major initiatives undertaken by AHCA as part of its quality strategy was the transition to SMMC. The SMMC brought with it a change in the delivery system structure, as well as an increased emphasis on quality improvement and measurement.

The SMMC program has two major components: the LTC program and the MMA program. The LTC program provides long-term care services, including nursing facility and home and community-based services, using a managed care model (with HMOs and PSNs being the two types

[6] Florida Medicaid Revised Comprehensive Quality Strategy 2013–2014 Update. Available at: http://ahca.myflorida.com/Medicaid/quality_mc/Archive/docs/Florida_Medicaid_Revised_Comprehensive_Quality_Strategy_2013-2014.pdf. Accessed on: January 30, 2015.

of health plans). The MMA program provides primary and acute medical assistance and related services. Services are provided by HMOs, PSNs, and a limited number of specialty plans. With both programs fully implemented, all NHDP health plans, SIPPs, PMHPs/CWPMHP, and PDHPs were phased out.

The phase-in of the SMMC program began with the LTC component. During SFY 2012–2013, seven managed care plans were selected, through a competitive bid process, to provide comprehensive LTC services to eligible enrollees. The LTC plans were phased in by region, with the first region becoming active in August 2013 and the last regions becoming active in March 2014. As part of its CQS the State established a Quality Improvement Team for the LTC program that includes staff from AHCA and DOEA. "The team is responsible for reviewing all program reports related to quality improvement activities as well as trending, prioritizing, and developing recommendations for implementation of system quality improvements."[7]

MMA activity also began in SFY 2012–2013, with the release of the Invitation to Negotiate in December 2012. Selection of managed care plans (plans), through a competitive bid process, was announced in fall 2013. Fourteen managed care plans and six specialty plans were selected to provide services for the MMA program. Plans were phased in from May 2014 through August 2014.

Due to the phasing out of specific plan types, HSAG, in conjunction with AHCA, developed a strategy to determine which plans would be required to participate in the mandatory EQR activities during the State's transition to SMMC.

AHCA and HSAG reviewed and discussed the existing CMS and contract requirements for EQR activities, as well as benefits and burdens to the plans and the State, and developed guiding principles for use in making these determinations. Based on this assessment, not all plan types were reviewed for each EQR activity during SFY 2013–2014. For example, due to the time frame needed to conduct the PMV audits in relation to the termination of the SIPPs, those plans were not included in the PMV process. LTC plans were part of the PMV activities conducted by HSAG; however, these plans were not operational in time to participate in PIP activities.

Appendix F includes a list of plans that were subject to validation of their PIPs and performance measures, as well as those plans that participated in EDV activities.

Purpose of the Report

The purpose of the SFY 2013–2014 External Quality Review Technical Report is to comply with the BBA, which requires states to prepare an annual technical report that describes the manner in which data from activities conducted in accordance with 42 CFR 438.352 were aggregated and analyzed. The report must describe how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the contracted plans. This includes assessing the degree to which the plans addressed recommendations made in the previous year.

[7] Ibid

How This Report Is Organized

The remainder of this report is organized into two main sections: Section 3—EQR Activities and Results, and Appendices A–F. With the exception of information pertaining to EDV, all information is organized by plan type.

In Section 3, HSAG presents information on the results, conclusions, and recommendations for each EQR required activity, as well as a comparison of performance results and follow-up from prior year recommendations (if applicable).

The BBA-required information on the methodology for conducting EQR activities may be found in Appendix A. Appendix B includes examples of plan PIP interventions. Appendices C, D, and E include plan-specific PIP, performance measure, and EDV results, respectively. Appendix F includes a complete list of plans that were reviewed for each EQR activity.

Validation of Performance Improvement Projects

During SFY 2013–2014, HSAG validated both collaborative and non-collaborative PIPs submitted by the plans for a total of 126 PIPs. The collaborative PIPs focused on State-mandated topics. While the topic, study question, and study indicators were consistent across plans for the collaborative PIPs, the plans developed and implemented interventions independently. The plans self-selected the topics for their non-collaborative PIPs. This section describes the validation activities and the overall findings across all contracted plans. Also included in this section are the actual PIP results, demonstrating the degree to which the improvements implemented by the plans had the desired results of improving access, timeliness, and quality of the care or services. As appropriate, plan comparative information is provided. Please refer to Appendix A of this report where the PIP validation methodology is described in greater detail.

Background Information

As part of its quality assessment and performance improvement program, AHCA required the plans to conduct PIPs in accordance with 42 CFR 438.240, although the number of required PIPs varied. AHCA also expected each plan to participate in a collaborative PIP, which could be used to meet contractual requirements. Beginning in SFY 2006–2007, HSAG facilitated the implementation of three statewide collaborative PIPs (one for the HMOs/PSNs, one for the PMHPs/CWPMHP, and one for the NHDP health plans), focusing quality improvement efforts on specific aspects of care and services. The SIPPs began their collaborative PIP during SFY 2010–2011. The plans continued with the collaborative PIPs until SFY 2012–2013. At that time, AHCA, HSAG, and the HMO/PSNs decided to abandon the use of the same interventions across all plans, as it was determined that not all of the collaborative interventions developed would impact each HMO's/PSN's population and study indicator rate. In SFY 2013–2014, for most HMOs and PSNs, four PIPs were contractually required: one focused on culturally and linguistically appropriate services, one focused on behavioral health services, one was a clinical PIP, and one was a collaborative PIP. Two additional PIPs were required for the one HMO with a program serving the frail and elderly.

In SFY 2013–2014, the PMHPs, the CWPMHP, and the SIPPs were required to conduct two PIPs each, one of which was the collaborative PIP. Due to the implementation of the SMMC program, the NHDP health plans did not submit PIPs for validation in SFY 2013–2014.

The PDHPs submitted PIPs for validation for the first time in SFY 2013–2014. Each PDHP submitted two non-collaborative PIPs for validation.

A listing of all plan PIP topics and validation results is included in this report in Appendix B. A listing of all plans included in the PIP validation activity, along with their full name, abbreviation, and shortened name as used throughout this section, is contained in Appendix F.

Two types of graphs are used in this section of the report: one for PIP Validation Results and one for PIP Study Indicator Results. The PIP Validation Results graph includes a bar for each activity and stage for the validation year. Each bar depicts the percentage of evaluation elements that were met, partially met, and not met. The green portion of the stack bar represents the percentage of *Met* evaluation elements, the yellow portion represents the percentage of *Partially Met* evaluation elements, and the red stack bar represents the percentage of *Not Met* evaluation elements.

In the PIP Study Indicator Results graph, the baseline rate is represented by a blue box, and the most recent measurement period is represented by an up or down arrow. The green (upward) and red (downward) arrows indicate either statistically significant improvement or decline, respectively, while the white arrows (up or down) indicate non-statistically significant improvement or decline. A diamond next to a rate indicates that the denominator for the rate was less than or equal to 30 and should be interpreted with caution. An additional symbol, a circle next to the rate, is used to signify that the indicator was an inverse indicator where lower rates equal better performance. For those PIPs with multiple study indicators, a study indicator identifier follows the plan name (i.e., SI1 for Study Indicator 1 and SI2 for Study Indicator 2).

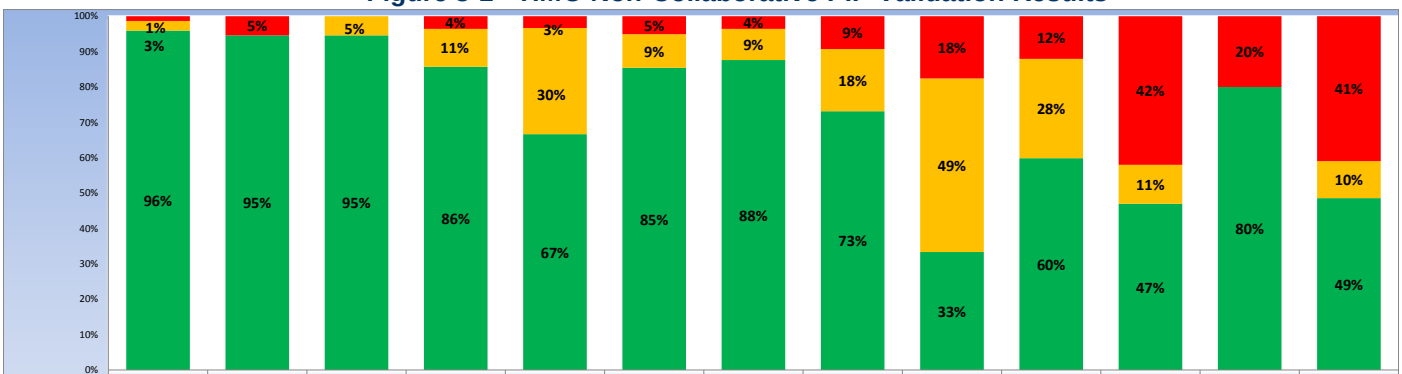
PIP Results and Comparisons by Plan Type

HMOs and PSNs

HMO Non-Collaborative Validation Results

HSAG validated 37 HMO non-collaborative Reform and Non-Reform PIPs in SFY 2013–2014. Figure 3-1 displays the percentage of evaluation elements achieving a *Met*, *Partially Met*, and *Not Met* validation score by activity and stage for the validation year. Percentage totals may not equal 100 due to rounding.

Figure 3-1—HMO Non-Collaborative PIP Validation Results



	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)	VI. Accurate Complete Data Collection	Design Total	VII. Sufficient Data Analysis and Interpretation	VIII. Appropriate Improvement Strategies	Implementation Total	IX. Real Improvement Achieved	X. Sustained Improvement Achieved	Outcomes Total
Not Met	1%	5%	0%	4%	3%	5%	4%	9%	18%	12%	42%	20%	41%
Partially Met	3%	0%	5%	11%	30%	9%	9%	18%	49%	28%	11%	0%	10%
Met	96%	95%	95%	86%	67%	85%	88%	73%	33%	60%	47%	80%	49%

The HMOs designed scientifically sound non-collaborative PIPs that were supported by using key research principles, with 88 percent of the Design evaluation elements receiving a *Met* score. There

were opportunities for improvement, however, in Activity V (sampling techniques), where only 67 percent of evaluation elements were scored *Met*. The five HMOs that used a sample for their non-collaborative PIP had room for improvement in the documentation of sampling methods, including documenting the sample size, population size, margin of error, and confidence level. The technical design of the 32 HMO non-collaborative PIPs that did not use sampling was sufficient to measure and monitor the outcomes associated with the HMOs' improvement strategies.

The overall percentage of evaluation elements receiving a *Met* score for the Implementation stage was 60 percent, which was lower than the Design stage. With 73 percent of evaluation elements in Activity VII (data analysis) and 33 percent of evaluation elements in Activity VIII (improvement strategies) receiving a *Met* score, the HMOs had opportunities for improvement throughout the Implementation stage. These results support the trend seen among the non-collaborative PIPs overall.

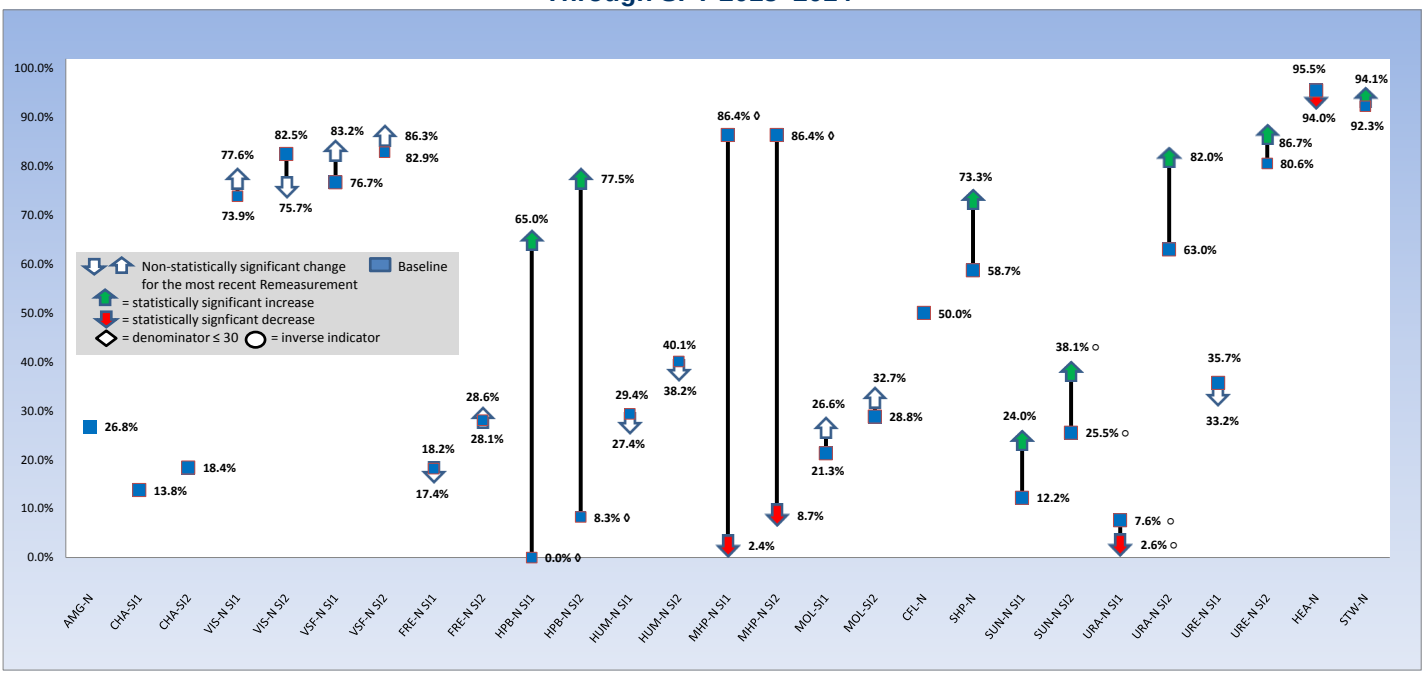
The Outcomes stage received the lowest overall score compared to the other study stages, with 49 percent of the elements receiving a *Met* score. While 47 percent of elements in Activity IX (real improvement) were scored *Met*, 80 percent of elements in Activity X achieved a *Met* score, suggesting that the HMOs were more challenged by demonstrating statistically significant improvement over baseline and year-to-year improvement than they were in sustaining improvement once it was achieved. Performance in the Outcomes stage will only improve after the HMOs address shortcomings in the Implementation stage of the PIPs.

The HMOs' greatest opportunities for improvement were similar to those identified for the non-collaborative PIPs overall. The lowest scores were identified in Activity VIII (improvement strategies) and Activity IX (real improvement), with scores of 33 percent and 47 percent elements *Met*, respectively. These findings suggest that the HMOs should revisit their quality improvement processes used to develop, implement, and evaluate interventions in order to achieve improved study indicator outcomes.

HMO Non-Collaborative PIP Study Indicator Results and Comparisons

Figure 3-2 displays the baseline and most recent remeasurement period rates for the Non-Reform HMOs' non-collaborative PIPs. An additional symbol, a circle next to the rate, is used to signify that the indicator was an inverse indicator where lower rates equal better performance. Note: For those PIPs with multiple study indicators, a study indicator identifier follows the HMO name (i.e., SI1 for Study Indicator 1 and SI2 for Study Indicator 2).

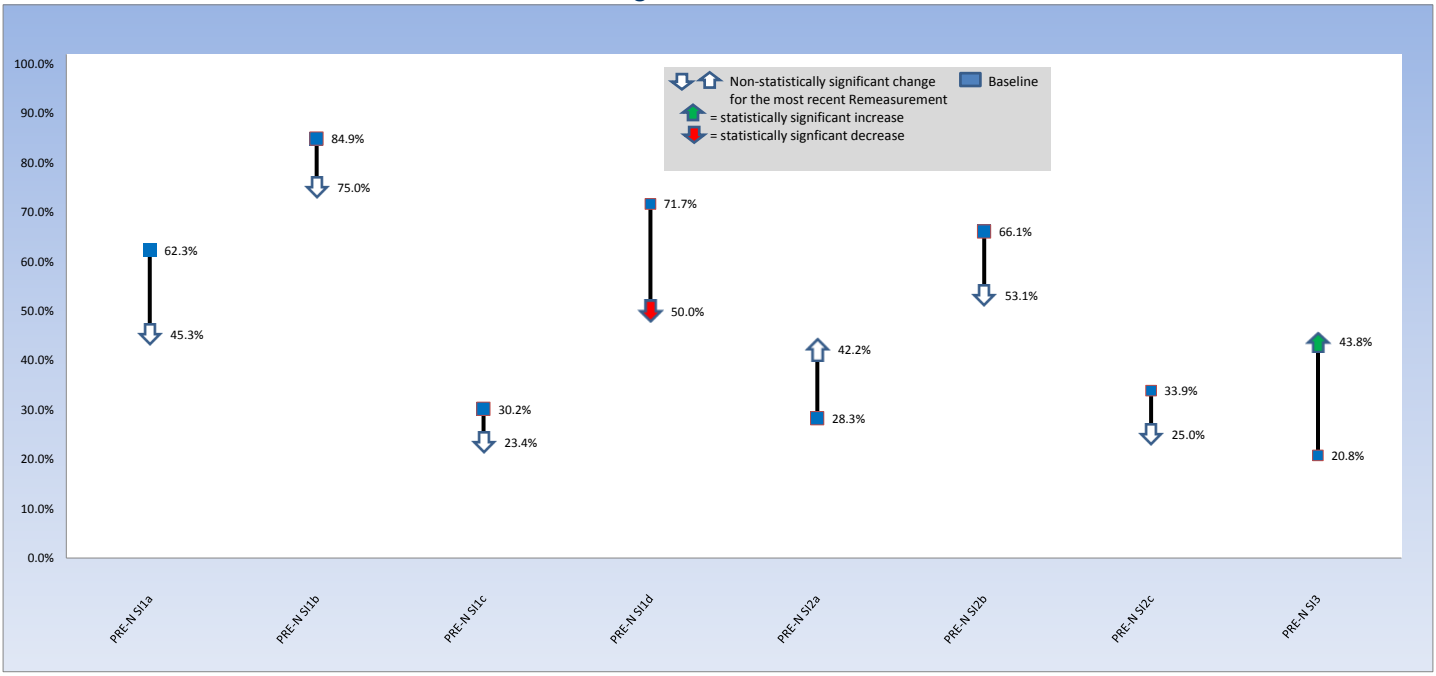
Figure 3-2—Non-Reform HMO Non-Collaborative Study Indicator Results Through SFY 2013–2014



Fifteen HMOs reported a combined total of 27 study indicators. Twelve of the HMOs reported both baseline and remeasurement data for 23 study indicators, while three HMOs reported only baseline data for four of the study indicators. Four (33 percent) of the 12 Non-Reform HMOs (Healthy Palm Beaches, Inc., Simply Healthcare Plans, WellCare Health Plans, Inc.—Staywell of Florida, Inc., and UnitedHealthcare Community Plan) achieved statistically significant improvement for all non-collaborative PIP study indicators between the baseline rate and the most recent measurement period. Healthy Palm Beaches also achieved the two largest improvements from baseline to the most recent remeasurement for the two study indicators in its non-collaborative PIP; Study Indicator 1 increased 65 percentage points, and Study Indicator 2 increased 69.2 percentage points. Two HMOs, Sunshine State Health Plan and United Healthcare of Florida, Inc.—Evercare at Home, achieved statistically significant improvement in some, but not all, of the study indicators in their non-collaborative PIPs. In contrast, two HMOs, Medica Health Plans of Florida and WellCare Health Plans, Inc.—HealthEase of Florida, Inc., demonstrated statistically significant declines among all study indicators for their non-collaborative PIPs.

Figure 3-3 displays the baseline and most recent remeasurement period rates for the Preferred Medical Plan Non-Reform HMO non-collaborative PIP. Due to the large number of study indicators included in the PIP, results are being displayed separately from the other Non-Reform HMO non-collaborative PIPs.

Figure 3-3—Preferred Medical Plan Non-Reform HMO Non-Collaborative Study Indicator Results Through SFY 2013–2014

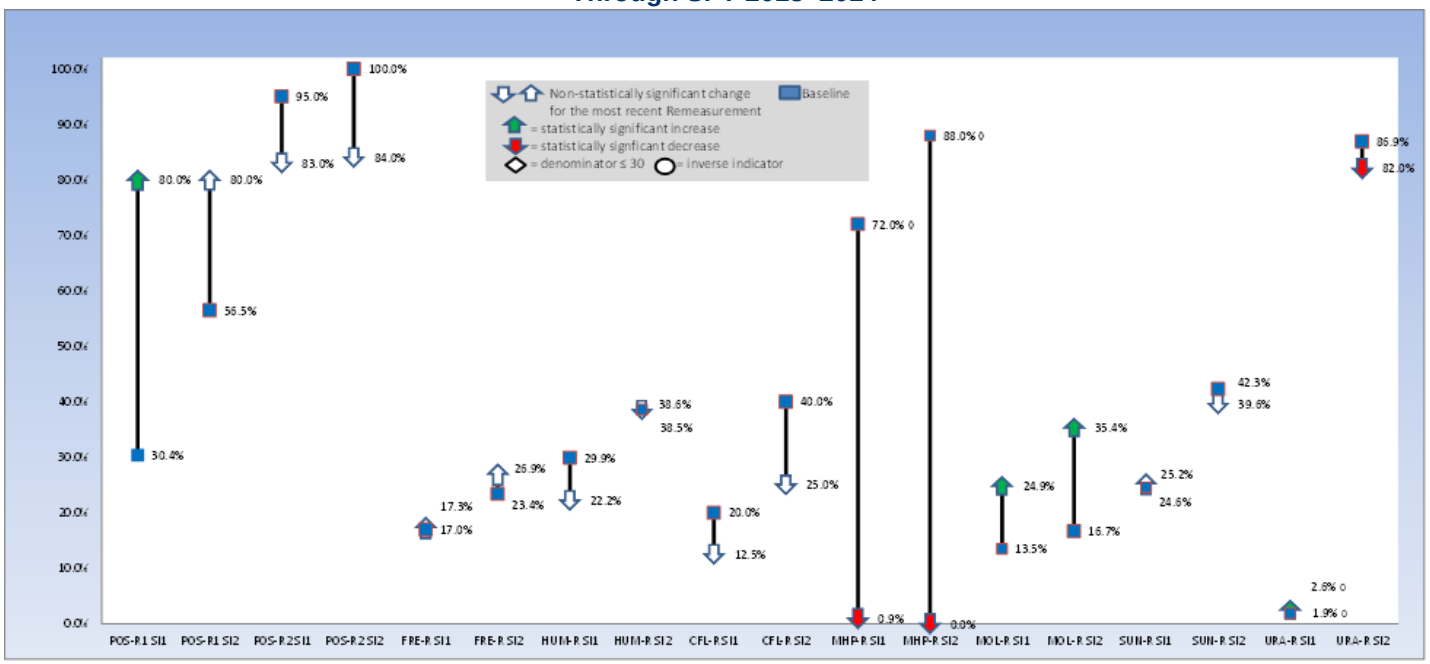


Preferred Medical Plan Non-Reform HMO reported baseline and remeasurement data on three study indicators, with multiple components of Study Indicators 1 and 2, for a total of eight study indicators in its non-collaborative PIP. The HMO achieved statistically significant improvement for Study Indicator 3 and non-statistically significant improvement for Study Indicator 2a. Study Indicator 3 demonstrated the greatest improvement, with an increase of 23 percentage points from baseline to the most recent remeasurement. Five of the eight study indicators (63 percent) demonstrated a non-statistically significant decline in performance; and one study indicator, Study Indicator 1d, demonstrated a statistically significant decline. Across the eight study indicators, the remeasurement rates ranged from 23.4 percent to 75.0 percent, with neither end of the range falling outside the range of remeasurement rates for all other Non-Reform HMO non-collaborative PIPs.

Figure 3-4 displays the baseline and most recent remeasurement period rates for the Reform HMO non-collaborative PIPs.

For those PIPs with multiple study indicators, a study indicator identifier follows the plan name (i.e., SI1 for Study Indicator 1 and SI2 for Study Indicator 2).

Figure 3-4—HMOs Reform Non-Collaborative Study Indicator Results Through SFY 2013–2014

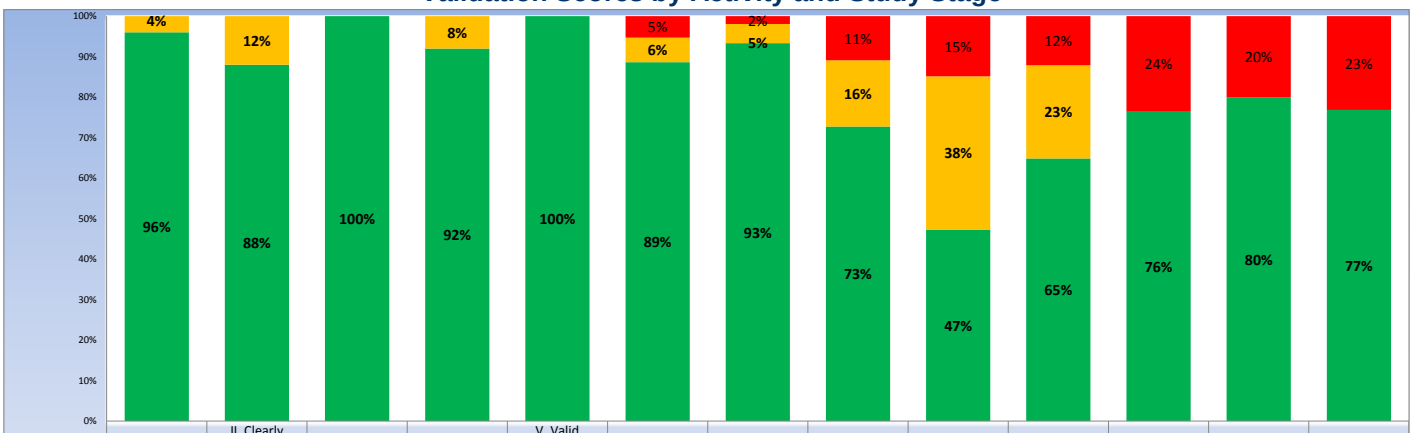


Nine Reform HMOs reported a combined total of 18 study indicators. All HMOs reported remeasurement rates for all study indicators. Only one (11 percent) of the Reform HMOs, Molina Healthcare of Florida, achieved statistically significant improvement between the baseline rate and the most recent remeasurement rate for all study indicators in the non-collaborative PIP. AHF of Florida, Inc. dba Positive Healthcare Florida, achieved statistically significant improvement for some, but not all, of the study indicators in the non-collaborative PIP. One HMO, Freedom Health, Inc., demonstrated non-statistically significant improvement across all study indicators, while two other HMOs, Humana Family c/o Humana Medical Plan, Inc., and Preferred Care Partners dba CareFlorida, reported non-statistically significant declines across all study indicators. Two Reform HMOs, Medica Health Plans of Florida and UnitedHealthcare Community Plan, had statistically significant declines across all study indicators for the non-collaborative PIP. As signified by the inverse indicator symbol in Figure 3-4, UnitedHealthcare Community Plan's Study Indicator 1 was an inverse indicator; therefore, the statistically significant increase indicated a decline in performance. With the lack of statistically significant improvement across the non-collaborative PIPs, there is a clear opportunity for improvement for the Reform HMOs.

HMO Collaborative PIP Validation Results

HSAG validated 25 Reform and Non-Reform HMO collaborative PIPs. Figure 3-5 displays the percentage of evaluation elements achieving a *Met*, *Partially Met*, and *Not Met* validation score by activity and stage for the SFY 2013–2014 validation year. Percentage totals may not equal 100 due to rounding.

Figure 3-5—HMOs Collaborative *Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIP Validation Scores by Activity and Study Stage



	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)	VI. Accurate Complete Data Collection	Design Total	VII. Sufficient Data Analysis and Interpretation	VIII. Appropriate Improvement Strategies	Implementation Total	IX. Real Improvement Achieved	X. Sustained Improvement Achieved	Outcomes Total
Not Met	0%	0%	0%	0%	0%	5%	2%	11%	15%	12%	24%	20%	23%
Partially Met	4%	12%	0%	8%	0%	6%	5%	16%	38%	23%	0%	0%	0%
Met	96%	88%	100%	92%	100%	89%	93%	73%	47%	65%	76%	80%	77%

The HMOs designed scientifically sound studies that were supported using key research principles, with 93 percent of the Design elements receiving a *Met* score. Two activities, Activity III (study population) and Activity V (sampling), had 100 percent of their evaluation elements scored *Met*. The percentage of evaluation elements scored *Met* for Activities I (study topic), II (study question), and IV (study indicators) ranged from 88 percent in Activity II to 96 percent in Activity I. The greatest opportunities for improvement in the Design stage appeared to be in Activity II (study question) and Activity VI (data collection), both of which had less than 90 percent of evaluation elements scored *Met*. Three HMO collaborative PIPs were scored down in Activity II because the study question was not properly defined. The primary reasons for deficient scores in Activity VI were lack of documentation of a manual data collection tool and insufficient documentation of the data analysis plan. In general, however, the technical design of the PIPs was sufficient to measure and monitor the outcomes associated with the HMOs' improvement strategies.

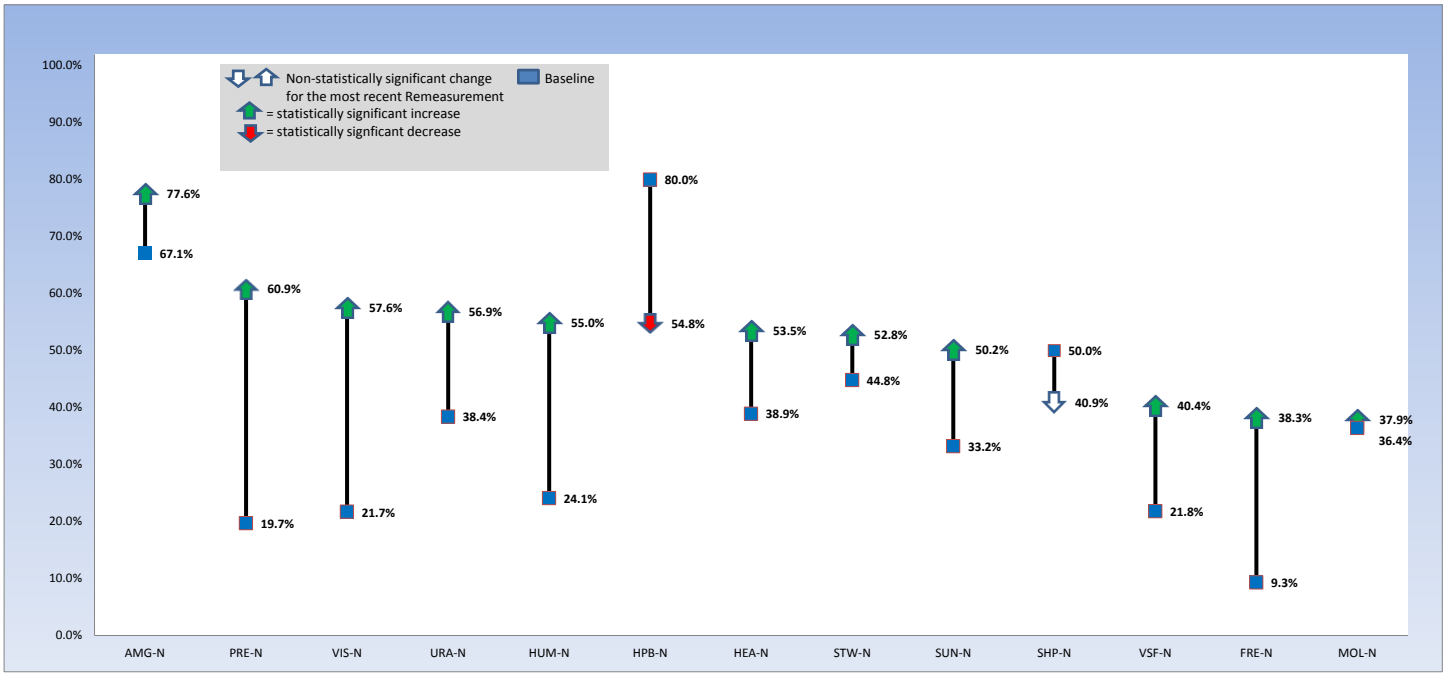
The percentage of elements receiving a *Met* score for the Implementation stage was 65 percent, which was 27 percentage points lower than the score for the Implementation stage in the 2012–2013 validation year. Potential reasons for the decline in performance from the previous year are the same for the HMO collaborative PIPs as those discussed for the collaborative PIPs across all plan types: (1) a shift in the participation of specific HMOs; and (2) changes in the PIP scoring methodology, which included redefining the Implementation stage to include only Activities VII and VIII, and the critical analysis of improvement strategies for Activity VIII. Within the Implementation stage, the HMO collaborative PIPs received a *Met* score for 73 percent of the evaluation elements in Activity VII and 47 percent of the elements in Activity VIII. The scores in Activity VII and Activity VIII for the HMO collaborative PIPs mirrored the scores for Activity VII and VIII for the collaborative PIPs across all plans. As with the collaborative PIPs overall, the critical analysis of quality improvement processes for barrier identification, intervention development, and evaluation of effectiveness were part of the new outcomes-focused scoring methodology which resulted in a sharp decline in the percent of evaluation elements receiving a *Met* score. Again, the Implementation stage demonstrated the greatest opportunity for improvement for the HMO collaborative PIPs, compared to other PIP stages.

In the Outcomes stage, the percentage of elements receiving a *Met* score was 77 percent. The HMO collaborative PIPs met the requirements for Activity IX (real improvement) and Activity X (sustained improvement) with similar rates of 76 percent and 80 percent of evaluation elements scored *Met* in the two activities, respectively.

HMO Collaborative PIP Study Indicator Results and Comparisons

Figure 3-6 displays the baseline and most recent measurement period rates for the Non-Reform HMOs' *Well-Child Visits in the First 15 Months of Life—Six or More Visits* collaborative PIP. The baseline rate is represented by a blue box, and the most recent measurement period is represented by an up or down arrow. The green and red arrows indicate either statistically significant improvement or decline, respectively, while the white arrows indicate non-statistically significant improvement or decline.

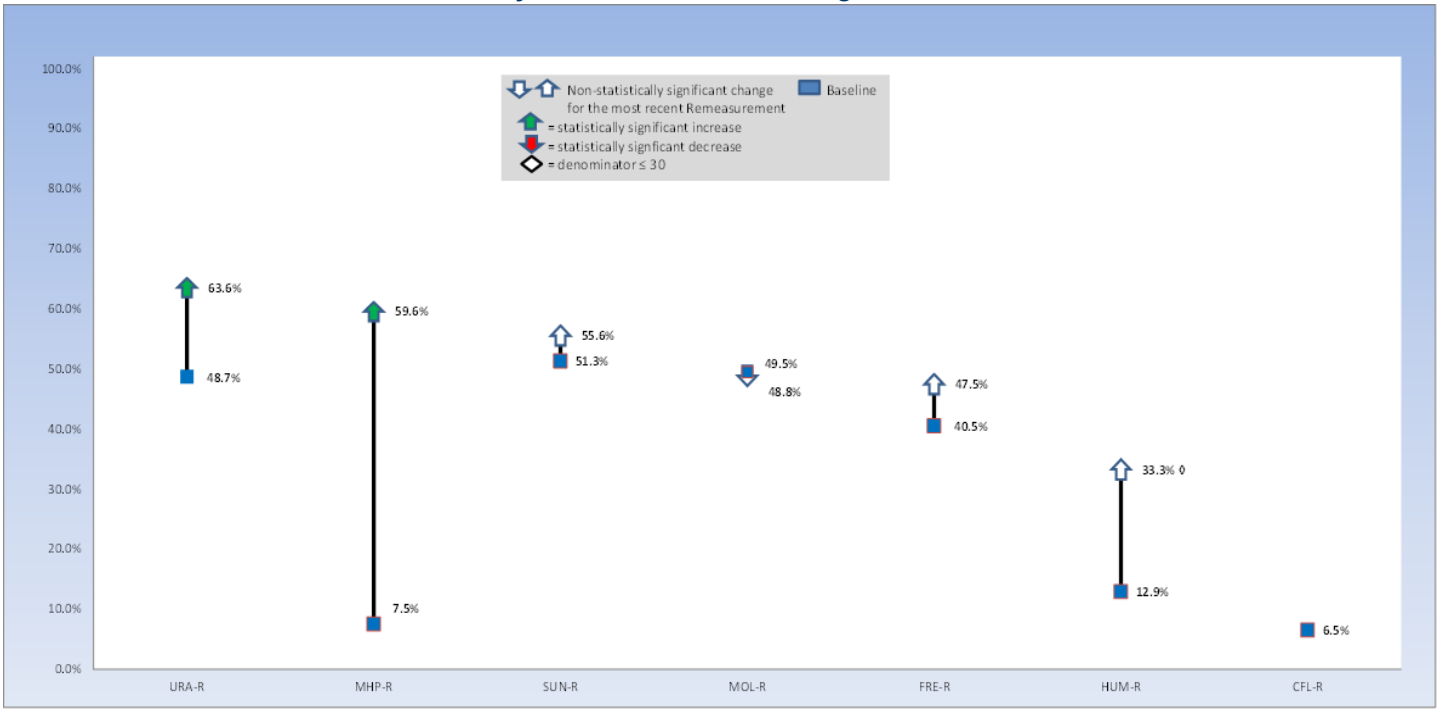
Figure 3-6—HMOs Non-Reform Collaborative *Well-Child Visits in the First 15 Months of Life—Six or More Visits* Study Indicator Results Through SFY 2013–2014



Thirteen HMOs reported a combined total of 13 study indicators with baseline and remeasurement rates. Overall, 11 of the 13 Non-Reform HMOs (85 percent) achieved statistically significant improvement between the baseline rate and the most recent measurement period. Amerigroup Community Care demonstrated a statistically significant increase with the highest remeasurement rate (77.6 percent) of the Non-Reform HMOs for the *Well-Child* collaborative PIP. Preferred Medical Plan, Inc., had the greatest improvement between the baseline rate and the most recent remeasurement with a 41.2 percentage point increase. Healthy Palm Beaches, Inc., and Simply Healthcare Plans were the only two Non-Reform HMOs that did not demonstrate statistically significant improvement.

Figure 3-7 displays the baseline and most recent remeasurement period rates by Reform HMOs for the *Well-Child Visits in the First 15 Months of Life—Six or More Visits* collaborative PIP.

Figure 3-7—HMOs Reform Collaborative *Well-Child Visits in the First 15 Months of Life—Six or More Visits* Study Indicator Results Through SFY 2012–2013



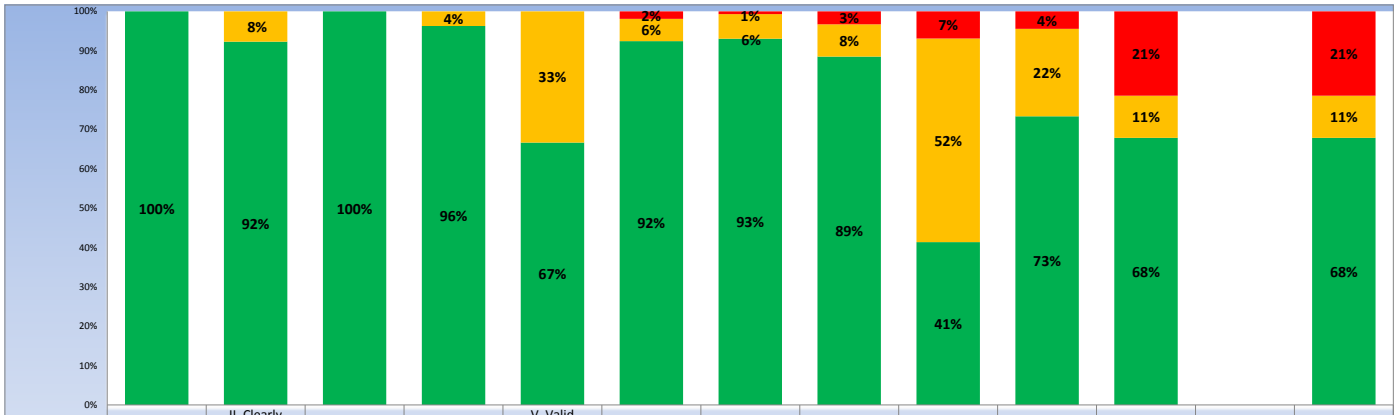
Seven HMOs reported a combined total of seven study indicators. All HMOs reported study indicators with remeasurement rates except for Preferred Care Partners dba CareFlorida, which had not progressed to the point of reporting remeasurement data. Two of the six Reform HMOs with a remeasurement (33 percent) achieved statistically significant improvement between the baseline rate and the most recent measurement period. UnitedHealthcare Community Plan reported a statistically significant increase resulting in the highest rate of well-child visits at the most recent remeasurement. Medica Health Plans of Florida achieved the greatest statistically significant improvement with an increase of 52.1 percentage points from baseline to the most recent remeasurement. Three of the six Reform HMOs with a remeasurement (50 percent) reported a non-statistically significant improvement from baseline to the most recent remeasurement. Only one Reform HMO, Molina Healthcare of Florida, reported a non-statistically significant decline from baseline at the most recent remeasurement.

PSN Non-Collaborative PIP Validation Results

HSAG validated 12 Reform and Non-Reform PSN non-collaborative PIPs for SFY 2013–2014.

Figure 3-8 displays the percentage of evaluation elements achieving a *Met*, *Partially Met*, and *Not Met* validation score by activity and stage for the SFY 2013–2014 validation year. Twelve PSN non-collaborative PIPs were validated for SFY 2013–2014. Percentage totals may not equal 100 due to rounding.

Figure 3-8—PSNs Non-Collaborative PIP Validation Scores by Activity and Study Stage



	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)	VI. Accurate Complete Data Collection	Design Total	VII. Sufficient Data Analysis and Interpretation	VIII. Appropriate Improvement Strategies	Implementation Total	IX. Real Improvement Achieved	X. Sustained Improvement Achieved*	Outcomes Total
Not Met	0%	0%	0%	0%	0%	2%	1%	3%	7%	4%	21%		21%
Partially Met	0%	8%	0%	4%	33%	6%	6%	8%	52%	22%	11%		11%
Met	100%	92%	100%	96%	67%	92%	93%	89%	41%	73%	68%		68%

***No data are displayed for Activity X because none of the PIPs progressed to the point of being assessed for sustained improvement.**

The PSNs designed scientifically sound studies that were supported by using key research principles, with 93 percent of the Design stage evaluation elements receiving a *Met* score. The PSNs met 100 percent of the validation requirements in Activity I (study topic) and Activity III (study population); they also demonstrated strong performance in Activity II (study question) and Activity IV (study indicators), where 92 percent and 96 percent of evaluation elements were scored *Met*, respectively. Activity V (sampling) was the only area of the Design stage with a clear opportunity for improvement. Two of the 12 PSNs used a sample for the non-collaborative PIP, and among these PSNs, only 67 percent of the evaluation elements in Activity V were scored *Met*. To accurately evaluate PIP outcomes, the PSNs using a sample need to thoroughly document the sampling methods, including sample size, population size, confidence interval, and margin of error. For the 10 PSNs not using a sample, the technical design of the PIPs was sufficient to measure and monitor the outcomes associated with the PSNs' improvement strategies.

The percentage of evaluation elements receiving a *Met* score for the Implementation stage was 73 percent, which was lower than the Design stage. The PSNs demonstrated solid performance in Activity VII (data analysis), with 89 percent of the elements receiving a *Met* score. Consistent with the pattern across all non-collaborative PIPs, the PSNs had opportunities for improvement in Activity VIII (improvement strategies), where only 41 percent of the elements were scored *Met*. Within Activity VIII, the greatest areas for improvement were in the elements of causal/barrier analysis and evaluation of intervention effectiveness. A thorough and ongoing causal/barrier analysis process, including evaluation and revision of interventions, is necessary for the PSNs to achieve improved outcomes.

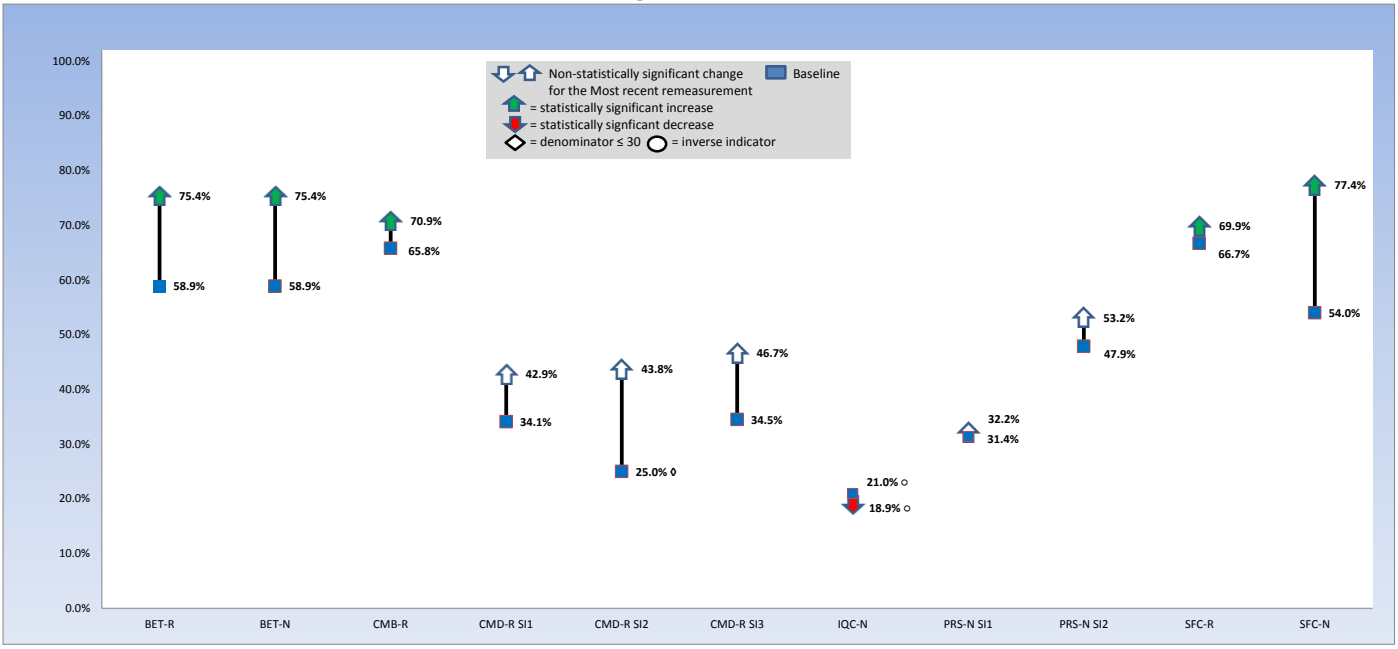
The Outcomes stage received the lowest overall score compared to the other study stages, with 68 percent of the evaluation elements receiving a *Met* score. The score for the Outcomes stage was based solely on Activity IX (real improvement); none of the PSNs progressed to Activity X (sustained improvement) in the non-collaborative PIPs. As evidenced by the score for this stage, the PSNs had opportunities for improvement in the Outcomes stage. Of the seven non-collaborative

PIPs that reported remeasurement data, only four achieved statistically significant improvement over the baseline across all study indicators.

PSN Non-Collaborative Study Indicator Results and Comparisons

Figure 3-9 displays the baseline and most recent remeasurement period rates for the Non-Reform/Reform PSN non-collaborative PIPs. An additional symbol, a circle next to the rate, is used to signify that the indicator was an inverse indicator where lower rates equal better performance. Note: For those PIPs with multiple study indicators, a study indicator identifier follows the PSN name (i.e., SI1 for Study Indicator 1, SI2 for Study Indicator 2, and SI3 for Study Indicator 3).

Figure 3-9—PSNs Non-Reform/Reform Non-Collaborative Study Indicator Results Through SFY 2013–2014

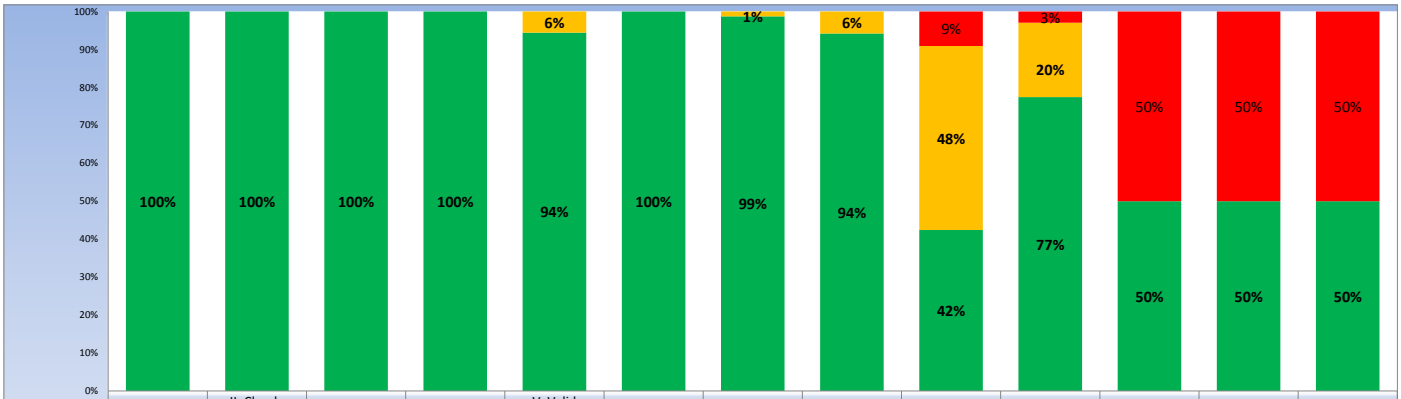


Eight PSNs reported baseline and remeasurement data for a combined total of 11 study indicators. None of the PSNs reported declines in performance during the most recent remeasurement period; six of the 11 study indicators (55 percent) demonstrated statistically significant improvement, and the remaining five study indicators demonstrated non-statistically significant improvement. One of the study indicators demonstrating statistically significant improvement was the inverse study indicator documented by Integral Quality Care, in which a decrease in the rate of emergency department visits indicated an improvement in performance. South Florida Community Care Network (Non-Reform) documented the greatest improvement among the PSN non-collaborative PIPs, with an increase of 23.4 percentage points, and the highest remeasurement rate of 77.4 percent.

PSN Collaborative PIP Validation Results

HSAG validated eight PSN collaborative PIPs for SFY 2013–2014. Figure 3-10 displays the percentage of evaluation elements achieving a *Met*, *Partially Met*, and *Not Met* validation score by activity and stage for the SFY 2013–2014 validation year. Percentage totals may not equal 100 due to rounding.

Figure 3-10—PSNs Collaborative *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
PIP Validation Scores by Activity and Study Stage



	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)	VI. Accurate Complete Data Collection	Design Total	VII. Sufficient Data Analysis and Interpretation	VIII. Appropriate Improvement Strategies	Implementation Total	IX. Real Improvement Achieved	X. Sustained Improvement Achieved	Outcomes Total
Not Met	0%	0%	0%	0%	0%	0%	0%	0%	9%	3%	50%	50%	50%
Partially Met	0%	0%	0%	0%	6%	0%	1%	6%	48%	20%	0%	0%	0%
Met	100%	100%	100%	100%	94%	100%	99%	94%	42%	77%	50%	50%	50%

The PSNs designed scientifically sound studies that were supported by using key research principles, with 100 percent of the evaluation elements receiving a *Met* score in five of the six activities and 99 percent of elements receiving a *Met* score across all activities in the Design stage. Activity V (sampling techniques) was the only area where less than 100 percent of the elements received a *Met* score. Overall, the technical design of the PIPs was sufficient to measure and monitor the outcomes associated with the PSNs' improvement strategies. This achievement in the PIP Design stage allowed for successful progression to the next stage of the PIP process.

The percentage of elements receiving a *Met* score for the Implementation stage was 77 percent, which was 19 percentage points lower than the score for the Implementation stage in the 2012–2013 validation year. For the current year, performance within the Implementation stage varied by activity. For Activity VII (data analysis), 94 percent of evaluation elements received a *Met* score, but only 42 percent of evaluation elements in Activity VIII (improvement strategies) received a *Met* score. The low score in Activity VIII followed the trend seen in the HMO collaborative PIPs (Figure 3-5), and the plans' collaborative PIPs overall, in that the new outcomes-focused scoring methodology with critical analysis of improvement strategies resulted in a substantially lower percentage of *Met* evaluation elements in Activity VIII. With less than half of the evaluation elements receiving a *Met* score, Activity VIII provides a clear opportunity for improvement among the PSNs.

The Outcomes stage received the lowest score compared to the other PIP stages, with 50 percent of the elements receiving a *Met* score. Within this stage, 50 percent of the evaluation elements for both

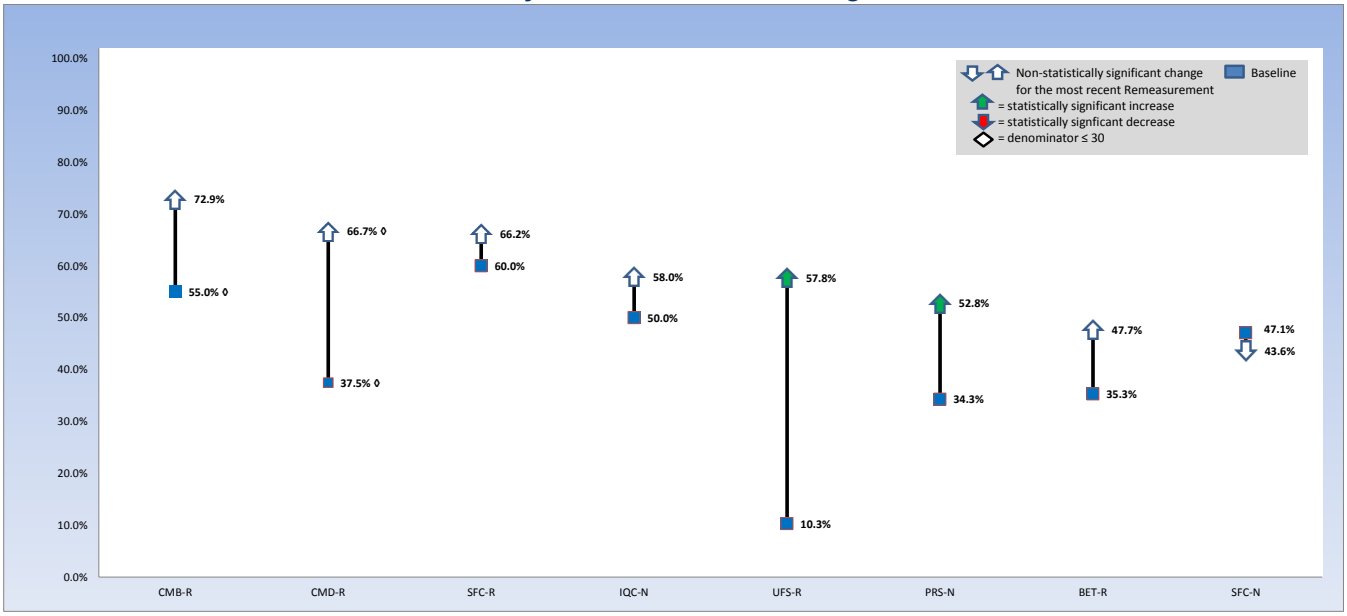
Activity IX (real improvement) and Activity X (sustained improvement) received a *Met* validation score.

Across the 10 PIP activities, the PSNs' greatest opportunity for improvement occurred within Activities VIII, IX, and X in which 42 percent, 50 percent, and 50 percent of elements were scored *Met*, respectively. To drive performance improvement in these areas, the accurate identification of barriers and successful implementation of appropriate improvement strategies are necessary pre-cursors to improved outcomes.

PSN Collaborative PIP Study Indicator Results and Comparisons

Figure 3-11 displays the baseline and most recent remeasurement period rates by Non-Reform/Reform PSNs for the *Well-Child Visits in the First 15 Months of Life—Six or More Visits* collaborative PIP.

Figure 3-11—PSNs Non-Reform/Reform Collaborative *Well-Child Visits in the First 15 Months of Life—Six or More Visits* Study Indicator Results Through SFY 2013–2014



Eight PSNs reported a combined total of eight study indicators. All PSNs reported study indicators with baseline and remeasurement rates. Two out of eight, or 25 percent, of the Non-Reform/Reform PSNs achieved statistically significant improvement from baseline to the most recent measurement period. First Coast Advantage demonstrated the greatest improvement among the PSNs for the *Well-Child* collaborative PIP, with a statistically significant increase from the lowest baseline rate (10.3 percent) to a remeasurement rate of 57.8 percent. Five PSNs documented non-statistically significant improvement between the baseline and the most recent remeasurement period. South Florida Community Care Network was the only PSN to document a non-statistically significant decline between the baseline rate and most recent remeasurement rate.

Conclusions and Recommendations

The results for the *Well-Child Visits in the First 15 Months of Life—Six or More Visits* collaborative PIP demonstrated the need for ongoing improvement. Many of the most recent remeasurement rates for the HMOs and PSNs were at or below 60 percent. In the non-collaborative PIPs, the PSNs performed better than the HMOs in achieving statistically significant improvement from baseline to the current remeasurement across all study indicators. Only five (23 percent) of the HMOs achieved this level of performance compared to six (75 percent) of the PSNs.

Considering the current activities related to the collaborative and non-collaborative PIPs and the PIP requirements of the individual Non-Reform and Reform HMOs/PSNs, HSAG offers the following recommendations:

AHCA

- Identify statewide goals or expected levels of performance for the study indicators in all new state-mandated PIPs with HSAG's assistance.
- Provide opportunities for plans that achieve statistically significant improvement in remeasurement periods to discuss lessons learned and successful improvement strategies with all plans.

HMOs/PSNs

- Verify that all information and results documented in the PIP Summary Form are accurate.
- Ensure that all data analysis, interpretation of results, and statistical testing are accurate and documented consistently throughout the PIP.
- Continue to ensure that performance measure results validated by HSAG and reported to AHCA are consistent with the results reported in the collaborative PIP submissions.
- Contact HSAG for technical assistance on how to conduct statistical testing, if needed.
- Integrate proven quality improvement processes, such as the Plan-Do-Study-Act (PDSA) cycle, into PIPs to ensure a robust causal/barrier analysis, identifying the root causes affecting outcomes improvement.
- Conduct an annual causal/barrier and drill-down analysis in addition to periodic analyses of the most recent data. The plans must accurately document the analysis, describing the work group or committee involved and process and/or tools used. Documentation should provide the data, identified barriers, and interventions logically linked to specific barriers.
- Conduct barrier analyses more frequently than annually. Analysis should also be performed as a plan evaluates the effectiveness of interventions to determine if adjustments are needed to make interventions more effective.
- Prioritize identified barriers and ensure there is a direct link between each intervention and its associated barrier.
- Document in the PIP Summary Form only the targeted interventions implemented to address the specific barriers identified.
- Have a process in place to evaluate the efficacy of each intervention and determine if it is having the desired effect. Each intervention's evaluation results should be included in the PIP documentation.

- Use and document problem-solving techniques to revise or replace ongoing interventions that are deemed ineffective, to achieve the desired improvement in the study indicator(s).
- Incorporate into standard processes and practices those interventions that are determined to be successful.
- Refer to the SFY 2013–2014 PIP Validation Tool and address all *Points of Clarification* and all *Partially Met* and *Not Met* scores.
- Refer to the PIP Summary Form Completion Instructions to ensure all documentation requirements are addressed for each applicable evaluation element and activity completed in the PIP Summary Form.

HMO/PSN Follow-Up on Prior Year Recommendations

Because the PIP Validation Tool and process changed in SFY 2013–2014 (see Appendix A), the SFY 2012–2013 validation scores by PIP stage were regrouped to provide a more accurate comparison between the two validation cycles. The percentages of *Met* scores by PIP stage noted below for HMOs/PSNs (and subsequently for other plan types) are based on the grouping of PIP activities by stage used for the SFY 2013–2014 PIP validation cycle: Activities I through VI for Design stage, Activities VII and VIII for Implementation stage, and Activities IX and X for Outcomes stage. This method of comparison enables the comparison of percentages of *Met* scores by PIP stage to accurately reflect performance changes in comparable PIP activities year over year.

Across all PIPs validated, the HMOs did not maintain their performance in the Design stage (Activities I through VI) in SFY 2013–2014. The percentage of evaluation elements receiving a *Met* score declined from 94 percent in SFY 2012–2013 to 90 percent in SFY 2013–2014. These declines resulted from not addressing the recommendations provided in the HMOs' SFY 2012–2013 PIP validation tools. It did appear that the HMOs also did not address recommendations in the subsequent PIP stages, as there was no improvement in the percentage of evaluation elements receiving a *Met* score in the Implementation or Outcomes stages. For the Implementation stage, the HMOs' overall *Met* validation scores declined from 79 percent to 62 percent. The HMOs did not address HSAG's recommendations related to conducting a causal/barrier analysis and implementing interventions to directly affect study indicator results. In the Outcomes stage, Activities IX and X are scored solely on study indicator outcomes. The HMOs' lack of response to the prior year's feedback on their quality improvement activities is related to the HMOs' ability to achieve real improvement and sustain the improvement.

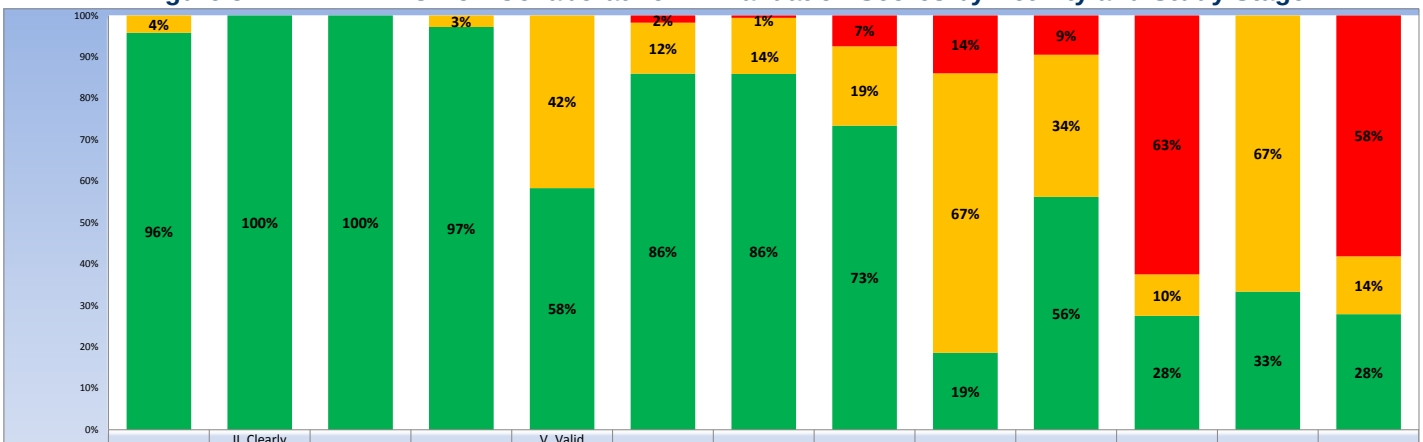
The PSNs also demonstrated declines in performance during SFY 2013–2014, showing that prior year recommendations were not addressed. There was a small decline in the PSNs' overall *Met* validation scores for the Design stage, from 97 percent to 96 percent. The PSNs had greater declines in performance for the subsequent two stages. In the Implementation stage their scores declined from 86 percent to 76 percent and, in the Outcomes stage, from 63 percent to 58 percent. Based on these findings, the HMOs/PSNs should ensure that HSAG's recommendations regarding causal/barrier analysis, interventions, and reporting of data are addressed and follow-up activities are initiated.

PMHPs/CWPMHP[8]

PMHP Non-Collaborative PIP Validation Results

HSAG validated 12 PMHP non-collaborative PIPs for SFY 2013–2014. Figure 3-12 displays the percentage of evaluation elements achieving a *Met*, *Partially Met*, and *Not Met* validation score by activity and stage for the SFY 2013–2014 validation year. Percentage totals may not equal 100 due to rounding.

Figure 3-12——PMHPs Non-Collaborative PIP Validation Scores by Activity and Study Stage



	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)	VI. Accurate Complete Data Collection	Design Total	VII. Sufficient Data Analysis and Interpretation	VIII. Appropriate Improvement Strategies	Implementation Total	IX. Real Improvement Achieved	X. Sustained Improvement Achieved	Outcomes Total
Not Met	0%	0%	0%	0%	0%	2%	1%	7%	14%	9%	63%	0%	58%
Partially Met	4%	0%	0%	3%	42%	12%	14%	19%	67%	34%	10%	67%	14%
Met	96%	100%	100%	97%	58%	86%	86%	73%	19%	56%	28%	33%	28%

In general, the PMHPs designed scientifically sound studies that were supported by using key research principles, with 86 percent of the Design stage evaluation elements receiving a *Met* score. The PMHPs had opportunities for improvement in Activities V (sampling) and VI (data collection), with 58 percent and 86 percent of elements being scored *Met* in these two activities, respectively. Six of the twelve PMHPs used a sample for their non-collaborative PIP; for these PMHPs, adequate documentation of sampling methods was a challenge. In Activity VI, the primary opportunity for improvement was accurate and consistent documentation of the plan for data analysis following collection of the data.

The percentage of evaluation elements receiving a *Met* score for the Implementation stage was 56 percent, which was lower than the Design stage. Following the trend across all non-collaborative PIPs, the PMHPs performed better in Activity VII (data analysis), with 73 percent of evaluation elements scored *Met*, than in Activity VIII (improvement strategies), where only 19 percent of elements scored *Met*. In Activity VII, the PMHPs encountered challenges in accurately presenting measurement findings in the data table and ensuring the narrative interpretation included a statement about the overall success of the PIP. In Activity VIII, the PMHPs had opportunities for improvement across all evaluation elements.

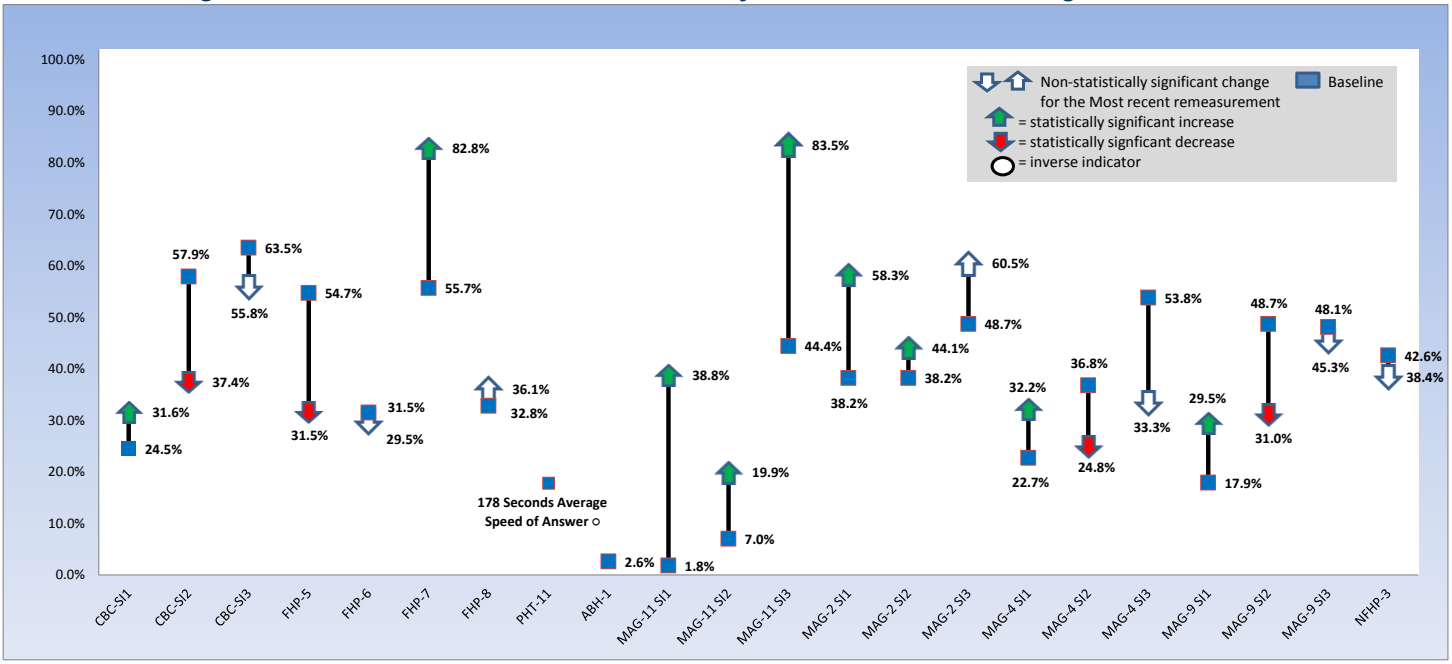
[8] The CWPMHP (Community Based Care Partnership) is included as part of all PMHPs for the PIP validation.

For the Outcomes stage, 28 percent of the evaluation elements received a *Met* score, suggesting further opportunities for improvement. In Activity IX, with 28 percent of the evaluation elements scored *Met*, the PMHPs did not use consistent measurement methods in 50 percent of the non-collaborative PIPs. Only 20 percent of the PIPs achieved improvement in study indicator rates during the current measurement period; and only 40 percent of the PIPs demonstrated statistically significant improvement over baseline across all study indicators during the life of the PIP. In Activity X, only 33 percent of PMHP PIPs sustained statistically significant improvement for all study indicators.

PMHP Non-Collaborative PIP Study Indicator Results and Comparisons

Figure 3-13 displays the baseline and most recent remeasurement period rates for the PMHP non-collaborative PIPs. An additional symbol, a circle next to the study indicator value label, is used to signify that the indicator was an inverse indicator where lower rates equal better performance. Additionally, it should be noted that the inverse study indicator reported by Jackson Health System/Public Health Trust of Dade County (Area 11) is an average (average number of seconds before call was answered) rather than a rate, as noted in the value label for this study indicator. Note: For those PIPs with multiple study indicators, a study indicator identifier follows the PMHP name (i.e., SI1 for Study Indicator 1 and SI2 for Study Indicator 2).

Figure 3-13—PMHPs Non-Collaborative Study Indicator Results Through SFY 2013–2014



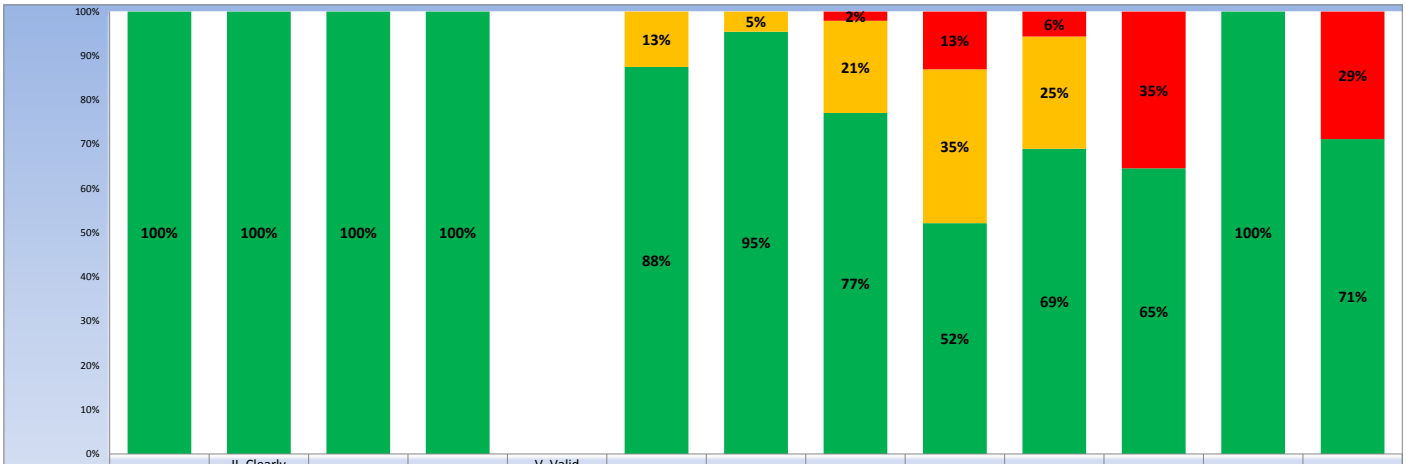
Twelve PMHPs reported a combined total of 22 study indicators. All PMHPs reported study indicators with remeasurement rates except for Public Health Trust (A11) and Lakeview Center dba Access Behavioral Health (Area 1), which had progressed to the point of reporting baseline data only. Nine of the 20 study indicators with remeasurement data (45 percent) demonstrated statistically significant improvement. Magellan Behavioral Health of Florida, Inc. (Area 11) achieved statistically significant improvement for all three study indicators in its non-collaborative PIP; this PMHP also documented the greatest improvement from baseline to the most recent

remeasurement and the highest remeasurement rate, with an increase from 44.4 percent to 83.5 percent in Study Indicator 3. In contrast, four PMHPs reported statistically significant declines in a total of four study indicators. There was wide variation in performance across all study indicators, with the most recent remeasurement rates ranging from 19.9 percent to 83.5 percent.

PMHP Collaborative PIP Validation Results

Figure 3-14 displays the percentage of evaluation elements achieving a *Met*, *Partially Met*, and *Not Met* validation score by activity and stage for the SFY 2013–2014 validation year. Twelve PMHP collaborative PIPs were validated. None of the PMHPs used sampling for the collaborative PIP; therefore, no data are presented for Activity V. Percentage totals may not equal 100 due to rounding.

Figure 3-14—PMHPs Collaborative *Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis* PIP Validation Scores by Activity and Study Stage



	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)*	VI. Accurate Complete Data Collection	Design Total	VII. Sufficient Data Analysis and Interpretation	VIII. Appropriate Improvement Strategies	Implementation Total	IX. Real Improvement Achieved	X. Sustained Improvement Achieved	Outcomes Total
Not Met	0%	0%	0%	0%		0%	0%	2%	13%	6%	35%	0%	29%
Partially Met	0%	0%	0%	0%		13%	5%	21%	35%	25%	0%	0%	0%
Met	100%	100%	100%	100%		88%	95%	77%	52%	69%	65%	100%	71%

***No data are displayed for Activity V because none of the PIPs involved sampling techniques.**

The PMHPs designed scientifically sound studies that were supported by using key research principles, with 95 percent of the Design evaluation elements receiving a *Met* score. Activity VI (data collection) was the only activity in the Design stage with less than 100 percent of the evaluation elements receiving a *Met* score. The technical design of the PIPs was sufficient to measure and monitor the outcomes associated with the PMHPs' improvement strategies. The PMHPs' achievements in the Design stage allowed for successful progression to the next stage of the PIP process.

The percentage of elements receiving a *Met* score for the Implementation stage was 69 percent, which was the lowest score among the three PIP stages. Similar to the HMOs and PSNs, the PMHPs performed better in Activity VII (data analysis), with 77 percent of elements being scored *Met*, than in Activity VIII (improvement strategies), with 52 percent of elements being scored *Met*. This pattern is consistent with the scoring trend among all collaborative PIPs related to the shift to the

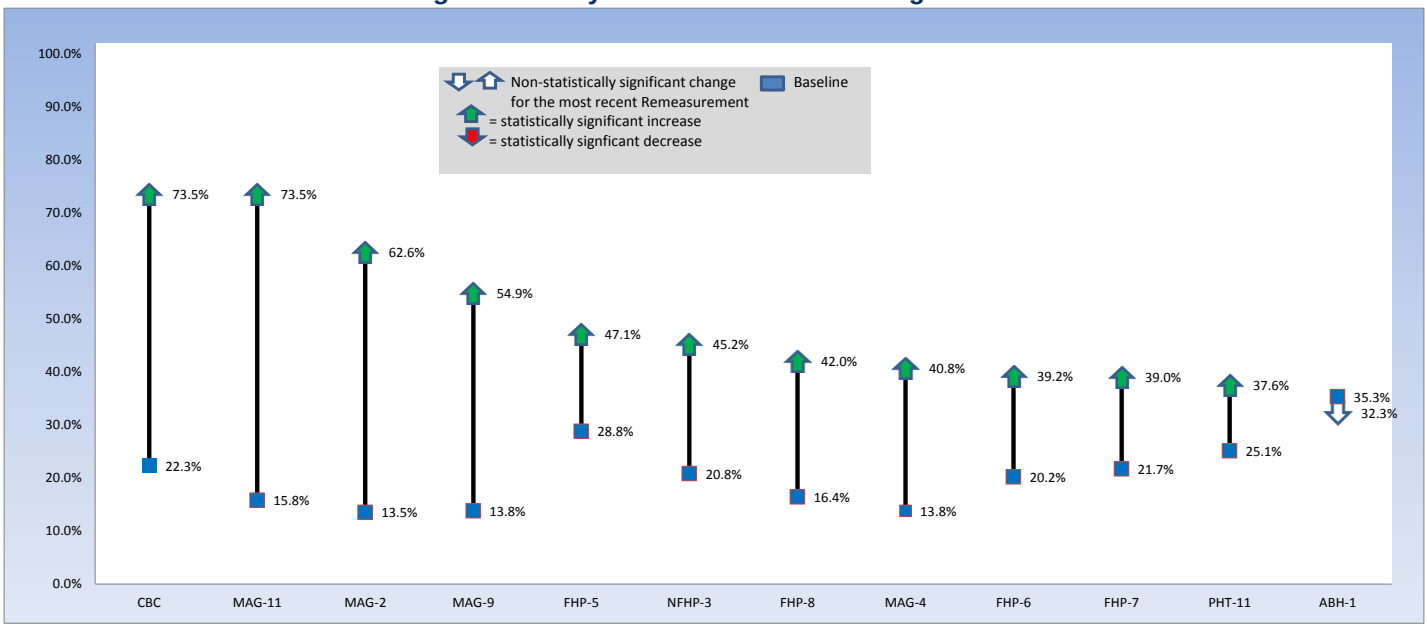
outcomes-focused methodology and critical analysis of improvement strategies. It is expected that performance improvements in Activity VIII will lead to greater success in the Outcomes stage.

In the Outcomes stage, the PMHPs received a *Met* score for 71 percent of the evaluation elements. Within this stage, 65 percent of the elements in Activity IX (real improvement) received a *Met* score, and 100 percent of the elements in Activity X (sustained improvement) received a *Met* score. The activity-specific scores suggest that while the PMHPs have opportunities to improve achieving statistically significant improvement, all PMHPs that had successfully achieved significant improvement in previous years were able to successfully sustain the improvement for the 2013–2014 validation cycle.

PMHP Collaborative PIP Study Indicator Results and Comparisons

Figure 3-15 displays the baseline and most recent remeasurement period rates by PMHPs for the *Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis* collaborative PIP.

Figure 3-15—PMHPs Collaborative *Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis* Study Indicator Results Through SFY 2013–2014



Twelve PMHPs reported a combined total of 12 study indicators. All PMHPs reported study indicators with baseline and remeasurement rates. Eleven of the 12 PMHPs (92 percent) demonstrated statistically significant improvement over baseline with remeasurement rates ranging from 37.6 percent to 73.5 percent. Two PMHPs, Community Based Care Partnership and Magellan Behavioral Health of Florida (Area 11), reported the highest remeasurement rate (both at 73.5 percent). The greatest improvement, 57.7 percentage points, was documented by Magellan Behavioral Health of Florida, Inc. (Area 11). Lakeview Center dba Access Behavioral Health was the only PMHP that reported a non-statistically significant decline from the baseline rate and the most recent remeasurement.

Conclusions and Recommendations

The PMHPs collected and reported baseline through Remeasurement 5 results for the *Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis* collaborative PIP. All but one of the PMHPs demonstrated statistically significant improvement over the baseline rate at the current remeasurement. While most of the PIPs demonstrated significant improvement, the most recent remeasurement period rates were at or below 50 percent for eight of the 12 PMHP collaborative PIPs (see Figure 3-15). The non-collaborative PIPs produced mixed results with study indicator rates from the most recent remeasurement period ranging from below 20 percent to above 80 percent. Only two PMHPs, Florida Health Partners (Area 7) and Magellan Behavioral Health of Florida, Inc. (Area 11), achieved statistically significant improvement over baseline at the current remeasurement period across all study indicators in the non-collaborative PIP (see Figure 3-13).

Although the PMHPs were discontinued due to the transition to Statewide Medicaid Managed Care (SMMC), many of the recommendations HSAG developed in response to performance by the PMHPs in the SFY 2013–2014 validation cycle can be applied to ongoing or future PIPs. Considering the PMHPs' performance on the collaborative and non-collaborative PIPs and the individual PIP requirements, HSAG recommends the following strategies:

AHCA

- Identify statewide goals or expected levels of performance for the study indicators in all new state-mandated PIPs with HSAG's assistance.
- Provide opportunities for plans that achieve statistically significant improvement in remeasurement periods to discuss lessons learned and successful improvement strategies with all plans.
- Relate to new and continuing plans the appropriate recommendations below that continue to be relevant for current and future PIPs.

PMHPs

- Verify that all information and results documented in the PIP Summary Form are accurate.
- Ensure that all data analysis, interpretation of results, and statistical testing are accurate and documented consistently throughout the PIP.
- Continue to ensure that performance measure results validated by HSAG and reported to AHCA are consistent with the results reported in the collaborative PIP submissions.
- Contact HSAG for technical assistance on how to conduct statistical testing, if needed.
- Integrate proven quality improvement processes, such as the Plan-Do-Study-Act (PDSA) cycle, into the PIPs to ensure a robust causal/barrier analysis, identifying the root causes affecting outcomes improvement.
- Conduct an annual causal/barrier and drill-down analysis in addition to periodic analyses of the most recent data. The plans must accurately document the analysis, describing the work group or committee involved and process and/or tools used. Documentation should provide the data, identified barriers, and interventions logically linked to specific barriers.
- Conduct barrier analyses more frequently than annually. Analysis should also be performed as a plan evaluates the effectiveness of interventions to determine if adjustments are needed to make interventions more effective.

- Prioritize identified barriers and ensure there is a direct link between each intervention and its associated barrier.
- Document in the PIP Summary Form only the targeted interventions implemented to address the specific barriers identified.
- Have a process in place to evaluate the efficacy of each intervention and determine if it is having the desired effect. Each intervention's evaluation results should be included in the PIP documentation.
- Use and document problem-solving techniques to revise or replace ongoing interventions that are deemed ineffective, to achieve the desired improvement in the study indicator(s).
- Incorporate into standard processes and practices those interventions that are determined to be successful.
- Refer to the SFY 2013–2014 PIP Validation Tool and address all *Points of Clarification* and all *Partially Met* and *Not Met* scores.
- Refer to the PIP Summary Form Completion Instructions to ensure they are addressing all documentation requirements for each applicable evaluation element and activity completed in the PIP Summary Form.

PMHP Follow-Up on Prior Year Recommendations

Based on the percentage of overall *Met* validation scores in each stage of the PIP, across all PIPs validated, the PMHPs did not appear to be addressing HSAG's recommendations provided in the SFY 2012–2013 validation tools. The percentage of evaluation elements receiving a *Met* score declined from SFY 2012–2013 to SFY 2013–2014 for all three PIP stages. In the Design stage, the percentage of *Met* scores declined from 97 percent to 90 percent. The declines were greater in the subsequent PIP stages, with a decline from 89 percent to 62 percent in the Implementation stage and a decline from 81 percent to 53 percent in the Outcomes stage. The findings suggest that the PMHPs should address HSAG's recommendations regarding quality improvement processes and strategies and data reporting and analysis. Addressing the recommendations should facilitate more effective quality improvement processes, greater improvement in outcomes, and subsequent improvements in validation scores in each PIP stage.

SIPPs

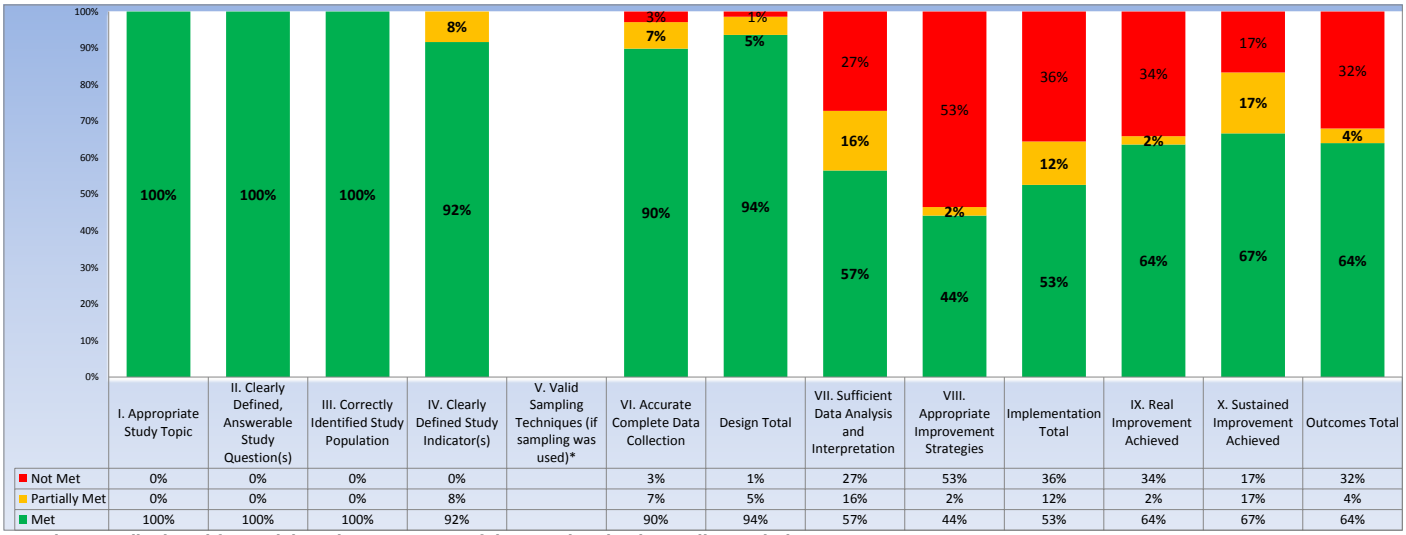
SIPP Non-Collaborative PIP Validation Results

HSAG did not validate SIPP non-collaborative PIPs for SFY 2012–2013.

SIPP Collaborative PIP Validation Results

HSAG validated 12 collaborative SIPP PIPs for SFY 2013–2014. Figure 3-16 displays the percentage of evaluation elements achieving a *Met*, *Partially Met*, and *Not Met* validation score by activity and stage for the SFY 2013–2014 validation year. None of the SIPPs used sampling for the collaborative PIP; therefore, no data are presented for Activity V.

Figure 3-16—SIPPs Collaborative *Seclusion and Restraints* PIP Validation Scores by Activity and Study Stage



	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)*	VI. Accurate Complete Data Collection	Design Total	VII. Sufficient Data Analysis and Interpretation	VIII. Appropriate Improvement Strategies	Implementation Total	IX. Real Improvement Achieved	X. Sustained Improvement Achieved	Outcomes Total
Not Met	0%	0%	0%	0%		3%	1%	27%	53%	36%	34%	17%	32%
Partially Met	0%	0%	0%	8%		7%	5%	16%	2%	12%	2%	17%	4%
Met	100%	100%	100%	92%		90%	94%	57%	44%	53%	64%	67%	64%

* **No data are displayed for Activity V because none of the PIPs involved sampling techniques.**

The SIPPs designed scientifically sound studies that were supported by using key research principles, with 94 percent of the Design evaluation elements receiving a *Met* score. The SIPPs achieved a *Met* score for 100 percent of the evaluation elements in Activities I (study topic), II (study question), and III (study population). The SIPPs had opportunities for improvement in Activity IV (study indicators) and Activity VI (data collection); although the percentages of evaluation elements receiving a *Met* score were high for these two activities (92 percent and 90 percent, respectively), some minor opportunities for improvement existed nonetheless. In Activity IV, some SIPPs did not document clear and complete study indicator definitions. In Activity VI, opportunities for improvement included documentation of the manual data collection tool, evaluation of administrative data completeness, and a thorough description of the data analysis plan. Aside from documentation omissions in Activities IV and VI, the technical design of the PIPs was sufficient to measure and monitor the outcomes associated with the SIPPs' improvement strategies.

The percentage of evaluation elements receiving a *Met* score for the Implementation stage was 53 percent, which was the lowest score among the three PIP stages. The SIPPs performed better in Activity VII (data analysis), with 57 percent of elements scored *Met*, than in Activity VIII (improvement strategies), with 44 percent of elements scored *Met*; however, there were opportunities for improvement in both activities. In Activity VII, the SIPPs had room for improvement in all of the evaluation elements, especially in the areas of statistical testing and clear reporting of the data and interpretation of the results. In Activity VIII, while 100 percent of the SIPPs implemented system-wide interventions, many SIPPs did not document an effective

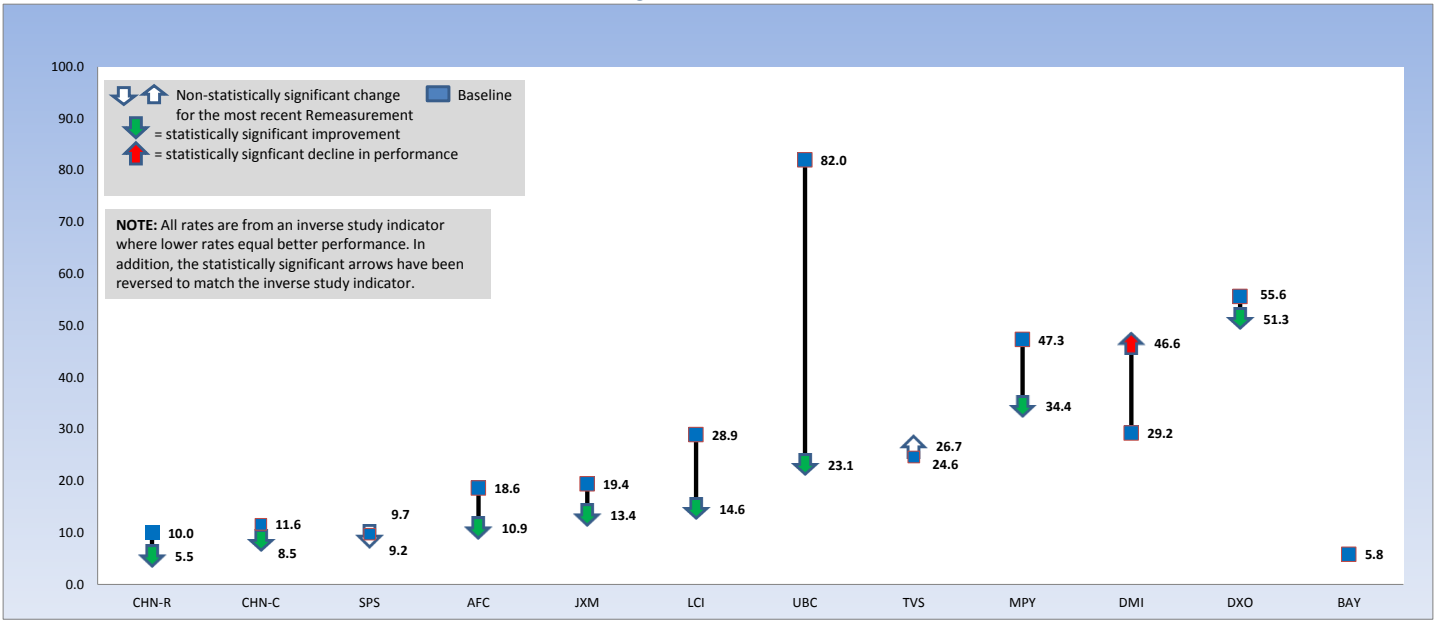
causal/barrier analysis process, evaluate the effectiveness of interventions, or revise interventions when improved outcomes were not achieved.

In the Outcomes stage, the SIPPs received a *Met* score for 64 percent of the evaluation elements. The performance in Activity IX (real improvement) and Activity X (sustained improvement) was similar, with 64 percent and 67 percent of the evaluation elements in each activity receiving *Met* scores, respectively. The SIPPs' challenges were related to achieving statistically significant improvement and sustaining improvement.

SIPP Collaborative PIP Study Indicator Results and Comparisons

Figure 3-17 displays the baseline and most recent remeasurement period rates by SIPPs for the *Seclusion and Restraints* collaborative PIP, Study Indicator 1—*the rate of restraints use during the measurement year*. Note: The direction of the arrows has been reversed to represent the inverse nature of the study indicators used in the *Seclusion and Restraints* collaborative PIP. A down arrow equals improvement while an up arrow equals a decline.

Figure 3-17—SIPPs Collaborative *Seclusion and Restraints* Study Indicator 1—*Restraints* Results Through SFY 2013–2014

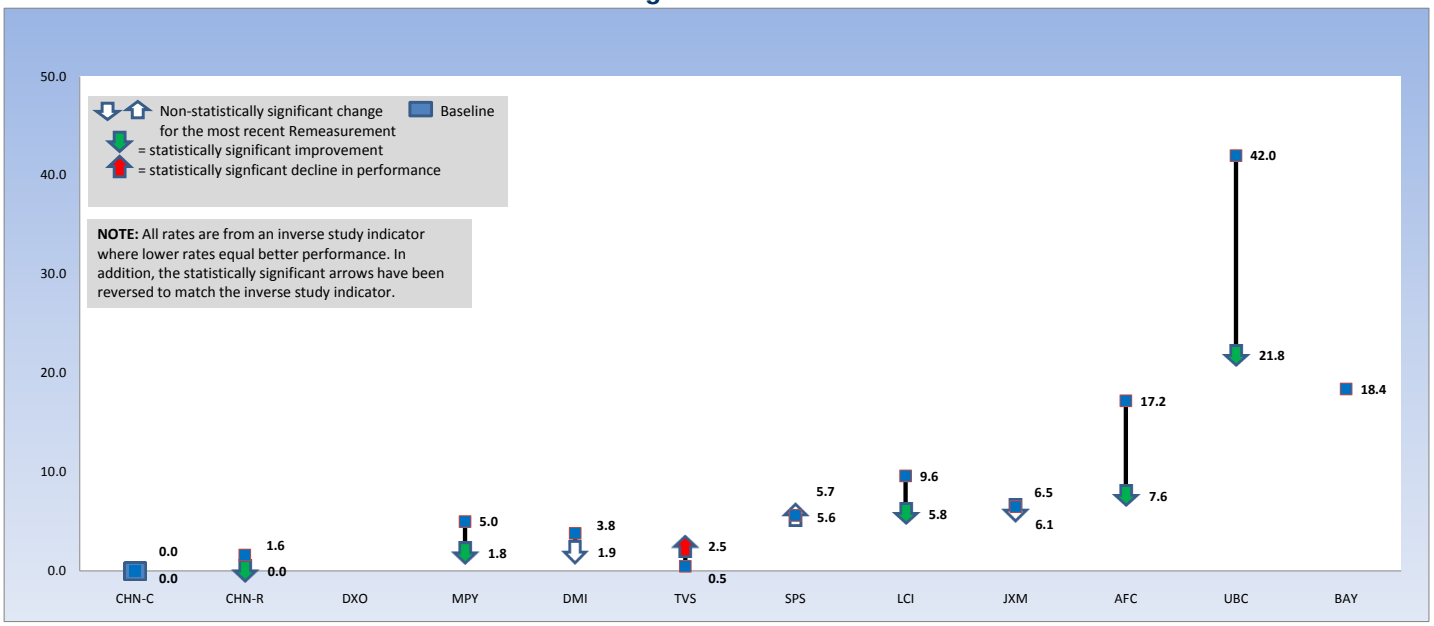


Twelve SIPPs reported a combined total of 12 results for Study Indicator 1. All SIPPs reported remeasurement rates for Study Indicator 1 except BayCare Behavioral Health, which had not progressed to the point of reporting remeasurement data. Eight of the 11 SIPPs reporting remeasurement data (73 percent) demonstrated statistically significant improvement from baseline to the most recent remeasurement period. Citrus Health Network, Inc.—RITS demonstrated the lowest remeasurement rate for Study Indicator 1 (a lower rate is better for this indicator) at 5.5 restraints per 1,000 bed days. The greatest improvement was documented by University Behavioral Center, with a decrease of 58.9 restraints per 1,000 bed days.

Figure 3-18 displays the baseline and most recent remeasurement period rates by SIPPs for the *Seclusion and Restraints* collaborative PIP, Study Indicator 2—*the rate of seclusion use during the*

measurement year. Note: The direction of the arrows has been reversed to represent the inverse nature of the study indicators. A down arrow equals improvement while an up arrow equals a decline. Devereux Orlando did not use seclusion; therefore, no data are presented for this SIPP.

Figure 3-18—SIPPs Collaborative *Seclusion and Restraints* Study Indicator 2 *Seclusion* Results Through SFY 2013–2014



Ten of the 12 SIPPs reported baseline and remeasurement data for Study Indicator 2. The two SIPPS that did not have both baseline and remeasurement data were BayCare Behavioral Health, which reported only baseline data, and Devereux Orlando, which does not use seclusion and did not report seclusion rates. One of the 10 SIPPs reporting baseline and remeasurement data, Citrus Health Network, Inc.—CATS, maintained a rate of zero seclusions per 1,000 bed days at both baseline and the most recent remeasurement period. Five of the 10 SIPPs achieved a statistically significant decrease (a lower rate is better for this indicator) between baseline and the most recent remeasurement. The greatest improvement was documented by University Behavioral Center, with a reduction of 20.2 seclusions per 1,000 bed days; however, its remeasurement rate of 21.8 seclusions per 1,000 bed days remained higher than the baseline and remeasurement rates of all other SIPPs. Two SIPPs reported increases in the rate of seclusions (a lower rate is better for this indicator) from baseline to the most recent remeasurement; The Vines reported a statistically significant increase, and Sandy Pines reported a non-statistically significant increase in the study indicator rate.

Conclusions and Recommendations

The SIPP collaborative PIP, *Seclusion and Restraints*, progressed to reporting baseline through Remeasurement 3 results. Eight (73 percent) of the 11 SIPPs reporting remeasurement data demonstrated statistically significant improvement in restraint use from baseline to the most recent measurement period. For seclusion use, 50 percent of the SIPPs reported statistically significant improvement over baseline. For both study indicators, an opportunity for improvement exists.

Although the SIPPs were discontinued due to the transition to SMMC, many of the recommendations HSAG developed in response to performance by the SIPPs in the SFY 2013–2014 validation cycle can be applied to ongoing or future PIPs. Considering the SIPPs' performance on the collaborative PIPs and the individual PIP requirements, HSAG recommends the following strategies:

AHCA

- Identify statewide goals or expected levels of performance for the study indicators in all new state-mandated PIPs with HSAG's assistance.
- Provide opportunities for plans that achieve statistically significant improvement in remeasurement periods to discuss lessons learned and successful improvement strategies with all plans.
- Relate to new and continuing plans the appropriate recommendations below that continue to be relevant for current and future PIPs.

SIPPs

- Verify that all information and results documented in the PIP Summary Form are accurate.
- Ensure that all data analysis, interpretation of results, and statistical testing are accurate and documented consistently throughout the PIP.
- Continue to ensure that performance measure results validated by HSAG and reported to AHCA are consistent with the results reported in the collaborative PIP submissions.
- Contact HSAG for technical assistance on how to conduct statistical testing, if needed.
- Integrate proven quality improvement processes, such as the Plan-Do-Study-Act (PDSA) cycle, into their PIPs to ensure a robust causal/barrier analysis, identifying the root causes affecting outcomes improvement.
- Conduct an annual causal/barrier and drill-down analysis in addition to periodic analyses of their most recent data. The plans must accurately document the analysis, describing the work group or committee involved and process and/or tools used. Documentation should provide the data, identified barriers, and interventions logically linked to specific barriers.
- Conduct barrier analyses more frequently than annually. Analysis should also be performed as a plan evaluates the effectiveness of interventions to determine if adjustments are needed to make interventions more effective.
- Prioritize their identified barriers and ensure there is a direct link between each intervention and its associated barrier.
- Document in the PIP Summary Form only the targeted interventions implemented to address the specific barriers identified.
- Have a process in place to evaluate the efficacy of each intervention and determine if it is having the desired effect. The results of each intervention's evaluation should be included in the PIP documentation.
- Use and document problem-solving techniques to revise or replace ongoing interventions that are deemed ineffective, to achieve the desired improvement in the study indicator(s).
- Incorporate into standard processes and practices those interventions that are determined to be successful.

- Refer to the SFY 2013–2014 PIP Validation Tool and address all *Points of Clarification* and all *Partially Met* and *Not Met* scores.
- Refer to the PIP Summary Form Completion Instructions to ensure they are addressing all documentation requirements for each applicable evaluation element and activity completed in the PIP Summary Form.

SIPP Follow-Up on Prior Year Recommendations

Based on the overall *Met* validation scores in the three stages of the PIP for all PIPs validated, the SIPPs appeared to be addressing and incorporating some but not all of HSAG's feedback provided in the prior year's validation tools. The SIPPs were the only plan type that demonstrated an increase from SFY 2012–2013 to SFY 2013–2014 in the overall percentage of *Met* validation scores in both the Design and Outcomes stages. There was a decline in the percentage of *Met* validation scores in the Implementation stage.

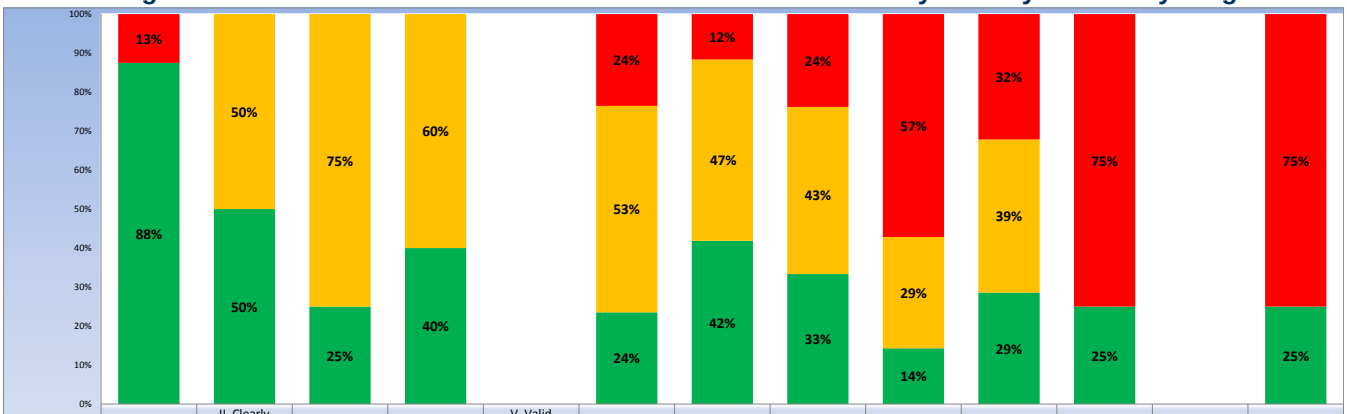
For the Design stage, 90 percent of all evaluation elements were *Met* in SFY 2012–2013. This percentage improved to 94 percent in SFY 2013–2014. For the Implementation stage, the percentage declined from 65 percent to 53 percent in SFY 2013–2014. In the Outcomes stage, the percentage improved from 57 percent to 64 percent; however, more than 33 percent of the scores in the Outcomes stage still received less than a *Met* validation score. As with the other plan types, the area with the greatest lack of compliance for addressing HSAG recommendations was in conducting appropriate quality improvement activities to identify accurate barriers and develop effective interventions. Without appropriate quality improvement strategies, the SIPPs will find it challenging to achieve real improvement and sustain this improvement over time.

PDHPs

PDHP Non-Collaborative PIP Validation Results

Figure 3-19 displays the percentage of evaluation elements achieving a *Met*, *Partially Met*, and *Not Met* validation score by activity and stage for the SFY 2013–2014 validation year. Four PDHP non-collaborative PIPs were validated for SFY 2013–2014. None of the PDHPs used sampling for the non-collaborative PIPs, and none had progressed to completing Activity X; therefore, no data are presented for Activities V or X. Percentage totals may not equal 100 due to rounding.

Figure 3-19—PDHPs Non-Collaborative PIP Validation Scores by Activity and Study Stage



	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)*	VI. Accurate Complete Data Collection	Design Total	VII. Sufficient Data Analysis and Interpretation	VIII. Appropriate Improvement Strategies	Implementation Total	IX. Real Improvement Achieved	X. Sustained Improvement Achieved*	Outcomes Total
Not Met	13%	0%	0%	0%		24%	12%	24%	57%	32%	75%		75%
Partially Met	0%	50%	75%	60%		53%	47%	43%	29%	39%	0%		0%
Met	88%	50%	25%	40%		24%	42%	33%	14%	29%	25%		25%

***No data are displayed for Activity V and Activity X because none of the PIPs used sampling techniques (Activity V) or progressed to the point of being assessed for sustained improvement (Activity X).**

The 2013–2014 validation was the first time that the PDHPs participated in PIP validation with HSAG. In general, their performance suggests that there is a need for additional training on the PIP process and PIP documentation requirements.

In the Design stage, 42 percent of the evaluation elements across the four PDHP PIPs received a *Met* validation score. The scores ranged from a low of 24 percent in Activity VI (data collection) to a high of 88 percent in Activity I (study topic). Activity V was not scored because neither of the PDHPs used a sample for the PIPs. The PDHPs had opportunities for improvement in clearly stating the study question in Activity II, accurately describing the study population in Activity III, and completely defining the study indicator(s) in Activity IV. In Activity VI (data collection), the PDHPs had opportunities for improvement in all six evaluation elements with the most prevalent issues being identified in the areas of defining the data elements, describing a systematic data collection process, and describing the data analysis plan.

The overall percentage of evaluation elements receiving a *Met* score for the Implementation stage was 29 percent, which was lower than the Design stage. The PDHPs had opportunities for improvement in both Activity VII (data analysis) and Activity VIII (improvement strategies), where 33 percent and 14 percent of evaluation elements were scored *Met* in each activity, respectively. There were opportunities for improvement throughout Activity VII, especially in the areas of narrative interpretation of findings and accuracy of the data table. Two of the four PIPs progressed to reporting improvement strategies in Activity VIII; there were opportunities for improvement throughout this activity for both PIPs.

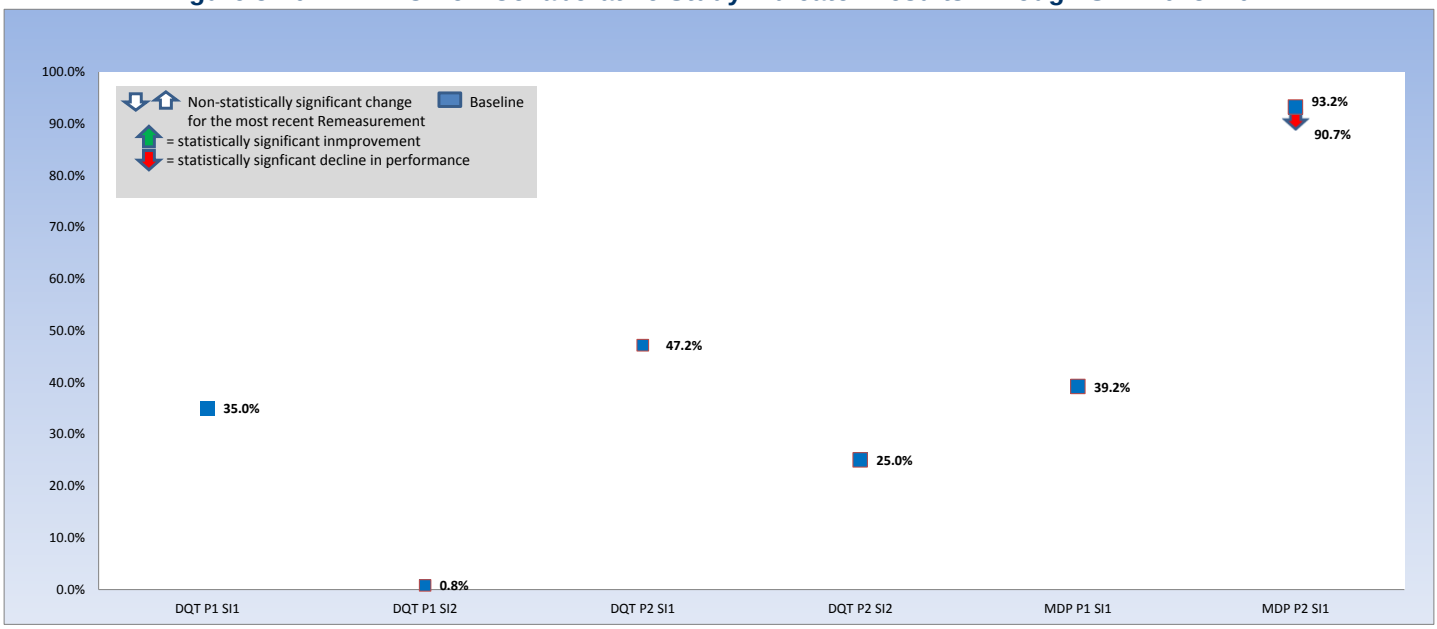
Only one PIP progressed to the point of being evaluated at the Outcomes stage; specifically, the PIP included baseline and Remeasurement 1 data and was validated through Activity IX (real improvement). The remaining three PIPs included only baseline data and, therefore, did not progress to the Outcomes stage. The PIP that progressed to Activity IX did not demonstrate improvement in study indicator rates from baseline to the first remeasurement.

Overall, the PDHPs have considerable room for improvement throughout the PIP process. The percent of evaluation elements that received a *Met* validation score for each PIP stage was 42 percent for the Design stage, 29 percent for the Implementation stage, and 25 percent for the Outcomes stage. For the PDHPs to achieve improved outcomes, deficiencies in the PIP study design will first need to be addressed; then, the PDHPs will need to ensure that a thorough and ongoing quality improvement process is in place to develop and implement effective improvement strategies. Once the first two PIP stages have been successfully completed, the PDHPs will be poised to achieve improvements at the Outcomes stage.

PDHP Non-Collaborative PIP Study Indicator Results and Comparisons

Figure 3-20 displays the baseline and most recent remeasurement period rates for the PDHP non-collaborative PIPs. Note: Each PDHP submitted two PIPs for validation. The PIPs are distinguished in the figure by a PIP identifier that follows the PDHP name (i.e., P1 for PIP 1 and P2 for PIP 2). For those PIPs with multiple study indicators, a study indicator identifier follows the PIP identifier (i.e., SI1 for Study Indicator 1 and SI2 for Study Indicator 2).

Figure 3-20—PDHPs Non-Collaborative Study Indicator Results Through SFY 2013–2014



Two PDHPs reported a combined total of six study indicators for their non-collaborative PIPs. DentaQuest of Florida (DQT) implemented two PIPs with two study indicators in each PIP, and MCNA Dental Plans (MDP) implemented two PIPs with one study indicator in each PIP. Only one of the PDHPs, MCNA Dental Plans, progressed to the point of reporting remeasurement data for one of its PIPs; the remaining PIPs included baseline data only. The baseline rates for the six study indicators ranged from 0.8 percent to 93.2 percent. The one PIP with remeasurement data demonstrated a statistically significant decline from baseline to the most recent remeasurement period.

Conclusions and Recommendations

The PDHPs appeared to have opportunities for improvement beyond those that applied to all other plan types. The PDHPs participated in PIP validation for the first time during the SFY 2013–2014 validation cycle. Only one of the four PIPs progressed to the point of reporting remeasurement results, and that PIP demonstrated a statistically significant decline in the study indicator rate. Across the four PIPs, only 42 percent of validation evaluation elements in the Design stage, 29 percent in the Implementation stage, and 25 percent in the Outcomes stage received a *Met* score. In general, the PDHPs' performance suggests a need for additional training on the PIP process and PIP documentation requirements. HSAG offers the following recommendations specifically for the PDHPs, in addition to the recommendations for all plans.

Although the PDHPs were discontinued due to the transition to SMMC, many of the recommendations HSAG developed in response to performance by the PDHPs in the SFY 2013–2014 validation cycle can be applied to ongoing or future PIPs. Considering the PDHPs' performance on the PIPs and the individual PIP requirements, HSAG recommends the following strategies:

AHCA

- Identify statewide goals or expected levels of performance for the study indicators in all new state-mandated PIPs with HSAG's assistance.
- Provide opportunities for plans that achieve statistically significant improvement in remeasurement periods to discuss lessons learned and successful improvement strategies with all plans.
- Relate to new and continuing plans the appropriate recommendations below that continue to be relevant for current and future PIPs.

PDHPs

- Ensure that the PIP study question is clearly stated in the X/Y format and aligns with the study indicator(s).
- Ensure that the PIP study population represents the population identified in the study question and aligns with the study indicator(s). Documentation of the study population should clearly define inclusion and exclusion criteria, enrollment criteria, and any billing codes used to identify the population.
- Ensure that the study indicators for the PIP align with the study question and are clearly defined.
- Document fully the PIP data collection methodology. The data collection methods should clearly define all data elements, include a systematic data collection process, and document a plan for data analysis.
- Ensure that data are presented accurately and consistently in table and narrative formats when presenting PIP study indicator results. The PIP documentation should include an interpretation of the statistical significance of remeasurement results and overall success of the PIP.
- Verify that all information and results documented in the PIP Summary Form are accurate.
- Ensure that all data analysis, interpretation of results, and statistical testing are accurate and documented consistently throughout the PIP.

- Ensure that performance measure results validated by HSAG and reported to AHCA are consistent with the results reported in the collaborative PIP submissions.
- Contact HSAG for technical assistance on how to conduct statistical testing, if needed.
- Integrate proven quality improvement processes, such as the Plan-Do-Study-Act (PDSA) cycle, into their PIPs to ensure a robust causal/barrier analysis, identifying the root causes affecting outcomes improvement.
- Conduct an annual causal/barrier and drill-down analysis in addition to periodic analyses of their most recent data. The plans must accurately document the analysis, describing the work group or committee involved and process and/or tools used. Documentation should provide the data, identified barriers, and interventions logically linked to specific barriers.
- Conduct barrier analyses more frequently than annually. Analysis should also be performed as a plan evaluates the effectiveness of interventions to determine if adjustments are needed to make interventions more effective.
- Prioritize their identified barriers and ensure there is a direct link between each intervention and its associated barrier.
- Document in the PIP Summary Form only the targeted interventions implemented to address the specific barriers identified.
- Have a process in place to evaluate the efficacy of each intervention and determine if it is having the desired effect. Each intervention's evaluation results should be included in the PIP documentation.
- Use and document problem-solving techniques to revise or replace ongoing interventions that are deemed ineffective, to achieve the desired improvement in the study indicator(s).
- Incorporate into standard processes and practices those interventions that are determined to be successful.
- Refer to the SFY 2013–2014 PIP Validation Tool and address all *Points of Clarification* and all *Partially Met* and *Not Met* scores.
- Refer to the PIP Summary Form Completion Instructions to ensure they are addressing all documentation requirements for each applicable evaluation element and activity completed in the PIP Summary Form.

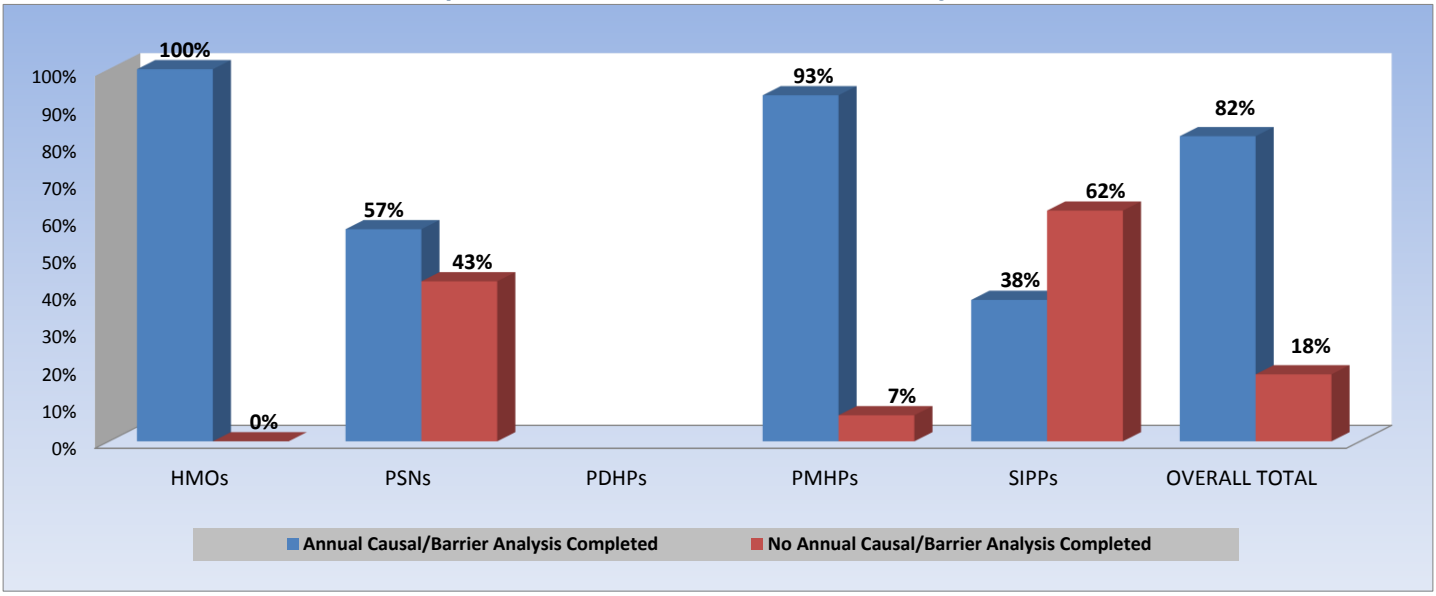
Notable Improvements Across All Plan Types

During the SFY 2013–2014 validation cycle, HSAG evaluated each plan's PIP study indicator results and identified those plans with statistically significant improvement above baseline for all study indicators and whether that improvement was sustained. For plans that met these criteria, HSAG performed an in-depth analysis of the plan's causal/barrier analysis and interventions, identifying those interventions that were notable improvements. Performing an annual causal/barrier analysis was a key component of the process to achieve desirable outcomes.

Figure 3-21 illustrates the percent of PIPs that achieved statistically significant improvement over baseline for all study indicators and had a documented causal/barrier analysis. Percentages are presented by plan type and overall. Both collaborative and non-collaborative PIPs were included.

No data are displayed for the PDHPs because none of the PDHP PIPs demonstrated statistically significant improvement over baseline for all study indicators.

Figure 3-21—Causal/Barrier Analysis Among PIPs That Achieved Statistically Significant Improvement Above Baseline for All Study Indicators



Across all plan types, a trend emerged, suggesting a direct relationship between performing an annual causal/barrier analysis and achieving statistically significant improvement, with 82 percent of all PIPs that had statistically significant improvement for all study indicators having a documented annual causal/barrier analysis. This pattern was consistent with the trend seen in three of the plan types—HMOs, PSNs, and PMHPs. The trend was most dramatic among the HMOs, with 100 percent, followed by the PMHPs with 93 percent, and finally, the PSNs with 57 percent of the PIPs demonstrating statistically significant improvement for all study indicators having a documented causal/barrier analysis. Only one plan type, SIPPs, did not follow the overall trend, with only 38 percent of the SIPPs achieving statistically significant improvement for all study indicators having documented a causal/barrier analysis. The pattern among SIPPs is substantially different than in the SFY 2012–2013 validation cycle, when 100 percent of the SIPP PIPs that achieved statistically significant improvement for all study indicators had a documented causal/barrier analysis. The small number of SIPP PIPs validated during the current cycle may explain the variability of results for this plan type.

For PIPs in which all study indicators achieved statistically significant improvement over baseline at the most recent remeasurement, HSAG identified innovative interventions that were associated with notable improvements.

Table 3-1 displays the plan type, plan name, study topic, notable intervention, and intervention type for PIPs that achieved statistically significant improvement above the baseline rate and sustained the improvement. All plan types and PIPs were included in the analysis to determine notable interventions, except for the PDHPs that did not achieve statistically significant improvement in any of their PIPs.

Table 3-1— Notable Interventions Associated With Statistically Significant Improvement Above Baseline for All Study Indicators				
Plan Type	**Plan Name**	**Study Topic**	**Notable Intervention**	**Intervention Type**
HMO	Amerigroup Community Care (Non-Reform)	*Well-Child Visits in the First 15 Months of Life—Six or More Visits (collaborative)*	Led a statewide initiative reminding providers of all the documentation requirements and supplied the providers with the Bright Futures forms.	Provider
HMO	WellCare Health Plans, Inc.—HealthEase of Florida, Inc. (Non-Reform) WellCare Health Plans, Inc.—Staywell of Florida, Inc. (Non-Reform)	*Well-Child Visits in the First 15 Months of Life—Six or More Visits (collaborative)*	Used the HEDIS Care Gap program that identified enrollees due for services at the time of an inbound call from an enrollee and supported an interactive HEDIS Online Portal (iHOP) for providers to access and update enrollee care gap data.	Enrollee/ System

Only three PIPs were identified for notable interventions during the SFY 2013–2014 validation cycle. All three PIPs were implemented by HMOs and shared the *Well-Child Visits in the First 15 Months of Life —Six or More Visits* collaborative PIP study topic. Two of the three PIPs, WellCare Health Plans, Inc.—HealthEase of Florida, Inc. (Non-Reform), and WellCare Health Plans, Inc.—Staywell of Florida, Inc. (Non-Reform), were identified for the same notable intervention, using the HEDIS Care Gap program during inbound enrollee calls in conjunction with iHOP to improve the well-child visit rate during the first 15 months of life. Amerigroup Community Care (Non-Reform) was identified for a statewide initiative targeting providers and providing information on the American Academy of Pediatrics Bright Futures initiative and documentation requirements. The three HMOs were part of the 11 Non-Reform HMOs that achieved statistically significant improvement for the collaborative PIP during the most recent measurement period (see Figure 3-6). Across all PIPs for both Reform and Non-Reform populations, 100 percent of the HMOs that achieved statistically significant improvement for all study indicators completed a causal/barrier analysis to support the development of appropriate and effective interventions (see Figure 3-21).

None of the PIPs implemented by the PSNs, PDHPs, PMHPs, or SIPPS were identified as having innovative or noteworthy interventions that could influence better access to, or quality of, care or health outcomes of the populations served, or promote better processes within the plan. Details of additional interventions implemented by each plan type are provided in Appendix C.

Validation of Performance Measures

The BBA requires states to ensure that their contracted plans collect and report performance measure data annually in accordance with 42 CFR 438.358. States can choose to directly perform the PMV activity mandated by CMS, or they can contract either with an agent that is not a managed care organization, or with an EQRO. AHCA contracted with HSAG to conduct the validation of performance measures for measures calculated and reported by MCOs and PIHPs for the CY 2013 measurement period.

HSAG was contracted to perform validation of performance measures on the five plan types: HMOs, PSNs, PMHPs/CWPMHP, LTC plans, and PDHPs. HSAG's role in the validation of performance measures was to ensure that validation activities were conducted as outlined in the CMS publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012[9] (CMS Performance Measure Validation Protocol). To determine if performance measure rates were collected, reported, and calculated according to the specifications required by the State, HSAG performed PMV audits for the PMHPs/CWPMHP during SFY 2013–2014 and for all HMOs/PSNs (including both Reform and Non-Reform plans[10]), PDHPs, and LTC plans during SFY 2014–2015. This section of the report includes the PMV audit findings and results for these plans. PMV activities were not conducted for SIPPs. Detailed PMV results may be found in the aggregate SFY 2014–2015 *Performance Measure Validation Findings Report.* Please refer to Appendix A of this report where the PMV methodology is described in greater detail and to Table F-2 in Appendix F for the plan names specific to the PMV reports.

HMOs and PSNs

AHCA required that each HMO and PSN undergo an NCQA HEDIS Compliance Audit on the performance measures selected for reporting. These audits were performed by NCQA-licensed organizations (LOs) during SFY 2013–2014.

Table 3-2 depicts the HMO/PSN HEDIS and AHCA-defined performance measures that were subject to validation. The table is organized by domains, such as pediatric care and women's care.

Table 3-2—Florida Medicaid Non-Reform and Reform HMO/PSN Performance Measures

Measures by Domain (Full Measure Name and Abbreviation)	Measure Type
Pediatric Care	
Well-Child Visits in the First 15 Months of Life (W15)	HEDIS

[9] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care-external-quality-review.html Accessed on: January 7, 2015.

[10] Reform refers to Florida's Medicaid Reform Pilot Program, which operates under an 1115 Research and Demonstration Waiver approved by CMS.

Table 3-2—Florida Medicaid Non-Reform and Reform HMO/PSN Performance Measures	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	HEDIS
Adolescent Well-Care Visits (AWC)	HEDIS
Lead Screening in Children (LSC)	HEDIS
Annual Dental Visit (ADV)	HEDIS
Childhood Immunization Status (Combinations 2 and 3) (CIS 2 and 3)	HEDIS
Immunizations for Adolescents (IMA)	HEDIS
Appropriate Testing for Children With Pharyngitis (CWP)	HEDIS
Follow-up Care for Children Prescribed ADHD Medication (ADD)	HEDIS
Women's Care	
Cervical Cancer Screening (CCS)	HEDIS
Chlamydia Screening in Women (CHL)	HEDIS
Breast Cancer Screening (BCS)	HEDIS
Prenatal and Postpartum Care (PPC)	HEDIS
Prenatal Care Frequency (PCF)	AHCA-defined
Living With Illness	
Comprehensive Diabetes Care (CDC)	HEDIS
Controlling High Blood Pressure (CBP)	HEDIS
Adult BMI Assessment (ABA)	HEDIS
Use of Appropriate Medications for People With Asthma (ASM)	HEDIS
Frequency of HIV Disease Monitoring Lab Tests (CD4) and (VL)	AHCA-defined
HIV-Related Medical Visits (HIVV)	AHCA-defined
Highly Active Anti-Retroviral Treatment (HAART)	AHCA-defined
Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy (ACE)	AHCA-defined
Lipid Profile Annually (LPA)	AHCA-defined
Use of Services	
Ambulatory Care (Outpatient and ED Visits per 1,000 MM) (AMB)	HEDIS
Access/Availability of Care	
Adults' Access to Preventive/Ambulatory Health Services (AAP)	HEDIS
Children and Adolescents' Access to Primary Care Practitioners (CAP)	HEDIS
Call Abandonment (CAB)[1]	HEDIS
Call Answer Timeliness (CAT)	HEDIS
Transportation Availability (TRA)	AHCA-defined
Transportation Timeliness (TRT)	AHCA-defined
Mental Health	
Follow-Up After Hospitalization for Mental Illness (FHM)	AHCA-defined
Antidepressant Medication Management (AMM)	HEDIS
Mental Health Readmission Rate (RER)	AHCA-defined
[1]This is a retired measure for HEDIS 2014. Nonetheless, plans were still required to report this measure to AHCA using CY 2013 data.	

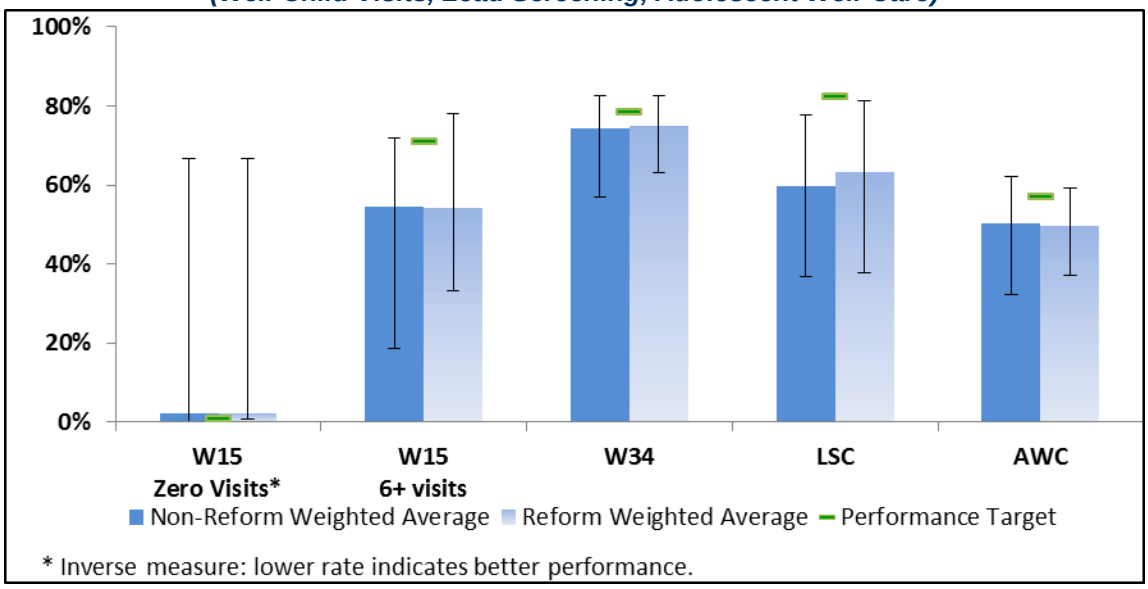
For this section of the report, performance measures, results, and plan comparisons are discussed by domain of care. AHCA developed performance targets for most of the HEDIS measures, using HEDIS national Medicaid HMO and preferred provider organization (PPO) 75th percentiles, both applicable to Florida's HMOs and PSNs.

Pediatric Care

Results

Figure 3-22 compares Non-Reform and Reform weighted averages for *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *6+ Visits*, *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life*, *Lead Screening in Children*, and *Adolescent Well-Care Visits*. The *Well-Child Visits in the First 15 Months of Life—Zero Visits* measure was an inverse measure; a lower rate indicated better performance. All of these measures have corresponding AHCA performance targets, as indicated by the green horizontal bars in Figure 3-22. The vertical black line in each bar denotes the magnitude of performance rate variation among plans (i.e., a longer line suggests wider variation).

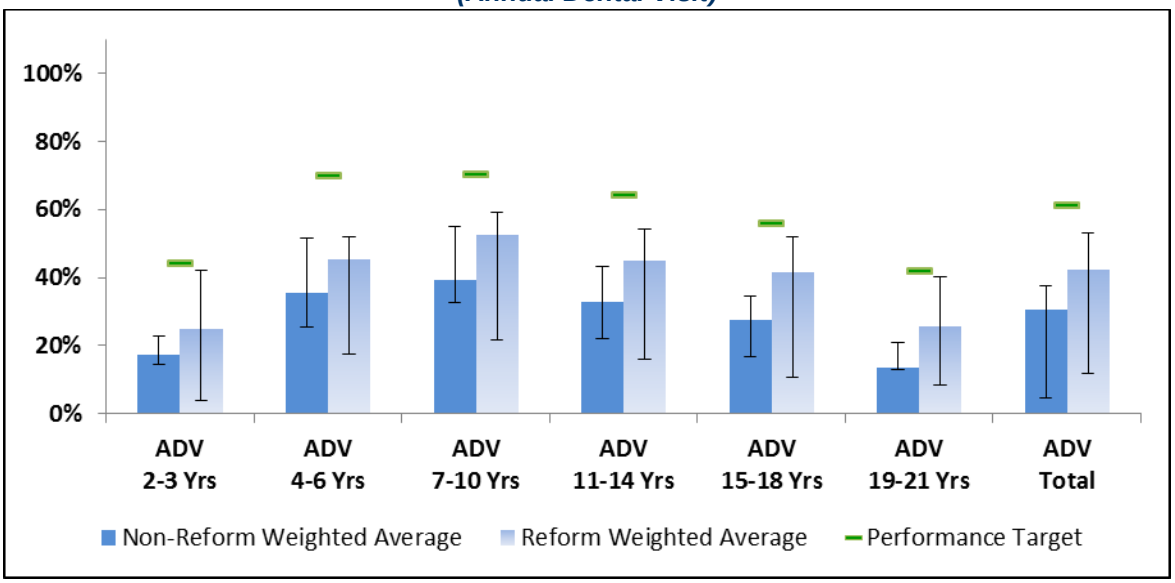
Figure 3-22—Florida Medicaid HEDIS 2014:
Weighted Average Compared With the AHCA Performance Target—Pediatric Care
(Well-Child Visits, Lead Screening, Adolescent Well-Care)



None of the weighted averages in this domain met the performance targets. Although the performance targets were met by some HMOs/PSNs (as denoted by the vertical black lines reaching above the green horizontal bars), the weighted averages were not. Statewide performance on *Lead Screening in Children* suggested the greatest possibility for improvement when compared to its performance target. For this measure, both Reform and Non-Reform weighted averages were at least 15 percentage points below the target. *Well-Child Visits in the First 15 Month of Life—Zero Visits* showed the greatest rate variation among HMOs/PSNs for Non-Reform and Reform. Nonetheless, this variation was due to both Preferred Care and Preferred Care-R reporting rates exceeding 60 percent. Rates for all other HMOs/PSNs did not exceed 13 percent.

Figure 3-23 compares Non-Reform and Reform weighted averages for *Annual Dental Visit*, which includes seven indicators (i.e., *2–3 years*, *4–6 years*, *7–10 years*, *11–14 years*, *15–18 years*, *19–21 years*, and *Total*). All of these measures have corresponding AHCA performance targets represented by the green horizontal bar. The vertical black line in each bar denotes the magnitude of performance rate variation among plans (i.e., a longer line suggests wider variation).

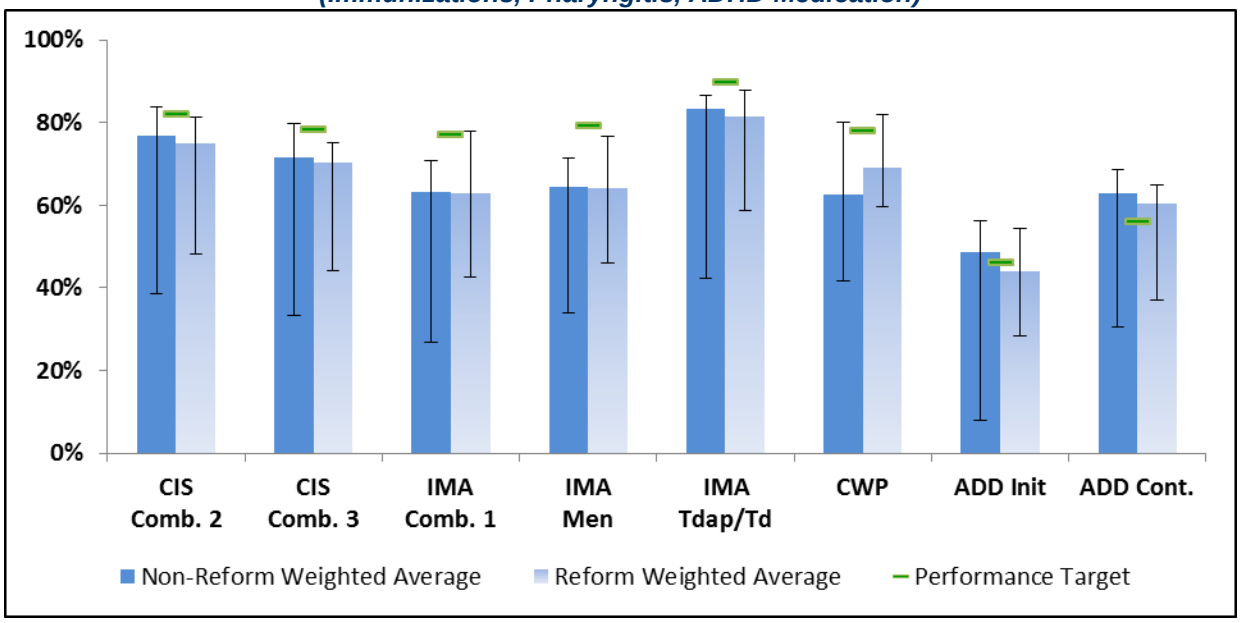
Figure 3-23—Florida Medicaid HEDIS 2014:
Weighted Average Compared With the AHCA Performance Target—Pediatric Care (Annual Dental Visit)



Neither the Reform nor Non-Reform weighted average met the performance target for any of the *Annual Dental Visit* indicators. In addition, no individual HMO/PSN rate met the performance target for any of the indicators. In general, Reform weighted averages showed better performance than Non-Reform weighted averages. Of all the indicators, the *4–6 years* age group suggested the greatest possibility for improvement when compared to its performance target. Both the Non-Reform and Reform weighted averages were at least 20 percentage points below the target.

Figure 3-24 compares Non-Reform and Reform weighted averages for *Childhood Immunization Status (Combinations 2 and 3)*, *Immunizations for Adolescents (Combination 1, Meningococcal*, and *Tdap/Td*), *Appropriate Testing for Children With Pharyngitis*, and *Follow-up Care for Children Prescribed ADHD Medication* (*Initiation Phase* and *Continuation and Maintenance Phase*). Performance targets, indicated by the horizontal green bars in Figure 3-24, were available for all of these measures. The vertical black line in each bar denotes the magnitude of performance rate variation among plans (i.e., a longer line suggests wider variation).

Figure 3-24—Florida Medicaid HEDIS 2014:
Weighted Average Compared With the AHCA Performance Target—Pediatric Care (Immunizations, Pharyngitis, ADHD Medication)



Both Non-Reform and Reform weighted averages met the performance target for *Children Prescribed ADHD Medication—Continuation and Maintenance Phase*. The Non-Reform weighted average also met the performance target for *Children Prescribed ADHD Medication—Initiation Phase*. Regarding all other measures in this domain, although some HMOs'/PSNs' rates exceeded the performance target, the overall weighted average did not. The Reform weighted average for *Children With Pharyngitis* was higher than that of Non-Reform, while Non-Reform weighted averages exceeded Reform weighted averages on all other measures.

Plan Comparison

Out of 24 Non-Reform HMOs/PSNs, six (Buena Vista, Freedom, Preferred Medical Plan, SFCCN, Sunshine, and Vista) reported at least four rates at or above the 90th percentile for this domain. Eight (Buena Vista, First Coast, Healthy PB, Integral, Medica, Molina, CareFlorida, and SFCCN) reported at least five rates below the 25th percentile. Most of the rates below the 25th percentile were from the *Annual Dental Visit* measure.

Out of 15 Reform HMOs/PSNs, one (Medica) reported at least four rates at or above the 90th percentile. Six (Humana, Medica, CareFlorida, SFCCN, Staywell, and Sunshine) reported at least five rates below the 25th percentile. Similar to the Non-Reform HMOs/PSNs, most of the low rates were from the *Annual Dental Visit* measure.

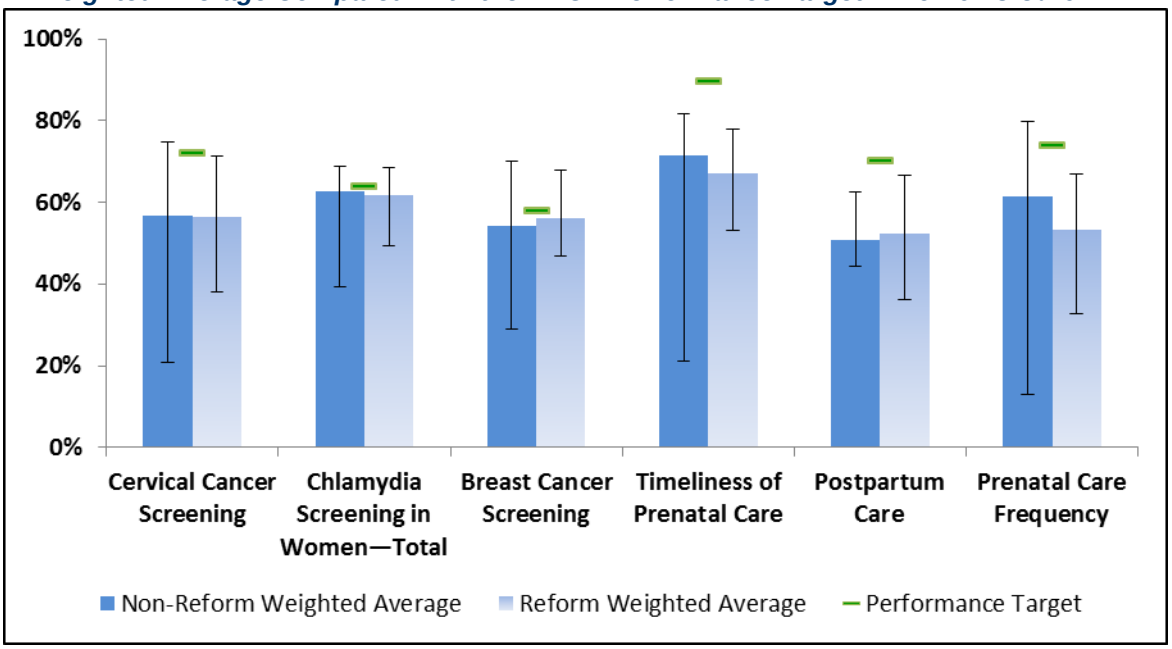
For this domain, it is possible to have at least four rates above the 90th percentile and five rates below the 25th percentile for the same plan.

Women's Care

Results

Figure 3-25 compares Non-Reform and Reform weighted averages for *Cervical Cancer Screening*, *Chlamydia Screening in Women—Total*, *Breast Cancer Screening*, *Timeliness of Prenatal Care*, *Postpartum Care*, and *Prenatal Care Frequency*. AHCA performance targets, indicated by the horizontal green bars in Figure 3-25, were available for all measures. The vertical black line in each bar denotes the magnitude of performance rate variation among plans (i.e., a longer line suggests wider variation).

Figure 3-25—Florida Medicaid HEDIS 2014:
Weighted Average Compared With the AHCA Performance Target—Women's Care



Neither the Reform nor Non-Reform weighted average met the AHCA performance target for any of the measures in this domain, although some HMOs'/PSNs' rates were higher than the performance targets. Non-Reform weighted averages were higher than Reform weighted averages for four of the six measures (*Cervical Cancer Screening*, *Chlamydia Screening in Women—Total*, *Timeliness of Prenatal Care* and *Prenatal Care Frequency)*, while Reform weighted averages were higher for *Breast Cancer Screening* and *Postpartum Care.*

Plan Comparison

Out of 24 Non-Reform HMOs/PSNs, none reported more than one rate at or above the 90th percentile. Five (Amerigroup, First Coast, Healthy PB, Humana, and Molina) reported one rate ranking at or above the 90th percentile. Five (Molina, Preferred, Prestige, SFCCN, and Simply Healthcare) reported four rates below the 25th percentile.

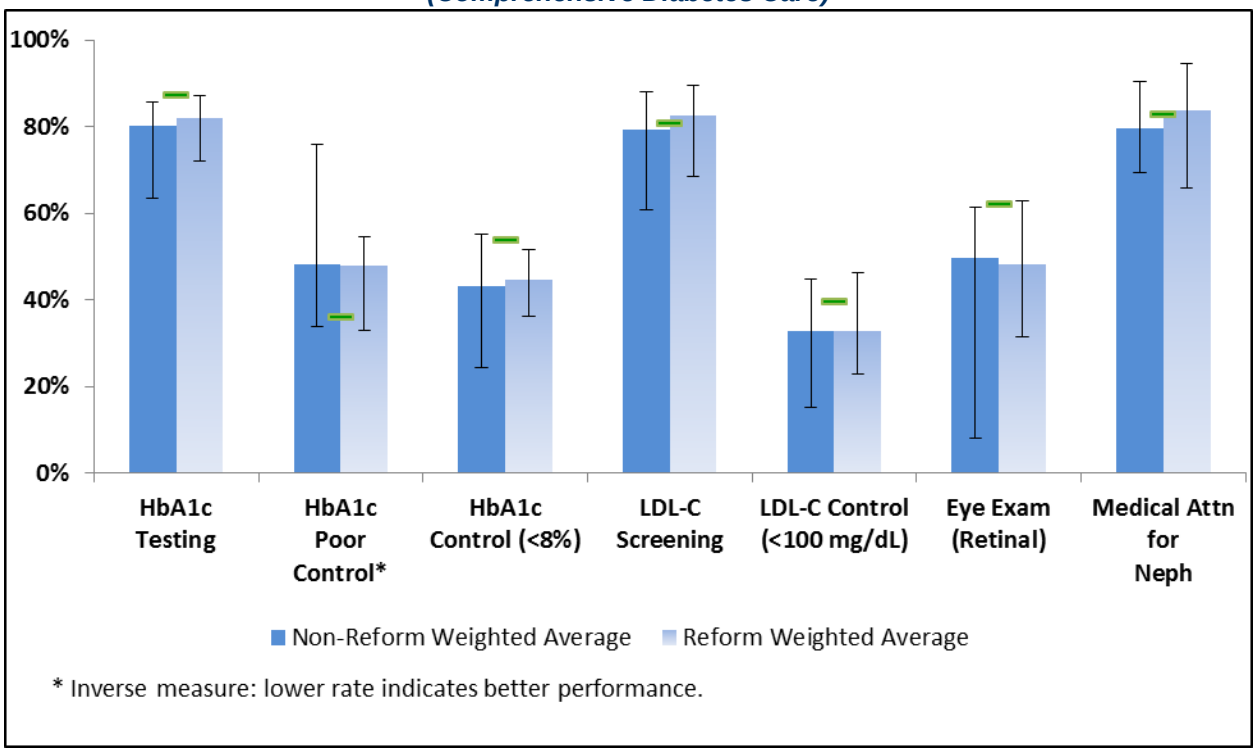
Out of 15 Reform HMOs/PSNs, one (SFCCN) reported more than one rate above the 90th percentile and one (Humana) reported one rate above the 90th percentile. One (United) reported four rates below the 25th percentile.

Living With Illness

Results

Figure 3-26 displays results for the *Comprehensive Diabetes Care* measure, which includes indicators for *HbA1c Testing*, *HbA1c Poor Control*, *HbA1c Control (<8%)*, *LDL-C Screening*, *LDL-C Control (<100 mg/dL)*, *Eye Exam (Retinal) Performed*, and *Medical Attention for Nephropathy*. *Comprehensive Diabetes Care—HbA1c Poor Control* is an inverse measure; a lower rate indicates better performance. Performance targets are indicated by the horizontal green bars. The vertical black line in each bar denotes the magnitude of performance rate variation among plans (i.e., a longer line suggests wider variation).

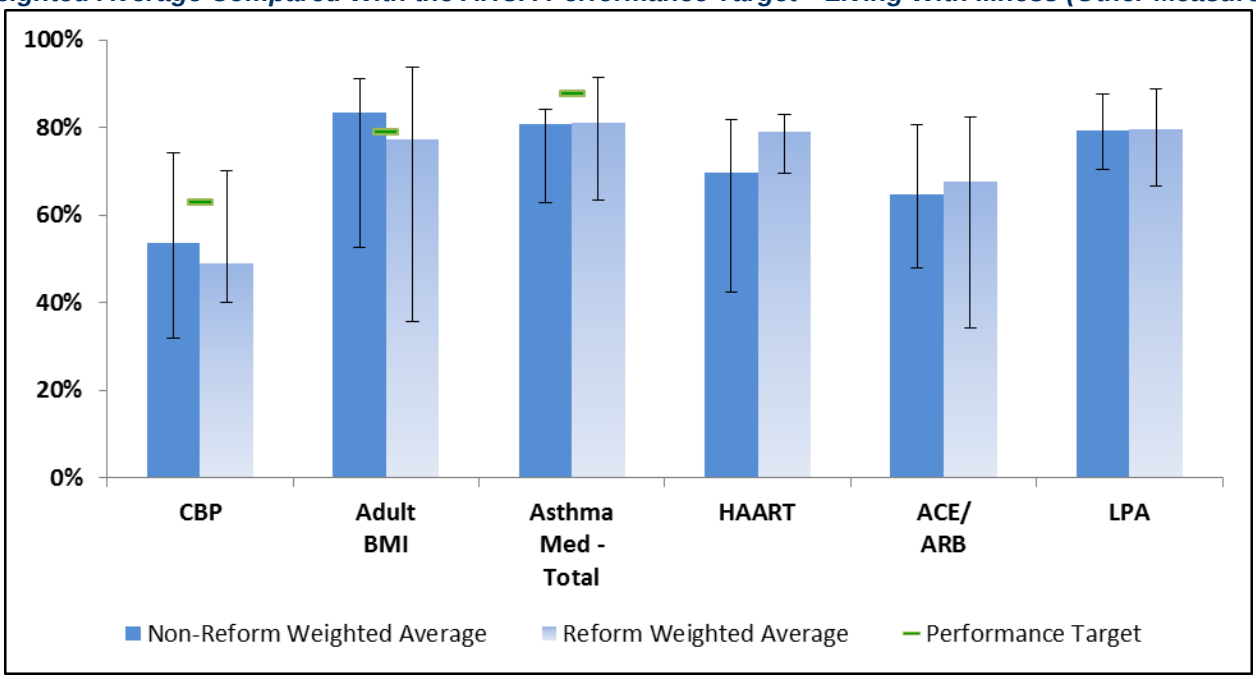
Figure 3-26—Florida Medicaid HEDIS 2014:
Weighted Average Compared With the AHCA Performance Target—Living With Illness (Comprehensive Diabetes Care)



Statewide Reform performance exceeded the AHCA targets on two measures (*Comprehensive Diabetes Care—LDL-C Screening* and *Medical Attention for Nephropathy*). Regarding all other measures in this domain, although some HMOs'/PSNs' rates exceeded the performance target, the overall weighted average did not. The Non-Reform weighted average showed better performance on the *Eye Exam (Retinal)* indicator than Reform. For all other indicators, Reform weighted averages reported higher rates than Non-Reform.

Figure 3-27 displays results for the other Living With Illness measures, including *Controlling High Blood Pressure, Adult BMI Assessment, Use of Appropriate Medications for People With Asthma—Total, Highly Active Anti-Retroviral Treatment, Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy*, and *Lipid Profile Annually*. AHCA performance targets, as indicated by the horizontal green bars in Figure 3-27, were not available for the *Highly Active Anti-Retroviral Treatment, Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy,* and *Lipid Profile Annually* measures. The vertical black line in each bar denotes the magnitude of performance rate variation among plans (i.e., a longer line suggests wider variation).

Figure 3-27—Florida Medicaid HEDIS 2014:
Weighted Average Compared With the AHCA Performance Target—Living With Illness (Other Measures)



Statewide Non-Reform performance exceeded the AHCA target on one measure (*Adult BMI Assessment*). Non-Reform weighted averages exceeded Reform weighted averages in two measures (*Controlling High Blood Pressure* and *Adult BMI Assessment)*. Reform weighted averages exceeded Non-Reform weighted averages in four measures (*Use of Appropriate Medications for People With Asthma—Total, Highly Active Anti-Retroviral Treatment, Use of Angiotensin-Converting Enzyme [ACE] Inhibitors/Angiotensin Receptor Blockers [ARB] Therapy,* and *Lipid Profile Annually).*

Plan Comparison

Out of 24 Non-Reform HMOs/PSNs, five (Amerigroup, Better Health, Humana, Simply Healthcare, and VISTA) reported more than one rate at or above the 90th percentile. Twelve (Better Health, Buena Vista, Clear Health, First Coast, Healthy PB, Molina, CareFlorida, Prestige, SFCCN, Simply Healthcare, Sunshine, and United) had at least four rates below the 25th percentile.

Out of 15 Reform HMOs/PSNs, three (First Coast, Humana, and CareFlorida) reported more than one measure with rates at or above the 90th percentile. Four (Molina, CareFlorida, SFCCN, and Staywell) reported more than four measures with rates below the 25th percentile.

Use of Services

Results

The Use of Services domain consisted of two utilization measures, both under *Ambulatory Care* (*Outpatient Visits* per 1,000 member months and *ED Visits* per 1,000 member months). Use of Services data are descriptive and are used to monitor patterns of utilization over time. Assessment of utilization should be based on the characteristics of the plan's population and service delivery model. Table 3-3 shows HEDIS 2014 plan-specific performance measure rates related to the Use of Services domain. Shaded gray cells indicated that the HMO/PSN did not have the specific Non-Reform or Reform contract with AHCA and therefore reported no rates.

Table 3-3—HEDIS 2014 Plan Results for the Ambulatory Care Measure, Non-Reform Versus Reform Plans

	Outpatient Visits Per 1,000 Member Months		ED Visits Per 1,000 Member Months	
Health Plan	Non-Reform Plans	Reform Plans	Non-Reform Plans	Reform Plans
Amerigroup	299.31		66.27	
Better Health		330.60		78.19
Buena Vista	251.11		73.52	
Clear Health	406.96	415.34	141.07	236.42
Children's Medical Services		519.92		75.16
FL Healthcare	98.85		60.90	
First Coast	288.48	347.54	94.85	83.35
Freedom	252.44	326.36	68.44	76.86
HealthEase	251.26		75.18	
Healthy PB	323.48		62.35	
Humana	368.02	361.88	57.81	66.15
Integral	187.28		68.45	
Magellan*		0.00		0.00
Medica	212.44	247.76	48.63	57.91
Molina	283.59	346.43	67.77	67.61
Positive	649.05	707.84	107.70	127.10
Preferred	181.89		48.52	
CareFlorida	210.70	244.19	66.35	77.13
Prestige	223.29		74.76	

Table 3-3—HEDIS 2014 Plan Results for the Ambulatory Care Measure, Non-Reform Versus Reform Plans				
	Outpatient Visits Per 1,000 Member Months		ED Visits Per 1,000 Member Months	
Health Plan	Non-Reform Plans	Reform Plans	Non-Reform Plans	Reform Plans
SFCCN	327.82	337.00	68.73	68.09
Salubris	116.03		56.83	
Simply Healthcare	295.08		66.01	
Staywell	296.13	254.81	71.81	81.24
Sunshine	274.24	292.55	68.14	66.34
TrueHealth	222.51		89.13	
United	325.07	380.51	70.75	70.81
VISTA	315.28		56.70	
2014 Florida Weighted Average	280.89	328.86	69.54	72.91
2013 Florida Weighted Average	286.37	336.97	66.69	70.29
2012 Florida Weighted Average	276.57	328.47	62.24	65.54
*Magellan became operational in July 2013 and indicated that although it had eligible enrollees for this measure; none of the enrollees had a qualifying outpatient or ED visit during the measurement year. The zero rates were validated by the auditor as *Reportable*, valid rates.				

For *Outpatient Visits*, the Non-Reform weighted average was lower than the Reform weighted average by 14.6 percent. In addition, the Non-Reform and Reform weighted averages showed a decline of 1.91 percent and 2.40 percent from CY 2012 (2013 Florida Weighted Averages), respectively.

For *ED Visits*, the Non-Reform weighted average was lower than the Reform weighted average by 4.6 percent. In addition, the Non-Reform and Reform weighted averages showed a 4.30 percent and 3.72 percent increase from CY 2012 (2013 Florida Weighted Averages), respectively.

Plan Comparison

For the *Ambulatory Care—Outpatient Visits* measure, individual Non-Reform HMO/PSN rates ranged from 98.85 to 649.05 outpatient visits per 1,000 member months. Rates from three Non-Reform HMOs/PSNs (Clear Health, Humana, and Positive) were above the national HEDIS 2013 Medicaid 50th percentile. Individual Reform HMO/PSN rates ranged from 0.00 to 707.84 outpatient visits per 1,000 member months. Rates from four HMOs/PSNs (Clear Health, CMS, Positive, and United) exceeded the national HEDIS 2013 Medicaid 50th percentile. Positive reported the highest Non-Reform and Reform rates for *Ambulatory Care—Outpatient Visits.*

For the *Ambulatory Care—ED Visits* measure, individual Non-Reform HMO/PSN rates ranged from 48.52 to 141.07 ED visits per 1,000 member months. Rates from 18 Non-Reform HMOs/PSNs (Amerigroup, Buena Vista, Clear Health, First Coast, Freedom, HealthEase, Integral, Molina, Positive, CareFlorida, Prestige, SFCCN, Simply Healthcare, Staywell, Sunshine, TrueHealth, United, and Vista) exceeded the national HEDIS 2013 Medicaid 50th percentile. Individual Reform

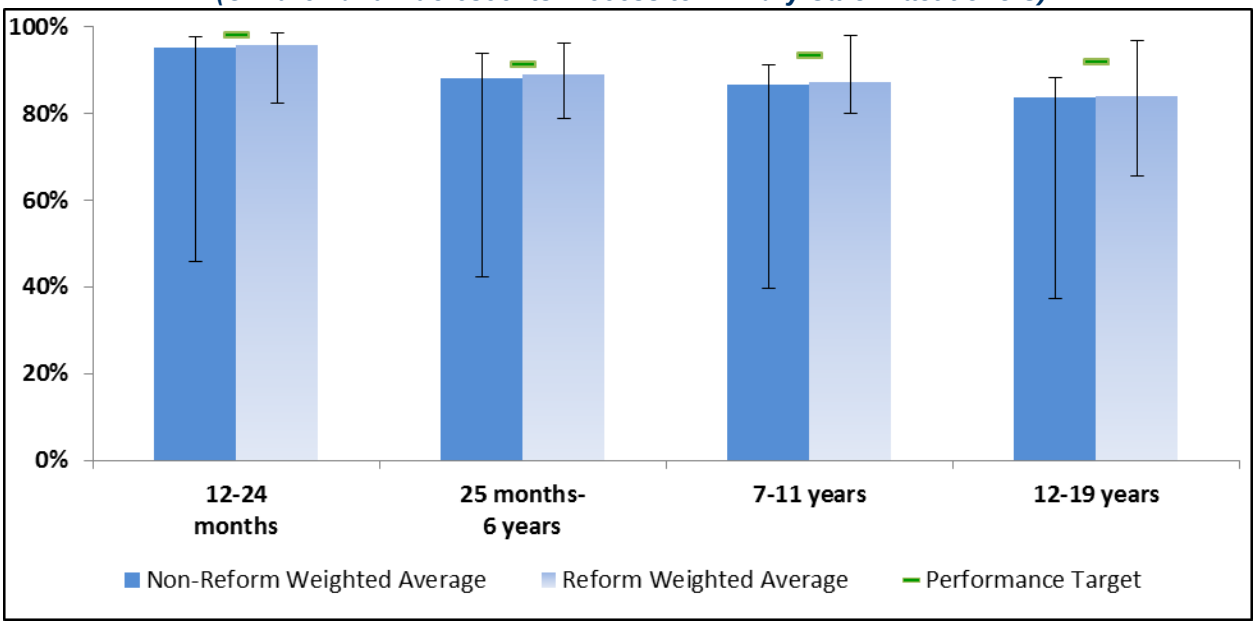
HMO/PSN rates ranged from 0.00 to 236.42 ED visits per 1,000 member months. Rates from 13 Reform HMOs/PSNs (Better Health, Clear Health, CMS, First Coast, Freedom, Humana, Molina, Positive, Preferred, SFCCN, Staywell, Sunshine, and United) exceeded the national HEDIS 2013 Medicaid 50th percentile. Clear Health reported the highest Non-Reform and Reform rates for *Ambulatory Care—ED Visits*.

Access to Care

Results

Figure 3-28 compares Non-Reform and Reform weighted averages for *Children and Adolescents' Access to Primary Care Practitioners*, which consisted of indicators for four age groups (i.e., 12–24 months, 25 months–6 years, 7–11 years, and 12–19 years). All of these measures have corresponding AHCA performance targets, as indicated by the green horizontal bars. The vertical black line in each bar denotes the magnitude of performance rate variation among plans (i.e., a longer line suggests wider variation).

Figure 3-28—Florida Medicaid HEDIS 2014:
Weighted Average Compared With the AHCA Performance Target—Access to Care
(Children and Adolescents' Access to Primary Care Practitioners)

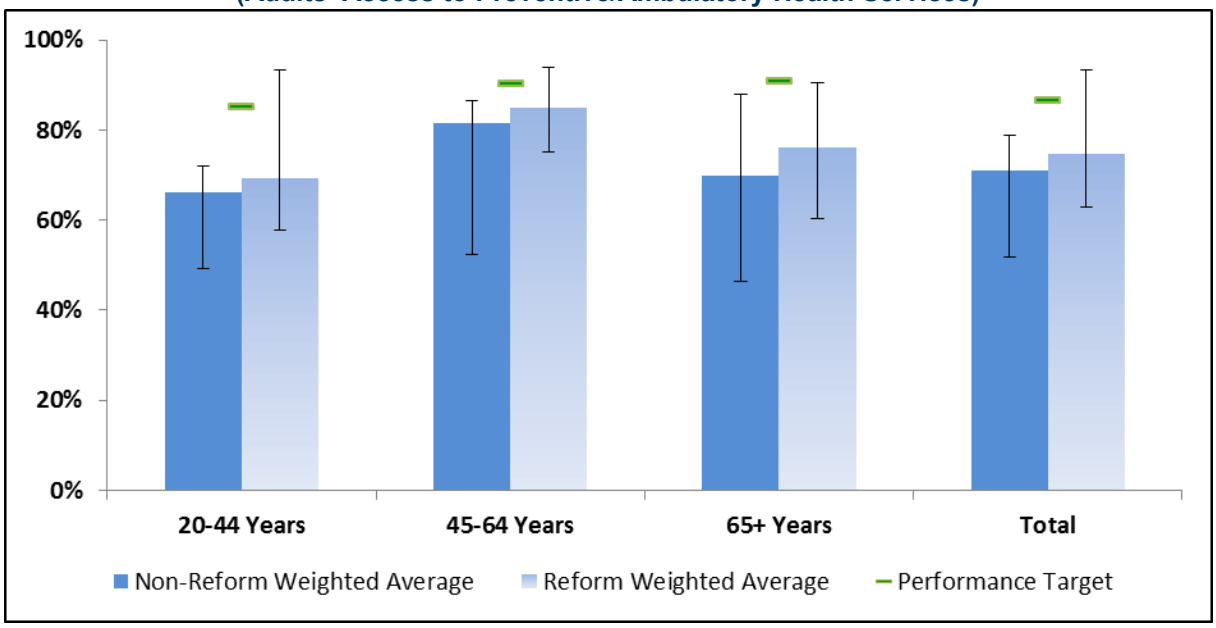


Neither the Reform nor Non-Reform weighted averages met the AHCA performance targets for any of the age groups. Although some HMOs/PSNs reported rates higher than the performance target, the weighted averages were not. Reform weighted averages were slightly higher than Non-Reform weighted averages in all four age groups of the *Children and Adolescents' Access to Primary Care Practitioners* measure.

Figure 3-29 compares Non-Reform and Reform weighted averages for *Adults' Access to Preventive/Ambulatory Health Services*, which includes three age groups (i.e., *20–44 Years, 45–64 Years, and 65+ Years*) and *Total*. AHCA performance targets, indicated by the horizontal green

bars in Figure 3-29 were available for all these measures. The vertical black line in each bar denotes the magnitude of performance rate variation among plans (i.e., a longer line suggests wider variation).

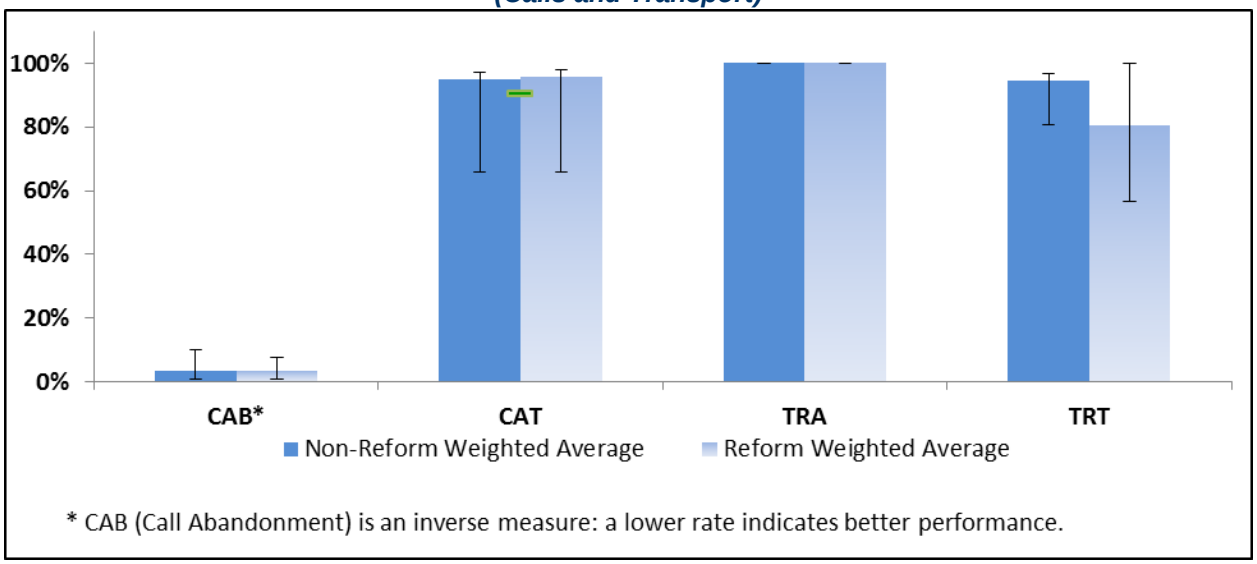
**Figure 3-29—Florida Medicaid HEDIS 2014:
Weighted Average Compared With the AHCA Performance Target—Access to Care
(Adults' Access to Preventive/Ambulatory Health Services)**



Neither the Reform nor Non-Reform weighted averages met the AHCA performance target for any of the age groups in this measure. Although some HMOs/PSNs reported rates higher than the performance targets, the weighted averages were not. Reform weighted averages were higher than Non-Reform weighted averages in all four age groups of the *Adults' Access to Preventive/Ambulatory Health Services* measure.

Figure 3-30 compares Non-Reform and Reform weighted averages for *Call Abandonment, Call Answer Timeliness, Transportation Availability*, and *Transportation Timeliness*. *Call Abandonment* is an inverse measure; a lower rate indicates better performance. AHCA performance targets are available for the *Call Answer Timeliness* measure. The vertical black line in each bar denotes the magnitude of performance rate variation among plans (i.e., a longer line suggests wider variation).

Figure 3-30—Florida Medicaid HEDIS 2014:
Weighted Average Compared With the AHCA Performance Target—Access to Care (Calls and Transport)



Both Non-Reform and Reform weighted averages were 100 percent for the *Transportation Availability* measure. The Non-Reform weighted average was slightly higher than the Reform weighted average for *Call Abandonment.* Conversely, the Reform weighted average for *Call Answer Timeliness* was slightly higher than the Non-Reform weighted average. Non-Reform weighted averages were higher than Reform weighted averages for the *Transportation Timeliness* measure.

Plan Comparison

Out of 24 Non-Reform HMOs/PSNs, one (Children's Medical Services) reported more than one rate at or above the 90th percentile for this domain. Eight (Buena Vista, Freedom, Integral, Medica, Molina, Preferred, Prestige, and Simply Healthcare) reported at least eight rates below the 25th percentile. The majority of the low rates were from two measures (*Children and Adolescents' Access to Primary Care* and *Adults' Access to Preventive/Ambulatory Health Services*).

Out of 15 Reform HMOs/PSNs, two (Positive and Staywell) reported more than one rate at or above the 90th percentile for this domain. Two (Medica and SFCCN) reported at least eight rates below the 25th percentile. Similar to the Non-Reform HMOs/PSNs, the majority of the low rates reported by these Reform HMOs/PSNs were from the *Children and Adolescents' Access to Primary Care* and *Adults' Access to Preventive/Ambulatory Health Services* measures.

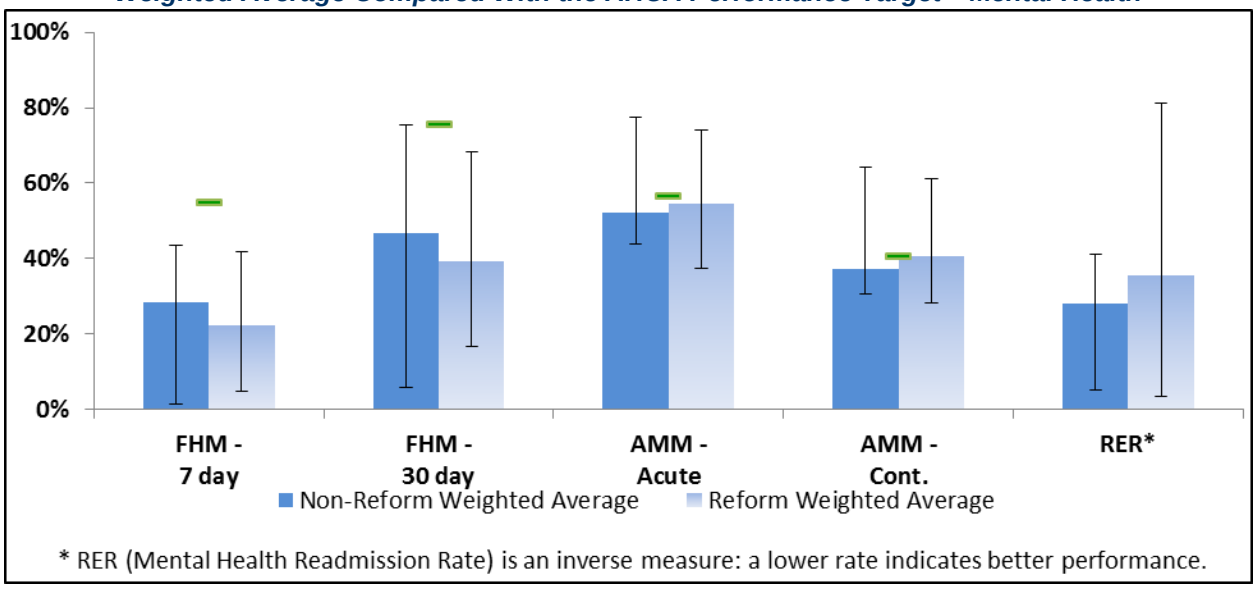
Mental Health

Results

Figure 3-31 compares Non-Reform and Reform weighted averages for *Follow-Up After Hospitalization for Mental Illness* (*7-Day* and *30-Day*), *Antidepressant Medication Management* (*Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*), and *Mental Health*

Readmission Rate. *Mental Health Readmission Rate* is an inverse measure and does not have a performance target; a lower rate indicates better performance. AHCA performance targets, indicated by the horizontal green bars in Figure 3-31, are available for all but one (*Mental Health Readmission Rate*) measure. The vertical black line in each bar denotes the magnitude of performance rate variation among plans (i.e., a longer line suggests wider variation).

Figure 3-31—Florida Medicaid HEDIS 2014:
Weighted Average Compared With the AHCA Performance Target—Mental Health



The Reform weighted average met the AHCA performance target for the *Antidepressant Medication Management—Effective Continuation Phase Treatment* measure. Neither the Reform nor Non-Reform individual HMOs/PSNs reached the performance target for the two *Follow-Up After Hospitalization for Mental Illness* measures (*7 Day* and 30 Day). Non-Reform weighted averages showed better performance than Reform weighted averages in three out of the five measures (two indicators under *Follow-Up After Hospitalization for Mental Illness*, and *Mental Health Readmission Rate).* The *Follow-Up After Hospitalization for Mental Illness 30–Day* measure demonstrated the greatest opportunity for improvement when compared to its performance target; both the Non-Reform and Reform weighted averages were at least 25 percentage points below the target.

Plan Comparison

Out of 24 Non-Reform HMOs/PSNs, five (Better Health, Healthy PB, Medica, Prestige, and SFCCN) reported at least one rate at or above the 90th percentile. Four Non-Reform HMOs/PSNs (Buena Vista, HealthEase, Integral, and Sunshine) reported one or more rates below the 25th percentile.

Out of 15 Reform HMOs/PSNs, three (First Coast, CareFlorida, and SFCCN) reported at least one rate at or above the 90th percentile. Two (Humana and Sunshine) reported one or more rates below the 25th percentile.

Conclusions and Recommendations

During SFY 2013–2014, HMOs/PSNs were required to undergo an NCQA HEDIS Compliance Audit for the performance measures they were contracted to report to AHCA. Based on the final audit statements and supporting documents submitted for HSAG's PMV (conducted during SFY 2014–2015), all PSNs were fully compliant with all seven applicable HEDIS IS standards. All HMOs were fully compliant with four of the seven applicable IS standards. Two HMOs (Positive and FL Healthcare) were not fully compliant with IS 1.0 (Medical Services Data), either due to failure to meet the timeliness standard or inability to provide their auditors with all requested claims' audit results. The HMOs' noncompliance with this standard did not severely impact measure reporting. One HMO (FL Healthcare) was not fully compliant with IS 6.0 (Member Call Center Data) because its call center system shut down resulting in an inability to collect specific data elements required for the *Call Answer Timelines* measure. Consequently, this HMO received an *NR* for the measure. Lastly, one HMO (FL Healthcare) was not fully compliant with IS 7.0 (Data Integration) due to insufficient documentation for the Extract-Transform-Load process. The HMO's noncompliance with this standard did not severely impact measure reporting.

The performance measures reported by the HMOs/PSNs were grouped into six domains (i.e., Pediatric Care, Women's Care, Living With Illness, Access to Care, Use of Services, and Mental Health). Plan performance varied widely in these domains.

Compared to Non-Reform, Reform statewide performance showed more CY 2013 rates in the Pediatric Care domain reporting statistically significant improvement, but one less rate meeting the AHCA performance target. Reform HMOs/PSNs had no Pediatric Care rates showing a statistically significant decline from CY 2012.

Under the Women's Care domain, Non-Reform statewide performance showed two more rates with statistically significant improvement from CY 2012 than Reform HMOs/PSNs. Both types reported that *Breast Cancer Screening* had a statistically significant increase. Nonetheless, none of the Women's Care rates from both types met the AHCA performance targets.

Under the Living With Illness domain, both Non-Reform and Reform HMOs/PSNs reported four CY 2013 rates with statistically significant improvement from CY 2012. Reform HMOs/PSNs had no rates with statistically significant decline whereas Non-Reform HMOs/PSNs had five rates with statistically significant decline. Reform HMOs/PSNs also showed one more rate meeting the AHCA performance target than Non-Reform HMOs/PSNs.

Statewide Use of Services rates for the *Ambulatory Care—ED Visits* measure showed an increase from CY 2012 rates for both Non-Reform and Reform HMO/PSNs. Plan variations were wider in outpatient visits than in ED visits. In general, both Non-Reform and Reform HMOs/PSNs had fewer outpatient visits and more ED visits when compared to national averages.

Under the Access to Care domain, both Reform and Non-Reform statewide performance on the *Call Answer Timeliness* measure met the AHCA performance target. Non-Reform HMOs/PSNs had one more CY 2013 rate than Reform HMOs/PSNs reporting statistically significant improvement. Additionally, Non-Reform HMOs/PSNs had no rates in this domain showing statistically significant declines. (Reform HMOs/PSNs reported two rates showing significant decline.)

Under the Mental Health domain, only one Reform statewide performance measure (*Antidepressant Medication Management—Effective Continuation Phase Treatment*) met the AHCA performance target. Non-Reform HMOs/PSNs reported two rates with statistically significant declines from CY 2012, while Reform HMOs/PSNs reported a decline in only one indicator (*Mental Health Readmission Rate*).

Based on these findings, HSAG offered the following recommendation to the HMOs/PSNs:

For both Non-Reform and Reform HMOs/PSNs, although statewide averages revealed significant improvements in several performance measures and declines in some other measures, performance for most of the measures reflected only minor changes from the prior year. HMOs/PSNs should focus their efforts on improving measures whose rates were at least 10 percentage points below the AHCA performance target (see Table 3-4 below).

Table 3-4—Measures Recommended for Targeted Improvement, by Domain of Care
Pediatric Care
◆ *Well-Child Visits in the First 15 Months—Six or More Visits* ◆ *Lead Screening in Children* ◆ *Annual Dental Visit—Total* ◆ *Immunization for Adolescents—Combination 1*
Women's Care
◆ *Cervical Cancer Screening* ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care* ◆ *Prenatal Care Frequency (>81%)*
Living With Illness
◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
Access to Care
◆ *Adults' Access to Preventive/Ambulatory Health Services*
Mental Health
◆ *Follow-Up After Hospitalization for Mental Illness*

Follow-Up From Last Year's Recommendations

HSAG listed four recommendations in the SFY 2013–2014 Performance Measure Validation Findings Report. First, HSAG recommended that the HMOs and PSNs manage and monitor their medical record reporting timelines. Although the FARs showed that all HMOs/PSNs met the required timeline for medical record abstraction, a large number still received an auditor's recommendation to develop a sound project plan to begin medical record abstraction as early as possible to allow adequate time for reviews and validations.

A second recommendation was related to requiring HMOs/PSNs to ensure that staff members involved in preparing the supplemental data for HEDIS 2014 reporting meet the required timeline and include appropriate proof-of-service documents for the auditor's review. One HMO did not use a supplemental data source for HEDIS 2014 reporting. All other HMOs/PSNs met the required timeline outlined by NCQA for the HEDIS 2014 reporting requirement.

The third recommendation, related to performance measure rates, involved HMOs/PSNs focusing their efforts toward improving measures with rates at least 10 percentage points below the AHCA performance target. Comparing CY 2013 rates with CY 2012 rates, HSAG found that, for those measures with rates falling below the AHCA performance target, at least half of the HMOs/PSNs reported a rate increase. Although most of the rate increases were small, this suggests that the HMOs/PSNs made some efforts to improve these measures.

HSAG's last recommendation was that the HMOs/PSNs continue to ensure that their auditors are aware of AHCA's reporting requirements and are responsible for validating the performance measure report. Based on HSAG's review, one PSN submitted this report with no audit designation. Nonetheless, the report appeared to be validated by the PSN's auditor. All other HMOs/PSNs provided acceptable and auditor-validated performance measure reports.

PMHPs/CWPMHP

PMHPs and the CWPMHP were required to undergo a PMV process conducted by HSAG, according to the CMS protocol. All required measures were calculated by the PMHPs/CWPMHP based on AHCA specifications. A listing of all plans included in the PMHPs/CWPMHP validation activity, along with their full name, shortened name, and abbreviation as used throughout this section, is contained in Appendix F.

Table 3-5—List of Performance Measures for Calendar Year 2013

Measure	Calculation Responsibility	Measurement Period
Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis—Mental Health Practitioner (Agency-defined measure)	PMHPs/CWPMHP	CY 2013
Thirty-Day Readmission Rate (Agency-defined measure)	PMHPs/CWPMHP	CY 2013
Follow-Up Within 30 Days After Acute Care Discharge for a Mental Health Diagnosis—Mental Health Practitioner (Agency-defined measure)	PMHPs/CWPMHP	CY 2013

Results

Figure 3-32 shows the statewide weighted averages of the PMHPs/CWPMHP three performance measures (i.e., *Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis—Mental Health Practitioner, Follow-up Within 30 Days After Acute Care Discharge for a Mental Health Diagnosis—Mental Health Practitioner*, and *Thirty-day Readmission Rate*). AHCA established performance targets (as denoted by the green horizontal bars) for the two *Follow-Up After Acute Care Discharge for a Mental Health Diagnosis* measures. The vertical black line in each bar denotes the magnitude of performance rate variation among plans (i.e., a longer line suggests wider variation).

Figure 3-32—Florida PMHP/CWPMHP CY 2013:
Weighted Averages for Required Performance Measures

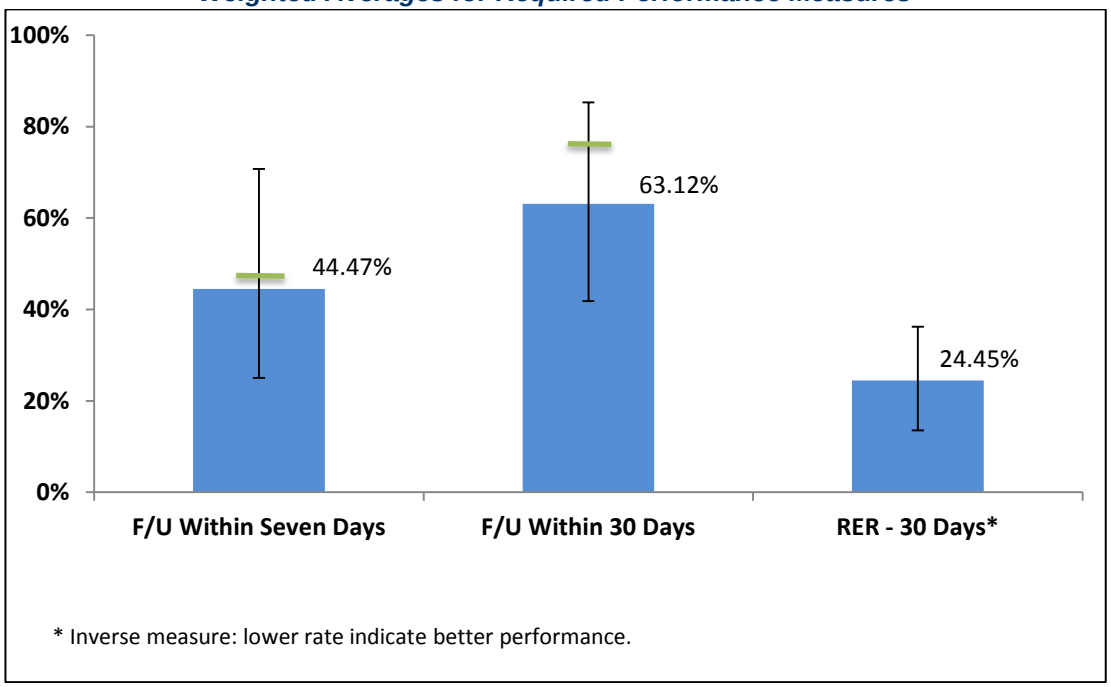


Figure 3-32 shows that within seven days of acute care discharge 44.47 percent of eligible enrollees had a follow-up visit with a mental health practitioner, an increase of 0.66 percentage points from last year's result (43.81 percent). Within 30 days of acute care discharge, 63.12 percent of eligible enrollees had a follow-up visit with a mental health practitioner. This measure also displayed an increase of 3.30 percentage points from last year's result of 59.82 percent. The *Thirty-day Readmission Rate* displayed an increase of 3.66 percentage points since last year. Since this is an inverse measure, the rate increase actually represents a decline in performance. Although statewide performance for the two *Follow-Up After Acute Care Discharge* measures did not meet the performance target, some of the PMHP/CWPMHP rates did meet the target. The extent in performance rate variation among plans was similar across all measures.

Plan Comparison

Five PMHPs and the CWPMHP were evaluated for this measurement period using three measures. Two PMHPs (Magellan and Florida Health Plan) reported separate measure rates for their four geographical areas.

Similar to last year's results, Community Based Care Partnership was the high performer for the *Follow-up Within Seven Days After Acute Discharge* measure (70.73 percent), while the low performer was Florida Health Partners, Area 7 (25.03 percent). Community Based Care Partnership was also the high performer for the *Follow-up Within 30 Days of Acute Care Discharge* (85.29 percent), and Florida Health Partners, Area 7 was the low performer (41.82 percent). This year's high performer for the *Thirty-day Readmission Rate* was Florida Health Partners, Area 6 (13.56 percent) while Magellan Behavioral Health of Florida, Area 11 was the low performer (36.21percent).

Conclusions and Recommendations

As in prior years all Florida PMHPs/CWPMHP maintained the same processes for receiving and processing data required to report performance measure rates. All PMHPs/ CWPMHP maintained dedicated team members who were actively involved in the performance measure reporting process to ensure that complete and accurate data were used for measure reporting. Regarding performance measure calculation, HSAG identified some issues; however, after HSAG's clarification with the PMHPs'/CWPMHP's analytical staff members, these issues were resolved, and revised rates were resubmitted before the end of the validation.

The PMHP/CWPMHP rates showed slight rate increases for both indicators under the *Follow-Up Visits After Acute Care Discharge for a Mental Health Diagnosis* measure and a decline for the *Thirty-day Readmission Rate*. Since the PMHP/CWPMHP models no longer exist under the SMMC program and these measures are required as part of the MMA measure reporting, HSAG recommends that service model or improvement strategies used by PMHPs/CWPMHP be shared with the MMA plans so that best practices can be adopted or continued to be used to improve care.

Follow-Up on Prior Year Recommendations

HSAG had no major recommendations for the PMHPs/CWPMHP during SFY 2013–2014. Where auditors identified issues related to calculating performance measures, HSAG found that staff members were responsive, resolved the discrepancies, and resubmitted the corrected rates.

LTC Plans

Seven LTC plans contracted with AHCA for providing long-term care services to their Medicaid enrollees were required to report select performance measures. For SFY 2013–2014, AHCA required the LTC plans to calculate and report three performance measures using CY 2013 data (see Table 3-6). The LTC plans underwent a performance measure review to ensure that the rates calculated and reported for these measures were valid and accurate. Although all performance measures were Agency-defined measures and not HEDIS measures, AHCA intended that an NCQA HEDIS Compliance Audit be conducted to the extent possible. All LTC plans contracted external audit firms to perform the audit during SFY 2013–2014. All audits were conducted by LOs. This was the first reporting year HSAG performed PMV activities for the LTC plans. A listing of all plans included in the LTC plan validation activity, along with their full name, shortened name, and abbreviation as used throughout this section, is contained in Appendix F.

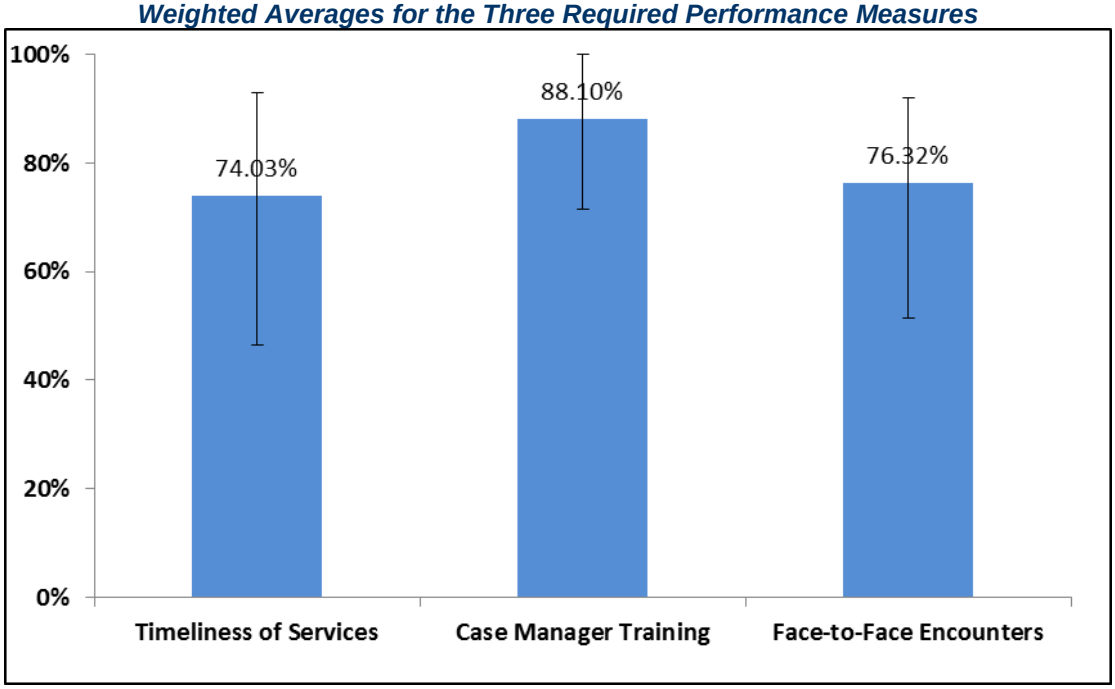
Table 3-6— List of SFY 2013–2014 Performance Measures

Measure	Calculation Responsibility	Measurement Period
Timeliness of Services	LTC Plan	CY 2013
Case Manager Training	LTC Plan	CY 2013
Face-to-Face Encounters	LTC Plan	CY 2013

Results

Figure 3-33 shows the statewide weighted averages for *Timeliness of Services*, *Case Manager Training*, and *Face-to Face Encounters*. AHCA did not establish a performance target for any of these measures. The vertical black line in each bar denotes the magnitude of performance rate variation among plans (i.e., a longer line suggests wider variation).

Figure 3-33—Florida LTC Plan CY 2013:
Weighted Averages for the Three Required Performance Measures



All seven LTC plans submitted a reportable rate for the *Timeliness of Services* measure. The table above shows that 74.03 percent of new enrollees received services within three days of enrollment. All LTC plans (except Amerigroup-LTC and Molina-LTC) submitted a reportable rate for the *Case Manager Training* measure, and 88.10 percent of the case managers received training on the mandate to report abuse, neglect, and exploitation. Four LTC plans submitted a reportable rate for the *Face-to-Face Encounters* measure. Two LTC plans (Amerigroup-LTC and Molina-LTC) had no enrollees who met the continuous enrollment requirement for this measure; Humana-LTC started operating in November of 2013 and was not required to report. Figure 3-33 shows that 76.32 percent of eligible enrollees had a face-to face encounter with a case manager every three months. Rate comparison was not available since this was the first year these measures were reported.

Plan Comparison

Performance measure rates were compared to determine the highest and lowest performers for each measure. The high performer for the *Timeliness of Services* measure was American Eldercare-LTC (92.91 percent) while the low performer was Coventry-LTC (46.38 percent). For the *Case Manager Training* measure, American Eldercare-LTC and Coventry-LTC reported 100.00 percent while Sunshine-LTC reported the lowest rate (71.43 percent). Out of the four LTC plans submitting reportable rates for the *Face to Face Encounters* measure, American Eldercare-LTC was the top performer (92.00 percent), and Sunshine-LTC was the low performer (51.49 percent).

Conclusions and Recommendations

This was the first year that the LTC plans participated in the audit process. Based on the FAR reviews, HSAG found that all seven LTC plans retained a dedicated and knowledgeable staff to collect and process data relevant to measure calculation. In addition, all LTC plans had adequate review and validation processes in place, to ensure accurate and complete data for performance measure reporting.

HSAG offers the following recommendations:

- Since this is the first year LTC plans were required to report these measures, LTC plan variation in performance is expected. HSAG recommended that all LTC plans and AHCA consider these rates as baseline performance from which investigation or intervention strategies can be developed to improve quality for future years.
- Since *Case Manager Training* measures represents LTC plan compliance to a mandate to report abuse, neglect, and exploitation, LTC plans reporting a rate less than 100 percent should investigate the root cause of the noncompliance and assure proper and timely training for their case managers.
- During its desk review of the FARs, HSAG identified that not all LTC plan audits were conducted following NCQA's HEDIS Compliance Audit policies and procedures. Although all performance measures were Agency-defined measures and not HEDIS measures, HSAG agreed with AHCA that to an extent possible, NCQA HEDIS Compliance Audit policies and procedures were followed when auditing these measures. HSAG recommended that the FAR include specific compliance findings related to each IS standard. Additionally, since some of the measures rely on data that are collected outside the usual data systems included in a typical NCQA HEDIS Compliance Audit, HSAG also recommends that the FAR include a brief description of the data systems used for calculating Agency-defined measures.

SIPPS

No PMV activities were conducted for the SIPPs.

PDHPs

For CY 2013, AHCA contracted with two PDHPs to provide dental services to their Medicaid enrollees in the Miami-Dade County and Statewide regions. The two PDHPs were required to calculate and report four performance measures (one HEDIS and three AHCA-defined) for CY 2013 (see Table 3-7), calculated separately for the Miami-Dade County region and the Statewide region. In addition, the PDHPs were also required to undergo an NCQA HEDIS Compliance Audit on the performance measures selected for reporting. These audits were performed by LOs selected by the PDHPs. A listing of all plans included in the PDHP validation activity, along with their full name, shortened name, and abbreviation as used throughout this section, is contained in Appendix F.

Table 3-7—List of SFY 2013–2014 Performance Measures			
Measure	**Calculation Responsibility**	**Measurement Period**	**Measure Type**
Annual Dental Visit (ADV)	PDHP	CY 2013	HEDIS
Complete Oral Evaluation (COE)	PDHP	CY 2013	Agency-defined
Sealants (SNT)	PDHP	CY 2013	Agency-defined
Member Outreach (MO)	PDHP	CY 2013	Agency-defined

Results

In the FARs, both PDHPs indicated a *Reportable* designation for all four performance measures. However, after reviewing the submitted documents and communicating with AHCA, HSAG found that due to insufficient information regarding the Agency-defined measure specifications, the PDHPs had their own interpretations of how these measures were calculated. Both PDHPs developed their own specifications, and for the measure validations, the auditors were following the guidelines provided by the PDHPs. HSAG could not ascertain measure calculation and reporting consistency, and assigned an *NR* designation to the Agency-defined measures. Nonetheless, HSAG agreed with the auditors' findings for both PDHPs and assigned an *R* audit designation for the *Annual Dental Visit* HEDIS measure.

The 2014 weighted average for the aggregate *Annual Dental Visit—Total* measure (based on the PDHPs' performance in both Miami-Dade and Statewide regions) was 37.04 percent. This means that over 33 percent of eligible enrollees had at least one dental visit during the measurement year. This result was a statistically significant decline of 3.88 percentage points from the 2013 weighted average. Both PDHPs' weighted averages fell below AHCA's performance target of 61.23 percent. Plan regional rates varied from 34.26 percent to 43.25 percent for this measure.

Plan Comparison

Out of the four performance measures, only the *Annual Dental Visit* measure is appropriate for plan comparison due to inconsistencies in each plan's interpretation of the measure specifications. The *Annual Dental Visit—Total* measure result indicated that both PDHPs performed better in the Miami-Dade region than in the Statewide region. Comparing individual PDHP rates for this measure, DentaQuest performed better than MCNA; its rate was 3.34 percentage points higher than MCNA's rate for the Miami-Dade region. DentaQuest also performed better than MCNA in the Statewide region, as indicated by its rate exceeding MCNA's rate by 2.92 percentage points.

Conclusions and Recommendations

HSAG performed a detailed review of the PDHP's FAR and submitted documentation. Five of the seven HEDIS IS standards were applicable to the PDHPs. Based on the final audit statements and supporting documents, HSAG found that both PDHPs were fully compliant with all five applicable HEDIS IS standards.

Starting in SFY 2014–2015, dental performance measures will no longer be reported by PDHPs. Instead, they will be reported by the MMA plans under the SMMC program. HSAG offers the following recommendation related to the performance measures that may still be applicable for the MMA plans:

- During the PMV process, although HSAG found no major issues associated with the PDHPs' data systems and processes, the PDHPs continued to have their own interpretations of the Agency-defined measures. This may be due to insufficient communication between AHCA and the PDHPs in clarifying the measure specifications to ensure accurate and consistent rate calculation. Consequently, HSAG could only validate the *Annual Dental Visit* measure as *Reportable*. For the remaining measures, an *NR* (*Not Report*) was assigned. To ensure that the MMA plans and their auditors obtain clear and complete information on how an Agency-defined measure should be interpreted for calculation, HSAG recommends that AHCA initiate early discussions with the MMA plans about the measures and delineate the specifications and reporting requirements before the annual compliance audit. However, at the time of finalizing this report, AHCA has indicated that due to these concerns, the Agency-defined dental measures have been dropped and that the MMA plans are required to report on CHCUP dental measures instead.

Follow-Up on Prior Year Recommendations

Based on the SFY 2013–2014 review, HSAG offers five recommendations for the PDHPs:

- Both PDHPs should request technical assistance from an LO regarding the audit process and PMV.
- The PDHPs should clarify the measure specifications with the State in order to calculate the rates accurately, prior to the annual performance measure compliance audit.
- PDHPs should contract with an LO early so they have adequate time to prepare for the upcoming audit. This would include sufficient time to complete the Roadmap and compile any supporting documentation.
- Both PDHPs should review and follow the Health Plan Report Guide provided by AHCA when submitting their rates to the State. PDHPs should also ensure that their auditors are familiar with AHCA's required reporting format.
- DentaQuest should provide documented policies and procedures to ensure the reliability and validity of the collected data, for the medical record review abstraction and process.

HSAG found that for the current review period, MCNA followed AHCA's Health Plan Report Guide when submitting rates to the State. In addition, HSAG also found that both PDHPs were better prepared for the current audit process, including having adequate time to complete the Roadmap sections required to perform the HEDIS audit. These improvements suggested that the PDHPs considered some of HSAG's recommendations.

Review of Compliance With Access, Structure, and Operations Standards

Overview of Compliance Review Activity

According to 42 CFR 438.358, which describes the activities related to external quality reviews, a state or its EQRO must conduct a review within a three-year period to determine a Medicaid MCO's compliance with federal requirements and standards established by the state for access to care, structure and operations, and quality measurement and improvement. In accordance with 42 CFR 438.204(g), these standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR 438.

AHCA completed its third year of a three-year standard review cycle in SFY 2011–2012. In January 2013, HSAG submitted its analysis of AHCA's review and included its findings in the SFY 2011–2012 EQR Technical Report. HSAG included its follow-up on these recommendations in the SFY 2012–2013 EQR Technical Report.

A new three-year review cycle began in SFY 2012–2013, which coincided with the implementation of the SMMC program. AHCA and DOEA conducted readiness reviews, which included on-site reviews, of all plans under the new SMMC contract and anticipate completing comprehensive compliance reviews in SFY 2015–2016

As part of its preparation process for upcoming compliance reviews, AHCA is exploring the possibility of taking advantage of the federal non-duplication regulations (42 CFR 438.60) that allow for deemed compliance based on accreditation of each health plan. Specifically, AHCA has contracted with HSAG to review each SMMC plan's accreditation results and complete a crosswalk, indicating which standards could potentially be deemed, along with any recommendations for non-duplication deeming.

In fall 2013, HSAG completed the development phase of a web-based managed care survey tool (MCST) for AHCA. The MCST will be an integral component in streamlining the compliance review process thereby making it more efficient. The standards AHCA and DOEA develop based on State contract language and federal requirements will be uploaded into the tool, tested, and used for the SFY 2015–2016 compliance reviews.

Encounter Data Validation

Accurate and complete encounter data are critical to the success of any managed care program. State Medicaid agencies rely on the quality of encounter data submissions from contracted plans in order to monitor and improve the quality of care; establish performance measure rates; generate accurate and reliable reports; and obtain utilization and cost information. The completeness and accuracy of these data are essential to the state's overall management and oversight of its Medicaid managed care program and in demonstrating the state's responsibility and stewardship.

During SFY 2013–2014, AHCA contracted with HSAG to conduct an EDV study. The goal of the study was to examine the extent to which encounters submitted to AHCA by its contracted managed care plans, PMHPs, and PDHPs (collectively referred to as plans) are complete and accurate. During the first contract year, 33 percent of the plans operational as of January 2013 were assessed. Please refer to Appendix A of this report where the EDV methodology is described in greater detail and to Table F-3 in Appendix F for the plan names specific to the EDV reports.

The result of several attempts by HSAG and AHCA to ensure that the data HSAG received from the state were complete and accurate was that final data were not received in time to conduct the comparative analysis during the current project. As a result of the data delays, the medical record review component was also delayed. The final data submission received between January and April 2014, comprised of two separate batches of files, was used to examine the extent to which the data extracted and submitted by AHCA were complete and reasonable.

Encounter Data Completeness and Reasonableness

Findings from the evaluation of the volume of submitted encounters showed a wide range of variation among plans for physician and pharmacy encounters while inpatient, outpatient, and dental showed a minimal variation among all plans.

Based on analyses of the key encounter data fields, HSAG found that most encounters submitted to AHCA's encounter data system contained reasonable and accurate values. While some fields exhibited minor data issues (e.g., *Billing Provider ID*, *Rendering Provider ID*, *Referring Provider ID*, and *Prescribing Provider ID*), the majority of the critical data fields contained accurate and reasonable values.

Moreover, during HSAG's processing of the data, several data anomalies associated with AHCA's extraction of the data were identified that affected the integrity of the assignments of specific encounters to a specific plan. Investigation of the submitted data showed that, for a subset of encounters, the *Provider Submitter ID* indicated a different plan than the recipient's[11] assigned plan (i.e., *Recipient PMP Provider ID* field). The majority of the anomalies were related to encounters that were associated with the PDHPs and the PMHPs. Due to data being extracted and submitted in two separate batches, encounters associated with recipients who were enrolled in both managed care

[11] Recipient and member are also used for the EDV validation (including MRR) when referring to Florida Medicaid enrollees while referencing data fields or member months.

plans and the PDHPs/PMHPs were potentially extracted during both batches of submitted files. This situation resulted in encounters being duplicated in the managed care plan file and the file containing the encounters associated with both the plans' and the PDHPs'/PMHPs' files.

Utilization Statistics and Monthly Encounter Trends

Results and Plan Comparison

The review of utilization statistics provided useful insight into the completeness of AHCA's electronic encounter data by measuring the volume of electronic encounter data submitted by the plans throughout the year. This evaluation examined the average number of encounters per member[12] per year (PMPY), by plan and by claim/encounter type (i.e., physician, inpatient, outpatient, dental, and pharmacy). HSAG also evaluated monthly variation in the submission of encounter data in order to identify any potential gaps in data submission.

The final set of encounter files (submitted in two separate batches) was used to evaluate the encounter volume and field completeness and reasonableness. Anomalies associated with AHCA's extraction of the final data, pulled directly from the data warehouse, were found that affected the integrity of the assignments of specific encounters to a specific plan. While the majority of the PDHPs' claims should be for dental services, the final set of encounter files included a significant number of other services. Similarly, the PMHPs do not provide dental or pharmacy services. However the final data received from AHCA represent these service types as transactions submitted by the PMHPs. As such, any resulting anomalies related to the PDHPs' pharmacy claims, inpatient, and outpatient encounters; and PMHPs' dental encounters and pharmacy claims that are presented in this section are due to inaccurate data extraction.

Tables E-1 through E-5 in Appendix E provide a general overview of the average utilization per member by plan in CY 2012 for physician, inpatient, outpatient, dental and pharmacy services. For CY 2012, AHCA received approximately 30 million physician encounters, nearly 5 million institutional (i.e., inpatient and outpatient) encounters, approximately 1 million dental encounters, and nearly 14 million pharmacy encounters for the 24 selected plans.

Florida Medicaid enrollees had an average of 16.6 physician encounters during CY 2012. Individual plans exhibited a wide range in physician encounters PMPY, with values ranging from 0.2 to 46.9. Nine plans (AMG, CBC, CHA, HEA, IHP, PHC, STW, SUN, and UHP) had a higher volume of encounters than the statewide physician encounters per member for CY 2012. While, the distribution of encounters PMPY was similar across plans for inpatient and dental encounters, there was a slight variation among the plans for outpatient encounters, where two plans (AMG and PHC) exhibited higher outpatient encounters PMPY compared to the statewide average of 2.6 outpatient encounters PMPY. The largest difference in utilization was noted among the pharmacy encounters where the number of prescriptions PMPY ranged from zero to 92.1 prescriptions PMPY. Thirteen plans (AMG, CHA, HEA, HUM, MOL, PHC, PRS, SHP, STW, SUN, UHP, VHP, and VIS) showed more prescriptions PMPY than the statewide average of 7.5 prescriptions PMPY.

[12] Recipient and member are also used for the EDV validation (including MRR) when referring to Florida Medicaid enrollees while referencing data fields or member months.

Physician Encounter Data

Results and Plan Comparison

Figure E-1 in Appendix E highlights the statewide percentage of missing, valid, and invalid values for each of the selected data fields in the physician encounter file. Detailed information on the percentage of missing and valid values for each of the selected data fields in the physician encounter file for each plan is shown in Table E-7 in Appendix E.

For the Physician encounter type, the key data elements *Member ID* and *Paid Date* each had accuracy rates greater than 99.9 percent. For the provider ID fields, the *Referring Provider ID* had the largest percentage of missing data (70.1 percent), while the *Rendering Provider ID* and the *Billing Provider ID* were missing 18.2 percent and 8.8 percent of values, respectively. While the *Referring Provider ID* had the largest percentage of missing data, this field was not required for every physician encounter transaction. The *Billing Provider ID* field had invalid values for 19.0 percent of records, and the *Rendering Provider ID* and *Procedure Code* fields each had invalid values in approximately 13 percent of the records.

The data elements *Member ID*, *Primary Diagnosis Code*, and *Paid Date* were complete and had accuracy rates above 99 percent. *Rendering Provider ID* and *Referring Provider ID* had statewide absence rates of 18.2 percent and 70.1 percent, respectively. For the *Rendering Provider ID* data element, three plans (HUM, UHP, and FCA) were missing over 47 percent of values. For *Referring Provider ID*, seven plans were missing more than 99 percent of values, and all plans were missing over 12 percent of values. *Diagnosis Codes 2–4* were missing more than 74.9 percent of values. However, these data fields were not required for every physician encounter transaction, and nearly all of the populated values were valid. *Rendering Provider ID* had valid values for 84.4 percent of populated records statewide. FCA had only 24.2 percent of values valid. *Procedure Code* had a validity rate of 87.0 percent statewide, with two plans, MBH and CBC, having validity rates below 40 percent.

Inpatient Encounter Data

Results and Plan Comparison

Figure E-2 in Appendix E highlights the statewide percentage of missing, valid, and invalid values for each of the selected data fields in the inpatient encounter file. Detailed information on the percentage of missing and valid values for each of the selected data fields in the physician encounter file for each plan is shown in Table E-8 in Appendix E.

For the Inpatient claim type, the data were fairly complete, with the exception of data elements *Procedure Code* and *Surgical Codes 1–4*. However, the *Procedure Code* and *Surgical Codes 1–4* fields, along with *Referring Provider ID*, *Diagnosis Codes 2–4*, *Primary Surgical Code*, and *Surgical Codes 1–4* fields, were not required for every inpatient encounter transaction. The *Procedure Code* data element was missing for 99.2 percent of records while *Surgical Codes* had missing rates ranging between 44.3 percent and 88.8 percent. The key data elements had very high validity rates, although the *Referring Provider ID* and *Performing Provider ID* data fields contained 10.8 percent and 8.8 percent invalid values, respectively.

The data elements *Member ID*, *Primary Diagnosis Code*, *Revenue Code,* and *Paid Date* were complete and had exceptional accuracy rates. The *Procedure Code* data element had a high overall absence rate of 99.2 percent, with all plans missing at least 96 percent of procedure code values. Statewide *Diagnosis Codes 2–4* were missing between 6.6 percent and 28.2 percent of values, and *Surgical Codes 1–4* were missing at least 40 percent of values, and over 99 percent of the populated values were valid. For the *Referring Provider ID* and *Performing Provider ID* data elements, 88.6 percent and 91.0 percent of the values were valid, respectively. HUM contained only 35.1 percent and 34.9 percent valid values for *Referring Provider ID* and *Performing Provider ID*, respectively. FHP had the second lowest validity percentages for these data elements—81.2 percent and 81.0 percent, respectively.

Outpatient Encounter Data

Results and Plan Comparison

Figure E-3 in Appendix E highlights the statewide percentage of missing, valid, and invalid values for each of the selected data fields in the outpatient encounter file. Detailed information on the percentage of missing and valid values for each of the selected data fields in the outpatient encounter file for each plan is shown in Table E-9 in Appendix E.

The absence rates for the Outpatient claim type key data elements were higher than other claim types. The *Referring Provider ID* and the *Procedure Code* fields had missing rates of 16.8 percent and 20.2 percent, respectively. The *Diagnosis Codes 2–4* fields were missing between 29.2 percent and 69.8 percent of values, and all *Surgical Codes* fields were missing for at least 99.9 percent of records. The provider IDs had the highest rates of invalid values, with rates of 20.2 percent and 29.8 percent for the *Referring Provider ID* and *Performing Provider ID* fields, respectively. All data elements with high missing rates, except *Performing Provider ID,* were not required for every outpatient encounter transaction.

The data elements *Member ID*, *Primary Diagnosis Code*, *Revenue Code,* and *Paid Date* were complete and had nearly perfect accuracy rates, except for ABH which had a validity rate of 60.2 percent for *Primary Diagnosis Code*. *Referring Provider ID* and *Procedure Code* data elements had statewide absence rates of 16.8 percent and 20.2 percent, respectively. For the *Referring Provider ID* data element, three plans (ABH, PHC, and UHP) were missing over 92 percent of values. For *Procedure Code*, ABH and MBH were missing 100.0 percent and 86.5 percent of values, respectively. *Diagnosis Codes 2–4* were missing between 29.2 percent and 69.8 percent of values statewide, and *Surgical Codes* were missing more than 99.9 percent of values; however, nearly all of the populated values were valid. The *Referring Provider ID* had valid values for 75.8 percent of populated records, with less than 70 percent of valid values for HEA and SUN. *Performing Provider ID* contained 68.9 percent of valid values, with the lowest validity rates of 0.0 percent and 3.1 percent for UHP and ABH, respectively.

Dental Encounter Data

Results and Plan Comparison

Figure E-4 in Appendix E highlights the statewide percentage of missing, valid, and invalid values for each of the selected data fields in the dental encounter file. Detailed information on the

percentage of missing and valid values for each of the selected data fields in the dental encounter file for each plan is shown in Table E-10 in Appendix E.

The Dental claim type had relatively complete data, although the *Billing Provider ID* field had an absence rate of 16.8 percent and the *Rendering Provider ID* field had a missing rate of 4.2 percent. However, the *Rendering Provider ID* field was not required for every dental encounter transaction. The data elements *Member ID, Procedure Code,* and *Paid Date* were populated with more than 99.9 percent valid values. The *Billing Provider ID* field contained 39.8 percent invalid values, and the *Rendering Provider ID* field contained 30.1 percent invalid values.

The data elements *Member ID*, *Procedure Code*, and *Paid Date* had no missing values and had accuracy rates of 100.0 percent. Overall, the *Billing Provider ID* data element was missing values for 16.8 percent of records, with eight plans that had missing rates over 20 percent. For this field, 52.2 percent of the values were valid at the statewide level, with the percent of valid values for the plans ranging between 28.2 percent (FCA) and 97.9 percent (IHP). The *Rendering Provider ID* had a low statewide absence rate of 4.2 percent, although UHP had an absence rate of 10.9 percent. ABH, DTQ, and IHP had more than 85 percent of valid values for the *Rendering Provider ID* field; however, the statewide rate was 68.6 percent, with two plans having less than 50 percent of valid values.

Pharmacy Encounter Data

Results and Plan Comparison

Figure E-5 in Appendix E highlights the statewide percentage of missing, valid, and invalid values for each of the selected data fields in the pharmacy encounter file. Detailed information on the percentage of missing and valid values for each of the selected data fields in the pharmacy encounter file for each plan is shown in Table E-11 in Appendix E.

The data for the Pharmacy claim type was nearly complete, with only 1.3 percent of records missing values for the *Dispensing Provider ID* data element. The records had high validity rates of 98.3 percent or higher for the majority of the key data elements. However, the *Billing Provider ID* and *Prescribing Provider ID* fields contained invalid values for 71.0 percent and 20.2 percent of records, respectively.

The data elements *Member ID*, *NDC*, *Paid Date*, and *Dispensed Date* were complete and had exceptional accuracy rates. The *Dispensing Provider ID* had a low overall missing rate of 1.3 percent. HUM and SHP had the highest *Dispensing Provider ID* missing rates of 2.8 percent and 2.1 percent, respectively. The *Billing Provider ID* had a low validity rate of 29.0 percent, with 17 plans containing less than 1 percent valid values. The *Prescribing Provider ID* contained 79.8 percent valid values, with FCA and AMG having the lowest rates of 69.2 percent and 73.1 percent, respectively. FCA submitted less than 30 records for this claim type, so caution should be used when interpreting the results.

Information Systems Review

As State Medicaid agencies increasingly use encounter data submitted by their contracted plans, the quality of these data becomes paramount. Depending on each plan's contractual arrangements with their providers, the completeness and accuracy of transactional data submitted to the state may vary. While plan encounter data submission requirements/manuals, regular feedback in terms of encounter rejection reports, and performance standards in encounter submission can be effective in managing the quality of the encounters received from the plans, other factors can affect the quality of these data.

Although most of the questions in the plan and AHCA questionnaires relate to policies, procedures, and specific approaches to handling various stages of claims and encounter processing, the questions were developed to provide a supplemental understanding of how each organization's unique processes might affect the quality of the encounter data submitted to AHCA by the plans. The questionnaires were intended to provide additional insight into quantitative results generated from the comparative claims analyses. In cases where data anomalies were identified in quantitative results, plan responses could be used to try to identify the root cause for the data discrepancies. Since the results from the desk review of the plan and AHCA questionnaires were not intended to be an independent study of each entity's processes, they are best viewed as a building block to explore process-oriented opportunities for improvement in the completeness and quality of submitted encounters.

Plans

Results and Plan Comparison

In general, each plan has its own policies and procedures; levels of automation; and processes for receiving, validating, and processing claims and encounters from its providers. It also appears that each plan has a process of extracting claims and encounters from either its claims systems or data warehouses to prepare the encounter files for submission to AHCA, as well as processes for receiving data submission feedback from AHCA (e.g., issues identified in the response files are investigated and researched). Third party claims, including Medicare crossover claims, generally account for a very small percentage of the overall claims processing, and the plans do not consider the submission of these claims to AHCA to be a major challenge. Many of the challenges cited by the plans are instead related to discrepancies created by accurate and timely provider registration and mapping to AHCA's database. These issues appear to pose significant challenges to the plans, especially for encounters rejected by AHCA for these reasons.

Within the constraints of the project, HSAG was not able to provide additional assessment on the quality and effectiveness of the various claims processing, validation, monitoring, and extraction processes described by the plans. Further triangulation of evidence would be needed to ensure that the plans are following the processes and procedures reported in their questionnaire responses.

Medical Record Review

HSAG collected and reviewed the medical records of AHCA's plan enrollees to assess the quality of AHCA's encounter data. The results are separately presented for encounter data and medical record omissions and for encounter data accuracy.

Encounter Data and Medical Record Omissions

Results and Plan Comparison

HSAG examined the extent to which services present in the encounter data were not documented in enrollees' corresponding medical records (known as medical record omissions) as well as the extent to which services documented in the medical record were not present in the encounter data (known as encounter omissions). Based on the cases sampled for medical record review, HSAG found that the encounters submitted to AHCA were generally supported by documentation in enrollees' medical records. Across the sampled plans, 86.2 percent of the dates of service identified in the electronic encounter data were supported by enrollees' medical records. Moreover, 79.1 percent of diagnosis codes and 78.0 percent of procedure codes identified in the electronic encounter data were found in enrollees' medical records. These findings suggest a moderate level of completeness of key data elements in AHCA's electronic encounter data when compared to documentation in enrollees' medical records.

Nonetheless, while encounters submitted to AHCA by the plans were generally supported by the medical records, not all services documented in the medical records were submitted to AHCA (i.e., encounter data omissions). For example, 23.8 percent of the diagnosis codes and 21.0 percent of the procedure codes documented in the enrollees' medical records were missing from the electronic encounter data. This finding represents an opportunity to improve the completeness of AHCA's encounter data by increasing the percentage of diagnosis and procedure codes submitted to the encounter data system to better align with what is found in the medical records.

Results from the medical record omission and encounter data omission analyses highlight existing discrepancies in the completeness of AHCA's encounter data. Although the discrepancies were not extensive, the results suggest that in CY 2012, some services rendered to enrollees were not incorporated into AHCA's encounter data system.

Additionally, during the procurement of medical records, it was identified that encounter data completeness was likely affected by the way plans approach the submission of adjusted encounters to AHCA. For many of the cases associated with unmatched encounters,[13] plans were unable to, or had difficulty with, procuring the medical records since they were frequently for services for which the plan was not responsible. Sometimes when an encounter is adjusted at the plan level, those adjustments are not submitted to AHCA, leading to discrepancies within the encounter data. This finding also suggests that eligibility verification was not in place when encounters were processed prior to submission to AHCA.

[13] Unmatched encounters represent those encounters where encounters attributed to a plan were associated with enrollees not enrolled with that plan at the time the service was rendered.

Encounter Data Accuracy

Results and Plan Comparison

HSAG evaluated the accuracy of diagnosis codes, procedure codes, and procedure modifiers submitted to AHCA's encounter data system based on documentation contained in enrollees' medical records. In general, when key data elements (i.e., diagnosis codes, procedure codes, and procedure code modifiers) were present in the encounter data submitted to AHCA, and evaluated separately for each of the individual data elements, they were found to be coded accurately. Among the codes that were evaluated, 90.6 percent of diagnosis codes, 86.9 percent of procedure codes, and 87.5 percent of procedure code modifiers identified in the encounter data were supported by medical record documentation. These findings suggested that less than 15 percent of the diagnosis codes, procedure codes, and procedure code modifiers in AHCA's encounter data were inaccurate. For both diagnosis and procedure codes, the majority of errors resulted from the use of inappropriate codes when compared to national coding standards.

Moreover, only one-third of those cases in medical record agreement accurately represent all three data elements (i.e., diagnosis code, procedure code, and procedure code modifier) when compared to enrollees' medical records. The overall accuracy findings indicated that there was at least one inaccurate data element for two-thirds of the dates of service reviewed in this study.

Conclusions and Recommendations

Encounter Data Completeness and Reasonableness

Based on HSAG's review of the electronic encounters submitted by AHCA, HSAG identified a few data concerns, the majority of which are related to either the timeliness of submitting data to HSAG or data issues associated with AHCA's data extraction process. To ensure the success of future encounter data validation activities and the quality of encounter data submissions from contracted plans, five areas of interest have been identified as potential opportunities for improvement.

- **AHCA should ensure there is a reliable process for timely submission of data.** For the SFY 2013–2014 encounter data validation activity, multiple attempts were made by HSAG and AHCA to ensure that the data received from AHCA were complete and accurate. However, based on the delays in receiving data from AHCA, HSAG was unable to initiate the comparative analysis, and the medical record review component of the study was reduced and delayed. AHCA anticipates that the encounter data validation activity will be performed annually. Therefore, to ensure that the completion of these activities is timely, data need to be submitted according to the scheduled timeline.
- **AHCA should work with its Medicaid Management Information System (MMIS) and data warehouse teams to develop standardized encounter extracts to facilitate the efficient production of analytic data files for use in reporting.** Most of the data concerns identified through the encounter data file review were related to errors in the process used to extract data for this study. For the SFY 2013–2014 study, the extraction process used to attribute claims to participating plans resulted in unreliable data. Although fields exist within the Florida MMIS (FMMIS) to capture the plan "responsible" for a given encounter (i.e., XXX), this information is inconsistently populated in plan submissions. As such, AHCA was forced to assign claims to

plans based on recipients' enrollment segment leading to erroneous data related to dental and mental health plans. By developing a standard extract process, AHCA can ensure the timeliness of future studies as well as the integrity of data extracted from its system. This process could also be applied to data extracts prepared for other AHCA units that potentially impact the State's encounter-based reporting.

- **AHCA should continue its efforts to monitor the submission of the *Plan Provider ID* (field used in the interchange control segment that plans are requested to use to indicate the submitting 9-digit ID) in order to identify the plans' encounter submission.** To ensure the accurate attribution of plans to encounters, submission of the field is critical. Based on ongoing monitoring of this field, AHCA should consider implementation of encounter edits on this field to promote submission; encounters submitted without valid plan provider IDs could then be rejected and force plans to resubmit them. AHCA noted that this issue was identified and a request for system edits was submitted to Florida's Medicaid fiscal agent in 2013. The final system edits to require a valid Plan Provider ID were implemented in May 2014. Therefore, this recommendation has already been implemented.
- **AHCA should implement standard data quality assurance protocols for validating the production of report and file extracts.** In general, sufficient processes and training should be put in place to ensure data are thoroughly validated for accuracy and completeness prior to submission and delivery. HSAG recommends that AHCA's data quality checks include, but not be limited to, the following:
  - Data were extracted according to the data submission requirements document.
  - Control totals for each of the requested data files are reasonable.
  - Determine if duplicate records are reasonable.
  - Distribution of the data field values is reasonable.
  - Presence check, i.e., Determine if there are data fields with missing values for all records in any of the data fields.
  - Data fields were populated with reasonable values.
- **AHCA should review current Agency reporting requirements to ensure that critical data fields that impact rates are complete.** Some plans did not submit any values in their encounter files for elements such as *Secondary Diagnosis Code, Primary Surgical Code*, and *Secondary Surgical Code*. Since many of these fields can be used to support performance measure calculation and federal reporting of quality measures, AHCA should evaluate the plans' processes and require them to collect and submit values for these data elements.

Information Systems Review

HSAG identified three areas as potential opportunities for improvement:

- **HSAG recommends that AHCA work with the plans to determine if the data submission requirements pertaining to provider mapping are too stringent.** State provider mapping was identified by the plans as a major challenge to the submission of complete and timely encounters to AHCA. Based on AHCA's questionnaire response, it appears that FMMIS is adjudicating both claims and encounters submitted by the plans, a process usually restricted to processing claims from fee-for-service (FFS) providers. Although accurate provider information is paramount when processing FFS claims, such verification and validation responsibilities should

reside with the plans, with AHCA acting as an oversight entity to ensure that the plans are collecting and processing accurate provider information. AHCA may want to consider strengthening its contractual requirements with the plans regarding the provision of oversight activities in this area, allowing the plans to identify any potential issues related to provider data when the claims/encounters are received in their data system. This approach would minimize any provider data anomalies noted at the end of the plan's encounter submission process and allow the plans to work with their contracted providers to ensure that information is provided accurately when the claims are first submitted to the plans.

- **HSAG recommends that AHCA organize a webinar to explain and discuss the comprehensive list of operational edits associated with the error categories identified in the feedback/response files.** Some plans indicated that resubmission of rejected encounters by the plan is challenging when reasons for the rejection are not clearly detailed. Distributing an updated, comprehensive list describing the nature of the errors and providing webinar technical assistance sessions allows the plans to (1) have a better understanding of which claims-related elements are important in their encounter submission process, and (2) conduct their own investigations in a more efficient manner. Additionally, inviting Helpdesk personnel to these sessions will allow them to become more knowledgeable about the operational edits list, which facilitates a better problem-solving experience between the plans and the Helpdesk. With an enhanced list of edits and error explanations, it is likely that the percentage of rejected encounters may decrease.
- **HSAG recommends that AHCA use the enhanced list of edits and error explanations to work with plans to refine categories of rejected encounters for resubmission and subsequently revise the resubmission time frame.** While it is important to ensure that the plans are resubmitting rejected encounters to AHCA, different rejection reasons may impact the plans' ability to resubmit the claims/encounters in a timely manner. As some of the plans indicated, claims paid to providers losing Medicaid status are less likely to be corrected and resubmitted. AHCA may want to consider adding a column to the list of edits and error explanations to demonstrate specific resubmission expectations for the plans. This will allow the plans the opportunity to prioritize their resources according to the volume of rejected encounters by edit/error category. It will also allow for more effective oversight by the Bureau of Fiscal Agent Operations, which will have the ability to communicate specific improvement in plan compliance based on these categories.

Medical Record Review

Results from the medical record review suggest that while submitted encounters and key data elements (i.e., diagnosis codes, procedure codes, and procedure code modifiers) were generally supported by enrollees' medical records, opportunities for improvement exist for the submission of complete and accurate encounters to AHCA.

- **AHCA may want to consider requiring the plans to audit provider encounter submissions for completeness and accuracy.** AHCA may want to require the plans to develop periodic provider education and training regarding encounter data submission, medical record documentation, and coding practices. These activities should include a review of both state and national coding requirements and standards, especially for new providers contracted with the plans. In addition, HSAG recommends that AHCA consider requiring the plans to perform

periodic reviews of submitted claims to verify appropriate coding and completeness to ensure encounter data quality. Results from these reviews can be submitted to AHCA and used in its ongoing monitoring of encounter data.

- **AHCA may want to consider working with the plans to explore the reasons for incomplete encounter data submissions and develop strategies to improve rates.** Since maintaining good encounter data quality is a responsibility involving multiple organizational entities—including the State, the plans, and the providers—HSAG recommends that AHCA work with the plans to explore the reasons for encounter data omissions. AHCA should ensure that there are no system issues that impact the acceptance of encounter data submitted by the plans. This process includes both file acceptance as well as data element acceptance. As noted earlier, AHCA may want to consider requiring the plans to conduct their own monitoring of claim/encounter submissions to ensure the completeness of information they are receiving.
- **AHCA may want to consider enhancing current submission requirements to ensure denied and adjusted encounters are submitted to the State.** Based on information obtained from the plans regarding the non-submission of unmatched encounters, it was identified that not all reversals or adjustments made to claims/encounters at the plan level are submitted to AHCA. As a result, AHCA's encounter data may contain surplus or erroneous encounter data. Additionally, since plans are not required to submit denied encounters to AHCA, the observed omission rates may be affected by the absence of these data. Moreover, since denied encounters are allowed in performance measure rates like HEDIS, acceptance of these encounter types may also impact reported performance measure rates.

Overview of Cultural Competency Focused Study

AHCA contracted with HSAG to conduct a statewide focused study related to cultural competencies with the goal of assisting AHCA and its managed care plans in identifying areas and strategies for improvement. The project consists of two main components:

- Complete a comparative analysis of each SMMC plan's cultural competency plan and any findings from each SMMC plan's evaluation of its cultural competency plan (CCP) from the previous year.
- Assess enrollees' perception of and satisfaction with the plans' and providers' cultural competency in the delivery of healthcare services.

For the first component of the study, HSAG developed a data collection tool to use in the review of each plan's CCP. Completion of the study tools and subsequent analysis will enable HSAG to meet its objective of providing meaningful information to AHCA regarding the SMMC plans' contract and regulatory compliance and consistency with National Culturally and Linguistically Appropriate Services (CLAS) standards in the area of cultural competency. Results of this portion of the focused study will be provided in a report to AHCA in May 2015 and will also be included in the 2014–2015 EQR Technical Report.

The second component of the study will commence in contract year 2014–2015 and be completed in contract year 2015–2016. During contract year 2014–2015, HSAG will assist AHCA in identifying cultural competency related survey items to add to the plans' CAHPS surveys. Based on the outcome of the 2014–2015 study, HSAG and AHCA will work together to determine next steps for the project for contract year 2015–2016.

Child Health Check-Up Participation Rates

States are responsible for providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services to all Medicaid-eligible children younger than 21 years of age. Florida's CHCUP program includes comprehensive and preventive health services provided according to the State's Child Health Check-Up Coverage and Limitations Handbook. Florida plans are contractually required to submit an annual report that includes basic data elements specified by the State. An independent auditor must certify the data. The State requires plans to screen at least 60 percent of those enrolled in the program for at least eight months. The plans also must meet a screening and participation goal of 80 percent. Plans that do not achieve a 60 percent screening rate or the 80 percent screening and participation goal must submit a corrective action plan to the State and are subject to liquidated damages. The most recent (October 1, 2012, to September 30, 2013) CHCUP statewide screening rate was 84 percent, and the participation rate was 57 percent.

Medicaid Health Plan Report Card

Florida Medicaid's MMA program is authorized under an 1115(a) Demonstration Waiver. The Special Terms and Conditions of the MMA program require that Florida create a health plan report

card that must be posted on the State's website and present an easily understandable summary of quality, access and timeliness of care based on performance data for each MMA plan. Recipients can use this information to compare plans and help them to decide which plan to choose.

Individual performance measures are used to compare plans and are rolled up into six performance measure categories:

- Pregnancy-related Care
- Keeping Kids Healthy
- Children's Dental Care
- Keeping Adults Healthy
- Living With Illness
- Mental Health Care

The first report card will be posted in 2015, is based on HEDIS 2014 data (i.e., CY 2013 data reported in CY 2014), and will include plan data for services provided under previous contracts with AHCA. Plans will be compared against national Medicaid benchmarks, published by NCQA, using a 5-star rating scale. The second annual report card will be posted in CY 2016 and will be based on HEDIS 2015 data (i.e., CY 2014 data reported in CY 2015), including data on enrollees served under previous plan contracts and new MMA contracts. The third annual report card and subsequent report cards will include enrollees and services under the MMA plan contracts. Only those who have been enrolled in plans for a specified amount of time are included in measure calculations.

The report card displays ratings by plan for each of the six performance measure categories. There are also options to see the plans' 1–5 star ratings per individual performance measure in the categories, and to see the plans' actual scores for each measure (e.g., the percentage of plan enrollees who received breast cancer screening).

The Medicaid Health Plan Report Card will be posted on the Florida Health Finder website at www.floridahealthfinder.gov.

Plan Accreditation Results

As a condition of participation in the SMMC program, all plans are required to be accredited by NCQA, the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), or another nationally recognized accrediting body, or have initiated the accreditation process within one year after their contract with AHCA is executed. For any plan not accredited within 18 months after contract execution, AHCA will suspend automatic assignment of enrollees to those plans. As of December 2014, 18 plans participating in the SMMC program are accredited (eight with NCQA, nine with AAAHC, and one with The Joint Commission), and one is pursuing accreditation status.

Validation of Performance Improvement Projects

As part of the State's quality strategy, each plan was required by AHCA to conduct PIPs in accordance with 42 CFR 438.240. The purpose of these PIPs was to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical care and services in nonclinical areas. For the projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, the PIPs must be designed, conducted, and reported using sound methodology and must be completed in a reasonable time. This structured method of assessing and improving plan processes is expected to have a favorable effect on health outcomes and member satisfaction. As one of the mandatory EQR activities required under the BBA, HSAG validated the PIPs through an independent review process that followed the CMS protocol. The primary objective of the PIP validation was to determine compliance with requirements set forth in 42 CFR 438.240, including:

- Measurement of performance using objective quality indicators.
- Implementation of system interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

While the primary purpose of HSAG's PIP validation methodology was to assess the validity and quality of processes for conducting PIPs, HSAG also verified that the plans' PIPs contained study indicators related to quality, access, and timeliness domains. More specifically, all of the PIPs provided opportunities for the plans to improve the quality of care for their enrollees.

Description of Data Obtained

Data obtained for the validation of PIPs was taken from the HSAG PIP Summary Forms completed by the plans and submitted to HSAG in October 2013. In addition, for verification of reported study indicator results from HEDIS-based PIP topics, HSAG used the information submitted to AHCA by the plans via the interactive data submission system (IDSS).

Technical Methods of Data Collection/Analysis

The methodology HSAG used to validate the PIPs was based on the Department of Health and Human Services, Centers for Medicare & Medicaid Services *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

HSAG, in collaboration with AHCA, developed the PIP Summary Form to be consistent with CMS' updated protocol for conducting PIPs and to assist the plans in meeting compliance requirements. The plans were provided the PIP Summary Form to complete and submit to HSAG for review.

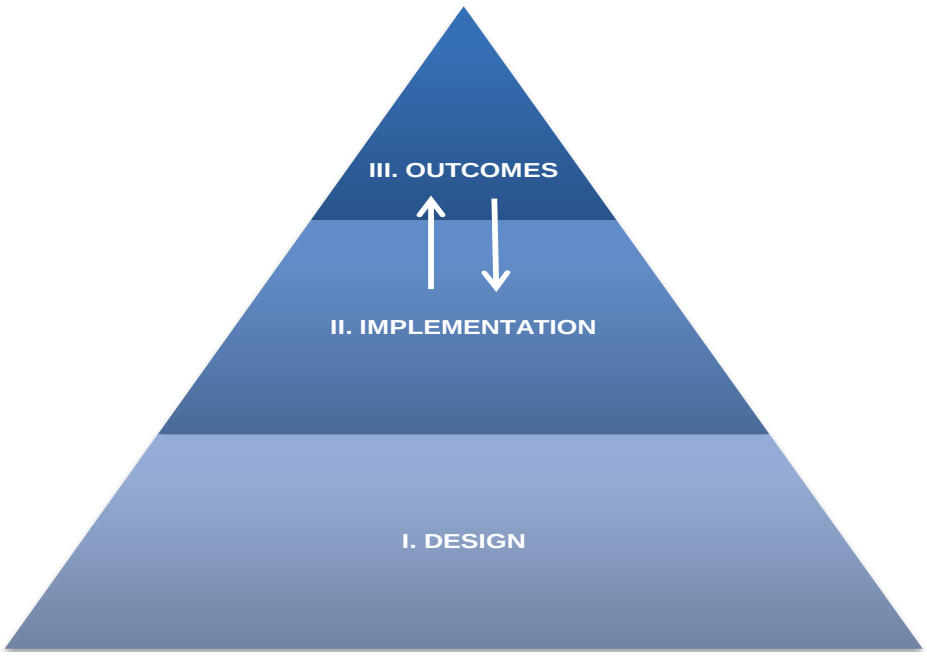
HSAG obtained the data needed to conduct the PIP validation from the plans' PIP Summary Forms. These forms provided detailed information about each plan's PIPs related to the activities completed by the plan and evaluated by HSAG for the SFY 2013–2014 validation cycle.

Each required activity was evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scored each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable,* or *Not Assessed*. HSAG designated some of the evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements had to be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that received a *Not Met* score resulted in an overall validation rating for the PIP of *Not Met*. A plan was given a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*. HSAG provided a *Point of Clarification* when enhanced documentation by the plan would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*), HSAG gave each PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculated the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculated a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

Figure A-1 illustrates the three stages of the PIP process—i.e., Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage establishes the methodological framework for the PIP. The activities in this section include identification of the study topic and study question; definition of the study indicators and eligible population; development of sampling techniques, if applicable; and the establishment of the data collection methodology. To implement successful improvement strategies, a strong study design is necessary.

Figure A-1—PIP Stages



Once a plan establishes the PIP study design, the Implementation stage of the PIP process begins. This stage includes data analysis and implementation of improvement strategies. During this stage, the plans analyze measurement data and interpret study indicator findings, evaluate and identify barriers to performance, and develop and evaluate interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve PIP outcomes. If the study indicator outcomes do not improve during remeasurement periods, the plans investigate the data they collected to ensure that they have correctly identified the barriers and implemented appropriate and effective interventions. If they have not, the plans revise their interventions and collect additional data to further evaluate outcomes for improvement. This process becomes cyclical until sustained improvement is achieved.

The final stage is Outcomes, which involves the evaluation of real and sustained improvement based on reported results and statistical testing. This stage is the culmination of the previous two stages. During SFY 2014, HSAG worked with AHCA to modify the existing PIP scoring methodology. The modifications were designed to ensure that the plans achieved real improvement across all study indicators. The plan must achieve statistically significant improvement over the baseline across all study indicators to receive a *Met* validation score. Once the plan achieves statistically significant improvement over the baseline across all study indicators, the improvement must be sustained during a subsequent measurement period to receive a *Met* validation score, as well as an overall *Met* validation status.

Validation of Performance Measures

Objectives

HSAG's role in the validation of performance measures for each plan type was to ensure that validation activities were conducted as outlined in the CMS publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),*[14] Version 2.0, September 1, 2012 (CMS Performance Measure Validation Protocol). More specifically, HSAG performed PMV audits to determine if performance measure rates were collected, reported, and calculated according to the specifications required by the State.

For HMOs/PSNs and PDHPs, AHCA required that the plans undergo a NCQA HEDIS Compliance Audit on the performance measures selected for reporting. To avoid any redundancy in the auditing process, HSAG evaluated the NCQA HEDIS Compliance Audit process in light of the steps described in the CMS protocol. AHCA required the LTC plans to undergo a PMV process conducted by an external audit firm, according to the CMS protocol. For PMHPs/CWPMHP, AHCA required the plans to undergo a PMV process conducted by HSAG according to the CMS protocol. Due to slightly different validation processes, while the information obtained from the plans is similar, the technical methods used for the PMV are different from those used for the NCQA HEDIS Compliance Audit.

Description of Data Obtained

Since the audits for HMOs/PSNs, PDHPs, and LTC plans were performed by NCQA-licensed organizations (LOs) during SFY 2013–2014, HSAG's role was to determine the extent to which the measures reported to AHCA were calculated according to AHCA's specifications. HSAG conducted its PMV activity for the HMOs/PSNs, PDHPs, and LTCs during SFY 2014–2015. In general, three primary data sources were used to conduct the PMV audits: the Roadmap, final audit results, and the FAR.

For PMHPs'/CWPMHP's PMV audits, data were obtained from the customized Information Systems Capabilities Assessment Tool (ISCAT), requested documents, and performance measure rates provided by the PMHPs/CWPMHP.

[14] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care-external-quality-review.html Accessed on: January 7, 2015.

Technical Methods of Data Collection/Analysis

HMOs/PSNs/PDHPs/LTC Plans

For HMOs/PSNs, LTC plans, and PDHPs, HSAG received each plan's performance measure report and final audit report from AHCA and detailed audit findings generated by the LOs for each plan. Since there are important documents used and/or generated by the plans/their auditors during a typical NCQA HEDIS Compliance Audit, HSAG reviewed these documents and verified the extent to which critical audit steps were followed during the audit.

Table A-1 presents critical elements and approaches that HSAG used to conduct the PMV activities.

Table A-1—Key PMV Steps Performed by HSAG
Pre-On-Site Visit Call/Meeting—HSAG verified that the LOs addressed key HEDIS topics, such as timelines and on-site review dates.
HEDIS Roadmap Review—HSAG examined the completeness of the Roadmap and looked for evidence in the FARs that the LOs completed a thorough review of all the components of the Roadmap.
Software Vendor—HSAG assessed whether a vendor was contracted to calculate and produce the rates for the required measures, and if this software vendor achieved full measure certification status by NCQA for the reported HEDIS measure. Where applicable, the NCQA Measure Certification letter was reviewed to ensure that each measure was under the scope of certification. Otherwise, HSAG examined whether source code review was conducted by the LOs (see next step below).
Source Code Review— HSAG ensured that if a software vendor with certified measures was not used, the LOs reviewed the plans' programming language for HEDIS measures. Source code review was used to determine compliance with the performance measure definitions, including accurate numerator and denominator identification, sampling, and algorithmic compliance (ensuring that rate calculations were performed correctly, medical record and administrative data were combined appropriately, and numerator events were counted accurately).
Primary Source Verification—HSAG verified that the LOs conducted appropriate checks to ensure that records used for HEDIS reporting matched primary data source records. This step is to determine the validity of the source data used to generate the HEDIS rates.
Convenience Sample Validation—HSAG verified that, as part of the medical record review (MRR) validation process, the LOs identified whether a convenience sample was required, and if not, whether specific reasons were documented.
MRR—HSAG examined whether the LOs performed a re-review of a random sample of medical records based on the NCQA MRR validation protocol to ensure the reliability and validity of the data collected.
MCO Quality Indicator Data File Review—HSAG evaluated whether there was any documentation in the FAR to show that the LOs performed a review of the plan quality indicator data file. The plans are required to submit a health plan quality indicator data file for the submission of audited rates to AHCA. The file should comply with the AHCA-specified reporting format and contain the denominator, numerator, and reported rate for each performance measure.

To evaluate an HMO's/PSN's, LTC plan's and PDHP's capabilities for accurate HEDIS reporting, HSAG reviewed each FAR submitted by the plans to confirm/evaluate the LO's assessment of IS capabilities,[15] specifically focusing on aspects of the plan's system that could affect the HEDIS Medicaid reporting set.

Since each plan received audit designation results from its LO for the performance measures being reported, HSAG assessed the reasonableness of these results by reviewing the performance measure reports and comparing them against the FARs where applicable. HSAG also evaluated the extent to which the plans complied with AHCA's reporting requirements for submitting their rates in the performance measure reports.

PMHPs/CWPMHP

For PMHPs/CWPMHP, HSAG obtained a list of measures for validation from AHCA. Additionally, the measure definitions, measure specifications, and reporting format were reviewed by HSAG prior to the audit.

HSAG prepared a documentation request for the ISCAT and forwarded it to each PMHP/CWPMHP with a timetable for completion and instructions for submission. HSAG responded to ISCAT-related questions directly from the PMHPs/CWPMHP prior to the web-assisted validation review sessions.

HSAG prepared an agenda describing all web-assisted site review activities and indicating the type of staff needed for each session. HSAG forwarded the agendas to the respective PMHPs/CWPMHP prior to the review.

During the web-assisted validation review with each of the PMHPs/CWPMHP, HSAG collected information using several methods including interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The review activities conducted by HSAG during each audit were as follows:

- **Opening meeting/session**—The opening meeting/session included introductions of the validation team members and key plan staff members involved in the performance measure activities. The meeting/session covered the review purpose, the required documentation, basic meeting logistics, and queries to be performed.
- **Evaluation of system compliance**—The evaluation included a review of the IS assessment focusing on the processing of enrollment data. Additionally, the review evaluated the processes used to collect and calculate the performance measures, including accurate numerator and denominator identification and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).
- **Review of ISCAT and supporting documentation**—This included a review of the processes used for collecting, storing, validating, and reporting performance measure data. This session

[15] The term "IS" was broadly used to include the computer and software environment, data collection procedures, and abstraction of medical records for hybrid measures. The IS evaluation also included a review of any manual processes used for HEDIS reporting. The LOs determined if the MCOs had the automated systems, information management practices, and processing environment and control procedures in place to capture, access, translate, analyze, and report each HEDIS measure.

was designed to be interactive with key plan staff members so that the review team could obtain a complete picture of all the steps taken to generate the performance measures and the degree of compliance with written documentation. HSAG used interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that the plan used and followed written policies and procedures in daily practice.

- **Overview of data integration and control procedures**—The overview included HSAG's discussion and observation of source code logic, and a review of how all data sources were combined and how the analytic file was produced to report the selected performance measures. HSAG performed primary source verification to further validate the output files. HSAG also reviewed backup documentation on data integration. This session addressed data control and security procedures as well.
- **Closing conference**—The closing conference summarized preliminary findings based on the review of the ISCAT and the web-assisted validation review sessions, and revisited the documentation requirements for any post-validation review activities.

Similar to the reviews conducted for the HMOs/PSNs and PDHPs, HSAG also performed an evaluation of the PMHPs'/CWPMHP's IS capabilities for accurate data reporting. To evaluate the calculation of performance measures, HSAG reviewed data integration, data control, and documentation of performance measure calculations. HSAG validated each of these components and reported on the processes used and the overall findings. Based on all validation activities for these PMHPs/CWPMHP, HSAG determined results for each performance measure (i.e., *Report* [R], *Not Reported* [NR], or *No Benefit* [NB]).

Encounter Validation Study

During SFY 2013–2014, AHCA contracted with HSAG to conduct an EDV study. The goal of the study was to examine the extent to which encounters submitted to AHCA by its contracted managed care plans, PMHPs, and PDHPs (collectively referred to as plans) are complete and accurate. During the first contract year, 33 percent (or 24) of the plans operational as of January 2013 were assessed. For a complete list of plan names, please see Table F-3 in Appendix F.

Encounter Data Completeness and Reasonableness

Objectives

The study was originally designed to encompass several analytic activities consistent with activities described in CMS' *EQR Protocol 4: Validation of Encounter Data Reported by the MCO: A Voluntary Protocol for External Quality Review (EQR),* Version 2.0, September 2012,[16] including:

- An IS assessment designed to ascertain the plans' abilities to submit encounter data according to the encounter data submission requirements established by AHCA.
- A comparative data analysis between the State's encounter data and the plans' administrative data, to evaluate the extent to which encounters submitted by the plans and maintained in the State's MMIS are accurate and complete when compared to data stored in the plans' data systems.
- An assessment of the completeness and accuracy of AHCA encounters using medical record review.

However, due to delays associated with the acquisition of encounter data as well as the integrity of the data, the comparative analysis component was limited to an AHCA encounter data file review. However, HSAG performed a series of preliminary analyses (e.g., producing file review documents as well as comparing the volume of records submitted by AHCA and records submitted by the plans) in order to understand the issues and potential causes for the anomalies identified within AHCA's data.

Descriptions of Data Obtained

Based on the approved scope of work, HSAG worked with AHCA's EDV team and the Decision Support System (DSS) team to develop the data submission requirements for conducting the EDV study. Once finalized, the data submission requirements were submitted to both the plans and AHCA to guide the extraction and collection of the study data. Data were requested for all claim/encounter records with dates of service between January 1, 2012, and December 31, 2012, and submitted to AHCA on or before August 1, 2013, for the 24 plans included in the EDV study.

[16] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 4: Validation of Encounter Data Reported by the MCO: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 5, 2015.

In addition to the file specifications, the data submission requirements also included information on the required data types (i.e., physician, inpatient, outpatient, dental, and pharmacy) and the associated required data elements. HSAG also requested AHCA to provide other supporting data files related to recipient enrollment, recipient demographics, and providers associated with the encounter files.

HSAG received an initial set of data files from AHCA in November 2013, but discovered numerous issues, including the receipt of incomplete data for all 24 plans. HSAG reviewed the data issues with AHCA during a conference call in December 2013 and requested that AHCA resubmit its encounter data files. AHCA's DSS team indicated that the encounter data were extracted using the *Plan Provider ID* field (i.e., a field that plans are requested to use to indicate the submitting 9-digit Medicaid ID) to identify the plans' encounter submission. However, due to the field not being populated consistently, there were discrepancies in the volume of records extracted when compared to the volume of records submitted by the plans. As a result, AHCA's DSS team modified its extraction approach and based the revised data pull on the *Recipient PMP Provider ID* (i.e., the plan's assignment for the recipient at the time the service was rendered) since this was the only consistently populated field that linked a plan to the recipient listed on the encounter record.

In January 2014, HSAG received the revised recipient and provider files from AHCA and received the revised Physician, Inpatient, Outpatient, Dental, and Pharmacy files in February. Upon reviewing the files, HSAG identified that encounters for the PDHP and PMHP plans were omitted from the files. This omission resulted from AHCA's use of the *Recipient PMP Provider ID* to identify encounters by plan. Since Florida Medicaid recipients can be enrolled in a managed care plan for their physical health services simultaneously with a PDHP and PMHP, an additional data pull was required to identify these claims. Additionally, HSAG noted that the *Provider Submitter ID* (i.e., the field used to validate a sender is authorized to submit batches of data to Florida Medicaid) for some of the encounters listed a different plan than identified in the *Recipient PMP Provider* field. Based on these findings, AHCA was required to generate an updated encounter file that included the PDHPs and PMHPs. HSAG received these files between February and April 2014.

Technical Methods of Data Collection/Analysis

As mentioned earlier, HSAG performed a series of preliminary analyses that included producing file review documents and comparing the volume of records submitted by AHCA with the records submitted by the plans. This process allowed HSAG to understand the issues and potential causes for the anomalies identified within AHCA's data. As requested by AHCA in December 2013, HSAG investigated and documented the results of its review.

The final set of encounter files was then used to examine the extent to which the data extracted and submitted by AHCA were reasonable and complete. HSAG's review involved multiple methods and evaluated that:

1. The volume of submitted encounters was reasonable.
2. Key encounter data fields contained complete and/or valid values.
3. Other anomalies associated with the data extraction and submission were documented.

Information Systems Review

Objectives

Under the CMS Protocol, an IS assessment provides information on the strengths and limitations of AHCA's and the plans' information systems in promoting and maintaining quality encounter data.

Descriptions of Data Obtained

HSAG worked with AHCA to obtain all relevant documentation related to the processing of encounter data by the plans and AHCA. Submitted to HSAG in October 2013, these documents included, but were not limited to, IS schema, processing diagrams, file/table layouts, submission requirements and standards, and current monitoring reports. These documents provided necessary context for refinement of the project methodology.

Technical Methods of Data Collection/Analysis

To gain an overall understanding of both AHCA's and the plans' internal data processing, HSAG developed customized questionnaires for AHCA and the plans to gather information regarding each organization's IS and data processing procedures. These customized questionnaires were developed based on the ISCAT to identify current processes and procedures that impact encounter submission and processing. HSAG also included supplemental questions specific to the plans' data processes that addressed the following topics:

- The processing and submission of denied encounters to Florida's Medicaid fiscal agent.
- The handling of encounter data submissions from capitated providers.
- The processing and submission of crossover claims to Florida's Medicaid fiscal agent.
- The operational and financial relationships between the plans and their downstream providers.
- Policies and procedures for ensuring accurate processing and payment to downstream providers.

By reviewing the plans' and AHCA's responses to these questions, HSAG was able to examine how the plans prepare their data files for submission to Florida's Medicaid fiscal agent and how these data files move through AHCA's data systems.

The questionnaires were approved by AHCA and distributed to the plans and AHCA's IS area in October 2013. Questionnaire responses and supporting documents were received from the plans and AHCA during October and November 2013. Upon receipt of these questionnaires, HSAG reviewed each organization's responses and supplemental information. Results from the assessment were based entirely on self-reported information by the plans and AHCA.

Medical Record Review

Objectives

Medical and clinical records are considered the "gold standard" for documenting Medicaid enrollees' access to services and quality of services they receive. The medical record review

component of an EDV study is designed to assess the completeness and accuracy of AHCA's encounters by verifying key data elements using enrollees' medical records.

This study, which included the review of fewer medical records, replaced a more comprehensive study for the SFY 2013–2014 EDV activities. HSAG performed medical record review on a sample of 130 cases[17] on a subset of capitated plans, operational as of January 2013, that were selected by AHCA. Table A-2 displays the specific data elements evaluated in the medical record review.

Table A-2—Key Data Elements for Medical Records Review: Physician Encounters
Date of Service
Diagnosis Code
Procedure Code (CPT/HCPCS)
Procedure Code Modifier

Pharmacy encounters and certain ancillary outpatient services (i.e., laboratory, radiology, durable medical equipment, and transportation) were excluded from the medical record review component of the study. Based on the data available at the initiation of this project, the current study focused on professional encounters associated with physician services, excluding services provided by behavioral health plans.

Descriptions of Data Obtained

To be eligible for the medical record review, an enrollee must have had at least one physician office visit during the study period (January 1, 2012– December 31, 2012).

AHCA encounter data and provider data were used to select the sample cases for the medical record review. During data preparation for this study, data anomalies were identified affecting the integrity of the assignments of specific encounters to a specific plan. In preparing the data for HSAG, AHCA assigned recipients to a plan based on recipients' enrollment segments. AHCA then matched the dates of service from encounters to recipients' enrollment segments to associate a plan to an encounter (i.e., *Recipient PMP Provider ID*). AHCA's DSS team had also provided the *Trading Partner ID* field (i.e., the field used to validate that the sender was authorized to submit batches of data to Florida Medicaid), where in some cases, the *Trading Partner ID* associated with the plan indicated a different plan had submitted the encounter than the one to which the recipient was assigned (i.e., there was a subset of encounters that were submitted for recipient s that were not enrolled with the identified plan at the time the service was rendered). To ensure both matched (i.e., where the encounter was submitted by the plan in which the enrollee was assigned) and unmatched (i.e., where the encounter was submitted by a plan different than the one in which the enrollee was assigned) encounters were incorporated into the analyses, HSAG employed a two-stage stratified

[17] Due to timing of the study, a single sample of 130 cases was selected across the 15 selected plans. The final sample size of 130 cases was based on a 90 percent confidence level, a margin of error of 6.5 percent, and a theoretical medical record omission rate of 27.5 percent.

sampling design such that (1) sample cases were selected from both matched and unmatched encounters, and (2) a representative sample of cases was selected across selected plans.

To select the sample, HSAG first categorized encounters based on whether an encounter for an enrollee was submitted by the plan in which the enrollee was enrolled.[18] Second, once categorized, HSAG randomly sampled 65 enrollees where the plan assignment matched the plan submitter and 65 enrollees where the plan assignment did not match the plan submitter. HSAG then randomly selected one physician visit associated with the sampled enrollees across the selected plans.

Technical Methods of Data Collection/Analysis

Once the sample was selected, HSAG prepared plan-specific sample lists that the plans used to coordinate the procurement of medical records from its contracted providers. To maximize its procurement rate, HSAG hosted a one-hour technical assistance call with the participating plans that included a review of the project and procurement protocols. In addition, HSAG worked with the plans throughout the procurement phase to monitor the submission of records from the providers.

Concurrent with the record procurement activities, HSAG trained the review staff on the specific study protocols and conducted interrater reliability and rater-to-standard testing. HSAG's staff included clinical nurses with bachelor's degrees in nursing, three or more years of clinical experience, and a minimum of two years of medical record review experience, as well as certified nurse coders. All reviewers were required to achieve a 95 percent accuracy rate before they were allowed to review medical records and collect data for the study. Trained HSAG reviewers conducted a medical record review of each sampled enrollee's submitted medical record. Reviewers used an electronic medical record abstraction tool and evaluated the documentation to determine whether the data elements extracted from the electronic encounter file were supported by the medical record.

Medical Record Review Indicators

Once the abstraction was completed, HSAG analysts exported the abstraction data from the electronic tool, reviewed these data, and conducted the analysis. In general, the following study indicators of encounter data completeness and accuracy were analyzed for reporting:

- *Medical record omission rate*—the percentage of data elements (i.e., diagnosis code, procedure code, and procedure code modifier) identified in the electronic encounter data that were not found in enrollees' medical records.

[18] In preparing the data for HSAG, AHCA assigned enrollees to a plan based on an enrollee's enrollment segments. AHCA then matched the dates of service from encounters to enrollees' enrollment segments to determine with which plan an encounter should be associated. However, in some cases, the submitter ID indicated a different plan than to which an enrollee was assigned.

- *Encounter data omission rate*[19]—the percentage of data elements (diagnosis code, procedure code, and procedure code modifier) from enrollees' medical records that were not found in the enrollees' encounter data.
- *Coding accuracy rate*—the percentage of a specific data element associated with validated dates of service from the electronic encounter data that were correctly coded based on enrollees' medical records.
- *Overall completeness and accuracy rate*—the percentage of dates of service where all data elements are complete and coded correctly among all validated dates of services from the electronic encounter data.

[19] To accommodate the review of unmatched encounters, no continuous enrollment parameters were applied for identification of the eligible population. As such, the *Encounter Data Omission* rate for the dates of service data element was not calculated for this study.

Appendix B. Listing of Plan PIP Validation Results for SFY 2013–2014

Table B-1 includes the following information for each HMO: PIP Topic and corresponding Validation Scores and Status. In the Validation Scores and Status column, the validation results for each PIP are listed in order from left to right, separated by slash marks: percentage of all evaluation elements receiving a *Met* score, percentage of critical elements receiving a *Met* score, and overall validation status.

Table B-1—Health Maintenance Organizations (HMOs)

Plan Name	PIP Topic	Validation Scores and Status
AHF MCO of Florida, Inc. dba Positive Healthcare Florida (Non-Reform)	*Follow-up After Hospitalization for Mental Illness*	*85% / 100% / Met*
	Improving Satisfaction with Cultural and Language Services for People Living with HIV/AIDs	*92% / 100% / Met*
AHF MCO of Florida, Inc. dba Positive Healthcare Florida (Reform)	*Follow-up After Hospitalization for Mental Illness*	*81% / 75% / Partially Met*
	Improving Satisfaction with Cultural and Language Services for People Living with HIV/AIDs	*81% / 89% / Not Met*
Amerigroup Community Care (Non-Reform)	*Improving LDL-C Outcomes for African American Women with Diabetes*	*94% / 100% / Met*
	Well-Child Visits in the First 15 Months of Life-Six or More Visits	*88% / 100% / Met*
Amerigroup Community Care (Non-Reform)	*Well-Child Visits in the First 15 Months of Life-Six or More Visits*	*96% / 100% / Met*
	Balance Billing	*97% / 100% / Met*
Clear Health Alliance (Non-Reform)	*Follow-up After Hospitalization for Mental Illness*	*88% / 100% / Met*
	Well-Child Visits in the First 15 Months of Life-Six or More Visits	*100% / 100% / Met*
Clear Health Alliance (Reform)	*Follow-up After Hospitalization for Mental Illness*	*100% / 100% / Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*100% / 100% / Met*
Coventry Health Care of Florida, Inc.—Buena Vista	*Improving Access of Medicaid Members to Culturally and Linguistically Appropriate Services*	*59% / 27% / Not Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*94% / 100% / Met*
Coventry Health Care of Florida, Inc.—VISTA	*Improving Access of Medicaid Members to Culturally and Linguistically Appropriate Services*	*65% / 27% / Not Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*94% / 100% / Met*

Table B-1—Health Maintenance Organizations (HMOs)		
Plan Name	**PIP Topic**	**Validation Scores and Status**
Florida True Health	*Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis*	*70% / 40% / Not Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*91% / 100% / Met*
Freedom Health, Inc. (Non-Reform)	*Behavioral Health Discharge Planning*	*68% / 88% / Not Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*83% / 92% / Partially Met*
Freedom Health, Inc. (Reform)	*Behavioral Health Discharge Planning*	*72% / 88% / Not Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*75% / 78% / Not Met*
Healthy Palm Beaches, Inc. (Non-Reform)	*Does Providing Discharge Planning Case Management Increase Compliance with Aftercare Appointments*	*92% / 100% / Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*79% / 78% / Not Met*
Humana Family c/o Humana Medical Plan, Inc. (Non-Reform)	*Follow-up After a Hospitalization for Mental Health*	*73% / 75% / Not Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*88% / 100% / Met*
Humana Family c/o Humana Medical Plan, Inc. (Reform)	*Follow-up After a Hospitalization for Mental Health*	*73% / 75% / Not Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*93% / 100% / Met*
Magellan Complete Care (Non-Reform)	*Increase the Rate of LDL and HbA1c Screenings for Hispanic Members*	*77% / 83% / Not Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*82% / 83% / Not Met*
Medica Health Plans of Florida (Non-Reform)	*Follow-up to Discharge After a Behavioral Health Admission*	*33% / 38% / Not Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*92% / 100% / Met*
Medica Health Plans of Florida (Reform)	*Follow-up to Discharge After a Behavioral Health Admission*	*33% / 38% / Not Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*85% / 100% / Met*
Molina Healthcare of Florida (Non-Reform)	*Seven- and 30-day Follow-up for Hospitalization for Mental Health*	*60% / 63% / Not Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*54% / 58% / Not Met*

Table B-1—Health Maintenance Organizations (HMOs)		
Plan Name	**PIP Topic**	**Validation Scores and Status**
Molina Healthcare of Florida (Reform)	*Seven- and 30-day Follow-up for Hospitalization for Mental Health*	*68% / 75% Partially Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*53% / 55% / Not Met*
Preferred Care Partners dba CareFlorida (Non-Reform)	*Improving the Process of Claims/Encounter Submissions for BMI Assessments*	*58% / 75% / Not Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*78% / 88% / Partially Met*
Preferred Care Partners dba CareFlorida (Reform)	*Follow-up After Hospitalization for Mental Illness*	*58% / 75% / Not Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*78% / 88% / Partially Met*
Preferred Medical Plan, Inc. (Non-Reform)	*Reducing Disparities Among Practicing Physicians—Cultural Competency*	*46% / 56% / Not Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*92% / 100% / Met*
Simply Healthcare Plans (Non-Reform)	*CLAS-Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	*69% / 73% / Not Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*76% / 82% / Not Met*
Simply Healthcare Plans (Reform)	*CLAS-Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	*71% / 86% / Partially Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*100% / 100% / Met*
Sunshine State Health Plan (Non-Reform)	*Seven- and 30-Day Follow-up for Hospitalization for Mental Health*	*81% / 78% / Partially Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*86% / 92% / Partially Met*
Sunshine State Health Plan (Reform)	*Seven- and 30-Day Follow-up for Hospitalization for Mental Health*	*65% / 63% / Not Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*72% / 75% / Not Met*
UnitedHealthcare Community Plan (Non-Reform)	*Member Service Call Answer Timeliness and Call Abandonment Rate*	*89% / 100% / Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*91% / 100% / Met*
UnitedHealthcare Community Plan (Reform)	*Member Service Call Answer Timeliness and Call Abandonment Rate*	*85% / 88% / Not Met*
	Well-Child Visits in the First 15 Months of Life—	*96% / 100% / Met*

Table B-1—Health Maintenance Organizations (HMOs)		
Plan Name	**PIP Topic**	**Validation Scores and Status**
	Six or More Visits	
United Healthcare of Florida, Inc. – Evercare at Home (Non-Reform)	*Flu Vaccine*	*86% / 80% / Not Met*
	Timeliness of Services	*86% / 89% / Partially Met*
WellCare Health Plans, Inc.—HealthEase of Florida, Inc. (Non-Reform)	*First Call Resolution*	*63% / 63% / Not Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*83% / 100% / Met*
WellCare Health Plans, Inc.—Staywell of Florida, Inc. (Non-Reform)	*First Call Resolution*	*69% / 63% / Partially Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*83% / 100% / Met*
WellCare Health Plans, Inc.—Staywell of Florida, Inc. (Reform)	*First Call Resolution*	*85% / 83% / Partially Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*50% / 33% / Not Met*

Table B-2 includes the following information for each PSN: PIP Topic and corresponding Validation Scores and Status. In the Validation Scores and Status column, the validation results for each PIP are listed in order from left to right, separated by slash marks: percentage of all evaluation elements receiving a *Met* score, percentage of critical elements receiving a *Met* score, and overall validation status.

Table B-2—Provider Service Networks (PSNs)

Plan Name	PIP Topic	Validation Scores and Status
Better Health (Non-Reform)	*Follow-up After Hospitalization for Mental Illness*	*88% / 86% / Partially Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*86% / 86% / Not Met*
Better Health (Reform)	*CLAS-Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	*50% / 64% / Not Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*85% / 91% / Not Met*
Care Access PSN (Non-Reform)	*Follow-up After Hospitalization for Mental Illness*	*70% / 60% / Partially Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*89% / 100% / Met*
Children's Medical Services—Broward (Reform)	*Improving Call Center Timeliness*	*92% / 88% / Partially Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*81% / 78% / Not Met*
Children's Medical Services—Duval (Reform)	*Eliminating Racial/Ethnic Disparities in the Rate of Lead Screening Participation*	*79% / 89% / Partially Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*76% / 80% / Not Met*
First Coast Advantage, LLC (Non-Reform)	*Follow-up After Hospitalization for Mental Illness*	*100% / 100% / Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*100% / 100% / Met*
First Coast Advantage, LLC (Reform)	*Getting Needed Care—CAHPS Survey*	*100% / 100% / Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*89% / 92% / Partially Met*
Integral Quality Care (Non-Reform)	*Emergency Department Use for Non-Emergency Care*	*96% / 100% / Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*76% / 82% / Not Met*
Prestige Health Choice (Non-Reform)	*Seven- and 30- Day Follow-up for Hospitalization for a Mental Health*	*72% / 75% / Not Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*94% / 100% / Met*

Table B-2—Provider Service Networks (PSNs)		
Plan Name	**PIP Topic**	**Validation Scores and Status**
Salubris,	*Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis*	*100% / 100% / Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*100% / 100% / Met*
South Florida Community Care Network (Non-Reform)	*Improving Call Center Timeliness*	*92% / 88% / Partially Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*85% / 78% / Not Met*
South Florida Community Care Network (Reform)	*Improving Call Center Timeliness*	*92% / 88% / Partially Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*85% / 82% / Not Met*

Table B-3 includes the following information for each PMHP/CWPMHP: PIP Topic and corresponding Validation Scores and Status. In the Validation Scores and Status column, the validation results for each PIP are listed in order from left to right, separated by slash marks: percentage of all evaluation elements receiving a *Met* score, percentage of critical elements receiving a *Met* score, and overall validation status.

Table B-3—Prepaid Mental Health Plans (PMHPs/CWPMHP)		
Plan Name	**PIP Topic**	**Validation Scores and Status**
Community Based Care Partnership (CWPMHP)	*Biannual Submission of Child Functional Assessment Rating Scales (CFARS)*	*79% / 89% / Partially Met*
	Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis	*89% / 89% / Partially Met*
Florida Health Partners (Area 5)	*Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis*	*71% / 89% / Partially Met*
	Improving Documentation of Communication Between Mental Health Practitioners and Primary Care Physicians in a PMHP	*61% / 55% / Not Met*
Florida Health Partners (Area 6)	*Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis*	*79% / 89% / Partially Met*
	Improving Documentation of Communication Between Mental Health Practitioners and Primary Care Physicians in a PMHP	*58% / 55% / Not Met*
Florida Health Partners (Area 7)	*Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis*	*75% / 89% / Partially Met*
	Improving Documentation of Communication Between Mental Health Practitioners and Primary Care Physicians in a PMHP	*66% / 64% / Not Met*
Florida Health Partners (Area 8)	*Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis*	*71% / 89% / Partially Met*
	Improving Documentation of Communication Between Mental Health Practitioners and Primary Care Physicians in a PMHP	*60% / 55% / Not Met*
Jackson Health System/ Public Health Trust of Dade County (Area 11)	*Decreasing Telephone Answer Speed*	*94% / 100% / Met*
	Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis	*82% / 100% / Met*
Lakeview Center dba Access Behavioral Health (Area 1)	*Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis*	*67% / 75% / Not Met*
	Using an Organization Assessment to Implement Trauma Informed Care	*52% / 56% / Not Met*
Magellan Behavioral Health of Florida, Inc. (Area 2)	*Biannual Submission of Functional Assessment Rating Scales/Child Functional Assessment Rating*	*74% / 88% / Partially Met*

Table B-3—Prepaid Mental Health Plans (PMHPs/CWPMHP)		
Plan Name	**PIP Topic**	**Validation Scores and Status**
	Scales (FARS/CFARS)	
	Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis	*93% / 89% / Partially Met*
Magellan Behavioral Health of Florida, Inc. (Area 4)	*Biannual Submission of Functional Assessment Rating Scales/Child Functional Assessment Rating Scales (FARS/CFARS)*	*70% / 75% / Partially Met*
	Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis	*86% / 89% / Partially Met*
Magellan Behavioral Health of Florida, Inc. (Area 9)	*Biannual Submission of Functional Assessment Rating Scales/Child Functional Assessment Rating Scales (FARS/CFARS)*	*71% / 89% / Partially Met*
	Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis	*86% / 89% / Partially Met*
Magellan Behavioral Health of Florida, Inc. (Area 11)	*Biannual Submission of Functional Assessment Rating Scales/Child Functional Assessment Rating Scales (FARS/CFARS)*	*82% / 100% / Met*
	Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis	*86% / 89% / Partially Met*
North Florida Behavioral Health Partners (Area 3)	*Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis*	*75% / 89% / Partially Met*
	Improving Documentation of Communication Between Mental Health Practitioners and Primary Care Physicians in a PMHP	*58% / 55% / Not Met*

Table B-4 includes the following information for each SIPP: PIP Topic and corresponding Validation Scores and Status. In the Validation Scores and Status column, the validation results for each PIP are listed in order from left to right, separated by slash marks: percentage of all evaluation elements receiving a *Met* score, percentage of critical elements receiving a *Met* score, and overall validation status.

Table B-4—Statewide Inpatient Psychiatric Programs (SIPPs)		
Plan Name	**PIP Topic**	**Validation Scores and Status**
Alternate Family Care	*Seclusion and Restraints*	*78% / 80% / Not Met*
BayCare Behavioral Health, Inc.	*Seclusion and Restraints*	*78% / 88% / Partially Met*
Citrus Health Network, Inc.—CATS	*Seclusion and Restraints*	*93% / 100% / Met*
Citrus Health Network, Inc.—RITS	*Seclusion and Restraints*	*90% / 100% / Met*
Daniel Memorial, Inc.	*Seclusion and Restraints*	*75% / 78% / Not Met*
Devereux Orlando	*Seclusion and Restraints*	*62% / 80% / Not Met*
Jackson Memorial Hospital	*Seclusion and Restraints*	*69% / 80% / Not Met*
Lakeview Center, Inc.	*Seclusion and Restraints*	*86% / 100% / Met*
Manatee Palms Youth Services	*Seclusion and Restraints*	*54% / 67% / Not Met*
Sandy Pines	*Seclusion and Restraints*	*68% / 67% / Not Met*
The Vines	*Seclusion and Restraints*	*61% / 67% / Not Met*
University Behavioral Center	*Seclusion and Restraints*	*54% / 70% / Not Met*

Table B-5 includes the following information for each PDHP: PIP Study Topic and corresponding Validation Scores and Status. In the Validation Scores and Status column, the validation results for each PIP are listed in order from left to right, separated by slash marks: percentage of all evaluation elements receiving a *Met* score, percentage of critical elements receiving a *Met* score, and overall validation status.

Table B-5—Prepaid Dental Health Programs (PDHPs)		
Plan Name	**PIP Topic**	**Validation Scores and Status**
DentaQuest of Florida	*Improving Provider and Member Satisfaction with the Statewide PDHP*	*35% / 38% / Not Met*
	Increasing Utilization of Dental Visits in the Statewide PDHP	*21% / 17% / Not Met*
MCNA Dental Plans (Non-Reform)	*Annual Dental Visits*	*59% / 71% / Not Met*
	Provider Satisfaction	*30% / 11% / Not Met*

Appendix C. Example Plan Interventions for SFY 2013–2014

Table C-1 includes information about interventions implemented by each plan type for the most common PIP topics submitted for validation in SFY 2013–2014.

Table C-1—Plan Interventions by Plan Type and PIP Topic

Plan Type	PIP Topic	Study Indicator Descriptions	Interventions
HMO/PSN	*Well-Child Visits in the First 15 Months of Life—Six or More Visits*	The percentage of enrollees who turned 15 months old during the measurement year and who had six or more well-child visits during the first 15 months of life.	◆ Reminder phone calls to parents of enrollees who are due or overdue for well-child services to inform and facilitate appointment scheduling. ◆ Enrollee incentive for completing well-child visits and other preventive services: enrollees can earn credits to spend on health-related products. ◆ Distribution of statewide collaborative-developed postcard reminder/incentive to enrollees. ◆ Use of new enrollee listing to perform outreach to enrollees with no claims identified within three months of enrollment; outreach also conducted to PCPs to obtain data on well-child visits completed prior to enrollment. ◆ Statewide initiative to remind providers of well-child visit documentation requirements. ◆ Community outreach activities, such as health fairs, to educate enrollees on the importance of well-child visits. ◆ Provider education via Provider Relations staff and provider newsletter articles on the importance of following up with enrollees due for well-child services. ◆ Distribution of an Immunization Report Card to enrollee parents, providing the recommended immunization schedule and tracking log for completed immunizations. ◆ Inclusion of educational materials on the importance of early well-child visits in the enrollee "welcome" mailing.

Table C-1—Plan Interventions by Plan Type and PIP Topic			
Plan Type	**PIP Topic**	**Study Indicator Descriptions**	**Interventions**
			◆ Clinical Practice Consultant (CPC) program to educate PCPs, promote well-child visits and other preventive healthcare, and maximize HEDIS rates. ◆ Distribution of "HEDIS in a Box," a user-friendly pocket guide for PCPs to provide an "at-a-glance" reference for the recommended preventive services and requirements for the HEDIS well-child visit measure.
PMHP/CWPMHP	*Follow-up After Hospitalization for Mental Illness*	The percentage of discharges of enrollees hospitalized for treatment of a mental illness that were followed by an outpatient visit with a mental health practitioner within seven days of discharge.	◆ "Welcome Home" phone calls to enrollees within 48 hours of discharge to assess and address barriers to keeping the seven-day follow-up appointment and improve enrollee understanding of the discharge plan and importance of follow-up appointments. ◆ Recruitment of additional in-network outpatient mental health providers to address a lack of available outpatient appointments. ◆ Training of child welfare community partners involved in the discharge process to address a lack of care coordination and ensure understanding of the purpose and process of completing the post-discharge follow-up appointment. ◆ Revision of monthly provider discharge detail reports including provider-specific data on seven-day follow-up appointment compliance in order to ensure providers' awareness of their patient's access to appropriate follow-up care. ◆ Requirement of providers to investigate and report to the PMHP the reasons why enrollees in their care with high utilization of inpatient services did not attend a follow-up appointment within seven days of discharge. ◆ Provider newsletter articles to address the importance of communication between in-network and out-of-network providers about discharge planning and post-discharge follow-up services.

Table C-1—Plan Interventions by Plan Type and PIP Topic			
Plan Type	**PIP Topic**	**Study Indicator Descriptions**	**Interventions**
SIPP	*Seclusion and Restraints*	1. The rate of critical events involving the use of restraints per total number of bed days in the measurement year. 2. The rate of critical events involving the use of seclusions per total number of bed days in the measurement year.	◆ Development of client-specific behavioral care plans by clinical treatment team, which included a behavioral analyst. ◆ Collaborative review of critical events involving seclusion and restraint use and debriefing to analyze factors that led to the use of these methods. ◆ Review and trend analysis of restraint and seclusion events by the Quality Council followed by recommendations for corrective actions when necessary. ◆ Enhanced hiring process, including a working interview for multiple candidates, to identify the candidate who best fit the philosophy of the care team. ◆ Training for care team members on NAPPI (Non-Abusive Psychological & Physical Intervention) techniques. ◆ Staff training on crisis prevention/intervention skills, Positive Parenting techniques, and Trauma Informed Care principles. ◆ Activities to empower clients, such as a client-led "Student Council" that advises staff on community decisions. ◆ Activities to increase family involvement, decrease frustration and irritability, and promote healthy behavior: holiday celebrations, therapeutic passes to local museums and parks, arts and crafts projects, and physical activity groups.
PDHP	*Annual Dental Visits*	The percentage of eligible enrollees 2–21 years of age who had at least one dental visit during the measurement year.	◆ Automated phone calls, postcards, emails, and text messages reminding enrollees to schedule a dental visit. ◆ Partnership with dental and healthcare providers to host community dental events; distribution of dental health flyers and an on-site dental hygienist educator to explain the importance of dental visits and proper dental hygiene at home. ◆ Member Services software system alert that alerts Member Services representative on inbound calls when the enrollee is due for a dental visit.

Table C-1—Plan Interventions by Plan Type and PIP Topic			
Plan Type	**PIP Topic**	**Study Indicator Descriptions**	**Interventions**
			◆ Scripted outbound calls to enrollees with no dental visit claims in the past 12 months to determine reason(s) for lack of visit and provide education on importance of regular dental visits.
	Dental Provider Satisfaction	The percentage of eligible dental providers who answered the overall provider satisfaction survey question with a response of "somewhat satisfied" or "very satisfied."	◆ Revision of the dental provider manual to provide more thorough and useful content. ◆ Distribution of the provider newsletter to connect with dental providers and provide information on plan operations and quality initiatives. ◆ Enhancement of dental provider Internet portal to improve ease of use for providers. ◆ Dental provider "lunch and learn" webinars to provide education and address provider concerns. ◆ Collection of provider feedback on dental provider field representative interactions to ensure helpful and informative field visits.

Appendix D. Plan Performance Measure Results

Appendix D displays plan-specific performance measure results. The appendix is organized into sections by plan model type.

HMOs/PSNs

This section represents the Florida Medicaid HEDIS 2014 (CY 2013) results by domain of care compared to the national HEDIS 2013 Medicaid HMO and PPO combined percentiles. With the exception of the Ambulatory Care measures where the values represent the number of outpatient or ED visits per 1,000 MM, all values are shown as percentages. This section also distinguishes between Reform and Non-Reform HMOs/PSNs, when applicable. Results in this report are rounded to the second decimal place.

For all tables presented in this section, the following legend applies to the Performance Level Analysis and 2014 Rate columns:

Symbols in the Performance Level Analysis Column		
★	=	Below-average performance relative to national Medicaid results
★★	=	Average performance relative to national Medicaid results
★★★	=	Above-average performance relative to national Medicaid results
+ +	=	Performance level analysis is not applicable for *Ambulatory Care* and *Mental Health Utilization* measures
- -	=	Indicates national Medicaid result is not available to compare or plan rate reported as *NA* or *NB*
Symbols in the 2014 Rate Column		
NR	=	Indicates *Not Reportable* for the following reasons: ◆ The calculated rate was materially biased, or ◆ The HMO/PSN chose not to report the measure, or ◆ The HMO/PSN was not required to report the measure.
NA	=	Indicates *Small Denominator* (i.e., the HMO/PSN followed the specifications but the denominator was too small [< 30] to report a valid rate.)
NB	=	Indicates *No Benefit* (i.e., the HMO/PSN did not offer the health benefits required by the measure)

Table D-1 contains the HEDIS 2014 Non-Reform rates and performance level analysis results for Amerigroup.

Table D-1—Florida Medicaid HEDIS 2014 Result Summary Table: Amerigroup			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★★	0.31%
	Well-Child Visits in the First 15 Months of Life—1 Visit	★★	1.23%
	Well-Child Visits in the First 15 Months of Life—2 Visits	★	1.53%
	Well-Child Visits in the First 15 Months of Life—3 Visits	★★	5.83%
	Well-Child Visits in the First 15 Months of Life—4 Visits	★★	7.67%
	Well-Child Visits in the First 15 Months of Life—5 Visits	★	11.66%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★★	71.78%
	Well-Child Visits in the 3rd–6th Years of Life	★★	79.88%
	Lead Screening in Children	★★	59.37%
	Adolescent Well-Care Visits	★★	58.45%
	Annual Dental Visit—2–3 years	- -	*NB*
	Annual Dental Visit—4–6 years	- -	*NB*
	Annual Dental Visit—7–10 years	- -	*NB*
	Annual Dental Visit—11–14 years	- -	*NB*
	Annual Dental Visit—15–18 years	- -	*NB*
	Annual Dental Visit—19–21 years	- -	*NB*
	Annual Dental Visit—Total	- -	*NB*
	Childhood Immunization Status—Combination 2	★★	82.18%
	Childhood Immunization Status—Combination 3	★★	78.01%
	Immunizations for Adolescents—Combination 1	★★	66.03%
	Immunizations for Adolescents—Meningococcal	★★	66.51%
	Immunizations for Adolescents—Tdap/Td	★★	87.65%
	Appropriate Testing for Children With Pharyngitis	★★	71.07%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★★	53.87%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	★★★	68.71%
Women's Care	*Cervical Cancer Screening*	★★	61.31%
	Chlamydia Screening in Women—16–20 Years	★★	60.14%
	Chlamydia Screening in Women—21–24 Years	★★★	75.78%
	Chlamydia Screening in Women—Total	★★	65.22%
	Breast Cancer Screening	★★	59.66%

Table D-1—Florida Medicaid HEDIS 2014 Result Summary Table: Amerigroup			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
	Timeliness of Prenatal Care	★	71.98%
	Postpartum Care	★	50.72%
	Prenatal Care Frequency	- -	69.08%
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	79.72%
	Diabetes Care—HbA1c Poor Control	★★	48.72%
	Diabetes Care—HbA1c Control (<8%)	★★	42.66%
	Diabetes Care—LDL-C Screening	★★	78.32%
	Diabetes Care—LDL-C Control (<100 mg/dL)	★★	31.24%
	Diabetes Care—Eye Exam (Retinal) Performed	★★	48.72%
	Diabetes Care—Medical Attention for Nephropathy	★★	79.95%
	Controlling High Blood Pressure	★★★	69.79%
	Adult BMI Assessment	★★★	91.14%
	Use of Appropriate Medications for People with Asthma—5–11 years	★★	88.96%
	Use of Appropriate Medications for People with Asthma—12–18 years	★★	84.39%
	Use of Appropriate Medications for People with Asthma—19–50 years	★	63.52%
	Use of Appropriate Medications for People with Asthma—51–64 years	★	48.81%
	Use of Appropriate Medications for People with Asthma—Total	★★	82.36%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	17.96%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	15.10%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	66.94%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	42.45%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	18.78%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	16.33%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	64.90%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	40.82%
	HIV-Related Medical Visits—0 Visits	- -	11.43%
	HIV-Related Medical Visits—1 Visit	- -	15.51%
	HIV-Related Medical Visits—>=2 Visits	- -	73.06%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	48.57%
	Highly Active Anti-Retroviral Treatment	- -	74.41%
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	68.17%
	Lipid Profile Annually	- -	79.33%

Table D-1—Florida Medicaid HEDIS 2014 Result Summary Table: Amerigroup			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	299.31
	Ambulatory Care—ED Visits per 1,000 MM	+ +	66.27
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★★	97.67%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★	90.54%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★★	89.43%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★★	86.85%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	68.99%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★★	84.91%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★★	87.43%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	74.31%
	Call Abandonment	- -	1.20%
	Call Answer Timeliness	★★	85.85%
	Transportation Availability	- -	*NB*
	Transportation Timeliness	- -	*NB*
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	43.58%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	61.69%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★	54.03%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★	37.65%
	Mental Health Readmission Rate	- -	33.59%

Five Non-Reform rates reported by Amerigroup were above and eight were below their respective national Medicaid averages. Compared to last year, Amerigroup reported fewer CY 2013 rates indicating below-average performance.

Table D-2 contains the HEDIS 2014 Reform rates and performance level analysis results for Better Health.

Table D-2—Florida Medicaid HEDIS 2014 Result Summary Table: Better Health			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★★	0.73%
	Well-Child Visits in the First 15 Months of Life—1 Visit	★	0.97%
	Well-Child Visits in the First 15 Months of Life—2 Visits	★	1.95%
	Well-Child Visits in the First 15 Months of Life—3 Visits	★★	3.65%
	Well-Child Visits in the First 15 Months of Life—4 Visits	★★	10.46%
	Well-Child Visits in the First 15 Months of Life—5 Visits	★★	15.09%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★★	67.15%
	Well-Child Visits in the 3rd–6th Years of Life	★★	81.75%
	Lead Screening in Children	★★	75.18%
	Adolescent Well-Care Visits	★★	50.85%
	Annual Dental Visit—2–3 years	★	24.55%
	Annual Dental Visit—4–6 years	★	45.05%
	Annual Dental Visit—7–10 years	★	50.73%
	Annual Dental Visit—11–14 years	★	39.37%
	Annual Dental Visit—15–18 years	★★	51.18%
	Annual Dental Visit—19–21 years	★★	29.98%
	Annual Dental Visit—Total	★	42.55%
	Childhood Immunization Status—Combination 2	★★	76.64%
	Childhood Immunization Status—Combination 3	★★	72.99%
	Immunizations for Adolescents—Combination 1	★★	68.13%
	Immunizations for Adolescents—Meningococcal	★★	69.59%
	Immunizations for Adolescents—Tdap/Td	★★	82.97%
	Appropriate Testing for Children With Pharyngitis	★★	75.12%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★	45.40%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	*NA*
Women's Care	*Cervical Cancer Screening*	★	55.96%
	Chlamydia Screening in Women—16–20 Years	★★	60.47%
	Chlamydia Screening in Women—21–24 Years	★★	70.27%
	Chlamydia Screening in Women—Total	★★	63.67%
	Breast Cancer Screening	★★	53.63%

Table D-2—Florida Medicaid HEDIS 2014 Result Summary Table: Better Health			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
	Timeliness of Prenatal Care	★	71.27%
	Postpartum Care	★	57.46%
	Prenatal Care Frequency	- -	66.48%
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	83.70%
	Diabetes Care—HbA1c Poor Control	★★	52.31%
	Diabetes Care—HbA1c Control (<8%)	★	37.96%
	Diabetes Care—LDL-C Screening	★★★	85.89%
	Diabetes Care—LDL-C Control (<100 mg/dL)	★★	33.82%
	Diabetes Care—Eye Exam (Retinal) Performed	★	42.58%
	Diabetes Care—Medical Attention for Nephropathy	★★★	94.65%
	Controlling High Blood Pressure	★★	55.72%
	Adult BMI Assessment	★★	79.56%
	Use of Appropriate Medications for People with Asthma—5–11 years	★	79.69%
	Use of Appropriate Medications for People with Asthma—12–18 years	★★	84.29%
	Use of Appropriate Medications for People with Asthma—19–50 years	★	60.00%
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	★	75.28%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	16.67%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	11.11%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	72.22%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	13.89%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	15.74%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	12.96%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	71.30%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	0.00%
	HIV-Related Medical Visits—0 Visits	- -	15.74%
	HIV-Related Medical Visits—1 Visit	- -	21.30%
	HIV-Related Medical Visits—>=2 Visits	- -	62.96%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	0.00%
	Highly Active Anti-Retroviral Treatment	- -	81.00%
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	69.91%
	Lipid Profile Annually	- -	83.70%

Table D-2—Florida Medicaid HEDIS 2014 Result Summary Table: Better Health			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	330.60
	Ambulatory Care—ED Visits per 1,000 MM	+ +	78.19
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★★	97.16%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★	91.83%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★★	89.66%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	84.50%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	67.08%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★★	85.36%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★	76.74%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	73.65%
	Call Abandonment	- -	7.06%
	Call Answer Timeliness	★★	92.94%
	Transportation Availability	- -	100.00%
	Transportation Timeliness	- -	81.82%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	19.01%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	38.98%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★	59.85%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★★	49.24%
	Mental Health Readmission Rate	- -	81.24%

Three Reform rates were above their respective national Medicaid averages. Compared to last year, Better Health had one less rate above the national averages but the same number of rates (19) below the national averages.

Table D-3 contains the HEDIS 2014 Non-Reform rates and performance level analysis results for Buena Vista.

Table D-3—Florida Medicaid HEDIS 2014 Result Summary Table: Buena Vista

Dimension of Care	2014 Measures	Performance Level Analysis	2014
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★	2.92%
	Well-Child Visits in the First 15 Months of Life—1 visit	★★★	3.41%
	Well-Child Visits in the First 15 Months of Life—2 Visits	★★	4.62%
	Well-Child Visits in the First 15 Months of Life—3 Visits	★★★	10.22%
	Well-Child Visits in the First 15 Months of Life—4 Visits	★★★	18.49%
	Well-Child Visits in the First 15 Months of Life—5 Visits	★★★	23.11%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★	37.23%
	Well-Child Visits in the 3rd–6th Years of Life	★★	70.80%
	Lead Screening in Children	★	36.74%
	Adolescent Well-Care Visits	★★	48.66%
	Annual Dental Visit—2–3 years	- -	*NB*
	Annual Dental Visit—4–6 years	- -	*NB*
	Annual Dental Visit—7–10 years	- -	*NB*
	Annual Dental Visit—11–14 years	- -	*NB*
	Annual Dental Visit—15–18 years	- -	*NB*
	Annual Dental Visit—19–21 years	- -	*NB*
	Annual Dental Visit—Total	- -	*NB*
	Childhood Immunization Status—Combination 2	★	60.34%
	Childhood Immunization Status—Combination 3	★	54.99%
	Immunizations for Adolescents—Combination 1	★	51.82%
	Immunizations for Adolescents—Meningococcal	★	54.01%
	Immunizations for Adolescents—Tdap/Td	★	76.64%
	Appropriate Testing for Children With Pharyngitis	★★	63.94%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★	46.99%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	*NA*
Women's Care	*Cervical Cancer Screening*	★★	59.61%
	Chlamydia Screening in Women—16–20 Years	★★	53.35%
	Chlamydia Screening in Women—21–24 Years	★★	73.24%
	Chlamydia Screening in Women—Total	★★	62.40%
	Breast Cancer Screening	★★	56.21%

Table D-3—Florida Medicaid HEDIS 2014 Result Summary Table: Buena Vista			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
	Timeliness of Prenatal Care	★	74.61%
	Postpartum Care	★	48.59%
	Prenatal Care Frequency	- -	58.93%
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	81.27%
	Diabetes Care—HbA1c Poor Control	★★	43.07%
	Diabetes Care—HbA1c Control (<8%)	★★	48.42%
	Diabetes Care—LDL-C Screening	★★	79.56%
	Diabetes Care—LDL-C Control (<100 mg/dL)	★★	33.58%
	Diabetes Care—Eye Exam (Retinal) Performed	★★	44.77%
	Diabetes Care—Medical Attention for Nephropathy	★★	75.67%
	Controlling High Blood Pressure	★	43.07%
	Adult BMI Assessment	★★	75.18%
	Use of Appropriate Medications for People with Asthma—5–11 years	★	80.00%
	Use of Appropriate Medications for People with Asthma—12–18 years	★	77.42%
	Use of Appropriate Medications for People with Asthma—19–50 years	★★	69.70%
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	★	76.97%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	20.37%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	20.37%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	59.26%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	42.59%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	16.67%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	18.52%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	64.81%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	40.74%
	HIV-Related Medical Visits—0 Visits	- -	9.26%
	HIV-Related Medical Visits—1 Visit	- -	20.37%
	HIV-Related Medical Visits—>=2 Visits	- -	70.37%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	53.70%
	Highly Active Anti-Retroviral Treatment	- -	65.96%
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	61.96%
	Lipid Profile Annually	- -	77.62%

Table D-3—Florida Medicaid HEDIS 2014 Result Summary Table: Buena Vista			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	251.11
	Ambulatory Care—ED Visits per 1,000 MM	+ +	73.52
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★	93.86%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★	84.97%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★	82.91%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	82.10%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	69.34%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	81.27%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★	66.29%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	71.97%
	Call Abandonment	- -	1.79%
	Call Answer Timeliness	★★	81.09%
	Transportation Availability	- -	*NB*
	Transportation Timeliness	- -	*NB*
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	8.99%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	23.25%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★	43.97%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★	30.50%
	Mental Health Readmission Rate	- -	27.01%

Four Non-Reform rates, all under the *Well-Child Visits in the First 15 Months of Life* measure, were above their respective national Medicaid averages. Compared to last year, Buena Vista reported more rates above these averages. However, Buena Vista reported 24 rates below their respective national averages, as compared to 15 rates last year.

Table D-4 contains the HEDIS 2014 Reform rates and performance level analysis results for CMS.

Table D-4—Florida Medicaid HEDIS 2014 Result Summary Table: Children's Medical Services			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★★	0.81%
	Well-Child Visits in the First 15 Months of Life—1 Visit	★	0.00%
	Well-Child Visits in the First 15 Months of Life—2 Visits	★	1.61%
	Well-Child Visits in the First 15 Months of Life—3 Visits	★★	5.65%
	Well-Child Visits in the First 15 Months of Life—4 Visits	★★	12.90%
	Well-Child Visits in the First 15 Months of Life—5 Visits	★★	18.55%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★★	60.48%
	Well-Child Visits in the 3rd–6th Years of Life	★★	77.76%
	Lead Screening in Children	★★	73.54%
	Adolescent Well-Care Visits	★★	59.23%
	Annual Dental Visit—2–3 years	★★	32.70%
	Annual Dental Visit—4–6 years	★★	55.76%
	Annual Dental Visit—7–10 years	★★	60.22%
	Annual Dental Visit—11–14 years	★★	56.51%
	Annual Dental Visit—15–18 years	★★	48.62%
	Annual Dental Visit—19–21 years	★★	36.22%
	Annual Dental Visit—Total	★★	53.00%
	Childhood Immunization Status—Combination 2	★★	75.89%
	Childhood Immunization Status—Combination 3	★★	69.86%
	Immunizations for Adolescents—Combination 1	★★	77.88%
	Immunizations for Adolescents—Meningococcal	★★	78.48%
	Immunizations for Adolescents—Tdap/Td	★★	86.67%
	Appropriate Testing for Children With Pharyngitis	★★	77.11%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★	50.81%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	★★★	64.81%
Women's Care	*Cervical Cancer Screening*	- -	*NB*
	Chlamydia Screening in Women—16–20 Years	★★	49.44%
	Chlamydia Screening in Women—21–24 Years	- -	*NA*
	Chlamydia Screening in Women—Total	★	49.44%
	Breast Cancer Screening	- -	*NB*
	Timeliness of Prenatal Care	- -	*NA*

Table D-4—Florida Medicaid HEDIS 2014 Result Summary Table: Children's Medical Services			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
	Postpartum Care	- -	*NA*
	Prenatal Care Frequency	- -	*NA*
Living With Illness	*Diabetes Care—HbA1c Testing*	- -	*NA*
	Diabetes Care—HbA1c Poor Control	- -	*NA*
	Diabetes Care—HbA1c Control (<8%)	- -	*NA*
	Diabetes Care—LDL-C Screening	- -	*NA*
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	*NA*
	Diabetes Care—Eye Exam (Retinal) Performed	- -	*NA*
	Diabetes Care—Medical Attention for Nephropathy	- -	*NA*
	Controlling High Blood Pressure	- -	*NB*
	Adult BMI Assessment	★	53.97%
	Use of Appropriate Medications for People with Asthma—5–11 years	★★	91.54%
	Use of Appropriate Medications for People with Asthma—12–18 years	★★	90.35%
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	★★★	91.30%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	13.33%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	13.33%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	73.33%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	53.33%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	8.89%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	17.78%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	73.33%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	53.33%
	HIV-Related Medical Visits—0 Visits	- -	2.22%
	HIV-Related Medical Visits—1 Visit	- -	8.89%
	HIV-Related Medical Visits—>=2 Visits	- -	88.89%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	55.56%
	Highly Active Anti-Retroviral Treatment	- -	82.35%
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	*NB*
	Lipid Profile Annually	- -	*NB*

Table D-4—Florida Medicaid HEDIS 2014 Result Summary Table: Children's Medical Services			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	519.92
	Ambulatory Care—ED Visits per 1,000 MM	+ +	75.16
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★★	97.38%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★★	96.15%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★★★	96.48%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★★★	95.14%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★★★	89.16%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—Total	★★★	89.16%
	Call Abandonment	- -	3.00%
	Call Answer Timeliness	★★	80.56%
	Transportation Availability	- -	99.98%
	Transportation Timeliness	- -	56.65%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	41.89%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	68.33%
	Antidepressant Medication Management—Effective Acute Phase Treatment	- -	*NA*
	Antidepressant Medication Management—Effective Continuation Phase Treatment	- -	*NA*
	Mental Health Readmission Rate	- -	11.43%

Seven Reform rates reported by CMS were above their respective national Medicaid averages. Four rates were below their respective national averages. Compared to last year, CMS had more rates indicating above-average performance and fewer rates indicating below-average performance.

Table D-5 contains the HEDIS 2014 Non-Reform and Reform rates and respective performance level analysis results for Clear Health.

Table D-5—Florida Medicaid HEDIS 2014 Result Summary Table: Clear Health					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	- -	*NA*	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	*NA*	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	*NA*	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	*NA*	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	*NA*	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	*NA*	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—6+ Visits	- -	*NA*	- -	*NA*
	Well-Child Visits in the 3rd–6th Years of Life	- -	*NA*	- -	*NA*
	Lead Screening in Children	- -	*NA*	- -	*NA*
	Adolescent Well-Care Visits	- -	*NA*	- -	*NA*
	Annual Dental Visit—2–3 years	- -	*NB*	- -	*NB*
	Annual Dental Visit—4–6 years	- -	*NB*	- -	*NB*
	Annual Dental Visit—7–10 years	- -	*NB*	- -	*NB*
	Annual Dental Visit—11–14 years	- -	*NB*	- -	*NB*
	Annual Dental Visit—15–18 years	- -	*NB*	- -	*NB*
	Annual Dental Visit—19–21 years	- -	*NB*	- -	*NB*
	Annual Dental Visit—Total	- -	*NB*	- -	*NB*
	Childhood Immunization Status—Combination 2	- -	*NA*	- -	*NA*
	Childhood Immunization Status—Combination 3	- -	*NA*	- -	*NA*
	Immunizations for Adolescents—Combination 1	- -	*NA*	- -	*NA*
	Immunizations for Adolescents—Meningococcal	- -	*NA*	- -	*NA*
	Immunizations for Adolescents—Tdap/Td	- -	*NA*	- -	*NA*
	Appropriate Testing for Children With Pharyngitis	- -	*NA*	- -	*NA*
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	- -	*NA*	- -	*NA*
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	*NA*	- -	*NA*
Women's Care	*Cervical Cancer Screening*	★	49.65%	- -	*NA*
	Chlamydia Screening in Women—16–20 Years	- -	*NA*	- -	*NA*

Table D-5—Florida Medicaid HEDIS 2014 Result Summary Table: Clear Health					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	Chlamydia Screening in Women—21–24 Years	- -	*NA*	- -	*NA*
	Chlamydia Screening in Women—Total	- -	*NA*	- -	*NA*
	Breast Cancer Screening	- -	*NA*	- -	*NA*
	Timeliness of Prenatal Care	- -	*NA*	- -	*NA*
	Postpartum Care	- -	*NA*	- -	*NA*
	Prenatal Care Frequency	- -	*NA*	- -	*NA*
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	82.00%	- -	*NA*
	Diabetes Care—HbA1c Poor Control	★	64.00%	- -	*NA*
	Diabetes Care—HbA1c Control (<8%)	★	32.00%	- -	*NA*
	Diabetes Care—LDL-C Screening	★★	82.00%	- -	*NA*
	Diabetes Care—LDL-C Control (<100 mg/dL)	★	24.00%	- -	*NA*
	Diabetes Care—Eye Exam (Retinal) Performed	★	8.00%	- -	*NA*
	Diabetes Care—Medical Attention for Nephropathy	★★	78.00%	- -	*NA*
	Controlling High Blood Pressure	★★	57.14%	- -	*NA*
	Adult BMI Assessment	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	- -	*NA*	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	6.69%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	4.14%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	89.17%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	43.31%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	7.32%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	12.74%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	79.94%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	0.00%	- -	*NA*
	HIV-Related Medical Visits—0 Visits	- -	20.06%	- -	*NA*
	HIV-Related Medical Visits—1 Visit	- -	16.24%	- -	*NA*

Table D-5—Florida Medicaid HEDIS 2014 Result Summary Table: Clear Health					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	HIV-Related Medical Visits—>=2 Visits	- -	63.69%	- -	*NA*
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	0.00%	- -	*NA*
	Highly Active Anti-Retroviral Treatment	- -	81.85%	- -	*NA*
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	*NA*	- -	*NA*
	Lipid Profile Annually	- -	81.43%	- -	*NA*
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	406.96	+ +	415.34
	Ambulatory Care—ED Visits per 1,000 MM	+ +	141.07	+ +	236.42
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	- -	*NA*	- -	*NA*
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	- -	*NA*	- -	*NA*
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	- -	*NA*	- -	*NA*
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	- -	*NA*	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★★	82.64%	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★★	85.77%	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	- -	*NA*	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—Total	★★	84.01%	- -	*NA*
	Call Abandonment	- -	5.12%	- -	*NR*
	Call Answer Timeliness	★★★	94.88%	- -	*NR*
	Transportation Availability	- -	100.00%	- -	100.00%
	Transportation Timeliness	- -	86.02%	- -	86.02%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	6.42%	- -	*NA*
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	15.33%	- -	*NA*
	Antidepressant Medication Management—Effective Acute Phase Treatment	- -	*NA*	- -	*NA*
	Antidepressant Medication Management—Effective Continuation Phase Treatment	- -	*NA*	- -	*NA*
	Mental Health Readmission Rate	- -	34.00%	- -	*NA*

Clear Health did not report valid Non-Reform and Reform rates (*NA* performance analysis results) for many measures because their eligible populations were less than 30. One Non-Reform rate was above the national Medicaid average and five were below their respective national averages. Clear Health had only four measures with valid, reportable Reform rates, two of which were non-HEDIS measures where national percentiles were not available for comparison. The other two rates were utilization indicators where performance level analysis was not applicable.

Table D-6 contains the HEDIS 2014 Non-Reform rates and performance level analysis results from FL Healthcare.

Table D-6—Florida Medicaid HEDIS 2014 Result Summary Table: FL Healthcare			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—6+ Visits	- -	*NA*
	Well-Child Visits in the 3rd–6th Years of Life	- -	*NA*
	Lead Screening in Children	- -	*NA*
	Adolescent Well-Care Visits	- -	*NA*
	Annual Dental Visit—2–3 years	- -	*NA*
	Annual Dental Visit—4–6 years	- -	*NA*
	Annual Dental Visit—7–10 years	- -	*NA*
	Annual Dental Visit—11–14 years	- -	*NA*
	Annual Dental Visit—15–18 years	- -	*NA*
	Annual Dental Visit—19–21 years	- -	*NA*
	Annual Dental Visit—Total	- -	*NA*
	Childhood Immunization Status—Combination 2	- -	*NA*
	Childhood Immunization Status—Combination 3	- -	*NA*
	Immunizations for Adolescents—Combination 1	- -	*NA*
	Immunizations for Adolescents—Meningococcal	- -	*NA*
	Immunizations for Adolescents—Tdap/Td	- -	*NA*
	Appropriate Testing for Children With Pharyngitis	- -	*NA*
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	- -	*NA*
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	*NA*
Women's Care	*Cervical Cancer Screening*	- -	*NA*
	Chlamydia Screening in Women—16–20 Years	- -	*NA*
	Chlamydia Screening in Women—21–24 Years	- -	*NA*
	Chlamydia Screening in Women—Total	- -	*NA*
	Breast Cancer Screening	- -	*NA*

Table D-6—Florida Medicaid HEDIS 2014 Result Summary Table: FL Healthcare			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
	Timeliness of Prenatal Care	- -	*NA*
	Postpartum Care	- -	*NA*
	Prenatal Care Frequency	- -	*NA*
Living With Illness	*Diabetes Care—HbA1c Testing*	- -	*NA*
	Diabetes Care—HbA1c Poor Control	- -	*NA*
	Diabetes Care—HbA1c Control (<8%)	- -	*NA*
	Diabetes Care—LDL-C Screening	- -	*NA*
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	*NA*
	Diabetes Care—Eye Exam (Retinal) Performed	- -	*NA*
	Diabetes Care—Medical Attention for Nephropathy	- -	*NA*
	Controlling High Blood Pressure	- -	*NA*
	Adult BMI Assessment	- -	*NA*
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	*NA*
	HIV-Related Medical Visits—0 Visits	- -	*NA*
	HIV-Related Medical Visits—1 Visit	- -	*NA*
	HIV-Related Medical Visits—>=2 Visits	- -	*NA*
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	*NA*
	Highly Active Anti-Retroviral Treatment	- -	*NA*
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	*NA*
	Lipid Profile Annually	- -	*NA*

Table D-6—Florida Medicaid HEDIS 2014 Result Summary Table: FL Healthcare			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	98.85
	Ambulatory Care—ED Visits per 1,000 MM	+ +	60.90
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	- -	*NA*
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	- -	*NA*
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	- -	*NA*
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—Total	- -	*NA*
	Call Abandonment	- -	*NR*
	Call Answer Timeliness	- -	*NR*
	Transportation Availability	- -	*NB*
	Transportation Timeliness	- -	*NB*
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	*NA*
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	*NA*
	Antidepressant Medication Management—Effective Acute Phase Treatment	- -	*NA*
	Antidepressant Medication Management—Effective Continuation Phase Treatment	- -	*NA*
	Mental Health Readmission Rate	- -	*NA*

FL Healthcare did not report valid rates (*NA* performance analysis results) for many measures because their eligible populations were less than 30. The two valid rates shown were utilization indicators where performance level analysis was not applicable.

Table D-7 contains the HEDIS 2014 Non-Reform and Reform rates and respective performance level analysis results for First Coast.

Table D-7—Florida Medicaid HEDIS 2014 Result Summary Table: First Coast					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★	2.31%	★★	1.32%
	Well-Child Visits in the First 15 Months of Life—1 Visit	★★	1.54%	★★	2.87%
	Well-Child Visits in the First 15 Months of Life—2 Visits	★★	3.85%	★★★	5.30%
	Well-Child Visits in the First 15 Months of Life—3 Visits	★★★	9.23%	★★★	8.61%
	Well-Child Visits in the First 15 Months of Life—4 Visits	★★	9.23%	★★	11.70%
	Well-Child Visits in the First 15 Months of Life—5 Visits	★★	12.31%	★★	20.09%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★★	61.54%	★	50.11%
	Well-Child Visits in the 3rd–6th Years of Life	★★	71.34%	★★	70.42%
	Lead Screening in Children	★	46.67%	★	46.14%
	Adolescent Well-Care Visits	★	41.00%	★	40.84%
	Annual Dental Visit—2–3 years	★	11.88%	★★	28.19%
	Annual Dental Visit—4–6 years	★	23.36%	★★	53.90%
	Annual Dental Visit—7–10 years	★	23.28%	★★	63.13%
	Annual Dental Visit—11–14 years	★	26.14%	★★	51.89%
	Annual Dental Visit—15–18 years	★	21.48%	★★	44.83%
	Annual Dental Visit—19–21 years	★	4.76%	★	28.46%
	Annual Dental Visit—Total	★	20.17%	★★	49.57%
	Childhood Immunization Status—Combination 2	★★	76.67%	★★	78.81%
	Childhood Immunization Status—Combination 3	★★	66.67%	★★	75.06%
	Immunizations for Adolescents—Combination 1	- -	*NA*	★	50.55%
	Immunizations for Adolescents—Meningococcal	- -	*NA*	★	50.99%
	Immunizations for Adolescents—Tdap/Td	- -	*NA*	★★	79.03%
	Appropriate Testing for Children With Pharyngitis	★★	80.00%	★	59.76%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	- -	*NA*	★★	44.61%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	*NA*	★★★	64.89%
Women's Care	*Cervical Cancer Screening*	★	44.26%	★	58.86%
	Chlamydia Screening in Women—16–20 Years	★★★	67.50%	★★	51.34%

Table D-7—Florida Medicaid HEDIS 2014 Result Summary Table: First Coast					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	Chlamydia Screening in Women—21–24 Years	★★	65.00%	★★	71.29%
	Chlamydia Screening in Women—Total	★★	66.00%	★★	59.88%
	Breast Cancer Screening	- -	*NA*	★★	57.98%
	Timeliness of Prenatal Care	★	65.38%	★	67.34%
	Postpartum Care	★	44.23%	★	41.61%
	Prenatal Care Frequency	- -	42.31%	- -	46.31%
Living With Illness	*Diabetes Care—HbA1c Testing*	★	78.79%	★★	81.64%
	Diabetes Care—HbA1c Poor Control	★	75.76%	★★	51.77%
	Diabetes Care—HbA1c Control (<8%)	★	24.24%	★★	41.15%
	Diabetes Care—LDL-C Screening	★	60.61%	★★★	83.63%
	Diabetes Care—LDL-C Control (<100 mg/dL)	★	15.15%	★★	30.97%
	Diabetes Care—Eye Exam (Retinal) Performed	★	12.12%	★★	47.79%
	Diabetes Care—Medical Attention for Nephropathy	★★	75.76%	★★★	87.83%
	Controlling High Blood Pressure	★	40.00%	★	49.55%
	Adult BMI Assessment	- -	*NA*	★★★	91.76%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	*NA*	★	83.29%
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	*NA*	★★	85.87%
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	*NA*	★★	75.81%
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	*NA*	★★	79.07%
	Use of Appropriate Medications for People with Asthma—Total	- -	*NA*	★★	81.79%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	*NA*	- -	13.13%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	*NA*	- -	15.22%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	*NA*	- -	71.64%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	*NA*	- -	45.37%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	*NA*	- -	12.24%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	*NA*	- -	18.51%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	*NA*	- -	69.25%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	*NA*	- -	39.10%
	HIV-Related Medical Visits—0 Visits	- -	*NA*	- -	7.76%
	HIV-Related Medical Visits—1 Visit	- -	*NA*	- -	10.75%

Table D-7—Florida Medicaid HEDIS 2014 Result Summary Table: First Coast					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	HIV-Related Medical Visits—>=2 Visits	- -	*NA*	- -	81.49%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	*NA*	- -	61.49%
	Highly Active Anti-Retroviral Treatment	- -	*NA*	- -	82.96%
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	58.14%	- -	76.73%
	Lipid Profile Annually	- -	71.01%	- -	76.61%
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	288.48	+ +	347.54
	Ambulatory Care—ED Visits per 1,000 MM	+ +	94.85	+ +	83.35
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★	95.35%	★★	95.84%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★	85.19%	★	85.67%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	- -	*NA*	★	82.50%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	- -	*NA*	★	81.48%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	64.41%	★	76.35%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	76.16%	★★	90.65%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	- -	*NA*	★★	92.18%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	66.85%	★★	81.29%
	Call Abandonment	- -	6.19%	- -	5.21%
	Call Answer Timeliness	★	65.99%	★	66.70%
	Transportation Availability	- -	*NB*	- -	100.00%
	Transportation Timeliness	- -	*NB*	- -	81.44%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	6.45%	- -	20.98%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	46.00%	- -	37.80%
	Antidepressant Medication Management—Effective Acute Phase Treatment	- -	*NA*	★★★	61.96%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	- -	*NA*	★★★	47.37%
	Mental Health Readmission Rate	- -	13.86%	- -	21.75%

First Coast did not report valid Non-Reform rates (*NA* performance analysis results) for some measures because their eligible populations were less than 30. Reform rates suggested better performance when compared to the Non-Reform rates. Two Non-Reform rates and eight Reform rates were above their respective national Medicaid averages, while 26 Non-Reform rates and 17 Reform rates showed below-average performance.

Table D-8 contains the HEDIS 2014 Non-Reform and Reform rates and respective performance level analysis results for Freedom.

Table D-8—Florida Medicaid HEDIS 2014 Result Summary Table: Freedom

		Non-Reform		Reform	
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**	**Performance Level Analysis**	**2014**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★	4.62%	★★	1.59%
	Well-Child Visits in the First 15 Months of Life—1 Visit	★★★	3.41%	★★	1.59%
	Well-Child Visits in the First 15 Months of Life—2 Visits	★★★	5.35%	★★	3.17%
	Well-Child Visits in the First 15 Months of Life—3 Visits	★★★	9.00%	★★★	9.52%
	Well-Child Visits in the First 15 Months of Life—4 Visits	★★★	16.55%	★★	12.70%
	Well-Child Visits in the First 15 Months of Life—5 Visits	★★★	22.87%	★★★	25.40%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★	38.20%	★	46.03%
	Well-Child Visits in the 3rd–6th Years of Life	★	66.42%	★★	75.91%
	Lead Screening in Children	★	49.64%	★★	58.91%
	Adolescent Well-Care Visits	★★	43.55%	★★	46.72%
	Annual Dental Visit—2–3 years	- -	*NB*	★★	32.06%
	Annual Dental Visit—4–6 years	- -	*NB*	★	46.15%
	Annual Dental Visit—7–10 years	- -	*NB*	★	50.00%
	Annual Dental Visit—11–14 years	- -	*NB*	★	37.65%
	Annual Dental Visit—15–18 years	- -	*NB*	★	38.04%
	Annual Dental Visit—19–21 years	- -	*NB*	★	27.91%
	Annual Dental Visit—Total	- -	*NB*	★	40.42%
	Childhood Immunization Status—Combination 2	★★	72.99%	★	66.67%
	Childhood Immunization Status—Combination 3	★★	68.86%	★	59.69%
	Immunizations for Adolescents—Combination 1	★	57.32%	★★	69.23%
	Immunizations for Adolescents—Meningococcal	★	58.31%	★★	72.31%
	Immunizations for Adolescents—Tdap/Td	★★	76.67%	★★	81.54%
	Appropriate Testing for Children With Pharyngitis	★★	64.75%	- -	*NA*
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★	51.81%	- -	*NA*
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	*NA*	- -	*NA*
Women's Care	*Cervical Cancer Screening*	★	54.50%	★★	62.53%
	Chlamydia Screening in Women—16–20 Years	★★	56.95%	★★	61.29%

Table D-8—Florida Medicaid HEDIS 2014 Result Summary Table: Freedom					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	Chlamydia Screening in Women—21–24 Years	★★	63.32%	- -	*NA*
	Chlamydia Screening in Women—Total	★★	60.10%	★★	66.67%
	Breast Cancer Screening	★★	48.53%	★★	53.52%
	Timeliness of Prenatal Care	★	72.05%	★	77.78%
	Postpartum Care	★	50.93%	★★	64.81%
	Prenatal Care Frequency	- -	70.81%	- -	61.11%
Living With Illness	*Diabetes Care—HbA1c Testing*	★	76.96%	★★	82.14%
	Diabetes Care—HbA1c Poor Control	★★	44.93%	★★	39.29%
	Diabetes Care—HbA1c Control (<8%)	★★	45.62%	★★	46.43%
	Diabetes Care—LDL-C Screening	★★	74.19%	★★	82.14%
	Diabetes Care—LDL-C Control (<100 mg/dL)	★★	29.95%	★★	29.46%
	Diabetes Care—Eye Exam (Retinal) Performed	★★	50.69%	★★	58.93%
	Diabetes Care—Medical Attention for Nephropathy	★★	79.49%	★★	82.14%
	Controlling High Blood Pressure	★★	55.47%	★★	52.35%
	Adult BMI Assessment	★★	81.51%	★★	68.42%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—19–50 years	★	53.33%	- -	*NA*
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	★	62.82%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	30.77%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	10.26%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	58.97%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	30.77%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	30.77%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	12.82%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	56.41%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	33.33%	- -	*NA*
	HIV-Related Medical Visits—0 Visits	- -	23.08%	- -	*NA*
	HIV-Related Medical Visits—1 Visit	- -	20.51%	- -	*NA*

Table D-8—Florida Medicaid HEDIS 2014 Result Summary Table: Freedom					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	HIV-Related Medical Visits—>=2 Visits	- -	56.41%	- -	*NA*
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	41.03%	- -	*NA*
	Highly Active Anti-Retroviral Treatment	- -	54.29%	- -	*NA*
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	59.51%	- -	73.47%
	Lipid Profile Annually	- -	77.62%	- -	88.61%
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	252.44	+ +	326.36
	Ambulatory Care—ED Visits per 1,000 MM	+ +	68.44	+ +	76.86
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★	90.09%	★★★	98.56%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★	82.16%	★★	88.39%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★	75.31%	★★	88.08%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	73.15%	★	80.66%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	64.02%	★	68.56%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	79.76%	★	82.13%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★	55.03%	★	69.33%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	67.44%	★	72.95%
	Call Abandonment	- -	2.55%	- -	2.55%
	Call Answer Timeliness	★★	85.20%	★★	85.20%
	Transportation Availability	- -	*NB*	- -	100.00%
	Transportation Timeliness	- -	*NB*	- -	87.87%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	22.01%	- -	17.02%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	38.55%	- -	35.90%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★	48.89%	- -	*NA*
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★	33.33%	- -	*NA*
	Mental Health Readmission Rate	- -	21.85%	- -	25.00%

Freedom performed above the national Medicaid averages for five Non-Reform rates but was below the national averages for 20 Non-Reform rates. Compared to last year, Freedom had one more rate indicating above-average performance and one more rate indicating below-average performance. Freedom reported three Reform rates above their respective national Medicaid averages and 15 Reform rates below their respective national averages. Compared to last year, Freedom had more rates indicating above-average performance and one less rate indicating below-average performance.

Table D-9 contains the HEDIS 2014 Non-Reform rates and performance level analysis results for HealthEase.

Table D-9—Florida Medicaid HEDIS 2014 Result Summary Table: HealthEase

Dimension of Care	2014 Measures	Performance Level Analysis	2014
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★★	1.22%
	Well-Child Visits in the First 15 Months of Life—1 Visit	★★	1.22%
	Well-Child Visits in the First 15 Months of Life—2 Visits	★★	3.41%
	Well-Child Visits in the First 15 Months of Life—3 Visits	★★	6.10%
	Well-Child Visits in the First 15 Months of Life—4 Visits	★★	12.68%
	Well-Child Visits in the First 15 Months of Life—5 Visits	★★	20.73%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★	54.63%
	Well-Child Visits in the 3rd–6th Years of Life	★★	74.85%
	Lead Screening in Children	★	51.85%
	Adolescent Well-Care Visits	★★	48.42%
	Annual Dental Visit—2–3 years	- -	*NB*
	Annual Dental Visit—4–6 years	- -	*NB*
	Annual Dental Visit—7–10 years	- -	*NB*
	Annual Dental Visit—11–14 years	- -	*NB*
	Annual Dental Visit—15–18 years	- -	*NB*
	Annual Dental Visit—19–21 years	- -	*NB*
	Annual Dental Visit—Total	- -	*NB*
	Childhood Immunization Status—Combination 2	★★	75.18%
	Childhood Immunization Status—Combination 3	★★	68.86%
	Immunizations for Adolescents—Combination 1	★★	59.30%
	Immunizations for Adolescents—Meningococcal	★★	60.80%
	Immunizations for Adolescents—Tdap/Td	★★	84.67%
	Appropriate Testing for Children With Pharyngitis	★	56.57%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★	50.32%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	★★★	64.34%
Women's Care	*Cervical Cancer Screening*	★★	59.66%
	Chlamydia Screening in Women—16–20 Years	★★	56.18%
	Chlamydia Screening in Women—21–24 Years	★★	66.28%
	Chlamydia Screening in Women—Total	★★	60.16%
	Breast Cancer Screening	★★	52.76%

Table D-9—Florida Medicaid HEDIS 2014 Result Summary Table: HealthEase			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
	Timeliness of Prenatal Care	★	74.70%
	Postpartum Care	★	54.01%
	Prenatal Care Frequency	- -	64.96%
Living With Illness	*Diabetes Care—HbA1c Testing*	★	77.62%
	Diabetes Care—HbA1c Poor Control	★★	52.07%
	Diabetes Care—HbA1c Control (<8%)	★★	41.61%
	Diabetes Care—LDL-C Screening	★★	75.18%
	Diabetes Care—LDL-C Control (<100 mg/dL)	★★	33.33%
	Diabetes Care—Eye Exam (Retinal) Performed	★★	45.26%
	Diabetes Care—Medical Attention for Nephropathy	★★	75.67%
	Controlling High Blood Pressure	★	48.18%
	Adult BMI Assessment	★★★	85.67%
	Use of Appropriate Medications for People with Asthma—5–11 years	★	86.05%
	Use of Appropriate Medications for People with Asthma—12–18 years	★★	82.99%
	Use of Appropriate Medications for People with Asthma—19–50 years	★★	73.51%
	Use of Appropriate Medications for People with Asthma—51–64 years	★★	70.77%
	Use of Appropriate Medications for People with Asthma—Total	★★	82.33%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	22.31%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	22.73%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	54.96%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	34.71%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	24.79%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	17.77%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	57.44%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	35.95%
	HIV-Related Medical Visits—0 Visits	- -	11.16%
	HIV-Related Medical Visits—1 Visit	- -	18.18%
	HIV-Related Medical Visits—>=2 Visits	- -	70.66%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	45.87%
	Highly Active Anti-Retroviral Treatment	- -	61.54%
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	59.76%
	Lipid Profile Annually	- -	73.48%

Table D-9—Florida Medicaid HEDIS 2014 Result Summary Table: HealthEase			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	251.26
	Ambulatory Care—ED Visits per 1,000 MM	+ +	75.18
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★★	96.05%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★	87.59%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★	86.04%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	83.75%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	67.16%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	81.53%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★	66.59%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	71.10%
	Call Abandonment	- -	2.89%
	Call Answer Timeliness	★★	84.27%
	Transportation Availability	- -	*NB*
	Transportation Timeliness	- -	*NB*
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	28.56%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	47.90%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★	48.45%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★	31.90%
	Mental Health Readmission Rate	- -	22.06%

Two Non-Reform rates were above and 15 rates were below their respective national Medicaid averages. Compared to CY 2012, when no rates were above and 18 rates were below their respective national averages, HealthEase's performance improved from last year.

Table D-10 contains the HEDIS 2014 Non-Reform rates and performance level analysis results for Healthy PB.

Table D-10—Florida Medicaid HEDIS 2014 Result Summary Table: Healthy PB			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★★	1.57%
	Well-Child Visits in the First 15 Months of Life—1 Visit	★★	1.57%
	Well-Child Visits in the First 15 Months of Life—2 Visits	★★	3.13%
	Well-Child Visits in the First 15 Months of Life—3 Visits	★★	5.22%
	Well-Child Visits in the First 15 Months of Life—4 Visits	★★★	13.32%
	Well-Child Visits in the First 15 Months of Life—5 Visits	★★★	25.33%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★	49.87%
	Well-Child Visits in the 3rd–6th Years of Life	★★	78.83%
	Lead Screening in Children	★★	75.43%
	Adolescent Well-Care Visits	★★	52.55%
	Annual Dental Visit—2–3 years	★	15.12%
	Annual Dental Visit—4–6 years	★	27.36%
	Annual Dental Visit—7–10 years	★	31.77%
	Annual Dental Visit—11–14 years	★	22.34%
	Annual Dental Visit—15–18 years	★	20.66%
	Annual Dental Visit—19–21 years	★	7.14%
	Annual Dental Visit—Total	★	23.48%
	Childhood Immunization Status—Combination 2	★★	72.99%
	Childhood Immunization Status—Combination 3	★★	70.32%
	Immunizations for Adolescents—Combination 1	★★	63.08%
	Immunizations for Adolescents—Meningococcal	★★	64.10%
	Immunizations for Adolescents—Tdap/Td	★★	81.54%
	Appropriate Testing for Children With Pharyngitis	★★	64.29%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★	30.91%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	*NA*
Women's Care	*Cervical Cancer Screening*	★★	66.42%
	Chlamydia Screening in Women—16–20 Years	★★	63.93%
	Chlamydia Screening in Women—21–24 Years	★★★	73.87%
	Chlamydia Screening in Women—Total	★★	68.67%
	Breast Cancer Screening	- -	*NA*

Table D-10—Florida Medicaid HEDIS 2014 Result Summary Table: Healthy PB			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
	Timeliness of Prenatal Care	★★	81.69%
	Postpartum Care	★★	62.68%
	Prenatal Care Frequency	- -	79.86%
Living With Illness	*Diabetes Care—HbA1c Testing*	★	78.46%
	Diabetes Care—HbA1c Poor Control	★	56.92%
	Diabetes Care—HbA1c Control (<8%)	★	36.92%
	Diabetes Care—LDL-C Screening	★★	73.85%
	Diabetes Care—LDL-C Control (<100 mg/dL)	★	23.08%
	Diabetes Care—Eye Exam (Retinal) Performed	★	40.00%
	Diabetes Care—Medical Attention for Nephropathy	★	69.23%
	Controlling High Blood Pressure	★	31.88%
	Adult BMI Assessment	★★	76.51%
	Use of Appropriate Medications for People with Asthma—5–11 years	★	82.50%
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	★	76.92%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	*NA*
	HIV-Related Medical Visits—0 Visits	- -	*NA*
	HIV-Related Medical Visits—1 Visit	- -	*NA*
	HIV-Related Medical Visits—>=2 Visits	- -	*NA*
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	*NA*
	Highly Active Anti-Retroviral Treatment	- -	*NA*
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	*NA*
	Lipid Profile Annually	- -	70.37%

Table D-10—Florida Medicaid HEDIS 2014 Result Summary Table: Healthy PB			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	323.48
	Ambulatory Care—ED Visits per 1,000 MM	+ +	62.35
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★★	97.19%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★	91.20%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★	87.38%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	81.38%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	69.16%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	75.31%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	70.02%
	Call Abandonment	- -	7.53%
	Call Answer Timeliness	★★	87.51%
	Transportation Availability	- -	*NB*
	Transportation Timeliness	- -	*NB*
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	25.68%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	45.95%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★★	77.42%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★★	58.06%
	Mental Health Readmission Rate	- -	23.58%

Five Non-Reform rates were above and 23 rates were below their respective national Medicaid averages. Overall, Healthy PB's performance level was fairly consistent with its CY 2012 performance level.

Table D-11 contains the HEDIS 2014 Non-Reform and Reform rates and respective performance level analysis results for Humana.

Table D-11—Florida Medicaid HEDIS 2014 Result Summary Table: Humana					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★	3.16%	★	2.25%
	Well-Child Visits in the First 15 Months of Life—1 Visit	★★	1.70%	★	0.00%
	Well-Child Visits in the First 15 Months of Life—2 Visits	★★	2.92%	★	1.69%
	Well-Child Visits in the First 15 Months of Life—3 Visits	★★	4.87%	★★	3.93%
	Well-Child Visits in the First 15 Months of Life—4 Visits	★★	10.71%	★	6.18%
	Well-Child Visits in the First 15 Months of Life—5 Visits	★★	20.19%	★	7.87%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★★	56.45%	★★★	78.09%
	Well-Child Visits in the 3rd–6th Years of Life	★★	76.35%	★★	80.41%
	Lead Screening in Children	★★	77.62%	★★	81.32%
	Adolescent Well-Care Visits	★★	53.66%	★★	53.90%
	Annual Dental Visit—2–3 years	- -	*NB*	★	18.26%
	Annual Dental Visit—4–6 years	- -	*NB*	★	39.08%
	Annual Dental Visit—7–10 years	- -	*NB*	★	42.89%
	Annual Dental Visit—11–14 years	- -	*NB*	★	34.68%
	Annual Dental Visit—15–18 years	- -	*NB*	★	32.07%
	Annual Dental Visit—19–21 years	- -	*NB*	★	17.89%
	Annual Dental Visit—Total	- -	*NB*	★	34.68%
	Childhood Immunization Status—Combination 2	★★	76.40%	★★	81.32%
	Childhood Immunization Status—Combination 3	★★	72.26%	★★	74.73%
	Immunizations for Adolescents—Combination 1	★★	68.61%	★★	77.42%
	Immunizations for Adolescents—Meningococcal	★★	71.05%	★★	77.42%
	Immunizations for Adolescents—Tdap/Td	★★	82.48%	★★	87.74%
	Appropriate Testing for Children With Pharyngitis	★★	76.80%	★★	81.58%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★	46.15%	★★★	54.29%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	*NA*	- -	*NA*
Women's Care	*Cervical Cancer Screening*	★★	74.74%	★★	61.73%
	Chlamydia Screening in Women—16–20 Years	★★	60.11%	★★	60.43%

Table D-11—Florida Medicaid HEDIS 2014 Result Summary Table: Humana					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	Chlamydia Screening in Women—21–24 Years	★★	68.34%	★★	62.96%
	Chlamydia Screening in Women—Total	★★	63.10%	★★	61.14%
	Breast Cancer Screening	★★★	70.09%	★★★	67.95%
	Timeliness of Prenatal Care	★	66.67%	★	74.74%
	Postpartum Care	★	52.27%	★	57.89%
	Prenatal Care Frequency	- -	51.87%	- -	58.95%
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	85.64%	★★	87.09%
	Diabetes Care—HbA1c Poor Control	★★	33.82%	★★	32.78%
	Diabetes Care—HbA1c Control (<8%)	★★	54.26%	★★	51.66%
	Diabetes Care—LDL-C Screening	★★★	88.08%	★★★	89.40%
	Diabetes Care—LDL-C Control (<100 mg/dL)	★★★	44.77%	★★★	46.36%
	Diabetes Care—Eye Exam (Retinal) Performed	★★	61.31%	★★	62.91%
	Diabetes Care—Medical Attention for Nephropathy	★★★	85.89%	★★★	88.41%
	Controlling High Blood Pressure	★★	67.15%	★★★	70.14%
	Adult BMI Assessment	★★★	90.20%	★★★	93.89%
	Use of Appropriate Medications for People with Asthma—5–11 years	★	83.61%	★	76.47%
	Use of Appropriate Medications for People with Asthma—12–18 years	★	77.78%	- -	*NA*
	Use of Appropriate Medications for People with Asthma—19–50 years	★★	70.97%	- -	*NA*
	Use of Appropriate Medications for People with Asthma—51–64 years	★★	68.75%	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	★	78.66%	★	71.21%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	44.79%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	6.75%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	48.47%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	31.29%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	46.63%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	7.98%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	45.40%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	28.83%	- -	*NA*
	HIV-Related Medical Visits—0 Visits	- -	42.33%	- -	*NA*
	HIV-Related Medical Visits—1 Visit	- -	6.75%	- -	*NA*

Table D-11—Florida Medicaid HEDIS 2014 Result Summary Table: Humana					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	HIV-Related Medical Visits—>=2 Visits	- -	50.92%	- -	*NA*
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	36.20%	- -	*NA*
	Highly Active Anti-Retroviral Treatment	- -	42.27%	- -	*NA*
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	73.27%	- -	66.87%
	Lipid Profile Annually	- -	83.06%	- -	82.54%
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	368.02	+ +	361.88
	Ambulatory Care—ED Visits per 1,000 MM	+ +	57.81	+ +	66.15
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★★	96.34%	★★	96.13%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★	92.31%	★★	91.54%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★★	89.13%	★★	92.25%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	85.09%	★★	87.02%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	71.09%	★	68.39%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★★	89.08%	★★	87.80%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★★	89.10%	★★	86.30%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★★	80.91%	★	78.59%
	Call Abandonment	- -	3.43%	- -	3.43%
	Call Answer Timeliness	★★★	96.57%	★★★	96.57%
	Transportation Availability	- -	100.00%	- -	100.00%
	Transportation Timeliness	- -	96.58%	- -	99.88%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	13.04%	- -	20.35%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	27.07%	- -	38.26%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★	50.91%	★	37.50%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★	37.14%	★	28.13%
	Mental Health Readmission Rate	- -	24.96%	- -	17.13%

Six Non-Reform rates and nine Reform rates were above their respective national Medicaid averages. Eight Non-Reform rates and 20 Reform rates were below their respective national averages. Compared to CY 2012, Humana's Non-Reform performance level suggested a slight improvement, but its Reform performance level showed more changes. Although Humana had more Reform rates indicating above-average performance this year, it also had more rates falling below the average.

Table D-12 contains the HEDIS 2014 Non-Reform rates and performance level analysis results for Integral.

Table D-12—Florida Medicaid HEDIS 2014 Result Summary Table: Integral			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★	4.17%
	Well-Child Visits in the First 15 Months of Life—1 Visit	★★	2.78%
	Well-Child Visits in the First 15 Months of Life—2 Visits	★★	2.78%
	Well-Child Visits in the First 15 Months of Life—3 Visits	★★	4.86%
	Well-Child Visits in the First 15 Months of Life—4 Visits	★★	7.87%
	Well-Child Visits in the First 15 Months of Life—5 Visits	★★	13.89%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★★	63.66%
	Well-Child Visits in the 3rd–6th Years of Life	★★	67.82%
	Lead Screening in Children	★★	59.03%
	Adolescent Well-Care Visits	★★	44.91%
	Annual Dental Visit—2–3 years	★	21.00%
	Annual Dental Visit—4–6 years	★	44.39%
	Annual Dental Visit—7–10 years	★	48.28%
	Annual Dental Visit—11–14 years	★	38.42%
	Annual Dental Visit—15–18 years	★	31.76%
	Annual Dental Visit—19–21 years	★	13.04%
	Annual Dental Visit—Total	★	37.56%
	Childhood Immunization Status—Combination 2	★★	79.17%
	Childhood Immunization Status—Combination 3	★★	72.45%
	Immunizations for Adolescents—Combination 1	★★	59.69%
	Immunizations for Adolescents—Meningococcal	★	59.95%
	Immunizations for Adolescents—Tdap/Td	★★	85.86%
	Appropriate Testing for Children With Pharyngitis	★	51.30%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★	45.76%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	*NA*
Women's Care	*Cervical Cancer Screening*	★	38.84%
	Chlamydia Screening in Women—16–20 Years	★★	47.57%
	Chlamydia Screening in Women—21–24 Years	★★	63.38%
	Chlamydia Screening in Women—Total	★★	54.58%
	Breast Cancer Screening	★★	49.09%

Table D-12—Florida Medicaid HEDIS 2014 Result Summary Table: Integral			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
	Timeliness of Prenatal Care	★	71.71%
	Postpartum Care	★	53.78%
	Prenatal Care Frequency	- -	64.94%
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	82.08%
	Diabetes Care—HbA1c Poor Control	★★	49.12%
	Diabetes Care—HbA1c Control (<8%)	★★	42.92%
	Diabetes Care—LDL-C Screening	★★	78.54%
	Diabetes Care—LDL-C Control (<100 mg/dL)	★★	35.62%
	Diabetes Care—Eye Exam (Retinal) Performed	★★	52.43%
	Diabetes Care—Medical Attention for Nephropathy	★★	76.11%
	Controlling High Blood Pressure	★★	51.74%
	Adult BMI Assessment	★★	81.21%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	★	73.68%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	18.75%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	14.58%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	66.67%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	43.75%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	16.67%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	16.67%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	66.67%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	43.75%
	HIV-Related Medical Visits—0 Visits	- -	16.67%
	HIV-Related Medical Visits—1 Visit	- -	20.83%
	HIV-Related Medical Visits—>=2 Visits	- -	62.50%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	39.58%
	Highly Active Anti-Retroviral Treatment	- -	76.47%
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	58.12%
	Lipid Profile Annually	- -	82.64%

Table D-12—Florida Medicaid HEDIS 2014 Result Summary Table: Integral			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	187.28
	Ambulatory Care—ED Visits per 1,000 MM	+ +	68.45
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★	92.44%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★	81.01%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★	82.84%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	73.40%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	58.03%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	74.78%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★	71.02%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	63.97%
	Call Abandonment	- -	1.54%
	Call Answer Timeliness	★★	86.75%
	Transportation Availability	- -	*NB*
	Transportation Timeliness	- -	*NB*
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	26.02%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	38.87%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★	46.60%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★	34.95%
	Mental Health Readmission Rate	- -	20.63%

Integral had no rates above the national Medicaid averages, but 23 rates fell below these averages. Integral's overall performance level demonstrated a decline from CY 2012.

Table D-13 contains the HEDIS 2014 Reform rates and performance level analysis results for Magellan.

Table D-13—Florida Medicaid HEDIS 2014 Result Summary Table: Magellan			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—6+ Visits	- -	*NA*
	Well-Child Visits in the 3rd–6th Years of Life	- -	*NA*
	Lead Screening in Children	- -	*NA*
	Adolescent Well-Care Visits	- -	*NA*
	Annual Dental Visit—2–3 years	- -	*NA*
	Annual Dental Visit—4–6 years	- -	*NA*
	Annual Dental Visit—7–10 years	- -	*NA*
	Annual Dental Visit—11–14 years	- -	*NA*
	Annual Dental Visit—15–18 years	- -	*NA*
	Annual Dental Visit—19–21 years	- -	*NA*
	Annual Dental Visit—Total	- -	*NA*
	Childhood Immunization Status—Combination 2	- -	*NA*
	Childhood Immunization Status—Combination 3	- -	*NA*
	Immunizations for Adolescents—Combination 1	- -	*NA*
	Immunizations for Adolescents—Meningococcal	- -	*NA*
	Immunizations for Adolescents—Tdap/Td	- -	*NA*
	Appropriate Testing for Children With Pharyngitis	- -	*NA*
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	- -	*NA*
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	*NA*
Women's Care	*Cervical Cancer Screening*	- -	*NA*
	Chlamydia Screening in Women—16–20 Years	- -	*NA*
	Chlamydia Screening in Women—21–24 Years	- -	*NA*
	Chlamydia Screening in Women—Total	- -	*NA*
	Breast Cancer Screening	- -	*NA*

Table D-13—Florida Medicaid HEDIS 2014 Result Summary Table: Magellan			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
	Timeliness of Prenatal Care	- -	*NA*
	Postpartum Care	- -	*NA*
	Prenatal Care Frequency	- -	*NA*
Living With Illness	*Diabetes Care—HbA1c Testing*	- -	*NA*
	Diabetes Care—HbA1c Poor Control	- -	*NA*
	Diabetes Care—HbA1c Control (<8%)	- -	*NA*
	Diabetes Care—LDL-C Screening	- -	*NA*
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	*NA*
	Diabetes Care—Eye Exam (Retinal) Performed	- -	*NA*
	Diabetes Care—Medical Attention for Nephropathy	- -	*NA*
	Controlling High Blood Pressure	- -	*NA*
	Adult BMI Assessment	- -	*NA*
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	*NA*
	HIV-Related Medical Visits—0 Visits	- -	*NA*
	HIV-Related Medical Visits—1 Visit	- -	*NA*
	HIV-Related Medical Visits—>=2 Visits	- -	*NA*
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	*NA*
	Highly Active Anti-Retroviral Treatment	- -	*NA*
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	*NA*
	Lipid Profile Annually	- -	*NA*

Table D-13—Florida Medicaid HEDIS 2014 Result Summary Table: Magellan			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	0.00
	Ambulatory Care—ED Visits per 1,000 MM	+ +	0.00
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	- -	*NA*
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	- -	*NA*
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	- -	*NA*
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—Total	- -	*NA*
	Call Abandonment	- -	1.05%
	Call Answer Timeliness	★★★	98.08%
	Transportation Availability	- -	100.00%
	Transportation Timeliness	- -	85.48%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	*NA*
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	*NA*
	Antidepressant Medication Management—Effective Acute Phase Treatment	- -	*NA*
	Antidepressant Medication Management—Effective Continuation Phase Treatment	- -	*NA*
	Mental Health Readmission Rate	- -	*NA*

Magellan had six valid, reportable rates, but only one (*Call Answer Timeliness*) had the national Medicaid percentiles available for comparison. For this measure, Magellan's performance was above the national Medicaid average. Three measures did not have performance level results because they were non-HEDIS measures. The remaining two valid, reportable rates were utilization indicators where performance level analysis was not applicable. For all other measures, *NA* audit designations were assigned because their eligible populations were less than 30.

Table D-14 contains the HEDIS 2014 Non-Reform and Reform rates and respective performance level analysis results for Medica.

Table D-14—Florida Medicaid HEDIS 2014 Result Summary Table: Medica

		Non-Reform		Reform	
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**	**Performance Level Analysis**	**2014**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★	6.52%	★	7.41%
	Well-Child Visits in the First 15 Months of Life—1 Visit	★★	2.17%	★★★	5.56%
	Well-Child Visits in the First 15 Months of Life—2 Visits	★★★	13.04%	★★★	5.56%
	Well-Child Visits in the First 15 Months of Life—3 Visits	★★★	17.39%	★★★	16.67%
	Well-Child Visits in the First 15 Months of Life—4 Visits	★★★	15.22%	★★★	14.81%
	Well-Child Visits in the First 15 Months of Life—5 Visits	★★	15.22%	★	7.41%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★	30.43%	★	42.59%
	Well-Child Visits in the 3rd–6th Years of Life	★	59.48%	★	66.03%
	Lead Screening in Children	★	54.17%	★	53.92%
	Adolescent Well-Care Visits	★	32.39%	★	37.29%
	Annual Dental Visit—2–3 years	- -	*NB*	★	15.48%
	Annual Dental Visit—4–6 years	- -	*NB*	★	29.61%
	Annual Dental Visit—7–10 years	- -	*NB*	★	31.05%
	Annual Dental Visit—11–14 years	- -	*NB*	★	22.22%
	Annual Dental Visit—15–18 years	- -	*NB*	★	16.46%
	Annual Dental Visit—19–21 years	- -	*NB*	★	18.00%
	Annual Dental Visit—Total	- -	*NB*	★	22.73%
	Childhood Immunization Status—Combination 2	★	50.00%	★	48.04%
	Childhood Immunization Status—Combination 3	★	38.89%	★	44.12%
	Immunizations for Adolescents—Combination 1	★	26.83%	★	42.55%
	Immunizations for Adolescents—Meningococcal	★	26.83%	★	46.81%
	Immunizations for Adolescents—Tdap/Td	★	31.71%	★	42.55%
	Appropriate Testing for Children With Pharyngitis	- -	*NA*	- -	*NA*
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	- -	*NA*	- -	*NA*
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	*NA*	- -	*NA*
Women's Care	*Cervical Cancer Screening*	★	39.41%	★	39.68%
	Chlamydia Screening in Women—16–20 Years	- -	*NA*	★★	60.00%

Table D-14—Florida Medicaid HEDIS 2014 Result Summary Table: Medica					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	Chlamydia Screening in Women—21–24 Years	- -	*NA*	- -	*NA*
	Chlamydia Screening in Women—Total	★★	65.79%	★★	57.38%
	Breast Cancer Screening	★	43.24%	★★	52.00%
	Timeliness of Prenatal Care	- -	*NA*	- -	*NA*
	Postpartum Care	- -	*NA*	- -	*NA*
	Prenatal Care Frequency	- -	*NA*	- -	*NA*
Living With Illness	*Diabetes Care—HbA1c Testing*	★	76.03%	★	76.81%
	Diabetes Care—HbA1c Poor Control	★★	46.28%	★★	42.03%
	Diabetes Care—HbA1c Control (<8%)	★★	40.50%	★★	47.83%
	Diabetes Care—LDL-C Screening	★★	71.90%	★★	83.33%
	Diabetes Care—LDL-C Control (<100 mg/dL)	★★	34.71%	★★	37.68%
	Diabetes Care—Eye Exam (Retinal) Performed	★	40.50%	★★	47.83%
	Diabetes Care—Medical Attention for Nephropathy	★★	81.82%	★★	82.61%
	Controlling High Blood Pressure	★	45.65%	★	47.80%
	Adult BMI Assessment	★★	69.96%	★★	78.18%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	- -	*NA*	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	*NA*	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	*NA*	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	*NA*	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	*NA*	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	*NA*	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	*NA*	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	*NA*	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	*NA*	- -	*NA*
	HIV-Related Medical Visits—0 Visits	- -	*NA*	- -	*NA*
	HIV-Related Medical Visits—1 Visit	- -	*NA*	- -	*NA*

Table D-14—Florida Medicaid HEDIS 2014 Result Summary Table: Medica					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	HIV-Related Medical Visits—>=2 Visits	- -	*NA*	- -	*NA*
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	*NA*	- -	*NA*
	Highly Active Anti-Retroviral Treatment	- -	*NA*	- -	*NA*
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	72.09%	- -	72.58%
	Lipid Profile Annually	- -	80.85%	- -	85.86%
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	212.44	+ +	247.76
	Ambulatory Care—ED Visits per 1,000 MM	+ +	48.63	+ +	57.91
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★	81.52%	★	88.98%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★	77.05%	★	79.11%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★	68.10%	★	80.00%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	56.81%	★	66.87%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	58.50%	★	62.08%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	75.71%	★★	86.18%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★	66.40%	★	74.00%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	66.14%	★	74.20%
	Call Abandonment	- -	4.87%	- -	4.87%
	Call Answer Timeliness	★	65.89%	★	65.89%
	Transportation Availability	- -	*NB*	- -	100.00%
	Transportation Timeliness	- -	*NB*	- -	100.00%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	1.35%	- -	4.69%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	5.66%	- -	16.67%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★	60.42%	- -	*NA*
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★★	52.08%	- -	*NA*
	Mental Health Readmission Rate	- -	41.07%	- -	29.27%

Medica's Non-Reform performance showed that four rates were above and 24 rates were below their respective national Medicaid averages. Medica showed more diverse performance when compared to CY 2012, as more rates indicated both above- and below-average performance. Medica's Reform performance showed that four rates were above and 29 rates were below the national Medicaid averages. Similar to its Non-Reform performance level, the Reform performance also was diverse as compared to CY 2012, with more rates indicating both above- and below-average performance.

Table D-15 contains the HEDIS 2014 Non-Reform and Reform rates and respective performance level analysis results for Molina.

Table D-15—Florida Medicaid HEDIS 2014 Result Summary Table: Molina					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★	3.75%	★★	0.66%
	Well-Child Visits in the First 15 Months of Life—1 Visit	★★	1.77%	★★	2.65%
	Well-Child Visits in the First 15 Months of Life—2 Visits	★★	4.19%	★★	3.09%
	Well-Child Visits in the First 15 Months of Life—3 Visits	★★	5.52%	★★	5.30%
	Well-Child Visits in the First 15 Months of Life—4 Visits	★★★	16.78%	★★	11.04%
	Well-Child Visits in the First 15 Months of Life—5 Visits	★★	20.97%	★★★	22.08%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★	47.02%	★	55.19%
	Well-Child Visits in the 3rd–6th Years of Life	★★	72.06%	★★★	82.44%
	Lead Screening in Children	★★	64.02%	★★	64.24%
	Adolescent Well-Care Visits	★★	46.14%	★★	51.21%
	Annual Dental Visit—2–3 years	★	15.99%	★	26.48%
	Annual Dental Visit—4–6 years	★	32.86%	★	47.95%
	Annual Dental Visit—7–10 years	★	35.72%	★	50.81%
	Annual Dental Visit—11–14 years	★	32.29%	★	44.83%
	Annual Dental Visit—15–18 years	★	27.10%	★★	39.03%
	Annual Dental Visit—19–21 years	★	19.47%	★	25.77%
	Annual Dental Visit—Total	★	29.10%	★	41.88%
	Childhood Immunization Status—Combination 2	★	65.34%	★	69.32%
	Childhood Immunization Status—Combination 3	★	61.37%	★	63.36%
	Immunizations for Adolescents—Combination 1	★	54.97%	★★	64.67%
	Immunizations for Adolescents—Meningococcal	★	57.40%	★★	66.22%
	Immunizations for Adolescents—Tdap/Td	★	75.50%	★★	79.56%
	Appropriate Testing for Children With Pharyngitis	★★	69.26%	★★	74.48%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★	28.89%	★	28.80%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	★★	57.58%	- -	*NA*
Women's Care	*Cervical Cancer Screening*	★	58.50%	★★	65.27%
	Chlamydia Screening in Women—16–20 Years	★★	64.02%	★★	57.10%

Table D-15—Florida Medicaid HEDIS 2014 Result Summary Table: Molina					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	Chlamydia Screening in Women—21–24 Years	★★★	74.88%	★★	66.84%
	Chlamydia Screening in Women—Total	★★	68.71%	★★	60.89%
	Breast Cancer Screening	★	45.04%	★★	56.99%
	Timeliness of Prenatal Care	★	69.78%	★	74.82%
	Postpartum Care	★	44.89%	★	56.20%
	Prenatal Care Frequency	- -	63.11%	- -	66.79%
Living With Illness	*Diabetes Care—HbA1c Testing*	★	76.01%	★★	81.11%
	Diabetes Care—HbA1c Poor Control	★★	50.90%	★★	44.22%
	Diabetes Care—HbA1c Control (<8%)	★★	42.60%	★★	47.78%
	Diabetes Care—LDL-C Screening	★★	73.54%	★★	80.67%
	Diabetes Care—LDL-C Control (<100 mg/dL)	★★	29.37%	★★	32.22%
	Diabetes Care—Eye Exam (Retinal) Performed	★★	47.31%	★★	49.33%
	Diabetes Care—Medical Attention for Nephropathy	★★	79.60%	★★★	86.00%
	Controlling High Blood Pressure	★	45.90%	★	45.80%
	Adult BMI Assessment	★★	74.77%	★★	73.12%
	Use of Appropriate Medications for People with Asthma—5–11 years	★	76.71%	★	73.91%
	Use of Appropriate Medications for People with Asthma—12–18 years	★	63.16%	★	71.88%
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	★	63.33%	★	63.45%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	23.38%	- -	15.07%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	19.48%	- -	19.18%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	57.14%	- -	65.75%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	38.96%	- -	47.95%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	24.68%	- -	17.81%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	18.18%	- -	15.07%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	57.14%	- -	67.12%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	41.56%	- -	49.32%
	HIV-Related Medical Visits—0 Visits	- -	14.29%	- -	9.59%
	HIV-Related Medical Visits—1 Visit	- -	19.48%	- -	13.70%

Table D-15—Florida Medicaid HEDIS 2014 Result Summary Table: Molina					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	HIV-Related Medical Visits—>=2 Visits	- -	66.23%	- -	76.71%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	48.05%	- -	54.79%
	Highly Active Anti-Retroviral Treatment	- -	71.01%	- -	80.88%
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	52.74%	- -	46.52%
	Lipid Profile Annually	- -	80.71%	- -	88.72%
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	283.59	+ +	346.43
	Ambulatory Care—ED Visits per 1,000 MM	+ +	67.77	+ +	67.61
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★	94.60%	★★	98.13%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★	87.17%	★★	91.46%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★	84.90%	★★	89.55%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	79.45%	★	84.37%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	64.68%	★	68.16%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	74.40%	★★	84.95%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★	68.43%	★	78.10%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	67.73%	★	74.78%
	Call Abandonment	- -	1.76%	- -	1.76%
	Call Answer Timeliness	★★	86.42%	★★	86.42%
	Transportation Availability	- -	*NB*	- -	100.00%
	Transportation Timeliness	- -	*NB*	- -	84.47%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	19.13%	- -	17.21%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	33.03%	- -	31.09%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★	51.55%	★★	52.98%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★	38.83%	★★	39.74%
	Mental Health Readmission Rate	- -	28.48%	- -	33.41%

Molina's Non-Reform performance showed that two rates were above and 31 rates were below their respective national Medicaid averages. Compared to CY 2012, Molina had fewer rates indicating above-average performance and slightly more rates indicating below-average performance. Molina's Reform performance showed that three rates were above and 20 rates were below their respective national averages. Compared to CY 2012, Molina had more rates falling below these averages.

Table D-16 contains the HEDIS 2014 Non-Reform and Reform rates and respective performance level analysis results for Positive.

Table D-16—Florida Medicaid HEDIS 2014 Result Summary Table: Positive					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	- -	*NA*	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	*NA*	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	*NA*	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	*NA*	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	*NA*	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	*NA*	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—6+ Visits	- -	*NA*	- -	*NA*
	Well-Child Visits in the 3rd–6th Years of Life	- -	*NA*	- -	*NA*
	Lead Screening in Children	- -	*NA*	- -	*NA*
	Adolescent Well-Care Visits	- -	*NA*	- -	*NA*
	Annual Dental Visit—2–3 years	- -	*NA*	- -	*NA*
	Annual Dental Visit—4–6 years	- -	*NA*	- -	*NA*
	Annual Dental Visit—7–10 years	- -	*NA*	- -	*NA*
	Annual Dental Visit—11–14 years	- -	*NA*	- -	*NA*
	Annual Dental Visit—15–18 years	- -	*NA*	- -	*NA*
	Annual Dental Visit—19–21 years	- -	*NA*	- -	*NA*
	Annual Dental Visit—Total	- -	*NA*	- -	*NA*
	Childhood Immunization Status—Combination 2	- -	*NA*	- -	*NA*
	Childhood Immunization Status—Combination 3	- -	*NA*	- -	*NA*
	Immunizations for Adolescents—Combination 1	- -	*NA*	- -	*NA*
	Immunizations for Adolescents—Meningococcal	- -	*NA*	- -	*NA*
	Immunizations for Adolescents—Tdap/Td	- -	*NA*	- -	*NA*
	Appropriate Testing for Children With Pharyngitis	- -	*NA*	- -	*NA*
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	- -	*NA*	- -	*NA*
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	*NA*	- -	*NA*
Women's Care	*Cervical Cancer Screening*	- -	*NA*	★★	71.43%
	Chlamydia Screening in Women—16–20 Years	- -	*NA*	- -	*NA*

Table D-16—Florida Medicaid HEDIS 2014 Result Summary Table: Positive					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	Chlamydia Screening in Women—21–24 Years	- -	*NA*	- -	*NA*
	Chlamydia Screening in Women—Total	- -	*NA*	- -	*NA*
	Breast Cancer Screening	- -	*NA*	- -	*NA*
	Timeliness of Prenatal Care	- -	*NA*	- -	*NA*
	Postpartum Care	- -	*NA*	- -	*NA*
	Prenatal Care Frequency	- -	*NA*	- -	*NA*
Living With Illness	*Diabetes Care—HbA1c Testing*	- -	*NA*	- -	*NA*
	Diabetes Care—HbA1c Poor Control	- -	*NA*	- -	*NA*
	Diabetes Care—HbA1c Control (<8%)	- -	*NA*	- -	*NA*
	Diabetes Care—LDL-C Screening	- -	*NA*	- -	*NA*
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	*NA*	- -	*NA*
	Diabetes Care—Eye Exam (Retinal) Performed	- -	*NA*	- -	*NA*
	Diabetes Care—Medical Attention for Nephropathy	- -	*NA*	- -	*NA*
	Controlling High Blood Pressure	- -	*NA*	★	44.74%
	Adult BMI Assessment	- -	*NA*	★★★	91.67%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	- -	*NA*	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	*NA*	- -	3.40%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	*NA*	- -	5.44%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	*NA*	- -	91.16%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	*NA*	- -	73.47%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	*NA*	- -	2.72%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	*NA*	- -	6.12%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	*NA*	- -	91.16%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	*NA*	- -	72.11%
	HIV-Related Medical Visits—0 Visits	- -	*NA*	- -	3.40%
	HIV-Related Medical Visits—1 Visit	- -	*NA*	- -	7.48%

Table D-16—Florida Medicaid HEDIS 2014 Result Summary Table: Positive					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	HIV-Related Medical Visits—>=2 Visits	- -	*NA*	- -	89.12%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	*NA*	- -	75.51%
	Highly Active Anti-Retroviral Treatment	- -	*NA*	- -	75.71%
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	*NA*	- -	*NA*
	Lipid Profile Annually	- -	*NA*	- -	66.67%
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	649.05	+ +	707.84
	Ambulatory Care—ED Visits per 1,000 MM	+ +	107.70	+ +	127.10
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	- -	*NA*	- -	*NA*
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	- -	*NA*	- -	*NA*
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	- -	*NA*	- -	*NA*
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	- -	*NA*	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	- -	*NA*	★★★	94.74%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	- -	*NA*	★★★	98.21%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	- -	*NA*	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—Total	- -	*NA*	★★★	97.37%
	Call Abandonment	- -	7.43%	- -	7.43%
	Call Answer Timeliness	★	79.37%	★	79.37%
	Transportation Availability	- -	100.00%	- -	100.00%
	Transportation Timeliness	- -	88.04%	- -	81.98%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	*NA*	- -	*NA*
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	*NA*	- -	*NA*
	Antidepressant Medication Management—Effective Acute Phase Treatment	- -	*NA*	- -	*NA*
	Antidepressant Medication Management—Effective Continuation Phase Treatment	- -	*NA*	- -	*NA*
	Mental Health Readmission Rate	- -	*NA*	- -	*NA*

Positive reported valid Non-Reform rates for only six measures/indicators; the remaining indicators received an *NA* audit designation because their eligible populations were less than 30. Of these six rates, only one (*Call Answer Timeliness*) had national percentiles available for comparison, and its performance level was below the national average. The national percentile for comparison was not available for the other five rates because either they were non-HEDIS measures or performance level analysis was not applicable.

Positive's Reform performance was fairly consistent with last year's performance level. Four rates were above and two rates were below their respective national averages. Although Positive reported more valid rates for its Reform population, many measures still had less than 30 eligible enrollees, resulting in an *NA* audit designation.

Table D-17 contains the HEDIS 2014 Non-Reform rates and performance level analysis results for Preferred.

Table D-17—Florida Medicaid HEDIS 2014 Result Summary Table: Preferred			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★	5.26%
	Well-Child Visits in the First 15 Months of Life—1 Visit	★★★	4.68%
	Well-Child Visits in the First 15 Months of Life—2 Visits	★★	4.09%
	Well-Child Visits in the First 15 Months of Life—3 Visits	★★★	8.19%
	Well-Child Visits in the First 15 Months of Life—4 Visits	★	4.09%
	Well-Child Visits in the First 15 Months of Life—5 Visits	★★	14.04%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★★	59.65%
	Well-Child Visits in the 3rd–6th Years of Life	★★★	82.48%
	Lead Screening in Children	★	50.72%
	Adolescent Well-Care Visits	★★	57.91%
	Annual Dental Visit—2–3 years	- -	*NB*
	Annual Dental Visit—4–6 years	- -	*NB*
	Annual Dental Visit—7–10 years	- -	*NB*
	Annual Dental Visit—11–14 years	- -	*NB*
	Annual Dental Visit—15–18 years	- -	*NB*
	Annual Dental Visit—19–21 years	- -	*NB*
	Annual Dental Visit—Total	- -	*NB*
	Childhood Immunization Status—Combination 2	★	68.41%
	Childhood Immunization Status—Combination 3	★	60.00%
	Immunizations for Adolescents—Combination 1	★	41.25%
	Immunizations for Adolescents—Meningococcal	★	42.50%
	Immunizations for Adolescents—Tdap/Td	★★	78.75%
	Appropriate Testing for Children With Pharyngitis	★	41.59%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★	38.10%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	*NA*
Women's Care	*Cervical Cancer Screening*	★	53.53%
	Chlamydia Screening in Women—16–20 Years	★★	65.73%
	Chlamydia Screening in Women—21–24 Years	★★	66.30%
	Chlamydia Screening in Women—Total	★★	65.90%
	Breast Cancer Screening	★	28.85%

Table D-17—Florida Medicaid HEDIS 2014 Result Summary Table: Preferred			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
	Timeliness of Prenatal Care	★	72.32%
	Postpartum Care	★	52.68%
	Prenatal Care Frequency	- -	64.29%
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	81.55%
	Diabetes Care—HbA1c Poor Control	★★	44.64%
	Diabetes Care—HbA1c Control (<8%)	★★	48.50%
	Diabetes Care—LDL-C Screening	★★	81.12%
	Diabetes Care—LDL-C Control (<100 mg/dL)	★★	33.91%
	Diabetes Care—Eye Exam (Retinal) Performed	★	42.49%
	Diabetes Care—Medical Attention for Nephropathy	★★	78.11%
	Controlling High Blood Pressure	★★★	74.27%
	Adult BMI Assessment	★★	74.45%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	*NA*
	HIV-Related Medical Visits—0 Visits	- -	*NA*
	HIV-Related Medical Visits—1 Visit	- -	*NA*
	HIV-Related Medical Visits—>=2 Visits	- -	*NA*
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	*NA*
	Highly Active Anti-Retroviral Treatment	- -	*NA*
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	47.83%
	Lipid Profile Annually	- -	78.36%

Table D-17—Florida Medicaid HEDIS 2014 Result Summary Table: Preferred			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	181.89
	Ambulatory Care—ED Visits per 1,000 MM	+ +	48.52
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★	89.25%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★	81.99%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★	84.76%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	78.36%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	55.40%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	70.85%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★	43.54%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	55.93%
	Call Abandonment	- -	2.44%
	Call Answer Timeliness	★★	89.50%
	Transportation Availability	- -	100.00%
	Transportation Timeliness	- -	80.84%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	40.96%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	75.41%
	Antidepressant Medication Management—Effective Acute Phase Treatment	- -	*NA*
	Antidepressant Medication Management—Effective Continuation Phase Treatment	- -	*NA*
	Mental Health Readmission Rate	- -	5.13%

Preferred had four Non-Reform rates that were above and 21 rates that were below their respective national Medicaid averages. Overall, Preferred's performance level was fairly consistent with that of CY 2012.

Table D-18 contains the HEDIS 2014 Non-Reform and Reform rates and respective performance level analysis results for CareFlorida.

Table D-18—Medicaid HEDIS 2014 Result Summary Table: CareFlorida

		Non-Reform		Reform	
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**	**Performance Level Analysis**	**2014**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★	66.67%	★	66.67%
	Well-Child Visits in the First 15 Months of Life—1 Visit	★	0.00%	★	0.00%
	Well-Child Visits in the First 15 Months of Life—2 Visits	★	0.00%	★	0.00%
	Well-Child Visits in the First 15 Months of Life—3 Visits	★	0.00%	★	0.00%
	Well-Child Visits in the First 15 Months of Life—4 Visits	★	0.00%	★	0.00%
	Well-Child Visits in the First 15 Months of Life—5 Visits	★	0.00%	★	0.00%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★	33.33%	★	33.33%
	Well-Child Visits in the 3rd–6th Years of Life	★	64.93%	★★	71.61%
	Lead Screening in Children	★★	64.00%	★★	64.13%
	Adolescent Well-Care Visits	★	35.32%	★★	43.62%
	Annual Dental Visit—2–3 years	- -	*NB*	★	2.24%
	Annual Dental Visit—4–6 years	- -	*NB*	★	9.91%
	Annual Dental Visit—7–10 years	- -	*NB*	★	17.27%
	Annual Dental Visit—11–14 years	- -	*NB*	★	19.85%
	Annual Dental Visit—15–18 years	- -	*NB*	★	11.11%
	Annual Dental Visit—19–21 years	- -	*NB*	★	7.55%
	Annual Dental Visit—Total	- -	*NB*	★	11.85%
	Childhood Immunization Status—Combination 2	★	38.67%	★	54.35%
	Childhood Immunization Status—Combination 3	★	33.33%	★	45.65%
	Immunizations for Adolescents—Combination 1	- -	*NA*	★	47.22%
	Immunizations for Adolescents—Meningococcal	- -	*NA*	★	47.22%
	Immunizations for Adolescents—Tdap/Td	- -	*NA*	★	61.11%
	Appropriate Testing for Children With Pharyngitis	- -	*NA*	- -	*NA*
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	- -	*NA*	- -	*NA*
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	*NA*	- -	*NA*
Women's Care	*Cervical Cancer Screening*	★	34.30%	★	45.88%
	Chlamydia Screening in Women—16–20 Years	- -	*NA*	- -	*NA*

Table D-18—Medicaid HEDIS 2014 Result Summary Table: CareFlorida					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	Chlamydia Screening in Women—21–24 Years	- -	*NA*	★★	63.33%
	Chlamydia Screening in Women—Total	★	39.39%	★★	57.14%
	Breast Cancer Screening	- -	*NA*	- -	*NA*
	Timeliness of Prenatal Care	- -	*NA*	★	53.06%
	Postpartum Care	- -	*NA*	★	53.06%
	Prenatal Care Frequency	- -	*NA*	- -	32.65%
Living With Illness	*Diabetes Care—HbA1c Testing*	★	63.27%	★	72.09%
	Diabetes Care—HbA1c Poor Control	★	63.27%	★	54.65%
	Diabetes Care—HbA1c Control (<8%)	★	34.69%	★	36.05%
	Diabetes Care—LDL-C Screening	★	67.35%	★★	74.42%
	Diabetes Care—LDL-C Control (<100 mg/dL)	★	22.45%	★	23.26%
	Diabetes Care—Eye Exam (Retinal) Performed	★	34.04%	★	32.94%
	Diabetes Care—Medical Attention for Nephropathy	★	72.34%	★★★	87.06%
	Controlling High Blood Pressure	★	48.57%	★	46.85%
	Adult BMI Assessment	★★	67.26%	★★★	85.71%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	- -	*NA*	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	*NA*	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	*NA*	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	*NA*	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	*NA*	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	*NA*	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	*NA*	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	*NA*	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	*NA*	- -	*NA*
	HIV-Related Medical Visits—0 Visits	- -	*NA*	- -	*NA*
	HIV-Related Medical Visits—1 Visit	- -	*NA*	- -	*NA*

Table D-18—Medicaid HEDIS 2014 Result Summary Table: CareFlorida					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	HIV-Related Medical Visits—>=2 Visits	- -	*NA*	- -	*NA*
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	*NA*	- -	*NA*
	Highly Active Anti-Retroviral Treatment	- -	*NA*	- -	*NA*
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	*NA*	- -	34.29%
	Lipid Profile Annually	- -	87.14%	- -	78.32%
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	210.70	+ +	244.19
	Ambulatory Care—ED Visits per 1,000 MM	+ +	66.35	+ +	77.13
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★	84.21%	★	82.35%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★	77.93%	★	82.70%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★	71.43%	★	83.33%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	67.62%	★	65.59%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	53.33%	★	65.16%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	66.67%	★	82.30%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★	59.09%	★	71.29%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	58.14%	★	71.43%
	Call Abandonment	- -	0.91%	- -	0.91%
	Call Answer Timeliness	★★	93.94%	★★	93.94%
	Transportation Availability	- -	*NR*	- -	*NR*
	Transportation Timeliness	- -	*NR*	- -	*NR*
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	*NA*	- -	*NA*
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	*NA*	- -	*NA*
	Antidepressant Medication Management—Effective Acute Phase Treatment	- -	*NA*	★★★	74.19%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	- -	*NA*	★★★	61.29%
	Mental Health Readmission Rate	- -	5.13%	- -	3.39%

CareFlorida's Non-Reform performance level showed that 29 rates were below their respective national Medicaid averages. None of the measures reported a rate above the national average. Compared to CY 2012, CareFlorida's performance declined as more rates fell below the national averages. CareFlorida's Reform performance level showed that four rates were above and 36 rates were below their respective national averages. Similar to CareFlorida's Non-Reform performance, the Reform performance declined when compared to CY 2012, with fewer rates indicating above-average performance and many more rates falling below their respective averages.

Table D-19 contains the HEDIS 2014 Non-Reform rates and performance level analysis results for Prestige.

Table D-19—Florida Medicaid HEDIS 2014 Result Summary Table: Prestige			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★	3.16%
	Well-Child Visits in the First 15 Months of Life—1 Visit	★★	2.43%
	Well-Child Visits in the First 15 Months of Life—2 Visits	★★★	5.60%
	Well-Child Visits in the First 15 Months of Life—3 Visits	★★★	9.98%
	Well-Child Visits in the First 15 Months of Life—4 Visits	★★★	16.55%
	Well-Child Visits in the First 15 Months of Life—5 Visits	★★	18.49%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★	43.80%
	Well-Child Visits in the 3rd–6th Years of Life	★★	70.56%
	Lead Screening in Children	★★	67.64%
	Adolescent Well-Care Visits	★★	44.53%
	Annual Dental Visit—2–3 years	- -	*NB*
	Annual Dental Visit—4–6 years	- -	*NB*
	Annual Dental Visit—7–10 years	- -	*NB*
	Annual Dental Visit—11–14 years	- -	*NB*
	Annual Dental Visit—15–18 years	- -	*NB*
	Annual Dental Visit—19–21 years	★	4.78%
	Annual Dental Visit—Total	★	4.78%
	Childhood Immunization Status—Combination 2	★★	74.94%
	Childhood Immunization Status—Combination 3	★★	68.86%
	Immunizations for Adolescents—Combination 1	★★	63.99%
	Immunizations for Adolescents—Meningococcal	★★	65.21%
	Immunizations for Adolescents—Tdap/Td	★★	80.29%
	Appropriate Testing for Children With Pharyngitis	★	57.96%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★	27.25%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	★	30.65%
Women's Care	*Cervical Cancer Screening*	★	48.18%
	Chlamydia Screening in Women—16–20 Years	★★	59.31%
	Chlamydia Screening in Women—21–24 Years	★★	67.23%
	Chlamydia Screening in Women—Total	★★	62.87%
	Breast Cancer Screening	★	42.62%

Table D-19—Florida Medicaid HEDIS 2014 Result Summary Table: Prestige			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
	Timeliness of Prenatal Care	★	67.88%
	Postpartum Care	★	46.47%
	Prenatal Care Frequency	- -	54.26%
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	80.47%
	Diabetes Care—HbA1c Poor Control	★★	48.54%
	Diabetes Care—HbA1c Control (<8%)	★★	40.69%
	Diabetes Care—LDL-C Screening	★★	74.45%
	Diabetes Care—LDL-C Control (<100 mg/dL)	★★	32.48%
	Diabetes Care—Eye Exam (Retinal) Performed	★	42.15%
	Diabetes Care—Medical Attention for Nephropathy	★★	79.20%
	Controlling High Blood Pressure	★	47.93%
	Adult BMI Assessment	★★★	86.13%
	Use of Appropriate Medications for People with Asthma—5–11 years	★	85.47%
	Use of Appropriate Medications for People with Asthma—12–18 years	★★	83.17%
	Use of Appropriate Medications for People with Asthma—19–50 years	★	65.00%
	Use of Appropriate Medications for People with Asthma—51–64 years	★	58.82%
	Use of Appropriate Medications for People with Asthma—Total	★	79.14%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	22.45%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	23.47%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	54.08%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	37.76%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	21.43%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	20.41%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	58.16%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	40.82%
	HIV-Related Medical Visits—0 Visits	- -	11.22%
	HIV-Related Medical Visits—1 Visit	- -	15.31%
	HIV-Related Medical Visits—>=2 Visits	- -	73.47%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	52.04%
	Highly Active Anti-Retroviral Treatment	- -	75.00%
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	63.64%
	Lipid Profile Annually	- -	75.43%

Table D-19—Florida Medicaid HEDIS 2014 Result Summary Table: Prestige			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	223.29
	Ambulatory Care—ED Visits per 1,000 MM	+ +	74.76
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★	91.33%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★	84.38%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★	81.39%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	77.37%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	58.74%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	76.14%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★	68.89%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	64.44%
	Call Abandonment	- -	4.02%
	Call Answer Timeliness	★	79.10%
	Transportation Availability	- -	*NB*
	Transportation Timeliness	- -	*NB*
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	34.09%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	63.12%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★★	73.90%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★★	64.29%
	Mental Health Readmission Rate	- -	23.11%

Six Non-Reform rates were above and 26 rates were below their respective national Medicaid averages. Compared to CY 2012, Prestige showed more diverse performance, with more rates indicated both above- and below-average performance.

Table D-20 contains the HEDIS 2014 Non-Reform and Reform rates and respective performance level analysis results for SFCCN.

Table D-20—Florida Medicaid HEDIS 2014 Result Summary Table: SFCCN					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★	12.50%	★	5.79%
	Well-Child Visits in the First 15 Months of Life—1 Visit	★★★	6.25%	★★	2.78%
	Well-Child Visits in the First 15 Months of Life—2 Visits	★★★	7.50%	★★★	6.94%
	Well-Child Visits in the First 15 Months of Life—3 Visits	★★★	13.75%	★★	7.18%
	Well-Child Visits in the First 15 Months of Life—4 Visits	★★★	17.50%	★★★	15.97%
	Well-Child Visits in the First 15 Months of Life—5 Visits	★★★	23.75%	★★★	22.22%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★	18.75%	★	39.12%
	Well-Child Visits in the 3rd–6th Years of Life	★	56.94%	★★	71.79%
	Lead Screening in Children	★★	61.54%	★★	74.83%
	Adolescent Well-Care Visits	★	34.03%	★★	54.86%
	Annual Dental Visit—2–3 years	- -	*NB*	★	23.26%
	Annual Dental Visit—4–6 years	- -	*NB*	★	38.11%
	Annual Dental Visit—7–10 years	- -	*NB*	★	44.21%
	Annual Dental Visit—11–14 years	- -	*NB*	★	40.38%
	Annual Dental Visit—15–18 years	- -	*NB*	★	33.14%
	Annual Dental Visit—19–21 years	- -	*NB*	★	21.67%
	Annual Dental Visit—Total	- -	*NB*	★	36.03%
	Childhood Immunization Status—Combination 2	★	55.62%	★	69.68%
	Childhood Immunization Status—Combination 3	★	47.34%	★★	66.90%
	Immunizations for Adolescents—Combination 1	★	27.27%	★★	71.58%
	Immunizations for Adolescents—Meningococcal	★	27.92%	★★	74.45%
	Immunizations for Adolescents—Tdap/Td	★	38.96%	★★	80.33%
	Appropriate Testing for Children With Pharyngitis	★★	62.86%	★★	82.02%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★	7.89%	★	28.35%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	*NA*	★★	37.14%
Women's Care	*Cervical Cancer Screening*	★	52.57%	★	50.36%
	Chlamydia Screening in Women—16–20 Years	★★	50.00%	★★★	69.30%

Table D-20—Florida Medicaid HEDIS 2014 Result Summary Table: SFCCN					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	Chlamydia Screening in Women—21–24 Years	★	54.10%	★★	66.17%
	Chlamydia Screening in Women—Total	★★	51.68%	★★	68.42%
	Breast Cancer Screening	★★	54.42%	★★★	63.60%
	Timeliness of Prenatal Care	★	20.97%	★	57.14%
	Postpartum Care	★	53.23%	★★	60.27%
	Prenatal Care Frequency	- -	12.90%	- -	53.57%
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	79.66%	★★	85.28%
	Diabetes Care—HbA1c Poor Control	★★	50.85%	★★	45.09%
	Diabetes Care—HbA1c Control (<8%)	★★	42.13%	★★	47.20%
	Diabetes Care—LDL-C Screening	★★★	84.75%	★★★	88.55%
	Diabetes Care—LDL-C Control (<100 mg/dL)	★★	37.77%	★★	28.97%
	Diabetes Care—Eye Exam (Retinal) Performed	★	35.11%	★	40.65%
	Diabetes Care—Medical Attention for Nephropathy	★★	82.32%	★★	76.17%
	Controlling High Blood Pressure	★	40.04%	★	39.89%
	Adult BMI Assessment	★	52.63%	★	35.66%
	Use of Appropriate Medications for People with Asthma—5–11 years	★	75.76%	★★	87.71%
	Use of Appropriate Medications for People with Asthma—12–18 years	★★	88.24%	★★	85.90%
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	*NA*	★	57.89%
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	*NA*	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	★	78.38%	★★	82.30%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	5.82%	- -	6.19%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	11.14%	- -	9.18%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	83.04%	- -	84.63%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	61.27%	- -	63.47%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	6.84%	- -	6.19%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	11.65%	- -	10.58%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	81.52%	- -	83.23%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	60.76%	- -	63.47%
	HIV-Related Medical Visits—0 Visits	- -	1.01%	- -	3.59%
	HIV-Related Medical Visits—1 Visit	- -	5.06%	- -	5.99%

Table D-20—Florida Medicaid HEDIS 2014 Result Summary Table: SFCCN					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	HIV-Related Medical Visits—>=2 Visits	- -	93.92%	- -	90.42%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	84.81%	- -	73.05%
	Highly Active Anti-Retroviral Treatment	- -	79.37%	- -	80.94%
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	80.68%	- -	64.41%
	Lipid Profile Annually	- -	82.63%	- -	85.05%
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	327.82	+ +	337.00
	Ambulatory Care—ED Visits per 1,000 MM	+ +	68.73	+ +	68.09
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★	45.92%	★	92.13%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★	42.35%	★★	86.80%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★	39.54%	★	86.17%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	37.29%	★	81.28%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	62.52%	★	63.65%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★★	87.56%	★	83.91%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★	69.17%	★	80.12%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	76.26%	★	74.01%
	Call Abandonment	- -	1.24%	- -	2.25%
	Call Answer Timeliness	★★	92.00%	★	75.40%
	Transportation Availability	- -	*NB*	- -	100.00%
	Transportation Timeliness	- -	*NB*	- -	82.71%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	6.40%	- -	28.74%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	8.60%	- -	48.25%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★★	73.58%	★★★	67.74%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★★	58.49%	★★★	52.42%
	Mental Health Readmission Rate	- -	29.25%	- -	19.57%

SFCCN's Non-Reform performance level showed that eight rates were above and 26 rates were below their respective national Medicaid averages. Compared to CY 2012, SFCCN had more diverse performance, with more rates indicated both above- and below-average performance. SFCCN's Reform performance level showed that eight rates were above and 25 rates were below their respective national Medicaid averages. Compared to CY 2012, SFCCN's CY 2013 performance was much worse, with fewer rates indicating above-average performance. Additionally, no rates were below the national averages for CY 2012 compared to 25 rates this year.

Table D-21 contains the HEDIS 2014 Non-Reform rates and performance level analysis results for Salubris.

Table D-21—Florida Medicaid HEDIS 2014 Result Summary Table: Salubris			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—6+ Visits	- -	*NA*
	Well-Child Visits in the 3rd–6th Years of Life	- -	*NA*
	Lead Screening in Children	- -	*NA*
	Adolescent Well-Care Visits	- -	*NA*
	Annual Dental Visit—2–3 years	- -	*NA*
	Annual Dental Visit—4–6 years	- -	*NA*
	Annual Dental Visit—7–10 years	- -	*NA*
	Annual Dental Visit—11–14 years	- -	*NA*
	Annual Dental Visit—15–18 years	- -	*NA*
	Annual Dental Visit—19–21 years	- -	*NA*
	Annual Dental Visit—Total	- -	*NA*
	Childhood Immunization Status—Combination 2	- -	*NA*
	Childhood Immunization Status—Combination 3	- -	*NA*
	Immunizations for Adolescents—Combination 1	- -	*NA*
	Immunizations for Adolescents—Meningococcal	- -	*NA*
	Immunizations for Adolescents—Tdap/Td	- -	*NA*
	Appropriate Testing for Children With Pharyngitis	- -	*NA*
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	- -	*NA*
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	*NA*
Women's Care	*Cervical Cancer Screening*	- -	*NA*
	Chlamydia Screening in Women—16–20 Years	- -	*NA*
	Chlamydia Screening in Women—21–24 Years	- -	*NA*
	Chlamydia Screening in Women—Total	- -	*NA*
	Breast Cancer Screening	- -	*NA*

Table D-21—Florida Medicaid HEDIS 2014 Result Summary Table: Salubris			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
	Timeliness of Prenatal Care	- -	*NA*
	Postpartum Care	- -	*NA*
	Prenatal Care Frequency	- -	*NA*
Living With Illness	*Diabetes Care—HbA1c Testing*	- -	*NA*
	Diabetes Care—HbA1c Poor Control	- -	*NA*
	Diabetes Care—HbA1c Control (<8%)	- -	*NA*
	Diabetes Care—LDL-C Screening	- -	*NA*
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	*NA*
	Diabetes Care—Eye Exam (Retinal) Performed	- -	*NA*
	Diabetes Care—Medical Attention for Nephropathy	- -	*NA*
	Controlling High Blood Pressure	- -	*NA*
	Adult BMI Assessment	- -	*NA*
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	*NA*
	HIV-Related Medical Visits—0 Visits	- -	*NA*
	HIV-Related Medical Visits—1 Visit	- -	*NA*
	HIV-Related Medical Visits—>=2 Visits	- -	*NA*
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	*NA*
	Highly Active Anti-Retroviral Treatment	- -	*NA*
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	*NA*
	Lipid Profile Annually	- -	*NA*

Table D-21—Florida Medicaid HEDIS 2014 Result Summary Table: Salubris			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	116.03
	Ambulatory Care—ED Visits per 1,000 MM	+ +	56.83
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	- -	*NA*
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	- -	*NA*
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	- -	*NA*
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—Total	- -	*NA*
	Call Abandonment	- -	1.62%
	Call Answer Timeliness	★★★	97.05%
	Transportation Availability	- -	*NB*
	Transportation Timeliness	- -	*NB*
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	*NA*
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	*NA*
	Antidepressant Medication Management—Effective Acute Phase Treatment	- -	*NA*
	Antidepressant Medication Management—Effective Continuation Phase Treatment	- -	*NA*
	Mental Health Readmission Rate	- -	*NA*

Salubris had four measures with valid, reportable rates. One measure (*Call Answer Timeliness*) had national percentiles available for comparison, and Salubris performed above the national Medicaid average. The remaining measures had an *NA* or *NB* audit designation result.

Table D-22 contains the HEDIS 2014 Non-Reform rates and performance level analysis for Simply Healthcare.

Table D-22—Florida Medicaid HEDIS 2014 Result Summary Table: Simply Healthcare			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★	3.89%
	Well-Child Visits in the First 15 Months of Life—1 Visit	★★	2.43%
	Well-Child Visits in the First 15 Months of Life—2 Visits	★★	3.65%
	Well-Child Visits in the First 15 Months of Life—3 Visits	★★	7.54%
	Well-Child Visits in the First 15 Months of Life—4 Visits	★★★	15.09%
	Well-Child Visits in the First 15 Months of Life—5 Visits	★★	19.46%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★	47.93%
	Well-Child Visits in the 3rd–6th Years of Life	★★	75.43%
	Lead Screening in Children	★★	60.34%
	Adolescent Well-Care Visits	★	39.42%
	Annual Dental Visit—2–3 years	- -	*NB*
	Annual Dental Visit—4–6 years	- -	*NB*
	Annual Dental Visit—7–10 years	- -	*NB*
	Annual Dental Visit—11–14 years	- -	*NB*
	Annual Dental Visit—15–18 years	- -	*NB*
	Annual Dental Visit—19–21 years	- -	*NB*
	Annual Dental Visit—Total	- -	*NB*
	Childhood Immunization Status—Combination 2	★★	77.37%
	Childhood Immunization Status—Combination 3	★★	69.83%
	Immunizations for Adolescents—Combination 1	★	53.04%
	Immunizations for Adolescents—Meningococcal	★	54.26%
	Immunizations for Adolescents—Tdap/Td	★	75.43%
	Appropriate Testing for Children With Pharyngitis	★	55.73%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★	45.79%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	*NA*
Women's Care	*Cervical Cancer Screening*	★	49.64%
	Chlamydia Screening in Women—16–20 Years	★★	59.56%
	Chlamydia Screening in Women—21–24 Years	★★	64.47%
	Chlamydia Screening in Women—Total	★★	61.62%
	Breast Cancer Screening	★	32.86%

Table D-22—Florida Medicaid HEDIS 2014 Result Summary Table: Simply Healthcare			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
	Timeliness of Prenatal Care	★	67.28%
	Postpartum Care	★	45.96%
	Prenatal Care Frequency	- -	54.78%
Living With Illness	*Diabetes Care—HbA1c Testing*	★	79.08%
	Diabetes Care—HbA1c Poor Control	★★	47.69%
	Diabetes Care—HbA1c Control (<8%)	★★	42.82%
	Diabetes Care—LDL-C Screening	★★	79.32%
	Diabetes Care—LDL-C Control (<100 mg/dL)	★	25.30%
	Diabetes Care—Eye Exam (Retinal) Performed	★	39.17%
	Diabetes Care—Medical Attention for Nephropathy	★★★	90.51%
	Controlling High Blood Pressure	★★	56.93%
	Adult BMI Assessment	★★★	84.91%
	Use of Appropriate Medications for People with Asthma—5–11 years	★	76.92%
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	★	79.31%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	46.81%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	8.51%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	44.68%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	23.40%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	53.19%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	12.77%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	34.04%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	0.00%
	HIV-Related Medical Visits—0 Visits	- -	46.81%
	HIV-Related Medical Visits—1 Visit	- -	17.02%
	HIV-Related Medical Visits—>=2 Visits	- -	36.17%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	0.00%
	Highly Active Anti-Retroviral Treatment	- -	44.74%
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	68.42%
	Lipid Profile Annually	- -	83.70%

Table D-22—Florida Medicaid HEDIS 2014 Result Summary Table: Simply Healthcare			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	295.08
	Ambulatory Care—ED Visits per 1,000 MM	+ +	66.01
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★	95.10%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★	85.92%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★	82.53%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	79.42%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	64.31%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	78.28%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★	71.88%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	68.97%
	Call Abandonment	- -	10.05%
	Call Answer Timeliness	★★	89.95%
	Transportation Availability	- -	*NB*
	Transportation Timeliness	- -	*NB*
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	16.04%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	36.21%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★	53.99%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★	36.20%
	Mental Health Readmission Rate	- -	36.71%

Three Non-Reform rates were above and 24 rates were below their respective national Medicaid averages. Compared to CY 2012, Simply Healthcare had a fairly consistent performance level.

Table D-23 contains the HEDIS 2014 Non-Reform and Reform rates and respective performance level analysis results for Staywell.

Table D-23—Florida Medicaid HEDIS 2014 Result Summary Table: Staywell					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★	3.02%	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—1 Visit	★	0.23%	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—2 Visits	★★	2.09%	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—3 Visits	★★	4.64%	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—4 Visits	★★	11.14%	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—5 Visits	★★	19.72%	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★★	59.16%	- -	*NA*
	Well-Child Visits in the 3rd–6th Years of Life	★★	73.21%	★	62.96%
	Lead Screening in Children	★★	59.43%	- -	*NA*
	Adolescent Well-Care Visits	★★	52.78%	★★	53.95%
	Annual Dental Visit—2–3 years	- -	*NB*	★	16.09%
	Annual Dental Visit—4–6 years	- -	*NB*	★	25.64%
	Annual Dental Visit—7–10 years	- -	*NB*	★	35.19%
	Annual Dental Visit—11–14 years	- -	*NB*	★	27.93%
	Annual Dental Visit—15–18 years	- -	*NB*	★	25.27%
	Annual Dental Visit—19–21 years	- -	*NB*	★	14.63%
	Annual Dental Visit—Total	- -	*NB*	★	25.59%
	Childhood Immunization Status—Combination 2	★★	83.80%	- -	*NA*
	Childhood Immunization Status—Combination 3	★★	79.63%	- -	*NA*
	Immunizations for Adolescents—Combination 1	★★	70.65%	- -	*NA*
	Immunizations for Adolescents—Meningococcal	★★	71.17%	- -	*NA*
	Immunizations for Adolescents—Tdap/Td	★★	87.27%	- -	*NA*
	Appropriate Testing for Children With Pharyngitis	★★	64.40%	- -	*NA*
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★	51.04%	- -	*NA*
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	★★★	66.03%	- -	*NA*
Women's Care	*Cervical Cancer Screening*	★★	59.48%	★	38.06%
	Chlamydia Screening in Women—16–20 Years	★★	58.26%	★★	57.14%

Table D-23—Florida Medicaid HEDIS 2014 Result Summary Table: Staywell					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	Chlamydia Screening in Women—21–24 Years	★★	71.45%	★★	71.88%
	Chlamydia Screening in Women—Total	★★	62.89%	★★	63.51%
	Breast Cancer Screening	★★	56.21%	- -	*NA*
	Timeliness of Prenatal Care	★	72.56%	★	58.62%
	Postpartum Care	★	49.77%	★	36.21%
	Prenatal Care Frequency	- -	64.19%	- -	41.38%
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	82.30%	★	74.29%
	Diabetes Care—HbA1c Poor Control	★★	44.69%	★	54.29%
	Diabetes Care—HbA1c Control (<8%)	★★	45.13%	★	37.14%
	Diabetes Care—LDL-C Screening	★★	82.96%	★	68.57%
	Diabetes Care—LDL-C Control (<100 mg/dL)	★★	34.07%	★	22.86%
	Diabetes Care—Eye Exam (Retinal) Performed	★★	54.87%	★	31.43%
	Diabetes Care—Medical Attention for Nephropathy	★★	80.53%	★	65.71%
	Controlling High Blood Pressure	★★	54.53%	★★	58.54%
	Adult BMI Assessment	★★★	87.32%	- -	*NA*
	Use of Appropriate Medications for People with Asthma—5–11 years	★★	87.49%	- -	*NA*
	Use of Appropriate Medications for People with Asthma—12–18 years	★★	87.30%	- -	*NA*
	Use of Appropriate Medications for People with Asthma—19–50 years	★★	70.00%	- -	*NA*
	Use of Appropriate Medications for People with Asthma—51–64 years	★★	73.08%	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	★★	84.15%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	23.51%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	16.23%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	60.26%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	42.05%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	23.51%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	15.89%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	60.60%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	40.40%	- -	*NA*
	HIV-Related Medical Visits—0 Visits	- -	16.89%	- -	*NA*
	HIV-Related Medical Visits—1 Visit	- -	14.57%	- -	*NA*

Table D-23—Florida Medicaid HEDIS 2014 Result Summary Table: Staywell					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	HIV-Related Medical Visits—>=2 Visits	- -	68.54%	- -	*NA*
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	46.36%	- -	*NA*
	Highly Active Anti-Retroviral Treatment	- -	71.09%	- -	*NA*
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	62.40%	- -	67.78%
	Lipid Profile Annually	- -	79.69%	- -	80.00%
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	296.13	+ +	254.81
	Ambulatory Care—ED Visits per 1,000 MM	+ +	71.81	+ +	81.24
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★★	96.53%	★	87.44%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★	89.58%	★	78.47%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★★	89.06%	★★★	98.02%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★★	87.01%	★★★	96.92%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	71.04%	★	56.52%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★★	86.64%	★	77.53%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★	73.30%	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	75.81%	★	61.12%
	Call Abandonment	- -	2.89%	- -	2.89%
	Call Answer Timeliness	★★	84.27%	★★	84.27%
	Transportation Availability	- -	*NB*	- -	100.00%
	Transportation Timeliness	- -	*NB*	- -	74.09%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	31.68%	- -	14.35%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	50.02%	- -	26.74%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★	50.12%	- -	*NA*
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★	34.57%	- -	*NA*
	Mental Health Readmission Rate	- -	24.91%	- -	28.35%

Staywell's Non-Reform performance level showed that two rates were above and seven rates were below their respective national Medicaid averages. Its Reform performance level showed that two rates were above but 23 rates were below their respective national Medicaid averages. Overall, Staywell's Non-Reform performance was better than its Reform performance.

Table D-24 contains the HEDIS 2014 Non-Reform and Reform rates and respective performance level analysis results for Sunshine.

Table D-24—Florida Medicaid HEDIS 2014 Result Summary Table: Sunshine

		Non-Reform		Reform	
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**	**Performance Level Analysis**	**2014**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★	2.78%	★★	1.85%
	Well-Child Visits in the First 15 Months of Life—1 Visit	★★	2.55%	★★	1.62%
	Well-Child Visits in the First 15 Months of Life—2 Visits	★★★	5.09%	★★	4.17%
	Well-Child Visits in the First 15 Months of Life—3 Visits	★★★	9.03%	★★	4.63%
	Well-Child Visits in the First 15 Months of Life—4 Visits	★★★	15.97%	★★★	16.44%
	Well-Child Visits in the First 15 Months of Life—5 Visits	★★★	22.69%	★★	19.68%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★	41.90%	★	51.62%
	Well-Child Visits in the 3rd–6th Years of Life	★★	72.33%	★★	75.16%
	Lead Screening in Children	★★	59.26%	★★	64.58%
	Adolescent Well-Care Visits	★★	44.09%	★★	51.10%
	Annual Dental Visit—2–3 years	- -	*NA*	★	23.36%
	Annual Dental Visit—4–6 years	- -	*NA*	★	41.58%
	Annual Dental Visit—7–10 years	- -	*NA*	★	48.91%
	Annual Dental Visit—11–14 years	- -	*NA*	★	43.12%
	Annual Dental Visit—15–18 years	- -	*NA*	★	38.09%
	Annual Dental Visit—19–21 years	- -	*NA*	★	23.81%
	Annual Dental Visit—Total	- -	*NA*	★	39.72%
	Childhood Immunization Status—Combination 2	★★	76.62%	★★	76.39%
	Childhood Immunization Status—Combination 3	★★	71.06%	★★	71.06%
	Immunizations for Adolescents—Combination 1	★★	62.50%	★★	64.58%
	Immunizations for Adolescents—Meningococcal	★★	63.89%	★★	65.28%
	Immunizations for Adolescents—Tdap/Td	★★	79.86%	★★	84.03%
	Appropriate Testing for Children With Pharyngitis	★	51.99%	★★	63.61%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★	50.81%	★★	46.87%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	★★	56.38%	★★	60.44%
Women's Care	*Cervical Cancer Screening*	★	48.02%	★	54.21%
	Chlamydia Screening in Women—16–20 Years	★★	56.12%	★★	59.79%

Table D-24—Florida Medicaid HEDIS 2014 Result Summary Table: Sunshine					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	Chlamydia Screening in Women—21–24 Years	★★	69.11%	★★	70.51%
	Chlamydia Screening in Women—Total	★★	61.81%	★★	63.83%
	Breast Cancer Screening	★★	47.14%	★★	46.81%
	Timeliness of Prenatal Care	★	72.39%	★	65.28%
	Postpartum Care	★	51.04%	★	52.31%
	Prenatal Care Frequency	- -	54.35%	- -	48.77%
Living With Illness	*Diabetes Care—HbA1c Testing*	★	77.54%	★★	80.28%
	Diabetes Care—HbA1c Poor Control	★★	47.28%	★★	47.89%
	Diabetes Care—HbA1c Control (<8%)	★★	43.26%	★★	47.18%
	Diabetes Care—LDL-C Screening	★★	77.54%	★★	76.76%
	Diabetes Care—LDL-C Control (<100 mg/dL)	★★	32.86%	★★	35.21%
	Diabetes Care—Eye Exam (Retinal) Performed	★★	55.32%	★★	53.52%
	Diabetes Care—Medical Attention for Nephropathy	★★	77.78%	★★	77.23%
	Controlling High Blood Pressure	★	46.71%	★	46.61%
	Adult BMI Assessment	★★	78.24%	★★	77.31%
	Use of Appropriate Medications for People with Asthma—5–11 years	★	83.77%	★	84.82%
	Use of Appropriate Medications for People with Asthma—12–18 years	★★	83.89%	★★	85.79%
	Use of Appropriate Medications for People with Asthma—19–50 years	★★	76.34%	★★	72.92%
	Use of Appropriate Medications for People with Asthma—51–64 years	★	60.56%	★★	71.43%
	Use of Appropriate Medications for People with Asthma—Total	★	79.55%	★★	82.50%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	26.11%	- -	20.98%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	17.22%	- -	13.84%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	56.67%	- -	65.18%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	36.11%	- -	44.20%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	25.00%	- -	23.66%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	18.33%	- -	12.50%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	56.67%	- -	63.84%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	36.11%	- -	44.64%
	HIV-Related Medical Visits—0 Visits	- -	15.00%	- -	11.61%
	HIV-Related Medical Visits—1 Visit	- -	18.89%	- -	18.75%

Table D-24—Florida Medicaid HEDIS 2014 Result Summary Table: Sunshine					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	HIV-Related Medical Visits—>=2 Visits	- -	66.11%	- -	69.64%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	41.67%	- -	50.00%
	Highly Active Anti-Retroviral Treatment	- -	69.59%	- -	69.57%
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	63.72%	- -	67.34%
	Lipid Profile Annually	- -	77.73%	- -	74.25%
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	274.24	+ +	292.55
	Ambulatory Care—ED Visits per 1,000 MM	+ +	68.14	+ +	66.34
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★★	95.76%	★★	96.17%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★	88.32%	★★	90.24%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★	83.23%	★★	87.94%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	79.62%	★	84.55%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	61.81%	★	68.84%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	78.12%	★	83.87%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★	67.11%	★	75.25%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	66.61%	★	73.04%
	Call Abandonment	- -	1.05%	- -	1.90%
	Call Answer Timeliness	★★	85.51%	★★	83.42%
	Transportation Availability	- -	*NA*	- -	100.00%
	Transportation Timeliness	- -	*NA*	- -	82.14%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	24.63%	- -	25.00%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	43.74%	- -	41.93%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★	45.74%	★	45.58%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★	31.80%	★	30.52%
	Mental Health Readmission Rate	- -	36.12%	- -	30.30%

Sunshine's Non-Reform performance level showed that four rates were above and 19 rates were below their respective national Medicaid averages. Compared to CY 2012, Sunshine had more rates indicating above-average performance and fewer rates indicating below-average performance. Sunshine's Reform performance also showed some improvement. One rate was above and 20 rates were below their respective national Medicaid averages. Compared to CY 2012, Sunshine had one less rate indicating above-average performance but fewer rates indicating below-average performance.

Table D-25 contains the HEDIS 2014 Non-Reform rates and performance level analysis results for TrueHealth.

Table D-25—Florida Medicaid HEDIS 2014 Result Summary Table: TrueHealth			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	*NA*
	Well-Child Visits in the First 15 Months of Life—6+ Visits	- -	*NA*
	Well-Child Visits in the 3rd–6th Years of Life	★	58.54%
	Lead Screening in Children	- -	*NA*
	Adolescent Well-Care Visits	★★	45.68%
	Annual Dental Visit—2–3 years	- -	*NB*
	Annual Dental Visit—4–6 years	- -	*NB*
	Annual Dental Visit—7–10 years	- -	*NB*
	Annual Dental Visit—11–14 years	- -	*NB*
	Annual Dental Visit—15–18 years	- -	*NB*
	Annual Dental Visit—19–21 years	- -	*NB*
	Annual Dental Visit—Total	- -	*NB*
	Childhood Immunization Status—Combination 2	- -	*NA*
	Childhood Immunization Status—Combination 3	- -	*NA*
	Immunizations for Adolescents—Combination 1	- -	*NA*
	Immunizations for Adolescents—Meningococcal	- -	*NA*
	Immunizations for Adolescents—Tdap/Td	- -	*NA*
	Appropriate Testing for Children With Pharyngitis	- -	*NA*
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	- -	*NA*
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	*NA*
Women's Care	*Cervical Cancer Screening*	★	20.79%
	Chlamydia Screening in Women—16–20 Years	- -	*NA*
	Chlamydia Screening in Women—21–24 Years	- -	*NA*
	Chlamydia Screening in Women—Total	- -	*NA*
	Breast Cancer Screening	- -	*NA*

Table D-25—Florida Medicaid HEDIS 2014 Result Summary Table: TrueHealth			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
	Timeliness of Prenatal Care	- -	*NA*
	Postpartum Care	- -	*NA*
	Prenatal Care Frequency	- -	*NA*
Living With Illness	*Diabetes Care—HbA1c Testing*	- -	*NA*
	Diabetes Care—HbA1c Poor Control	- -	*NA*
	Diabetes Care—HbA1c Control (<8%)	- -	*NA*
	Diabetes Care—LDL-C Screening	- -	*NA*
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	*NA*
	Diabetes Care—Eye Exam (Retinal) Performed	- -	*NA*
	Diabetes Care—Medical Attention for Nephropathy	- -	*NA*
	Controlling High Blood Pressure	- -	*NA*
	Adult BMI Assessment	- -	*NA*
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	*NA*
	HIV-Related Medical Visits—0 Visits	- -	*NA*
	HIV-Related Medical Visits—1 Visit	- -	*NA*
	HIV-Related Medical Visits—>=2 Visits	- -	*NA*
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	*NA*
	Highly Active Anti-Retroviral Treatment	- -	*NA*
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	*NA*
	Lipid Profile Annually	- -	*NA*

Table D-25—Florida Medicaid HEDIS 2014 Result Summary Table: TrueHealth			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	222.51
	Ambulatory Care—ED Visits per 1,000 MM	+ +	89.13
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★	84.00%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★	76.15%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	- -	*NA*
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	50.00%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	68.29%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	54.10%
	Call Abandonment	- -	1.36%
	Call Answer Timeliness	★★	93.22%
	Transportation Availability	- -	*NB*
	Transportation Timeliness	- -	*NB*
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	13.33%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	27.78%
	Antidepressant Medication Management—Effective Acute Phase Treatment	- -	*NA*
	Antidepressant Medication Management—Effective Continuation Phase Treatment	- -	*NA*
	Mental Health Readmission Rate	- -	33.93%

TrueHealth reported 15 valid, reportable rates. None were above their respective national Medicaid averages, and seven were below their respective national averages. The remaining measures had either an *NA* or *NB* audit designation result.

Table D-26 contains the HEDIS 2014 Non-Reform and Reform rates and respective performance level analysis results for United.

Table D-26—Florida Medicaid HEDIS 2014 Result Summary Table: United					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★★	0.99%	★★	0.66%
	Well-Child Visits in the First 15 Months of Life—1 Visit	★★	1.48%	★★	1.32%
	Well-Child Visits in the First 15 Months of Life—2 Visits	★★	2.22%	★★	2.63%
	Well-Child Visits in the First 15 Months of Life—3 Visits	★★	7.41%	★★	5.26%
	Well-Child Visits in the First 15 Months of Life—4 Visits	★★★	17.04%	★★	9.21%
	Well-Child Visits in the First 15 Months of Life—5 Visits	★★	16.05%	★★	15.79%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★	54.81%	★★	65.13%
	Well-Child Visits in the 3rd–6th Years of Life	★★	72.84%	★★	69.49%
	Lead Screening in Children	★★	62.53%	★	37.91%
	Adolescent Well-Care Visits	★★	44.77%	★★	46.72%
	Annual Dental Visit—2–3 years	- -	*NB*	★	20.56%
	Annual Dental Visit—4–6 years	- -	*NB*	★	48.47%
	Annual Dental Visit—7–10 years	- -	*NB*	★★	56.63%
	Annual Dental Visit—11–14 years	- -	*NB*	★★	50.35%
	Annual Dental Visit—15–18 years	- -	*NB*	★★	42.48%
	Annual Dental Visit—19–21 years	- -	*NB*	★	22.77%
	Annual Dental Visit—Total	- -	*NB*	★★	46.35%
	Childhood Immunization Status—Combination 2	★★	72.99%	★★	77.73%
	Childhood Immunization Status—Combination 3	★★	67.40%	★★	71.56%
	Immunizations for Adolescents—Combination 1	★★	59.01%	★	50.23%
	Immunizations for Adolescents—Meningococcal	★	59.75%	★	51.64%
	Immunizations for Adolescents—Tdap/Td	★★	80.25%	★★	77.93%
	Appropriate Testing for Children With Pharyngitis	★	59.44%	★★	62.66%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★	44.18%	★★★	54.02%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	★★	60.54%	- -	*NA*
Women's Care	*Cervical Cancer Screening*	★	55.96%	★	51.09%
	Chlamydia Screening in Women—16–20 Years	★★	56.25%	★★	48.80%

Table D-26—Florida Medicaid HEDIS 2014 Result Summary Table: United					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	Chlamydia Screening in Women—21–24 Years	★★	70.44%	★	54.05%
	Chlamydia Screening in Women—Total	★★	61.77%	★	50.00%
	Breast Cancer Screening	★★	59.98%	★★	59.50%
	Timeliness of Prenatal Care	★	69.34%	★	71.67%
	Postpartum Care	★	51.34%	★★	66.67%
	Prenatal Care Frequency	- -	54.01%	- -	55.00%
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	80.05%	★★	80.63%
	Diabetes Care—HbA1c Poor Control	★	60.83%	★★	48.65%
	Diabetes Care—HbA1c Control (<8%)	★	32.85%	★★	43.69%
	Diabetes Care—LDL-C Screening	★★	79.32%	★★	80.63%
	Diabetes Care—LDL-C Control (<100 mg/dL)	★	25.79%	★	23.87%
	Diabetes Care—Eye Exam (Retinal) Performed	★★	46.96%	★	36.49%
	Diabetes Care—Medical Attention for Nephropathy	★★	78.83%	★★	76.58%
	Controlling High Blood Pressure	★	42.58%	★★	50.35%
	Adult BMI Assessment	★★	72.16%	★★	72.62%
	Use of Appropriate Medications for People with Asthma—5–11 years	★	84.82%	★★	89.19%
	Use of Appropriate Medications for People with Asthma—12–18 years	★★	84.85%	- -	*NA*
	Use of Appropriate Medications for People with Asthma—19–50 years	★	58.42%	- -	*NA*
	Use of Appropriate Medications for People with Asthma—51–64 years	★	62.26%	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	★	78.62%	★	78.08%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	27.37%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	8.42%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	64.21%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	41.05%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	26.32%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	8.95%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	64.74%	- -	*NA*
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	40.00%	- -	*NA*
	HIV-Related Medical Visits—0 Visits	- -	28.42%	- -	*NA*
	HIV-Related Medical Visits—1 Visit	- -	11.05%	- -	*NA*

Table D-26—Florida Medicaid HEDIS 2014 Result Summary Table: United					
		Non-Reform		Reform	
Dimension of Care	2014 Measures	Performance Level Analysis	2014	Performance Level Analysis	2014
	HIV-Related Medical Visits—>=2 Visits	- -	60.53%	- -	*NA*
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	41.58%	- -	*NA*
	Highly Active Anti-Retroviral Treatment	- -	43.88%	- -	*NA*
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	70.92%	- -	82.35%
	Lipid Profile Annually	- -	81.27%	- -	77.30%
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	325.07	+ +	380.51
	Ambulatory Care—ED Visits per 1,000 MM	+ +	70.75	+ +	70.81
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★★	96.00%	★★	98.42%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★	88.97%	★★	89.30%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★★	87.79%	★	85.79%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	84.19%	★	85.91%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	70.76%	★★	80.45%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★★	86.09%	★★	91.14%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★★	85.94%	- -	*NA*
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	76.20%	★★	84.65%
	Call Abandonment	- -	1.69%	- -	1.69%
	Call Answer Timeliness	★★	87.52%	★★	87.52%
	Transportation Availability	- -	*NB*	- -	100.00%
	Transportation Timeliness	- -	*NB*	- -	78.90%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	30.18%	- -	24.26%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	49.03%	- -	36.09%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★	52.94%	★★	50.88%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★	38.58%	★★	40.35%
	Mental Health Readmission Rate	- -	26.03%	- -	33.20%

United's Non-Reform performance level showed that one rate was above and 17 rates were below their respective national Medicaid averages. Its performance level was fairly consistent with that of CY 2012. United's Reform performance level showed that one rate was above and 15 rates were below their respective national Medicaid averages. Similar to its Non-Reform population, United's Reform performance was fairly consistent with CY 2012 results.

Table D-27 contains the HEDIS 2014 Non-Reform rates and performance level analysis results for VISTA.

Table D-27—Florida Medicaid HEDIS 2014 Result Summary Table: VISTA			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★★	1.49%
	Well-Child Visits in the First 15 Months of Life—1 Visit	★★	1.79%
	Well-Child Visits in the First 15 Months of Life—2 Visits	★★	3.27%
	Well-Child Visits in the First 15 Months of Life—3 Visits	★★★	12.80%
	Well-Child Visits in the First 15 Months of Life—4 Visits	★★★	17.26%
	Well-Child Visits in the First 15 Months of Life—5 Visits	★★★	27.08%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★	36.31%
	Well-Child Visits in the 3rd–6th Years of Life	★★	81.71%
	Lead Screening in Children	★★	70.14%
	Adolescent Well-Care Visits	★★	62.27%
	Annual Dental Visit—2–3 years	- -	*NB*
	Annual Dental Visit—4–6 years	- -	*NB*
	Annual Dental Visit—7–10 years	- -	*NB*
	Annual Dental Visit—11–14 years	- -	*NB*
	Annual Dental Visit—15–18 years	- -	*NB*
	Annual Dental Visit—19–21 years	- -	*NB*
	Annual Dental Visit—Total	- -	*NB*
	Childhood Immunization Status—Combination 2	★	69.68%
	Childhood Immunization Status—Combination 3	★	63.66%
	Immunizations for Adolescents—Combination 1	★★	70.83%
	Immunizations for Adolescents—Meningococcal	★★	74.07%
	Immunizations for Adolescents—Tdap/Td	★★	85.88%
	Appropriate Testing for Children With Pharyngitis	★★	77.96%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★★	56.19%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	*NA*
Women's Care	*Cervical Cancer Screening*	★★	62.18%
	Chlamydia Screening in Women—16–20 Years	★★	64.10%
	Chlamydia Screening in Women—21–24 Years	★★	67.94%
	Chlamydia Screening in Women—Total	★★	65.15%
	Breast Cancer Screening	★★	55.51%

Table D-27—Florida Medicaid HEDIS 2014 Result Summary Table: VISTA			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
	Timeliness of Prenatal Care	★	73.91%
	Postpartum Care	★	48.55%
	Prenatal Care Frequency	- -	63.77%
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	84.47%
	Diabetes Care—HbA1c Poor Control	★★	35.69%
	Diabetes Care—HbA1c Control (<8%)	★★	55.04%
	Diabetes Care—LDL-C Screening	★★★	86.38%
	Diabetes Care—LDL-C Control (<100 mg/dL)	★★	34.06%
	Diabetes Care—Eye Exam (Retinal) Performed	★★	54.22%
	Diabetes Care—Medical Attention for Nephropathy	★★	83.11%
	Controlling High Blood Pressure	★★	60.56%
	Adult BMI Assessment	★★★	88.40%
	Use of Appropriate Medications for People with Asthma—5–11 years	★	83.33%
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	*NA*
	Use of Appropriate Medications for People with Asthma—Total	★	72.73%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—0 Tests	- -	24.24%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—1 Test	- -	18.18%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>=2 Tests	- -	57.58%
	Frequency of HIV Disease Monitoring Lab Tests (CD4)—>= 2 Tests (182)	- -	36.36%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—0 Tests	- -	30.30%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—1 Test	- -	12.12%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>=2 Tests	- -	57.58%
	Frequency of HIV Disease Monitoring Lab Tests (VL)—>= 2 Tests (182)	- -	30.30%
	HIV-Related Medical Visits—0 Visits	- -	12.12%
	HIV-Related Medical Visits—1 Visit	- -	21.21%
	HIV-Related Medical Visits—>=2 Visits	- -	66.67%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	42.42%
	Highly Active Anti-Retroviral Treatment	- -	*NA*
	Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy	- -	69.18%
	Lipid Profile Annually	- -	87.50%

Table D-27—Florida Medicaid HEDIS 2014 Result Summary Table: VISTA			
Dimension of Care	**2014 Measures**	**Performance Level Analysis**	**2014**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	+ +	315.28
	Ambulatory Care—ED Visits per 1,000 MM	+ +	56.70
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★★	97.24%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★★	93.94%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★★	91.24%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★★	88.29%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	69.58%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	80.91%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★	69.81%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	72.71%
	Call Abandonment	- -	1.79%
	Call Answer Timeliness	★★	81.09%
	Transportation Availability	- -	*NB*
	Transportation Timeliness	- -	*NB*
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	- -	17.77%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	- -	30.00%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★	54.31%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★	36.21%
	Mental Health Readmission Rate	- -	20.95%

Seven rates were above and 11 rates were below their respective national Medicaid averages. Compared to CY 2012, VISTA's performance was slightly diverse, with two more rates indicating above-average performance and two more rates indicating below-average performance.

PMHPs/CWPMHP

This section presents PMHP /CWPMHP-specific performance measure rates for CY 2013.

Table D-28 displays Public Health Trust/PHT's performance rates on the three performance measures for Area 11.

Table D-28—Florida Medicaid CY 2013 Results for Jackson Health System/Public Health Trust of Dade County (Area 11)	
Measure	**2013**
Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis—Mental Health Practitioner	35.43%
*Thirty-day Readmission Rate**	21.20%
Follow-up Within 30 Days of an Acute Care Discharge for a Mental Health Diagnosis—Mental Health Practitioner	56.45%
*This is an inverse measure; a lower rate suggests better performance.	

Similar to last year, PHT reported that more than 35 percent of discharged enrollees had a follow-up visit with a mental health practitioner within seven days, and more than 56 percent of enrollees had a follow-up visit within 30 days of discharge. PHT's performance on the *Thirty-day Readmission Rate* measure was slightly worse than CY 2012 (a 2.97 percentage point increase in rate).

Table D-29 displays Magellan's performance rates on the three performance measures for Areas 2, 4, 9, and 11.

Table D-29—Florida Medicaid CY 2013 Results for Magellan Behavioral Health of Florida, Inc. (Areas 2, 4, 9, and 11)		
Measure	**Area**	**2013**
Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis—Mental Health Practitioner	Area 2	57.48%
	Area 4	43.67%
	Area 9	61.71%
	Area 11	52.36%
*Thirty-day Readmission Rate**	Area 2	18.02%
	Area 4	23.51%
	Area 9	21.54%
	Area 11	36.21%
Follow-up Within 30 Days of an Acute Care Discharge for a Mental Health Diagnosis—Mental Health Practitioner	Area 2	75.64%
	Area 4	70.28%
	Area 9	76.88%
	Area 11	72.65%
*This is an inverse measure; a lower rate suggests better performance.		

Magellan's Area 9 performed better than the other three areas in both *Follow-Up After Acute Care Discharge* measures. This was a change from CY 2012's result, when Area 2 was the top performer. However, Area 2 outperformed the other three areas for the *Thirty-day Readmission Rate* measure. This was also a change from CY 2012, when Area 4 was the top performer.

Table D-30 displays Access/ABH's performance rates on the three performance measures for Area1.

Table D-30—Florida Medicaid CY 2013 Results for Lakeview Center dba Access Behavioral Health (Area 1)	
Measure	**2013**
Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis—Mental Health Practitioner	35.48%
*Thirty-day Readmission Rate**	20.02%
Follow-up Within 30 Days of an Acute Care Discharge for a Mental Health Diagnosis—Mental Health Practitioner	56.00%
*This is an inverse measure; a lower rate suggests better performance.	

Compared to last year, ABH performed slightly better on both *Follow-Up After Acute Care Discharge* measures (at least 2 percentage points increase). Nevertheless, its CY 2013 rates on the *Thirty-day Readmission Rate* measure suggested a slight decline in performance (less than 2 percentage points).

Table D-31 displays North Florida/NFHP's performance rates on the three performance measures for Area 3.

Table D-31—Florida Medicaid CY 2013 Results for North Florida Behavioral Health Partners (Area 3)	
Measure	**2013**
Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis—Mental Health Practitioner	27.86%
*Thirty-day Readmission Rate**	17.86%
Follow-up Within 30 Days of an Acute Care Discharge for a Mental Health Diagnosis—Mental Health Practitioner	52.93%
*This is an inverse measure; a lower rate suggests better performance.	

For NFHP, about 28 percent of discharged enrollees had follow-up visits with mental health practitioners within seven days. This result was a decline from CY 2012 (37.79 percent). Nevertheless, NFHP showed an improvement (a 7.6 percentage point increase) on the *Follow-up Within 30 Days* measure. For the *Thirty-day Readmission Rate* measure, NFHP reported a slight decline in performance from CY 2012 (2.79 percentage points).

Table D-32 displays Florida HP/FHP's performance rates on the three performance measures for Areas 5, 6, 7, and 8.

Table D-32—Florida Medicaid CY 2013 Results for Florida Health Partners (Areas 5, 6, 7, and 8)		
Measure	**Area**	**2013**
Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis—Mental Health Practitioner	Area 5	26.34%
	Area 6	31.48%
	Area 7	25.03%
	Area 8	32.95%
*Thirty-day Readmission Rate**	Area 5	17.70%
	Area 6	13.56%
	Area 7	24.71%
	Area 8	15.17%
Follow-up Within 30 Days of an Acute Care Discharge for a Mental Health Diagnosis—Mental Health Practitioner	Area 5	48.05%
	Area 6	49.83%
	Area 7	41.82%
	Area 8	55.40%
*This is an inverse measure; a lower rate suggests better performance.		

FHP's Area 8 performed better than the other three areas in both *Follow-Up After Acute Care Discharge* measures. For the *Thirty-day Readmission Rate* measure, Area 6 was the top performer (lower rate indicates better performance). CY 2012 results indicated that Area 5 was the top performer for all three measures.

Table D-33 displays CBC Partnership/CBC's performance rates on the three performance measures for all CWPMHP areas.

Table D-33—Florida Medicaid CY 2013 Results for Community Based Care Partnership (All CWPMHP Areas)	
Measure	**2013**
Follow-up Within Seven Days After Acute Care Discharge for a Mental Health Diagnosis—Mental Health Practitioner	70.73%
*Thirty-day Readmission Rate**	29.71%
Follow-up Within 30 Days of an Acute Care Discharge for a Mental Health Diagnosis—Mental Health Practitioner	85.29%
*This is an inverse measure; a lower rate suggests better performance.	

For CBC, slightly over 70 percent of discharged enrollees had follow-up visits with a mental health practitioner within seven days, and slightly over 85 percent had follow-up visits within 30 days of the discharge. Both measures showed a decline in performance from last year, with the *Follow-up Within Seven Days* measure showing a rate decrease for more than 5 percentage points. Nearly 30 percent of the discharged enrollees were readmitted within 30 days, which was a decline in performance from the CY 2012 rate (23.34 percent).

LTC Plans

This section presents CY 2013 performance measure rates for each LTC plan. Measures for which the LTC plan did not have an eligible population large enough (<30) to calculate a valid rate received an audit designation of *NA*.

Table D-34 displays American Eldercare's performance rates on the three performance measures.

Table D-34—Florida Medicaid CY 2013 Results for American Eldercare-LTC	
Measure	**2013**
Face-to-Face Encounters (F2F)	92.00%
Case Manager Training (CMT)	100.00%
Timeliness of Service (TOS)	92.90%

American Eldercare's performance results showed that at least nine out of 10 enrollees had a face-to face encounter with a case manager every three months. In addition, at least nine out of 10 enrollees received services within three days of enrollment. All case managers with at least three months of employment received training on the mandate to report abuse, neglect, and exploitation.

Table D-35 displays Amerigroup's performance rates on the three performance measures.

Table D-35—Florida Medicaid CY 2013 Results for Amerigroup-LTC	
Measure	**2013**
F2F	*NA*
CMT	*NA*
TOS	77.21%

Timeliness of Service was the only measure with a valid, reportable rate. For this measure, at least seven out of 10 enrollees received services within three days of enrollment.

Table D-36 displays Coventry's performance rates on the three performance measures.

Table D-36—Florida Medicaid CY 2013 Results for Coventry-LTC	
Measure	**2013**
F2F	89.49%
CMT	100.00%
TOS	46.38%

Coventry's performance results showed that nearly nine out of 10 enrollees had a face-to face encounter with a case manager every three months. Nearly half of the enrollees received services within three days of enrollment. All case managers with at least three months of employment received training on the mandate to report abuse, neglect, and exploitation.

Table D-37 displays Humana's performance rates on the three performance measures.

Table D-37—Florida Medicaid CY 2013 Results for Humana-LTC	
Measure	**2013**
*F2F**	*NR*
CMT	89.23%
TOS	87.12%
Note: * This measure requires three consecutive months with no enrollment gap to be included in the eligible population. Since Humana-LTC was only operational in November and December of CY 2013, no rate was reported for this measure.	

For the current measurement year, Humana had two measures with reportable rates. The *Timeliness of Service* measure showed that nearly nine out of 10 enrollees received services within three days of enrollment. In addition, nearly nine out of 10 case managers with at least three months of employment received training on the mandate to report abuse, neglect, and exploitation.

Table D-38 displays Molina's performance rates on the three performance measures.

Table D-38—Florida Medicaid CY 2013 Results for Molina-LTC	
Measure	**2013**
F2F	*NA*
CMT	*NA*
TOS	82.05%

The *Timeliness of Service* measure was the only measure with a valid, reportable rate. For this measure, at least eight out of 10 enrollees received services within three days of enrollment.

Table D-39 displays Sunshine's performance rates on the three performance measures.

Table D-39—Florida Medicaid CY 2013 LTC Plan-Specific Results for Sunshine-LTC	
Measure	**2013**
F2F	51.49%
CMT	71.43%
TOS	60.04%

Sunshine's performance results showed that slightly more than 50 percent of enrollees had a face-to face encounter with a case manager every three months. The *Timeliness of Service* measure showed that six out of 10 enrollees received services within three days of enrollment. In addition, seven out of 10 case managers with at least three months of employment received training on the mandate to report abuse, neglect, and exploitation.

Table D-40 displays United's performance rates on the three performance measures.

Table D-40—Florida Medicaid CY 2013 Results for United-LTC	
Measure	**2013**
F2F	91.08%
CMT	94.61%
TOS	82.05%

United's performance result shows that at least nine out of 10 enrollees had a face-to face encounter with a case manager every three months. The *Timeliness of Service* measure showed that at least eight out of 10 enrollees received services within three days of enrollment. In addition, at least nine out of 10 case managers with at least three months of employment received training on the mandate to report abuse, neglect, and exploitation.

PDHPs

This section presents CY 2013 performance measure rates for each PDHP. Please note that for both PDHPs, only the *Annual Dental Visit* measure was determined by HSAG as *Reportable.* All other measures received an *NR* (*Not Reportable*) audit designation from HSAG due to insufficient information to verify calculation and reporting consistency across all PDHPs. Nonetheless, since the PDHPs' auditors determined the rates for these measures to be *Reportable*, they are displayed in the tables below.

Table D-41 displays DentaQuest's Miami-Dade and Statewide performance.

Table D-41—Florida Medicaid CY 2013 Results for DentaQuest		
Measure	**Miami-Dade Rates**	**Statewide Rates**
Annual Dental Visit		
Ages 2–3	27.78%	21.31%
Ages 4–6	48.48%	36.07%
Ages 7–10	53.65%	48.04%
Ages 11–14	46.02%	41.31%
Ages 15–18	37.13%	35.94%
Ages 19–21	25.77%	22.40%
Total	43.25%	37.18%

Table D-41—Florida Medicaid CY 2013 Results for DentaQuest		
Complete Oral Evaluation 1 (COE1)	75.91%	72.99%
Complete Oral Evaluation 2 (COE2)	90.29%	71.06%
Sealants	25.01%	17.34%
Member Outreach 1 (MO1)	22.71%	25.82%
Member Outreach 2 (MO2)	12.91%	20.11%

DentaQuest's performance in the Miami-Dade region exceeded its performance in the Statewide region for all measures except *Member Outreach 2 (MO2)*. Last year, the reverse was true—Statewide rates exceeded Miami-Dade rates. Although DentaQuest's *Sealants* rate was the lowest across all measures, the Statewide region's largest improvement opportunity was in the *Complete Oral Evaluation* (*COE2*) measure, with the Statewide rate being 19.23 percentage points lower than the Miami-Dade rate.

Table D-42 displays MCNA's Miami-Dade and Statewide performance.

Table D-42—Florida Medicaid CY 2013 Results for MCNA		
Population	**Miami-Dade Rates**	**Statewide Rates**
Annual Dental Visit		
Ages 2–3	23.03%	18.35%
Ages 4–6	43.79%	37.79%
Ages 7–10	50.22%	42.33%
Ages 11–14	45.74%	37.54%
Ages 15–18	38.25%	32.31%
Ages 19–21	26.16%	20.75%
Total	39.91%	34.26%
Complete Oral Evaluation 1 (COE1)	100.00%	100.00%
Complete Oral Evaluation 2 (COE2)	80.85%	70.53%
Sealants	12.46%	12.19%
Member Outreach 1 (MO1)	83.28%	62.77%
Member Outreach 2 (MO2)	39.67%	69.03%

MCNA's performance in the Miami-Dade region exceeded its performance in the Statewide region for all measures except *Member Outreach 2 (MO2)*. Both regions reported a rate of 100 percent for the *Complete Oral Evaluation 1 (COE1)* measure. The *Sealants* measure presents the largest improvement opportunity for both regions, where both rates were below 15 percent.

Encounter Data Completeness and Reasonableness

Physician Encounter Data

Table E-1 shows physician encounter data utilization for all plans.

Table E-1—Physician Encounter Data Overview			
Plan	Average Number of Members per Month[1]	Physician	
		Total Number of Encounters	Total Encounters PMPY[2]
Prepaid Dental Health Plans			
DentaQuest	344,545.10	2,971,295	8.6
MCNA Dental Plan	246,277.00	2,152,299	8.7
Prepaid Mental Health Plans			
Access Behavioral Health	46,462.10	161,733	3.5
Florida Health Partners	189,543.30	124,601	0.7
Magellan Behavioral Health of Florida	226,327.10	1,388,338	6.1
Child Welfare Prepaid Mental Health Plan[3]			
Community Based Care Partnership	22,472.40	971,565	43.2
Specialty Plans[4]			
Clear Health Alliance (Simply)	316.5	5,916	18.7
Positive HealthCare	193	9,056	46.9
Managed Care Plans			
Amerigroup	186,715.80	4,666,408	25
Better Health, LLC	35,932.80	67,133	1.9
Buena Vista	1,289.80	292	0.2
First Coast Advantage Central, LLC	28,788.30	90,526	3.1
Freedom	170,775.80	3,339,317	19.6
Healthease	46,274.80	459,897	9.9
Humana Family	21,893.80	462,405	21.1
Integral	69,989.10	907,047	13
Molina Healthcare of Florida, Inc.	15,898.60	168,157	10.6
Preferred Medical Plan, Inc.	73,494.40	411,694	5.6
Prestige Health Choice	26,306.30	212,482	8.1
Simply Healthcare Plans, Inc.	198,081.50	4,440,718	22.4
Staywell	203,200.80	4,572,797	22.5
Sunshine	111,544.70	2,654,976	23.8

Table E-1—Physician Encounter Data Overview			
Plan	Average Number of Members per Month[1]	Physician	
		Total Number of Encounters	Total Encounters PMPY[2]
United Evercare / United Healthcare Plan	22,667.80	242,521	10.7
Vista Healthplan of South Florida	23,635.50	232,063	9.8
All Plans	**1,847,052.80**	**30,713,239**	**16.6**

[1] The average number of members was calculated by dividing the total number of member months by 12. This calculation is the basis for reporting per member per year (PMPY) rates.
[2] The total encounters per member per year (PMPY) rate was calculated by dividing the total number of encounters by the average number of members.
[3] This CWPMHP is a statewide, specialized PMHP that addresses the complex needs of Medicaid-eligible children who are receiving specific services from the Department of Children and Families. As such, utilization of services may be higher than for other PMHPs.
[4] These specialty health plans enroll HIV-positive/AIDS members. As such, utilization of services may appear higher than for plans that enroll a mix of users and non-users.

Inpatient Encounter Data

Table E-2 shows inpatient encounter data utilization for all plans.

Table E-2—Inpatient Encounter Data Overview			
Plan	Average Number of Members per Month[1]	Inpatient	
		Total Number of Encounters	Total Encounters PMPY[2]
Prepaid Dental Health Plans[3]			
DentaQuest	344,545.10	13,029	0
MCNA Dental Plan	246,277.00	9,877	0
Prepaid Mental Health Plans			
Access Behavioral Health	46,462.10	9,080	0.2
Florida Health Partners	189,543.30	135	0
Magellan Behavioral Health of Florida	226,327.10	10,350	0
Child Welfare Prepaid Mental Health Plan[4]			
Community Based Care Partnership	22,472.40	4,249	0.2
Specialty Plans[5]			
Clear Health Alliance (Simply)	316.5	165	0.5
Positive HealthCare	193	108	0.6
Managed Care Plans			
Amerigroup	186,715.80	27,565	0.1
Better Health, LLC	35,932.80	11	0
Buena Vista	1,289.80	23	0
First Coast Advantage Central, LLC	28,788.30	2,162	0.1
Freedom	170,775.80	30,433	0.2
Healthease	46,274.80	4,656	0.1
Humana Family	21,893.80	2,886	0.1

Table E-2—Inpatient Encounter Data Overview			
Plan	Average Number of Members per Month[1]	Inpatient	
		Total Number of Encounters	Total Encounters PMPY[2]
Integral	69,989.10	10,389	0.1
Molina Healthcare of Florida, Inc.	15,898.60	2,655	0.2
Preferred Medical Plan, Inc.	73,494.40	10,786	0.1
Prestige Health Choice	26,306.30	2,256	0.1
Simply Healthcare Plans, Inc.	198,081.50	35,874	0.2
Staywell	203,200.80	34,263	0.2
Sunshine	111,544.70	20,190	0.2
United Evercare / United Healthcare Plan	22,667.80	1,704	0.1
Vista Healthplan of South Florida	23,635.50	2,600	0.1
All Plans	**1,847,052.80**	**235,446**	**0.1**

[1] The average number of members was calculated by dividing the total number of member months by 12. This calculation is the basis for reporting per member per year (PMPY) rates.
[2] The total encounters per member per year (PMPY) rate was calculated by dividing the total number of encounters by the average number of members.
[3] PDHPs do not cover pharmacy and have limited inpatient and outpatient services.
[4] This CWPMHP is a statewide, specialized PMHP that addresses the complex needs of Medicaid-eligible children who are receiving specific services from the Department of Children and Families. As such, utilization of services may be higher than for other PMHPs.
[5] These specialty health plans enroll HIV-positive/AIDS members. As such, utilization of services may appear higher than for plans that enroll a mix of users and non-users.

Outpatient Encounter Data

Table E-3 shows outpatient encounter data utilization for all plans.

Table E-3—Outpatient Encounter Data Overview			
Plan	Average Number of Members per Month[1]	Outpatient	
		Total Number of Encounters	Total Encounters PMPY[2]
Prepaid Dental Health Plans[3]			
DentaQuest	344,545.10	380,080	1.1
MCNA Dental Plan	246,277.00	306,902	1.2
Prepaid Mental Health Plans			
Access Behavioral Health	46,462.10	103	0
Florida Health Partners	189,543.30	956	0
Magellan Behavioral Health of Florida	226,327.10	2,006	0
Child Welfare Prepaid Mental Health Plan[4]			
Community Based Care Partnership	22,472.40	18,924	0.8
Specialty Plans[5]			
Clear Health Alliance (Simply)	316.5	443	1.4
Positive HealthCare	193	981	5.1

Table E-3—Outpatient Encounter Data Overview			
Plan	Average Number of Members per Month[1]	Outpatient	
		Total Number of Encounters	Total Encounters PMPY[2]
Managed Care Plans			
Amerigroup	186,715.80	2,395,494	12.8
Better Health, LLC	35,932.80	35	0
Buena Vista	1,289.80	0	0
First Coast Advantage Central, LLC	28,788.30	24,495	0.9
Freedom	170,775.80	277,105	1.6
Healthease	46,274.80	42,707	0.9
Humana Family	21,893.80	39,260	1.8
Integral	69,989.10	118,206	1.7
Molina Healthcare of Florida, Inc.	15,898.60	17,250	1.1
Preferred Medical Plan, Inc.	73,494.40	60,274	0.8
Prestige Health Choice	26,306.30	19,541	0.7
Simply Healthcare Plans, Inc.	198,081.50	321,321	1.6
Staywell	203,200.80	345,816	1.7
Sunshine	111,544.70	289,258	2.6
United Evercare / United Healthcare Plan	22,667.80	26,914	1.2
Vista Healthplan of South Florida	23,635.50	27,707	1.2
All Plans	**1,847,052.80**	**4,715,778**	**2.6**

[1] The average number of members was calculated by dividing the total number of member months by 12. This calculation is the basis for reporting per member per year (PMPY) rates.
[2] The total encounters per member per year (PMPY) rate was calculated by dividing the total number of encounters by the average number of members.
[3] PDHPs do not cover pharmacy and have limited inpatient and outpatient services.
[4] This CWPMHP is a statewide, specialized PMHP that addresses the complex needs of Medicaid-eligible children who are receiving specific services from the Department of Children and Families. As such, utilization of services may be higher than for other PMHPs.
[5] These specialty health plans enroll HIV-positive/AIDS members. As such, utilization of services may appear higher than a plan that enrolls a mix of users and non-users.

Dental Encounter Data

Table E-4 shows dental encounter data utilization for all plans.

Table E-4—Dental Encounter Data Overview			
Plan	Average Number of Members per Month[1]	Dental	
		Total Number of Encounters	Total Encounters PMPY[2]
Prepaid Dental Health Plans			
DentaQuest	344,545.10	240,840	0.7
MCNA Dental Plan	246,277.00	247,747	1

Table E-4—Dental Encounter Data Overview			
Plan	Average Number of Members per Month[1]	Dental	
		Total Number of Encounters	Total Encounters PMPY[2]
Prepaid Mental Health Plan[3]			
Access Behavioral Health	46,462.10	785	0
Florida Health Partners	189,543.30	18,918	0.1
Magellan Behavioral Health of Florida	226,327.10	136,404	0.6
Child Welfare Prepaid Mental Health Plan[4]			
Community Based Care Partnership	22,472.40	10,249	0.5
Specialty Plans[5]			
Clear Health Alliance (Simply)	316.5	38	0.1
Positive HealthCare	193	0	0
Managed Care Plans			
Amerigroup	186,715.80	35,054	0.2
Better Health, LLC	35,932.80	19,442	0.5
Buena Vista	1,289.80	48	0
First Coast Advantage Central, LLC	28,788.30	9,446	0.3
Freedom	170,775.80	26,881	0.2
Healthease	46,274.80	27,393	0.6
Humana Family	21,893.80	25,352	1.2
Integral	69,989.10	40,039	0.6
Molina Healthcare of Florida, Inc.	15,898.60	7,716	0.5
Preferred Medical Plan, Inc.	73,494.40	11,658	0.2
Prestige Health Choice	26,306.30	8,046	0.3
Simply Healthcare Plans, Inc.	198,081.50	46,015	0.2
Staywell	203,200.80	82,379	0.4
Sunshine	111,544.70	34,283	0.3
United Evercare / United Healthcare Plan	22,667.80	15,580	0.7
Vista Healthplan of South Florida	23,635.50	5,089	0.2
All Plans	**1,847,052.80**	**1,049,402**	**0.6**

[1] The average number of members was calculated by dividing the total number of member months by 12. This calculation is the basis for reporting per member per year (PMPY) rates.
[2] The total encounters per member per year (PMPY) rate was calculated by dividing the total number of encounters by the average number of members.
[3] PDHPs do not cover dental and pharmacy services.
[4] This CWPMHP is a statewide, specialized PMHP that addresses the complex needs of Medicaid-eligible children who are receiving specific services from the Department of Children and Families. As such, utilization of services may be higher than for other PMHPs.
[5] These specialty health plans enroll HIV-positive/AIDS members. As such, utilization of services may appear higher than for plans that enroll a mix of users and non-users.

Pharmacy Encounter Data

Table E-5 shows pharmacy encounter data utilization for all plans.

Table E-5—Pharmacy Encounter Data Overview			
Plan	Average Number of Members per Month[1]	Pharmacy	
		Total Number of Encounters	Total Encounters PMPY[2]
Prepaid Dental Health Plans[3]			
DentaQuest	344,545.10	814,965	2.4
MCNA Dental Plan	246,277.00	631,850	2.6
Prepaid Mental Health Plans[4]			
Access Behavioral Health	46,462.10	2	0
Florida Health Partners	189,543.30	6,447	0
Magellan Behavioral Health of Florida	226,327.10	3,185	0
Child Welfare Prepaid Mental Health Plan[5]			
Community Based Care Partnership	22,472.40	49,238	2.2
Specialty Plans[6]			
Clear Health Alliance (Simply)	316.5	7,089	22.4
Positive HealthCare	193	17,772	92.1
Managed Care Plans			
Amerigroup	186,715.80	2,044,886	11
Better Health, LLC	35,932.80	47	0
Buena Vista	1,289.80	13	0
First Coast Advantage Central, LLC	28,788.30	216,501	7.5
Freedom	170,775.80	1,541,180	9
Healthease	46,274.80	610,093	13.2
Humana Family	21,893.80	126,597	5.8
Integral	69,989.10	696,018	9.9
Molina Healthcare of Florida, Inc.	15,898.60	80,149	5
Preferred Medical Plan, Inc.	73,494.40	1,383,338	18.8
Prestige Health Choice	26,306.30	217,000	8.2
Simply Healthcare Plans, Inc.	198,081.50	2,021,319	10.2
Staywell	203,200.80	1,803,571	8.9
Sunshine	111,544.70	1,194,413	10.7
United Evercare / United Healthcare Plan	22,667.80	182,141	8
Vista Healthplan of South Florida	23,635.50	186,976	7.9
All Plans	**1,847,052.80**	**13,834,790**	**7.5**

[1] The average number of members was calculated by dividing the total number of member months by 12. This calculation is the basis for reporting per member per year (PMPY) rates.

[2] The total encounters per member per year (PMPY) rate was calculated by dividing the total number of encounters by the average number of members.
[3] PDHPs do not cover pharmacy and have limited inpatient and outpatient services.
[4] PMHPs do not cover dental and pharmacy services.
[5] This CWPMHP is a statewide, specialized PMHP that addresses the complex needs of Medicaid-eligible children who are receiving specific services from the Department of Children and Families. As such, utilization of services may be higher than for other PMHPs.
[6] These specialty health plans enroll HIV-positive/AIDS members. As such, utilization of services may appear higher than for plans that enroll a mix of users and non-users.

Encounter Field Completeness and Reasonableness

Table E-6 shows the data fields and the associated acceptable ranges or values for each of the claim/encounter types included in the study.

Table E-6—Valid Ranges or Values for the Data Field Completeness Analyses

Field	Format	Valid Ranges or Values	Analyses Applied				
			Physician Encounters	Inpatient Encounters	Outpatient Encounters	Dental Encounters	Pharmacy Claims
Member ID	Character	State-supplied eligibility/ enrollment file	√	√	√	√	√
Billing Provider ID	Character	State-supplied provider file	√	√	√	√	√
Rendering Provider ID	Character	State-supplied provider file	√			√	
Referring Provider ID	Character	State-supplied provider file	√	√	√		
Performing Provider ID	Character	State-supplied provider file		√	√		
Prescribing Provider ID	Character	State-supplied provider file					√
Dispensing Provider ID	Character	State-supplied provider file					√
Principal/ Primary Diagnosis	Character	ICD-9 Manual	√	√	√		
Additional Diagnoses	Character	ICD-9 Manual	√	√	√		
Surgical Codes 1 – 4	Character	ICD-9 Manual		√	√		
Procedure Codes	Character	CPT and HCPCS Manual	√	√	√	√	

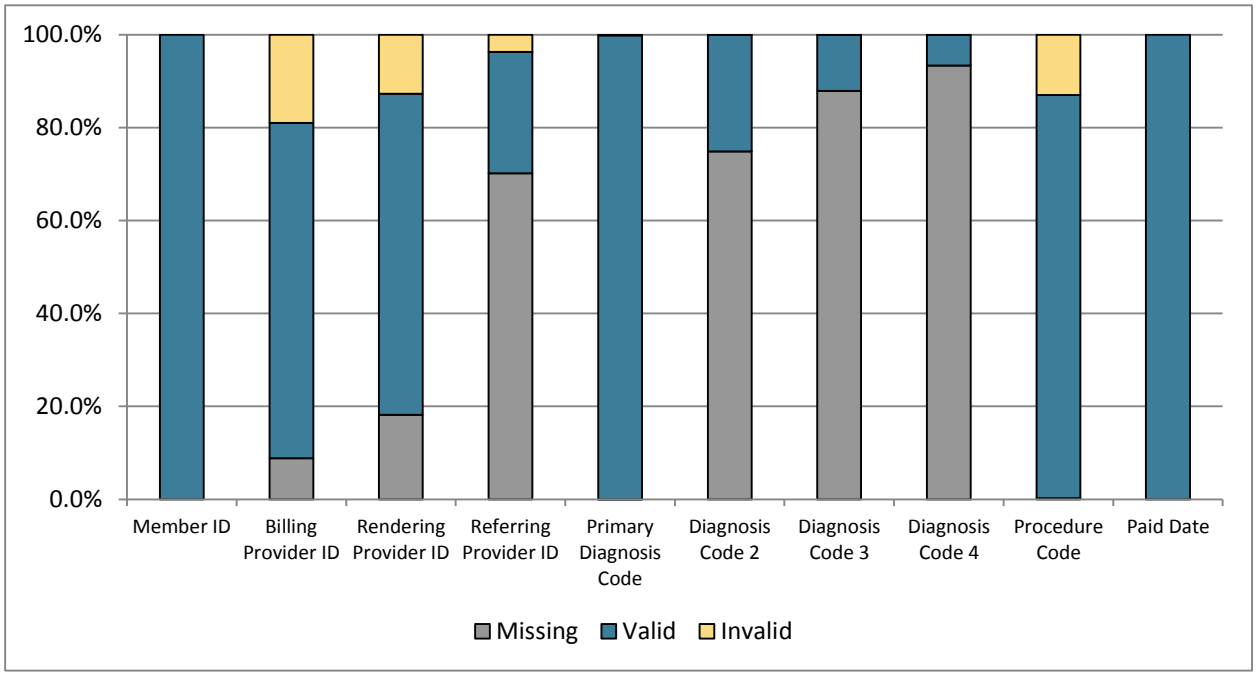
Table E-6—Valid Ranges or Values for the Data Field Completeness Analyses							
Field	Format	Valid Ranges or Values	Analyses Applied				
			Physician Encounters	Inpatient Encounters	Outpatient Encounters	Dental Encounters	Pharmacy Claims
NDC	Character	Medi-Span database					√
Revenue Codes	Character	UB-04 Revenue Code Manual		√	√		
Paid Date	Date	≥ Date of Service	√	√	√	√	√
Dispensed Date	Date	≥ Prescribed Date					√

Note: Gray blank cells indicate that the data field values were not applicable for the associated encounter/claim types and therefore were not evaluated.

Physician Encounter Field Reasonableness and Completeness

Figure E-1 shows the results for reasonableness and completeness across plans.

Figure E-1—Percentage of Physician Records With Missing, Valid, or Invalid Values for Select Fields



Note: *Rendering Provider ID*, *Referring Provider ID*, *Diagnosis Code 2*, *Diagnosis Code 3*, and *Diagnosis Code 4* fields are situational (i.e., not required for every physician encounter transaction).

Table E-7 shows the results for reasonableness and completeness by each plan.

Table E-7—Percentage of Physician Records With Missing or Valid Values										
	Member ID		Billing Provider ID		Rendering Provider ID		Referring Provider ID		Primary Diagnosis Code	
Plan	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
Prepaid Dental Health Plans[1]										
DTQ	0.0%	100.0%	7.8%	79.6%	18.7%	84.8%	79.7%	89.7%	0.0%	99.1%
MDP	0.0%	100.0%	7.1%	78.4%	16.7%	85.1%	77.3%	89.1%	0.0%	99.6%
Prepaid Mental Health Plans[2]										
ABH	0.0%	100.0%	14.8%	75.6%	15.6%	90.4%	>99.9%	52.9%	0.0%	91.4%
FHP	0.0%	100.0%	4.6%	66.2%	19.3%	57.0%	99.3%	79.3%	0.0%	99.8%
MBH	0.0%	100.0%	2.2%	66.6%	9.6%	61.6%	>99.9%	92.7%	0.0%	100.0%
Child Welfare Prepaid Mental Health Plan[3]										
CBC	0.0%	100.0%	3.1%	73.8%	7.3%	58.4%	95.6%	86.6%	0.0%	100.0%
Specialty Plans[4]										
CHA	0.0%	100.0%	2.1%	94.4%	2.9%	96.1%	29.7%	93.9%	0.0%	99.9%
PHC	0.0%	100.0%	19.2%	82.7%	28.4%	90.9%	68.4%	94.7%	0.0%	99.9%
Managed Care Plans										
AMG	0.0%	100.0%	14.1%	80.4%	22.2%	87.9%	98.8%	86.1%	0.0%	100.0%
BET[5]	0.0%	100.0%	9.2%	77.8%	9.3%	78.4%	33.9%	91.6%	0.0%	99.9%
FCA[5]	0.0%	100.0%	0.0%	84.2%	47.3%	24.2%	12.1%	64.9%	0.0%	100.0%
FRE	0.0%	100.0%	10.6%	82.8%	11.9%	90.9%	100.0%	-	0.0%	100.0%
HEA	0.0%	100.0%	1.7%	71.9%	10.6%	83.6%	50.0%	83.3%	0.0%	100.0%
HUM	0.0%	100.0%	3.8%	66.3%	50.9%	57.3%	>99.9%	84.8%	0.0%	100.0%
IHP	0.0%	100.0%	6.4%	92.7%	8.5%	93.4%	98.4%	94.1%	0.0%	100.0%
MOL	0.0%	100.0%	7.8%	84.5%	11.1%	89.9%	51.6%	89.1%	0.0%	100.0%
PRE	0.0%	100.0%	8.2%	89.6%	10.0%	91.2%	71.4%	92.7%	0.0%	99.3%
PRS	0.0%	100.0%	2.0%	83.8%	4.8%	86.8%	>99.9%	83.9%	0.0%	100.0%
SHP	0.0%	100.0%	7.9%	84.4%	11.5%	92.5%	55.5%	86.1%	0.0%	99.9%
STW	0.0%	100.0%	1.6%	78.1%	9.6%	87.3%	51.9%	86.3%	0.0%	100.0%
SUN	0.0%	100.0%	0.2%	84.9%	8.4%	86.3%	23.4%	90.9%	0.0%	100.0%
UHP	0.0%	100.0%	35.9%	86.7%	49.6%	87.3%	99.8%	89.7%	0.0%	100.0%
VHP	0.0%	100.0%	12.0%	88.5%	13.8%	87.9%	92.8%	88.4%	0.0%	99.9%
VIS	0.0%	100.0%	8.9%	86.2%	10.6%	86.6%	95.6%	89.1%	0.0%	99.9%
All Plans	**0.0%**	**100.0%**	**8.8%**	**79.2%**	**18.2%**	**84.4%**	**70.1%**	**87.5%**	**0.0%**	**99.8%**

Note: Valid values with percentages greater than 99.99 percent were rounded to 100 percent.
- Denotes that all records had missing values for this data element; therefore, the validity could not be assessed.
-- Denotes that no data were received from the plan.

* Denotes that the plan had less than 30 records. Caution should be used when interpreting the results.
[1] PDHPs do not cover pharmacy and have limited inpatient and outpatient services.
[2] PMHPs do not cover dental and pharmacy services.
[3] This CWPMHP is a statewide, specialized PMHP that addresses the complex needs of Medicaid-eligible children who are receiving specific services from the Department of Children and Families. As such, utilization of services may be higher than for other PMHPs.
[4] These specialty health plans enroll HIV-positive/AIDS members. As such, utilization of services may appear higher than for plans that enroll a mix of users and non-users.
[5] These plans submit limited encounter data.

Table E-7—Percentage of Physician Records With Missing or Valid Values (cont.)

	Diagnosis Code 2		Diagnosis Code 3		Diagnosis Code 4		Procedure Code		Paid Date	
Plan	**Missing**	**Valid**	**Missing**	**Valid**	**Missing**	**Valid**	**Missing**	**Valid**	**Missing**	**Valid**
Prepaid Dental Health Plans[1]										
DTQ	83.2%	99.8%	93.3%	100.0%	97.2%	99.9%	0.1%	78.4%	0.0%	100.0%
MDP	81.2%	99.9%	92.6%	100.0%	97.0%	100.0%	0.1%	81.9%	0.0%	100.0%
Prepaid Mental Health Plans[2]										
ABH	>99.9%	100.0%	100.0%	-	100.0%	-	4.5%	55.9%	0.0%	100.0%
FHP	97.9%	98.6%	99.4%	99.9%	99.8%	100.0%	0.0%	52.6%	0.0%	100.0%
MBH	91.0%	100.0%	97.6%	100.0%	99.1%	99.9%	0.0%	38.2%	0.0%	100.0%
Child Welfare Prepaid Mental Health Plan[3]										
CBC	89.5%	100.0%	95.7%	100.0%	98.3%	100.0%	0.0%	30.4%	0.0%	100.0%
Specialty Plans[4]										
CHA	62.0%	99.8%	74.9%	99.9%	80.3%	99.9%	0.0%	99.9%	0.0%	100.0%
PHC	99.8%	100.0%	99.9%	100.0%	>99.9%	100.0%	0.1%	99.4%	0.0%	100.0%
Managed Care Plans										
AMG	69.5%	100.0%	84.9%	100.0%	91.5%	100.0%	0.3%	89.9%	0.0%	100.0%
BET[5]	60.6%	99.9%	77.3%	99.9%	86.8%	99.8%	0.0%	99.9%	0.0%	100.0%
FCA[5]	100.0%	-	100.0%	-	100.0%	-	0.0%	71.5%	0.0%	100.0%
FRE	62.3%	99.9%	84.5%	99.7%	91.4%	99.8%	0.1%	98.2%	0.0%	100.0%
HEA	70.6%	100.0%	85.9%	100.0%	92.3%	100.0%	0.1%	93.5%	0.0%	100.0%
HUM	>99.9%	100.0%	>99.9%	100.0%	>99.9%	100.0%	4.1%	98.7%	0.0%	100.0%
IHP	68.4%	100.0%	84.7%	100.0%	92.4%	100.0%	0.0%	98.2%	0.0%	100.0%
MOL	61.9%	100.0%	79.5%	100.0%	87.5%	100.0%	0.0%	98.5%	0.0%	100.0%
PRE	75.9%	99.9%	87.8%	99.9%	93.2%	100.0%	0.0%	94.5%	0.0%	100.0%
PRS	89.3%	100.0%	90.3%	100.0%	90.8%	100.0%	0.0%	91.9%	0.0%	100.0%
SHP	66.6%	99.9%	82.6%	99.9%	90.0%	99.9%	0.2%	96.4%	0.0%	100.0%
STW	69.4%	100.0%	85.6%	100.0%	92.0%	100.0%	0.3%	93.9%	0.0%	100.0%
SUN	69.0%	100.0%	84.8%	100.0%	91.7%	100.0%	0.0%	93.2%	0.0%	100.0%
UHP	74.8%	100.0%	87.0%	100.0%	92.2%	100.0%	0.1%	84.7%	0.0%	100.0%

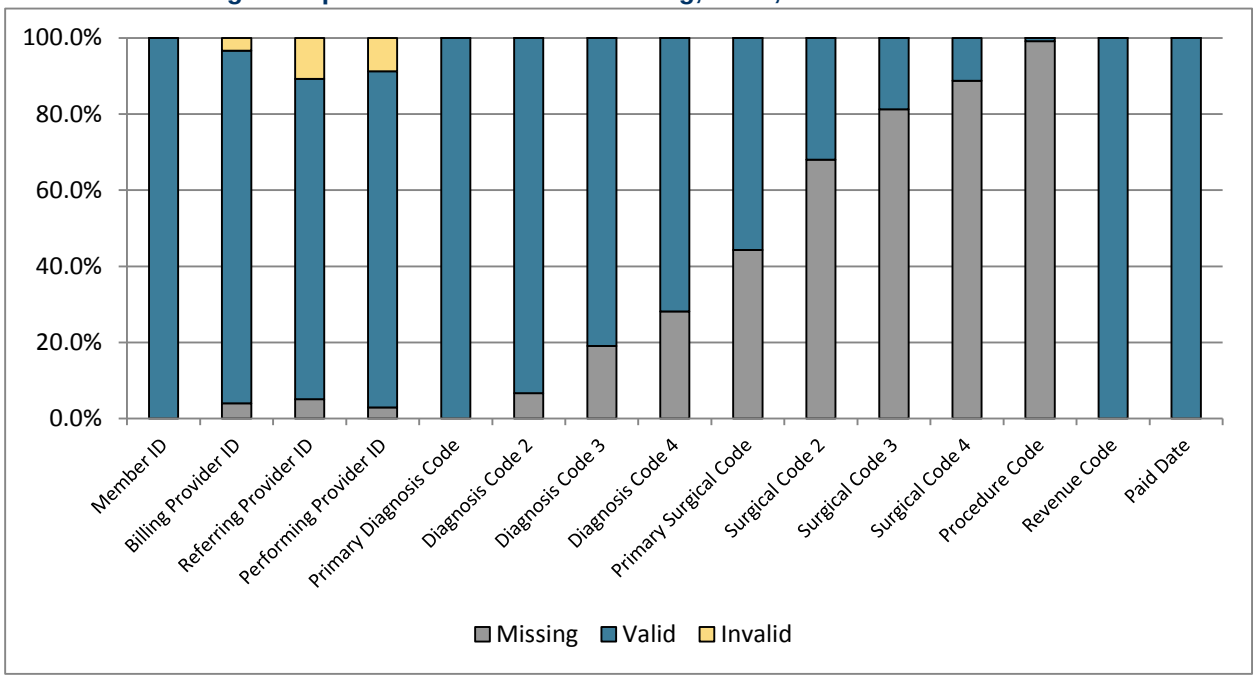
Table E-7—Percentage of Physician Records With Missing or Valid Values (cont.)										
	Diagnosis Code 2		Diagnosis Code 3		Diagnosis Code 4		Procedure Code		Paid Date	
Plan	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
VHP	96.3%	98.4%	98.0%	98.2%	98.8%	96.7%	0.2%	99.4%	0.0%	100.0%
VIS	97.5%	98.6%	98.7%	97.5%	99.3%	97.8%	0.4%	95.4%	0.0%	100.0%
All Plans	**74.9%**	**100.0%**	**87.9%**	**100.0%**	**93.3%**	**100.0%**	**0.2%**	**87.0%**	**0.0%**	**100.0%**

Note: Valid values with percentages greater than 99.99 percent were rounded to 100 percent.
- Denotes that all records had missing values for this data element; therefore, the validity could not be assessed.
-- Denotes that no data were received from the plan.
* Denotes that the plan had less than 30 records. Caution should be used when interpreting the results.
[1] PDHPs do not cover pharmacy and have limited inpatient and outpatient services.
[2] PMHPs do not cover dental and pharmacy services.
[3] This CWPMHP is a statewide, specialized PMHP that addresses the complex needs of Medicaid-eligible children who are receiving specific services from the Department of Children and Families. As such, utilization of services may be higher than for other PMHPs.
[4] These specialty health plans enroll HIV-positive/AIDS members. As such, utilization of services may appear higher than for plans that enroll a mix of users and non-users.
[5] These plans submit limited encounter data.

Inpatient Encounter Field Reasonableness and Completeness

Figure E-2 shows the results for reasonableness and completeness across plans.

Figure E-2—Percentage of Inpatient Records With Missing, Valid, or Invalid Values for Select Data Fields



Note: Referring Provider ID, Diagnosis Code 2, Diagnosis Code 3, Diagnosis Code 4, Primary Surgical Code, Surgical Code 1, Surgical Code 2, Surgical Code 3, Surgical Code 4, and Procedure Code fields are situational (i.e., not required for every inpatient encounter transaction).

Table E-8 shows the results for reasonableness and completeness by each plan.

Table E-8—Percentage of Inpatient Records With Missing or Valid Values										
	Member ID		Billing Provider ID		Referring Provider ID		Performing Provider ID		Primary Diagnosis Code	
Plan	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
Prepaid Dental Health Plans[1]										
DTQ	0.0%	100.0%	4.4%	96.7%	7.3%	90.6%	6.6%	93.7%	0.0%	100.0%
MDP	0.0%	100.0%	3.5%	97.0%	5.0%	89.4%	4.3%	92.1%	0.0%	100.0%
Prepaid Mental Health Plans[2]										
ABH	0.0%	100.0%	3.2%	99.8%	4.6%	99.4%	0.0%	95.0%	0.0%	97.9%
FHP	0.0%	100.0%	0.1%	95.2%	10.5%	81.2%	0.1%	81.0%	0.0%	100.0%
MBH	0.0%	100.0%	7.5%	89.0%	3.3%	87.6%	0.0%	90.9%	0.0%	100.0%
Child Welfare Prepaid Mental Health Plan[3]										
CBC	0.0%	99.9%	4.3%	90.6%	1.7%	90.7%	0.4%	92.8%	0.0%	100.0%
Specialty Plans[4]										
CHA	0.0%	100.0%	5.7%	100.0%	1.7%	89.8%	0.0%	93.8%	0.0%	100.0%
PHC	0.0%	100.0%	0.3%	89.5%	96.7%	97.5%	96.7%	100.0%	0.0%	100.0%
Managed Care Plans										
AMG	0.0%	100.0%	0.7%	96.0%	2.1%	87.4%	0.0%	91.0%	0.0%	100.0%
BET[5]	0.0%	100.0%	0.0%	100.0%	28.4%	100.0%	28.4%	87.5%	0.0%	100.0%
FCA[5]	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%
FRE	0.0%	99.9%	0.0%	94.2%	0.0%	98.8%	0.0%	99.1%	0.0%	100.0%
HEA	0.0%	100.0%	0.0%	97.5%	2.1%	88.4%	0.2%	91.4%	0.0%	100.0%
HUM	0.0%	100.0%	3.3%	86.7%	99.3%	35.1%	99.3%	34.9%	0.0%	100.0%
IHP	0.0%	100.0%	0.6%	99.9%	0.1%	97.8%	0.0%	98.1%	0.0%	100.0%
MOL	0.0%	100.0%	0.5%	100.0%	1.4%	92.5%	0.2%	92.1%	0.0%	100.0%
PRE	0.0%	100.0%	0.5%	99.7%	1.3%	94.3%	0.0%	95.6%	0.0%	100.0%
PRS	0.0%	100.0%	0.3%	93.2%	2.2%	85.7%	0.0%	88.0%	0.0%	100.0%
SHP	0.0%	100.0%	1.4%	99.1%	1.7%	89.0%	0.4%	95.2%	0.0%	99.9%
STW	0.0%	100.0%	0.0%	97.1%	2.4%	89.5%	0.3%	92.7%	0.0%	100.0%
SUN	0.0%	99.9%	0.0%	99.9%	1.8%	86.3%	0.0%	89.4%	0.0%	100.0%
UHP	0.0%	100.0%	32.5%	93.8%	6.6%	85.3%	0.0%	84.6%	0.0%	100.0%
VHP	0.0%	100.0%	0.1%	100.0%	0.1%	99.6%	0.0%	99.9%	0.0%	100.0%
VIS	0.0%	100.0%	0.5%	99.8%	0.4%	98.5%	0.0%	99.6%	0.0%	100.0%
All Plans	**0.0%**	**100.0%**	**4.0%**	**96.5%**	**5.1%**	**88.6%**	**2.9%**	**91.0%**	**0.0%**	**100.0%**

Note: Valid values with percentages greater than 99.99 percent were rounded to 100 percent.
- Denotes that all records had missing values for this data element; therefore, the validity could not be assessed.
-- Denotes that no data were received from the plan.
* Denotes that the plan had less than 30 records. Caution should be used when interpreting the results.
[1] PDHPs do not cover pharmacy and have limited inpatient and outpatient services.

[2] PMHPs do not cover dental and pharmacy services.
[3] This CWPMHP is a statewide, specialized PMHP that addresses the complex needs of Medicaid-eligible children who are receiving specific services from the Department of Children and Families. As such, utilization of services may be higher than for other PMHPs.
[4] These specialty health plans enroll HIV-positive/AIDS members. As such, utilization of services may appear higher than for plans that enroll a mix of users and non-users.
[5] These plans submit limited encounter data.

Table E-8—Percentage of Inpatient Records With Missing or Valid Values (cont.)

	Diagnosis Code 2		Diagnosis Code 3		Diagnosis Code 4		Primary Surgical Code		Surgical Code 2	
Plan	**Missing**	**Valid**	**Missing**	**Valid**	**Missing**	**Valid**	**Missing**	**Valid**	**Missing**	**Valid**
Prepaid Dental Health Plans[1]										
DTQ	16.5%	99.9%	43.7%	100.0%	60.1%	100.0%	57.1%	100.0%	79.3%	100.0%
MDP	17.0%	100.0%	40.2%	100.0%	58.1%	100.0%	56.9%	100.0%	78.1%	100.0%
Prepaid Mental Health Plans[2]										
ABH	99.3%	100.0%	99.3%	100.0%	99.3%	100.0%	99.6%	100.0%	99.9%	100.0%
FHP	3.9%	100.0%	7.0%	100.0%	8.9%	100.0%	24.3%	100.0%	44.4%	100.0%
MBH	32.4%	100.0%	41.5%	100.0%	51.7%	100.0%	92.3%	100.0%	94.6%	100.0%
Child Welfare Prepaid Mental Health Plan[3]										
CBC	35.9%	100.0%	50.7%	100.0%	66.3%	99.9%	76.1%	100.0%	85.9%	100.0%
Specialty Plans[4]										
CHA	0.0%	100.0%	0.7%	100.0%	3.8%	100.0%	57.4%	100.0%	71.4%	100.0%
PHC	7.8%	100.0%	7.8%	100.0%	18.1%	100.0%	63.5%	100.0%	71.7%	100.0%
Managed Care Plans										
AMG	5.0%	100.0%	13.4%	100.0%	21.6%	100.0%	43.4%	100.0%	66.4%	100.0%
BET[5]	0.0%	100.0%	11.9%	100.0%	11.9%	100.0%	55.2%	100.0%	88.1%	100.0%
FCA[5]	13.5%	100.0%	13.5%	100.0%	15.4%	100.0%	>99.9%	100.0%	100.0%	-
FRE	4.9%	99.9%	14.7%	99.9%	23.9%	100.0%	100.0%	-	100.0%	-
HEA	5.6%	100.0%	15.7%	100.0%	24.9%	100.0%	37.1%	100.0%	63.8%	100.0%
HUM	4.4%	99.9%	99.8%	100.0%	99.8%	100.0%	95.7%	100.0%	>99.9%	100.0%
IHP	5.2%	100.0%	14.8%	100.0%	23.8%	100.0%	39.3%	100.0%	65.5%	100.0%
MOL	4.3%	100.0%	12.9%	100.0%	21.6%	100.0%	40.1%	100.0%	65.1%	100.0%
PRE	7.3%	99.9%	17.3%	100.0%	28.4%	100.0%	44.2%	100.0%	71.3%	100.0%
PRS	4.9%	100.0%	12.6%	100.0%	21.1%	100.0%	39.0%	100.0%	64.4%	100.0%
SHP	4.8%	99.7%	14.5%	100.0%	24.0%	99.9%	42.7%	100.0%	65.5%	100.0%
STW	5.2%	100.0%	14.8%	100.0%	23.8%	100.0%	38.9%	100.0%	64.8%	100.0%
SUN	6.1%	100.0%	15.8%	100.0%	25.1%	100.0%	44.1%	100.0%	68.9%	100.0%
UHP	4.2%	100.0%	11.6%	100.0%	18.6%	100.0%	39.3%	100.0%	62.5%	100.0%
VHP	7.5%	100.0%	21.7%	100.0%	32.8%	100.0%	41.4%	100.0%	67.8%	100.0%
VIS	6.0%	99.9%	19.0%	100.0%	28.7%	100.0%	38.6%	99.9%	65.2%	99.8%
All Plans	**6.6%**	**100.0%**	**19.0%**	**100.0%**	**28.2%**	**100.0%**	**44.3%**	**100.0%**	**68.0%**	**100.0%**

Note: Valid values with percentages greater than 99.99 percent were rounded to 100 percent.
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[4] These specialty health plans enroll HIV-positive/AIDS members. As such, utilization of services may appear higher than for plans that enroll a mix of users and non-users.
[5] These plans submit limited encounter data.

Table E-8—Percentage of Inpatient Records With Missing or Valid Values (cont.)

	Surgical Code 3		Surgical Code 4		Procedure Code		Revenue Code		Paid Date	
Plan	**Missing**	**Valid**	**Missing**	**Valid**	**Missing**	**Valid**	**Missing**	**Valid**	**Missing**	**Valid**
Prepaid Dental Health Plans[1]										
DTQ	88.0%	100.0%	93.1%	100.0%	99.7%	100.0%	0.0%	100.0%	0.0%	100.0%
MDP	87.9%	100.0%	93.6%	100.0%	99.5%	100.0%	0.0%	100.0%	0.0%	100.0%
Prepaid Mental Health Plans[2]										
ABH	100.0%	-	100.0%	-	100.0%	-	0.0%	100.0%	0.0%	100.0%
FHP	50.1%	100.0%	66.9%	100.0%	96.7%	100.0%	0.0%	100.0%	0.0%	100.0%
MBH	95.7%	100.0%	97.1%	100.0%	99.8%	100.0%	0.0%	100.0%	0.0%	100.0%
Child Welfare Prepaid Mental Health Plan[3]										
CBC	92.0%	100.0%	92.9%	100.0%	99.2%	100.0%	0.0%	100.0%	0.0%	100.0%
Specialty Plans[4]										
CHA	80.4%	100.0%	86.7%	100.0%	100.0%	-	0.0%	100.0%	0.0%	100.0%
PHC	82.4%	100.0%	95.6%	100.0%	98.0%	100.0%	0.0%	100.0%	0.0%	100.0%
Managed Care Plans										
AMG	79.6%	100.0%	87.4%	100.0%	97.7%	100.0%	0.0%	100.0%	0.0%	100.0%
BET[5]	100.0%	-	100.0%	-	100.0%	-	0.0%	100.0%	0.0%	100.0%
FCA[5]	100.0%	-	100.0%	-	100.0%	-	0.0%	100.0%	0.0%	100.0%
FRE	100.0%	-	100.0%	-	99.6%	100.0%	0.0%	100.0%	0.0%	100.0%
HEA	79.4%	100.0%	88.1%	100.0%	99.2%	100.0%	0.0%	100.0%	0.0%	100.0%
HUM	100.0%	-	100.0%	-	100.0%	-	0.0%	100.0%	0.0%	100.0%
IHP	78.1%	100.0%	87.8%	100.0%	99.8%	100.0%	0.0%	100.0%	0.0%	100.0%
MOL	79.8%	100.0%	87.9%	100.0%	99.9%	97.8%	0.0%	100.0%	0.0%	100.0%
PRE	83.3%	100.0%	89.5%	100.0%	99.9%	100.0%	0.0%	99.9%	0.0%	100.0%
PRS	78.3%	100.0%	85.8%	100.0%	99.5%	100.0%	0.0%	100.0%	0.0%	100.0%
SHP	80.3%	100.0%	88.1%	100.0%	99.4%	100.0%	0.0%	100.0%	0.0%	100.0%
STW	79.2%	100.0%	87.5%	100.0%	99.3%	100.0%	0.0%	100.0%	0.0%	100.0%
SUN	82.6%	100.0%	90.1%	100.0%	99.0%	100.0%	0.0%	100.0%	0.0%	100.0%
UHP	76.8%	100.0%	85.8%	100.0%	99.4%	99.9%	0.0%	100.0%	0.0%	100.0%

Table E-8—Percentage of Inpatient Records With Missing or Valid Values (cont.)										
	Surgical Code 3		Surgical Code 4		Procedure Code		Revenue Code		Paid Date	
Plan	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
VHP	83.1%	100.0%	89.0%	100.0%	99.6%	100.0%	0.0%	100.0%	0.0%	100.0%
VIS	80.2%	100.0%	87.8%	100.0%	99.5%	100.0%	0.0%	100.0%	0.0%	100.0%
All Plans	**81.2%**	**100.0%**	**88.8%**	**100.0%**	**99.2%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**

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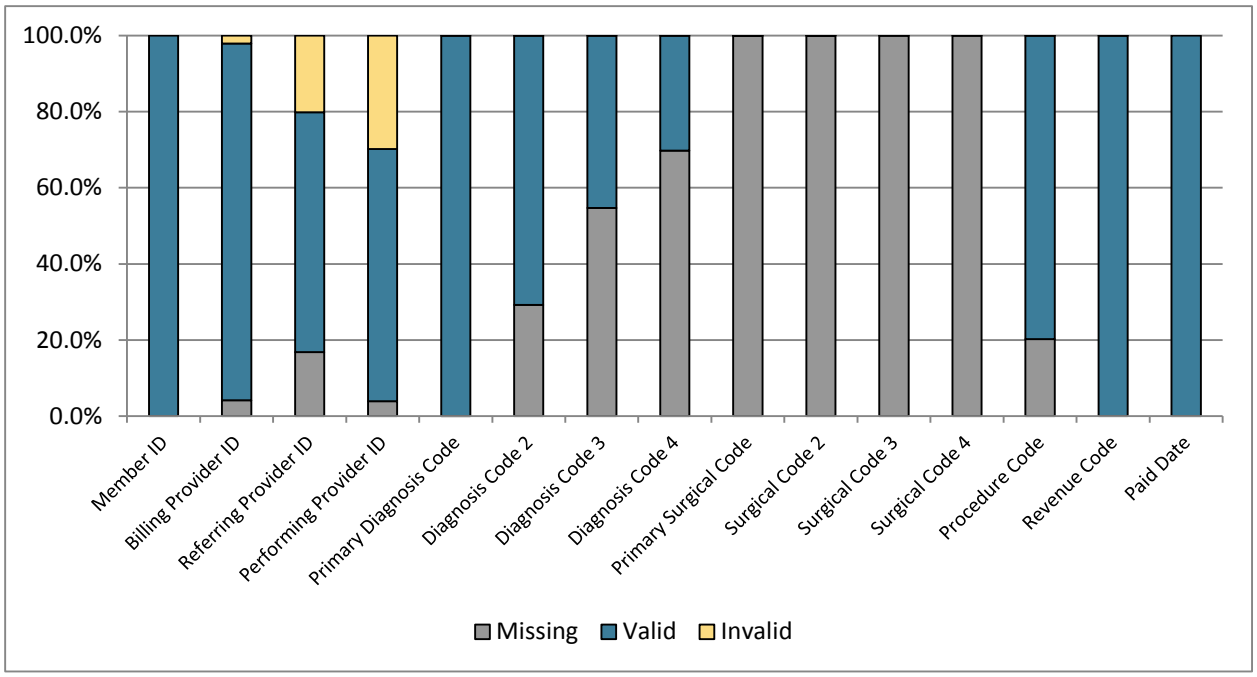
[5] These plans submit limited encounter data.

Outpatient Encounter Field Reasonableness and Completeness

Figure E-3 shows the results for reasonableness and completeness across plans.

Figure E-3—Percentage of Outpatient Records With Missing, Valid, or Invalid Values for Select Data Fields



Note: Referring Provider ID, Diagnosis Code 2, Diagnosis Code 3, Diagnosis Code 4, Primary Surgical Code, Surgical Code 1, Surgical Code 2, Surgical Code 3, Surgical Code 4, and Procedure Code fields are situational (i.e., not required for every outpatient encounter transaction).

Table E-9 shows the results for reasonableness and completeness by each plan.

Table E-9—Percentage of Outpatient Records With Missing or Valid Values										
	Member ID		Billing Provider ID		Referring Provider ID		Performing Provider ID		Primary Diagnosis Code	
Plan	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
Prepaid Dental Health Plans[1]										
DTQ	0.0%	100.0%	3.8%	98.3%	26.2%	81.0%	15.2%	73.6%	0.0%	100.0%
MDP	0.0%	100.0%	2.9%	98.2%	23.0%	76.0%	12.9%	70.3%	0.0%	100.0%
Prepaid Mental Health Plans[2]										
ABH	0.0%	100.0%	91.3%	100.0%	97.1%	100.0%	5.8%	3.1%	0.0%	60.2%
FHP	0.0%	100.0%	1.3%	97.3%	30.8%	78.7%	27.0%	75.3%	0.0%	100.0%
MBH	0.0%	100.0%	1.4%	63.6%	11.6%	81.1%	4.1%	85.8%	0.0%	100.0%
Child Welfare Prepaid Health Plan[3]										
CBC	0.0%	100.0%	4.4%	97.0%	26.1%	72.2%	13.0%	64.5%	0.0%	100.0%
Specialty Plans[4]										
CHA	0.0%	100.0%	3.4%	99.9%	1.4%	93.1%	0.6%	95.7%	0.0%	100.0%
PHC	0.0%	100.0%	0.0%	95.1%	92.1%	97.3%	92.1%	100.0%	30.6%	100.0%
Managed Care Plans										
AMG	0.0%	100.0%	0.1%	98.1%	2.0%	75.1%	0.6%	78.2%	0.0%	100.0%
BET[5]	0.0%	100.0%	0.0%	100.0%	80.3%	100.0%	55.7%	44.4%	0.0%	100.0%
FCA[5]	--	--	--	--	--	--	--	--	--	--
FRE	0.0%	100.0%	0.3%	92.0%	0.3%	95.9%	0.0%	96.0%	0.0%	100.0%
HEA	0.0%	100.0%	0.0%	98.4%	1.9%	67.3%	0.4%	71.6%	0.0%	100.0%
HUM	0.0%	100.0%	3.3%	91.0%	82.3%	92.1%	81.5%	88.3%	0.0%	100.0%
IHP	0.0%	100.0%	0.2%	100.0%	1.7%	97.8%	1.5%	98.1%	0.0%	100.0%
MOL	0.0%	100.0%	1.0%	99.8%	1.0%	91.6%	0.3%	91.7%	0.0%	100.0%
PRE	0.0%	100.0%	0.8%	99.3%	2.2%	94.3%	1.4%	96.5%	0.0%	99.9%
PRS	0.0%	100.0%	0.5%	99.4%	0.8%	75.2%	0.0%	78.1%	0.0%	100.0%
SHP	0.0%	100.0%	0.4%	99.2%	1.6%	80.8%	0.7%	84.3%	0.0%	100.0%
STW	0.0%	100.0%	0.0%	97.9%	2.0%	71.7%	0.6%	75.5%	0.0%	100.0%
SUN	0.0%	100.0%	0.0%	97.8%	1.5%	69.0%	0.0%	71.8%	0.0%	100.0%
UHP	0.0%	100.0%	33.7%	95.0%	>99.9%	71.2%	0.3%	0.0%	0.0%	100.0%
VHP	0.0%	100.0%	0.1%	99.4%	0.4%	99.2%	0.3%	99.4%	0.0%	100.0%
VIS	0.0%	100.0%	0.5%	99.3%	0.8%	99.0%	0.2%	99.2%	0.0%	100.0%
All Plans	**0.0%**	**100.0%**	**4.2%**	**97.8%**	**16.8%**	**75.8%**	**3.9%**	**68.9%**	**0.0%**	**100.0%**

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[5] These plans submit limited encounter data.

Table E-9—Percentage of Outpatient Records With Missing or Valid Values (cont.)

	Diagnosis Code 2		Diagnosis Code 3		Diagnosis Code 4		Primary Surgical Code		Surgical Code 2	
Plan	**Missing**	**Valid**	**Missing**	**Valid**	**Missing**	**Valid**	**Missing**	**Valid**	**Missing**	**Valid**
Prepaid Dental Health Plans[1]										
DTQ	44.3%	100.0%	75.3%	100.0%	88.8%	100.0%	99.8%	100.0%	99.9%	100.0%
MDP	41.5%	100.0%	72.6%	100.0%	87.0%	100.0%	99.7%	100.0%	99.9%	100.0%
Prepaid Mental Health Plans[2]										
ABH	100.0%	-	100.0%	-	100.0%	-	100.0%	-	100.0%	-
FHP	26.1%	100.0%	48.1%	100.0%	68.4%	100.0%	100.0%	-	100.0%	-
MBH	27.3%	100.0%	39.7%	100.0%	45.9%	100.0%	100.0%	-	100.0%	-
Child Welfare Prepaid Mental Health Plan[3]										
CBC	37.8%	100.0%	66.1%	100.0%	83.2%	100.0%	99.4%	100.0%	99.9%	100.0%
Specialty Plans[4]										
CHA	14.0%	100.0%	30.4%	100.0%	44.9%	100.0%	99.8%	100.0%	99.8%	100.0%
PHC	14.3%	100.0%	38.7%	100.0%	60.6%	100.0%	99.9%	100.0%	100.0%	-
Managed Care Plans										
AMG	23.4%	100.0%	44.8%	100.0%	60.1%	100.0%	100.0%	-	100.0%	-
BET[5]	32.8%	100.0%	52.5%	100.0%	52.5%	100.0%	100.0%	-	100.0%	-
FCA[5]	--	--	--	--	--	--	--	--	--	--
FRE	27.1%	99.4%	50.8%	99.9%	67.0%	99.9%	100.0%	-	100.0%	-
HEA	28.8%	100.0%	53.8%	100.0%	70.1%	100.0%	100.0%	-	100.0%	-
HUM	33.4%	100.0%	>99.9%	100.0%	>99.9%	100.0%	100.0%	-	100.0%	-
IHP	25.1%	100.0%	50.2%	100.0%	67.3%	100.0%	99.8%	100.0%	99.9%	100.0%
MOL	25.6%	100.0%	50.6%	100.0%	66.9%	100.0%	100.0%	-	100.0%	-
PRE	28.9%	100.0%	52.8%	100.0%	69.5%	99.9%	98.2%	100.0%	99.5%	100.0%
PRS	22.6%	100.0%	44.5%	100.0%	59.8%	100.0%	99.4%	100.0%	99.9%	100.0%
SHP	27.2%	99.8%	52.3%	100.0%	68.8%	100.0%	98.4%	99.7%	99.5%	99.2%
STW	27.5%	100.0%	52.3%	100.0%	68.5%	100.0%	>99.9%	100.0%	100.0%	-
SUN	30.7%	100.0%	55.7%	100.0%	70.8%	100.0%	>99.9%	100.0%	>99.9%	100.0%
UHP	25.9%	100.0%	48.4%	100.0%	63.5%	100.0%	100.0%	-	100.0%	-

Table E-9—Percentage of Outpatient Records With Missing or Valid Values (cont.)										
	Diagnosis Code 2		Diagnosis Code 3		Diagnosis Code 4		Primary Surgical Code		Surgical Code 2	
Plan	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
VHP	38.4%	100.0%	64.2%	100.0%	77.3%	100.0%	100.0%	-	100.0%	-
VIS	30.4%	100.0%	55.5%	100.0%	69.9%	100.0%	100.0%	-	100.0%	-
All Plans	**29.2%**	**100.0%**	**54.7%**	**100.0%**	**69.8%**	**100.0%**	**99.9%**	**100.0%**	**>99.9%**	**99.8%**

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[5] These plans submit limited encounter data.

Table E-9—Percentage of Outpatient Records With Missing or Valid Values (cont.)										
	Surgical Code 3		Surgical Code 4		Procedure Code		Revenue Code		Paid Date	
Plan	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
Prepaid Dental Health Plans[1]										
DTQ	>99.9%	100.0%	>99.9%	100.0%	25.0%	100.0%	0.0%	100.0%	0.0%	100.0%
MDP	>99.9%	100.0%	>99.9%	100.0%	23.0%	100.0%	0.0%	100.0%	0.0%	100.0%
Prepaid Mental Health Plans[2]										
ABH	100.0%	-	100.0%	-	100.0%	-	0.0%	100.0%	0.0%	100.0%
FHP	100.0%	-	100.0%	-	14.5%	100.0%	0.0%	100.0%	0.0%	100.0%
MBH	100.0%	-	100.0%	-	86.5%	100.0%	0.0%	100.0%	0.0%	100.0%
Child Welfare Prepaid Mental Health Plan[3]										
CBC	99.9%	100.0%	>99.9%	100.0%	22.9%	100.0%	0.0%	100.0%	0.0%	100.0%
Specialty Plans[4]										
CHA	99.8%	100.0%	99.8%	100.0%	15.7%	100.0%	0.0%	100.0%	0.0%	100.0%
PHC	100.0%	-	100.0%	-	15.8%	99.9%	0.0%	100.0%	0.0%	100.0%
Managed Care Plans										
AMG	100.0%	-	100.0%	-	21.5%	100.0%	0.0%	100.0%	0.0%	100.0%
BET[5]	100.0%	-	100.0%	-	21.3%	100.0%	0.0%	100.0%	0.0%	100.0%
FCA[5]	--	--	--	--	--	--	--	--	--	--
FRE	100.0%	-	100.0%	-	16.5%	100.0%	0.0%	100.0%	0.0%	100.0%
HEA	100.0%	-	100.0%	-	16.4%	100.0%	0.0%	100.0%	0.0%	100.0%
HUM	100.0%	-	100.0%	-	64.0%	100.0%	0.0%	100.0%	0.0%	100.0%
IHP	99.9%	100.0%	>99.9%	100.0%	14.5%	100.0%	0.0%	100.0%	0.0%	100.0%
MOL	100.0%	-	100.0%	-	16.4%	100.0%	0.0%	100.0%	0.0%	100.0%

Table E-9—Percentage of Outpatient Records With Missing or Valid Values (cont.)										
	Surgical Code 3		Surgical Code 4		Procedure Code		Revenue Code		Paid Date	
Plan	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
PRE	99.6%	100.0%	99.8%	100.0%	15.2%	100.0%	0.0%	100.0%	0.0%	100.0%
PRS	>99.9%	100.0%	>99.9%	100.0%	15.6%	100.0%	0.0%	100.0%	0.0%	100.0%
SHP	99.8%	100.0%	99.9%	100.0%	16.3%	100.0%	0.0%	100.0%	0.0%	100.0%
STW	100.0%	-	100.0%	-	15.7%	100.0%	0.0%	100.0%	0.0%	100.0%
SUN	>99.9%	100.0%	>99.9%	100.0%	21.2%	100.0%	0.0%	100.0%	0.0%	100.0%
UHP	100.0%	-	100.0%	-	18.0%	100.0%	0.0%	100.0%	0.0%	100.0%
VHP	100.0%	-	100.0%	-	18.8%	100.0%	0.0%	100.0%	0.0%	100.0%
VIS	100.0%	-	100.0%	-	21.3%	100.0%	0.0%	100.0%	0.0%	100.0%
All Plans	**>99.9%**	**100.0%**	**>99.9%**	**100.0%**	**20.2%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**

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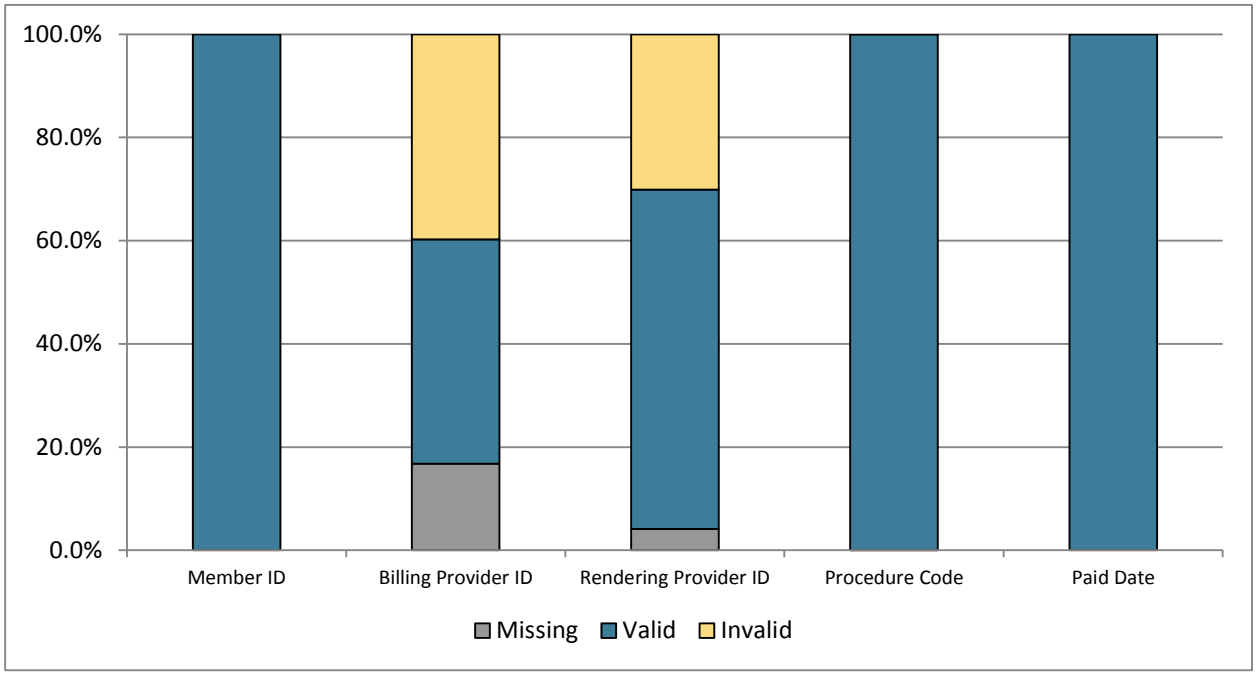
[4] These specialty health plans enroll HIV-positive/AIDS members. As such, utilization of services may appear higher than for plans that enroll a mix of users and non-users.
[5] These plans submit limited encounter data.

Dental Encounter Field Reasonableness and Completeness

Figure E-4 shows the results for reasonableness and completeness across plans.

Figure E-4—Percentage of Dental Records With Missing, Valid, or Invalid Values for Select Data Fields



Note: *Rendering Provider ID* field is situational (i.e., not required for every dental encounter transaction).

Table E-10 shows the results for reasonableness and completeness by each plan.

Table E-10—Percentage of Dental Records With Missing or Valid Values										
	Member ID		Billing Provider ID		Rendering Provider ID		Procedure Code		Paid Date	
Plan	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
Prepaid Dental Health Plans[1]										
DTQ	0.0%	100.0%	28.7%	53.1%	4.5%	86.8%	0.0%	100.0%	0.0%	100.0%
MDP	0.0%	100.0%	5.3%	53.7%	2.4%	52.1%	0.0%	100.0%	0.0%	100.0%
Prepaid Mental Health Plans[2]										
ABH	0.0%	100.0%	9.3%	58.2%	5.3%	97.2%	0.0%	100.0%	0.0%	100.0%
FHP	0.0%	100.0%	7.0%	53.0%	2.9%	61.2%	0.0%	100.0%	0.0%	100.0%
MBH	0.0%	100.0%	18.6%	54.7%	4.9%	76.9%	0.0%	100.0%	0.0%	100.0%
Child Welfare Prepaid Mental Health Plan[3]										
CBC	0.0%	100.0%	15.1%	54.8%	4.1%	71.4%	0.0%	100.0%	0.0%	100.0%
Specialty Plans[4]										
CHA	0.0%	100.0%	17.0%	51.1%	2.4%	69.6%	0.0%	100.0%	0.0%	100.0%
PHC	--	--	--	--	--	--	--	--	--	-
Managed Care Plans										
AMG	0.0%	100.0%	14.4%	53.0%	3.1%	65.1%	0.0%	100.0%	0.0%	100.0%
BET[5]	0.0%	100.0%	24.5%	36.6%	7.7%	75.3%	0.0%	100.0%	0.0%	100.0%
FCA[5]	0.0%	100.0%	0.0%	28.2%	0.0%	40.9%	0.0%	100.0%	0.0%	100.0%
FRE	0.0%	100.0%	10.9%	54.2%	5.5%	62.0%	0.0%	100.0%	0.0%	100.0%
HEA	0.0%	100.0%	14.3%	48.1%	4.2%	66.2%	0.0%	100.0%	0.0%	100.0%
HUM	0.0%	100.0%	20.5%	54.6%	3.5%	69.9%	0.0%	100.0%	0.0%	100.0%
IHP	0.0%	100.0%	1.1%	97.9%	0.0%	85.5%	0.0%	100.0%	0.0%	100.0%
MOL	0.0%	100.0%	27.8%	47.6%	6.4%	74.7%	0.0%	100.0%	0.0%	100.0%
PRE	0.0%	100.0%	21.5%	58.5%	3.3%	69.3%	0.0%	100.0%	0.0%	100.0%
PRS	0.0%	100.0%	10.0%	55.4%	1.9%	67.1%	0.0%	100.0%	0.0%	100.0%
SHP	0.0%	100.0%	22.1%	58.1%	2.5%	69.9%	0.0%	100.0%	0.0%	100.0%
STW	0.0%	100.0%	14.2%	49.6%	3.2%	66.1%	0.0%	100.0%	0.0%	100.0%
SUN	0.0%	100.0%	5.5%	39.9%	4.8%	47.0%	0.0%	100.0%	0.0%	100.0%
UHP	0.0%	100.0%	20.4%	56.1%	10.9%	63.5%	0.0%	100.0%	0.0%	100.0%
VHP	0.0%	100.0%	24.4%	58.1%	2.0%	69.9%	0.0%	100.0%	0.0%	100.0%
VIS	0.0%	100.0%	17.9%	57.5%	1.1%	68.1%	0.0%	100.0%	0.0%	100.0%
All Plans	**0.0%**	**100.0%**	**16.8%**	**52.2%**	**4.2%**	**68.6%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**

Note: Valid values with percentages greater than 99.99 percent were rounded to 100 percent.
- Denotes that all records had missing values for this data element; therefore, the validity could not be assessed.
-- Denotes that no data were received from the plan.
* Denotes that the plan had less than 30 records. Caution should be used when interpreting the results.
[1] PDHPs do not cover pharmacy and have limited inpatient and outpatient services.

[2] PMHPs do not cover dental and pharmacy services.
[3] This CWPMHP is a statewide, specialized PMHP that addresses the complex needs of Medicaid-eligible children who are receiving specific services from the Department of Children and Families. As such, utilization of services may be higher than for other PMHPs.
[4] These specialty health plans enroll HIV-positive/AIDS members. As such, utilization of services may appear higher than for plans that enroll a mix of users and non-users.
[5] These plans submit limited encounter data.

Pharmacy Encounter Field Completeness and Reasonableness

Figure E-5 shows the results for reasonableness and completeness across plans.

Figure E-5—Percentage of Pharmacy Records With Missing, Valid, or Invalid Values in Select Data Fields

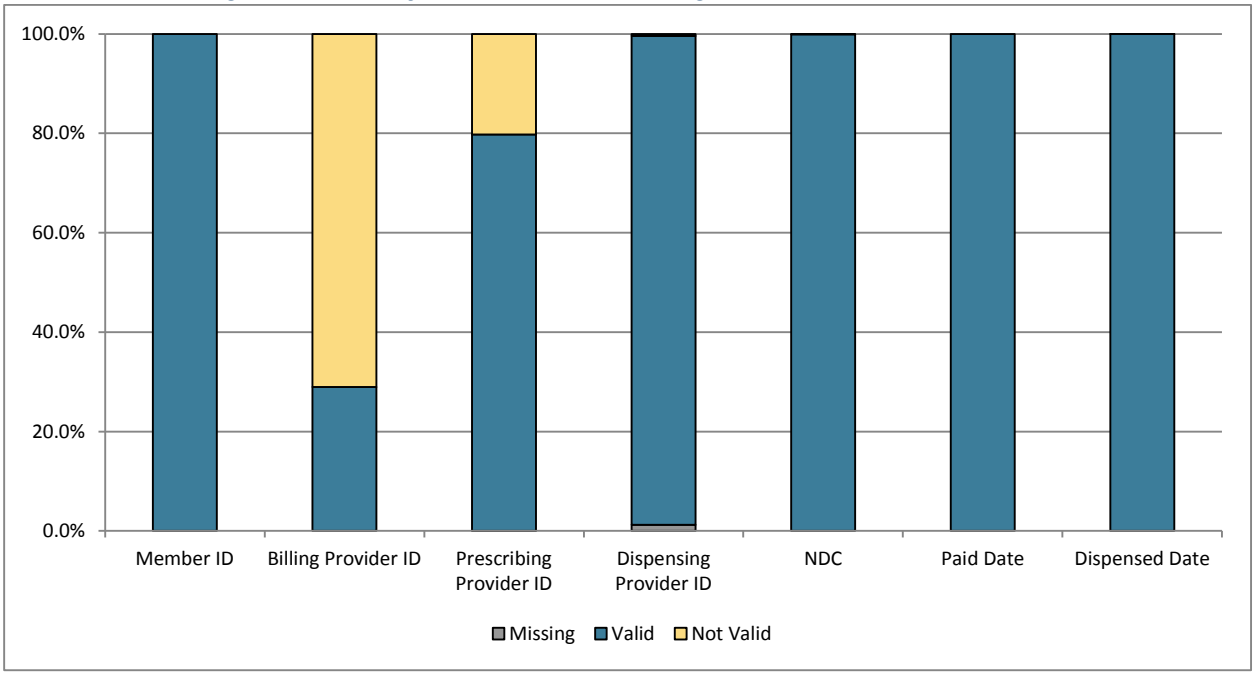


Table E-11 shows the results for reasonableness and completeness by each plan.

Table E-11—Percentage of Pharmacy Records With Missing or Valid Values

	Member ID		Billing Provider ID		Prescribing Provider ID		Dispensing Provider ID		NDC	
Plan	**Missing**	**Valid**	**Missing**	**Valid**	**Missing**	**Valid**	**Missing**	**Valid**	**Missing**	**Valid**
Prepaid Dental Health Plans[1]										
DTQ	0.0%	100.0%	0.0%	28.6%	0.0%	83.9%	0.7%	99.8%	0.0%	99.9%
MDP	0.0%	100.0%	0.0%	31.0%	0.0%	81.6%	0.8%	99.9%	0.0%	99.9%
Prepaid Mental Health Plans[2]										
ABH*	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%
FHP	0.0%	100.0%	0.0%	12.8%	0.0%	80.5%	1.8%	99.9%	0.0%	99.9%
MBH	0.0%	100.0%	0.0%	0.5%	0.0%	80.4%	0.0%	99.9%	0.0%	99.9%
Child Welfare Prepaid Mental Health Plan[3]										
CBC	0.0%	100.0%	0.0%	35.0%	0.0%	79.2%	0.5%	99.9%	0.0%	99.9%

Table E-11—Percentage of Pharmacy Records With Missing or Valid Values										
	Member ID		Billing Provider ID		Prescribing Provider ID		Dispensing Provider ID		NDC	
Plan	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
Specialty Plans[4]										
CHA	0.0%	100.0%	0.0%	0.0%	0.0%	93.4%	1.1%	99.8%	0.0%	100.0%
PHC	0.0%	100.0%	0.0%	0.0%	0.1%	81.4%	1.5%	99.4%	0.0%	99.8%
Managed Care Plans										
AMG	0.0%	100.0%	0.0%	0.0%	0.0%	73.1%	1.3%	99.6%	0.0%	99.9%
BET[5]	0.0%	100.0%	0.0%	0.0%	0.0%	97.9%	0.0%	100.0%	0.0%	100.0%
FCA*,[5]	0.0%	100.0%	0.0%	0.0%	0.0%	69.2%	0.0%	100.0%	0.0%	100.0%
FRE	0.0%	100.0%	0.0%	0.0%	0.0%	79.2%	1.6%	99.8%	0.0%	100.0%
HEA	0.0%	100.0%	0.0%	100.0%	0.0%	81.6%	1.9%	99.3%	0.0%	99.9%
HUM	0.0%	100.0%	0.0%	0.0%	0.1%	82.1%	2.8%	98.3%	0.0%	99.8%
IHP	0.0%	100.0%	0.0%	0.0%	0.0%	84.3%	1.2%	99.9%	0.0%	100.0%
MOL	0.0%	100.0%	0.0%	0.0%	0.0%	75.7%	0.3%	99.7%	0.0%	99.9%
PRE	0.0%	100.0%	0.0%	0.0%	0.0%	94.8%	0.3%	100.0%	0.0%	100.0%
PRS	0.0%	100.0%	0.0%	0.0%	0.0%	75.7%	0.5%	99.8%	0.0%	99.8%
SHP	0.0%	100.0%	0.0%	0.0%	0.0%	82.2%	2.1%	99.7%	0.0%	100.0%
STW	0.0%	100.0%	0.0%	100.0%	0.0%	83.2%	1.8%	99.6%	0.0%	99.9%
SUN	0.0%	100.0%	0.0%	0.0%	0.0%	80.9%	1.0%	99.7%	0.0%	99.9%
UHP	0.0%	100.0%	0.0%	0.0%	0.0%	80.6%	1.1%	99.6%	0.0%	100.0%
VHP	0.0%	100.0%	0.0%	0.0%	0.0%	87.5%	0.7%	99.1%	0.0%	99.9%
VIS	0.0%	100.0%	0.0%	0.0%	0.0%	78.0%	0.7%	99.9%	0.0%	100.0%
All Plans	**0.0%**	**100.0%**	**0.0%**	**29.0%**	**0.0%**	**79.8%**	**1.3%**	**99.6%**	**0.0%**	**99.9%**

Note: Valid values with percentages greater than 99.99 percent were rounded to 100 percent.
- Denotes that all records had missing values for this data element; therefore, the validity could not be assessed.
-- Denotes that no data were received from the plan.
* Denotes that the plan had less than 30 records. Caution should be used when interpreting the results.
[1] PDHPs do not cover pharmacy and have limited inpatient and outpatient services.
[2] PMHPs do not cover dental and pharmacy services.
[3] This CWPMHP is a statewide, specialized PMHP that addresses the complex needs of Medicaid-eligible children who are receiving specific services from the Department of Children and Families. As such, utilization of services may be higher than for other PMHPs.
[4] These specialty health plans enroll HIV-positive/AIDS members. As such, utilization of services may appear higher than for plans that enroll a mix of users and non-users.
[5] These plans submit limited encounter data.

Table E-11—Percentage of Pharmacy Records With Missing or Valid Values (cont.)				
	Paid Date		Dispensed Date	
Plan	Missing	Valid	Missing	Valid
Prepaid Dental Health Plans[1]				
DTQ	0.0%	100.0%	0.0%	100.0%
MDP	0.0%	100.0%	0.0%	100.0%
Prepaid Mental Health Plans[2]				
ABH*	0.0%	100.0%	0.0%	100.0%
FHP	0.0%	100.0%	0.0%	100.0%
MBH	0.0%	100.0%	0.0%	100.0%
Child Welfare Prepaid Mental Health Plan[3]				
CBC	0.0%	100.0%	0.0%	100.0%
Specialty Plans[4]				
CHA	0.0%	100.0%	0.0%	100.0%
PHC	0.0%	100.0%	0.0%	100.0%
Managed Care Plans				
AMG	0.0%	100.0%	0.0%	100.0%
BET[5]	0.0%	100.0%	0.0%	100.0%
FCA*,[5]	0.0%	100.0%	0.0%	100.0%
FRE	0.0%	100.0%	0.0%	100.0%
HEA	0.0%	100.0%	0.0%	100.0%
HUM	0.0%	100.0%	0.0%	100.0%
IHP	0.0%	100.0%	0.0%	100.0%
MOL	0.0%	100.0%	0.0%	100.0%
PRE	0.0%	100.0%	0.0%	100.0%
PRS	0.0%	100.0%	0.0%	100.0%
SHP	0.0%	100.0%	0.0%	100.0%
STW	0.0%	100.0%	0.0%	100.0%
SUN	0.0%	100.0%	0.0%	100.0%
UHP	0.0%	100.0%	0.0%	100.0%
VHP	0.0%	100.0%	0.0%	100.0%
VIS	0.0%	100.0%	0.0%	100.0%
All Plans	**0.0%**	**100.0%**	**0.0%**	**100.0%**

Note: Valid values with percentages greater than 99.99 percent were rounded to 100 percent.
- Denotes that all records had missing values for this data element; therefore, the validity could not be assessed.
-- Denotes that no data were received from the plan.
* Denotes that the plan had less than 30 records. Caution should be used when interpreting the results.

[1] PDHPs do not cover pharmacy and have limited inpatient and outpatient services.
[2] PMHPs do not cover dental and pharmacy services.
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[4] These specialty health plans enroll HIV-positive/AIDS members. As such, utilization of services may appear higher than for plans that enroll a mix of users and non-users.
[5] These plans submit limited encounter data.

Medical Record Review

Table E-12 shows the overall results for record submissions by plan.

Table E-12—Medical Record Submission

	Sample Size			Records Submitted		
Plan	Total	Matched Plan Assignment	Unmatched Plan Assignment	Total	Matched Plan Assignment	Unmatched Plan Assignment
AMG	20	8	12	17	8	9
FRE	3	3	0	3	3	0
HEA	8	7	1	8	7	1
HUM	9	0	9	8	0	8
IHP	6	2	4	5	1	4
MOL	5	2	3	5	2	3
PHC	2	0	2	0	0	0
PRE	5	1	4	5	1	4
PRS	11	8	3	11	8	3
SHP	4	3	1	3	3	0
STW	18	17	1	13	12	1
SUN	18	10	8	16	10	6
UHP	17	4	13	16	4	12
VHP	2	0	2	2	0	2
VIS	2	0	2	2	0	2
All Plans	**130**	**65**	**65**	**114**	**59**	**55**

Encounter Data Completeness

Date of Service Medical Record Omission

Table E-13 shows the overall results for Date of Service completeness by plan.

Table E-13—Date of Service Completeness					
		Medical Record Omission		Medical Record Agreement	
Plan	Date of Service Identified in Encounter Data	Number Without Supporting Documentation in Medical Record	Percent	Number With Supporting Documentation in Medical Record	Percent
AMG	20	3	15.0%	17	85.0%
FRE	3	0	0.0%	3	100.0%
HEA	8	0	0.0%	8	100.0%
HUM	9	2	22.2%	7	77.8%
IHP	6	1	16.7%	5	83.3%
MOL	5	0	0.0%	5	100.0%
PHC	2	2	100.0%	0	0.0%
PRE	5	0	0.0%	5	100.0%
PRS	11	0	0.0%	11	100.0%
SHP	4	1	25.0%	3	75.0%
STW	18	5	27.8%	13	72.2%
SUN	18	3	16.7%	15	83.3%
UHP	17	1	5.9%	16	94.1%
VHP	2	0	0.0%	2	100.0%
VIS	2	0	0.0%	2	100.0%
All Plans	**130**	**18**	**13.8%**	**112**	**86.2%**

Diagnosis Code Medical Record Omission and Encounter Data Omission

Table E-14 shows the overall results for Diagnosis Code completeness by plan.

Table E-14—Diagnosis Code Completeness						
	Medical Record Omission			Encounter Data Omission		
Plan	Number of Diagnoses Identified in Encounter Data	Number Without Supporting Documentation in Medical Record	Percent	Number of Diagnoses Identified in Medical Records	Number With No Evidence of Submission in Encounter Data	Percent
AMG	35	11	31.4%	39	15	38.5%
FRE	4	0	0.0%	4	0	0.0%
HEA	10	0	0.0%	21	11	52.4%
HUM	9	2	22.2%	7	0	0.0%
IHP	8	2	25.0%	8	2	25.0%
MOL	9	0	0.0%	10	1	10.0%
PHC	2	2	100.0%	N/A	N/A	N/A
PRE	12	0	0.0%	14	2	14.3%
PRS	18	3	16.7%	23	8	34.8%
SHP	7	4	57.1%	3	0	0.0%
STW	30	12	40.0%	24	6	25.0%
SUN	38	5	13.2%	36	3	8.3%
UHP	28	3	10.7%	29	4	13.8%
VHP	2	0	0.0%	3	1	33.3%
VIS	3	1	33.3%	2	0	0.0%
All Plans	**215**	**45**	**20.9%**	**223**	**53**	**23.8%**

Note: N/A indicates that a rate could not be calculated for a plan; PHC submitted no medical record documentation for the study.

Procedure Code Medical Record Omission and Encounter Data Omission

Table E-15 shows the overall results for Procedure Code completeness by plan.

Table E-15—Procedure Code Completeness						
	Medical Record Omission			Encounter Data Omission		
Plan	Number of Procedures Identified in Encounter Data	Number Without Any Supporting Documentation in Medical Record	Percent	Number of Procedures Identified in Medical Records	Number With No Evidence of Submission in the Encounter Data	Percent
AMG	55	15	27.3%	52	12	23.1%
FRE	5	0	0.0%	5	0	0.0%
HEA	20	1	5.0%	31	12	38.7%
HUM	10	2	20.0%	8	0	0.0%
IHP	7	1	14.3%	11	5	45.5%
MOL	10	4	40.0%	7	1	14.3%
PHC	2	2	100.0%	N/A	N/A	N/A
PRE	9	0	0.0%	12	3	25.0%
PRS	20	2	10.0%	26	8	30.8%
SHP	5	2	40.0%	3	0	0.0%
STW	45	13	28.9%	34	2	5.9%
SUN	31	7	22.6%	30	6	20.0%
UHP	28	5	17.9%	27	4	14.8%
VHP	2	0	0.0%	2	0	0.0%
VIS	6	2	33.3%	4	0	0.0%
All Plans	**255**	**56**	**22.0%**	**252**	**53**	**21.0%**

Note: N/A indicates that a rate could not be calculated for a plan; PHC did not submit any medical record documentation for the study.

Procedure Code Modifier Medical Record Omission and Encounter Data Omission

Table E-16 shows the overall results for Procedure Code Modifiers completeness by plan.

Table E-16—Procedure Code Modifiers Completeness						
	Medical Record Omission			Encounter Data Omission		
Plan	Number of Procedure Code Modifiers Identified in Encounter Data	Number Without Supporting Documentation in Medical Record	Percent	Number of Procedure Code Modifiers Identified in Medical Records	Number With No Evidence of Submission in the Encounter Data	Percent
AMG	15	10	66.7%	12	7	58.3%
FRE	1	0	0.0%	2	1	50.0%
HEA	1	0	0.0%	6	5	83.3%
HUM	N/A	N/A	N/A	N/A	N/A	N/A
IHP	N/A	N/A	N/A	1	1	100.0%
MOL	1	1	100.0%	1	1	100.0%
PHC	1	1	100.0%	N/A	N/A	N/A
PRE	2	0	0.0%	3	1	33.3%
PRS	3	0	0.0%	6	3	50.0%
SHP	N/A	N/A	N/A	N/A	N/A	N/A
STW	5	3	60.0%	6	4	66.7%
SUN	1	1	100.0%	1	1	100.0%
UHP	6	5	83.3%	4	3	75.0%
VHP	1	0	0.0%	2	1	50.0%
VIS	2	2	100.0%	N/A	N/A	N/A
All Plans	**39**	**23**	**59.0%**	**44**	**28**	**63.6%**

Note: N/A indicates that a rate could not be calculated for a plan since no procedure code modifiers were present in the encounter data or the medical records. PHC did not submit any medical record documentation for the study.

Encounter Data Accuracy

Diagnosis Code Accuracy

Table E-17 shows the overall results for Diagnosis Code accuracy by plan.

Table E-17—Diagnosis Code Accuracy Rates and Types of Error						
	Accuracy Results			Error Types		
Plan	Number of Diagnoses Present in Both Sources	Validated by Medical Records	Percent	Number of Invalid Diagnoses	Percent from Inaccurate Code	Percent from Specificity Error
AMG	24	21	87.5%	3	100.0%	0.0%
FRE	4	4	100.0%	0	N/A	N/A
HEA	10	10	100.0%	0	N/A	N/A
HUM	7	7	100.0%	0	N/A	N/A
IHP	6	6	100.0%	0	N/A	N/A
MOL	9	8	88.9%	1	100.0%	0.0%
PHC	N/A	N/A	N/A	N/A	N/A	N/A
PRE	12	8	66.7%	4	100.0%	0.0%
PRS	15	15	100.0%	0	N/A	N/A
SHP	3	3	100.0%	0	N/A	N/A
STW	18	17	94.4%	1	100.0%	0.0%
SUN	33	31	93.9%	2	100.0%	0.0%
UHP	25	21	84.0%	4	100.0%	0.0%
VHP	2	2	100.0%	0	N/A	N/A
VIS	2	1	50.0%	1	100.0%	0.0%
All Plans	**170**	**154**	**90.6%**	**16**	**100.0%**	**0.0%**

Note: N/A indicates that a rate could not be calculated for a plan—i.e., no valid diagnosis codes were identified or the plan did not submit any medical record documentation for the study.

Procedure Code Accuracy

Table E-18 shows the overall results for Procedure Code accuracy by plan.

Table E-18—Procedure Code Accuracy Rates and Types of Error

	Accuracy Results			Error Types				
Plan	Number of Procedures Present in Both Sources	Validated by Medical Records	Percent	Total Number of Invalid Codes	Percent from Inaccurate Code	Percent from Higher Level of Services in Medical Records	Percent from Lower Level of Services in Medical Records	Percent from Inaccurate Units
AMG	40	35	87.5%	5	40.0%	0.0%	60.0%	0.0%
FRE	5	5	100.0%	0	N/A	N/A	N/A	N/A
HEA	19	19	100.0%	0	N/A	N/A	N/A	N/A
HUM	8	2	25.0%	6	33.3%	0.0%	66.7%	0.0%
IHP	6	4	66.7%	2	50.0%	0.0%	0.0%	50.0%
MOL	6	5	83.3%	1	0.0%	0.0%	100.0%	0.0%
PHC	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A
PRE	9	8	88.9%	1	100.0%	0.0%	0.0%	0.0%
PRS	18	16	88.9%	2	100.0%	0.0%	0.0%	0.0%
SHP	3	3	100.0%	N/A	N/A	N/A	N/A	N/A
STW	32	29	90.6%	3	100.0%	0.0%	0.0%	0.0%
SUN	24	22	91.7%	2	50.0%	50.0%	0.0%	0.0%
UHP	23	21	91.3%	2	50.0%	0.0%	50.0%	0.0%
VHP	2	0	0.0%	2	50.0%	0.0%	50.0%	0.0%
VIS	4	4	100.0%	N/A	N/A	N/A	N/A	N/A
All Plans	**199**	**173**	**86.9%**	**26**	**53.8%**	**3.8%**	**38.5%**	**3.8%**

Note: N/A indicates that a rate could not be calculated for a plan—i.e., no valid procedure codes were identified or the plan did not submit any medical record documentation for the study.

Procedure Code Modifier Accuracy

Table E-19 shows the overall results for Procedure Code Modifier accuracy by plan.

Table E-19—Procedure Code Modifier Accuracy			
	Accuracy Results		
Plan	Number of Modifiers Present in Both Sources	Validated by Medical Records	Percent
AMG	5	3	60.0%
FRE	1	1	100.0%
HEA	1	1	100.0%
HUM	N/A	N/A	N/A
IHP	N/A	N/A	N/A
MOL	N/A	N/A	N/A
PHC	N/A	N/A	N/A
PRE	2	2	100.0%
PRS	3	3	100.0%
SHP	N/A	N/A	N/A
STW	2	2	100.0%
SUN	N/A	N/A	N/A
UHP	1	1	100.0%
VHP	1	1	100.0%
VIS	N/A	N/A	N/A
All Plans	**16**	**14**	**87.5%**

Note: N/A indicates that a rate could not be calculated for a plan—i.e., no procedure code modifiers were identified or the plan did not submit any medical record documentation for the study.

Overall Completeness and Accuracy Composite

Table E-20 shows the overall results for Overall Completeness and Accuracy by plan.

Table E-20—Overall Completeness and Accuracy Rates			
Plan	**Number of Validated Dates of Service Identified in Encounter Data**	**Number of Dates of Service With Same Values For All Key Data Elements**	**Percent**
AMG	17	4	23.5%
FRE	3	2	66.7%
HEA	8	2	25.0%
HUM	7	1	14.3%
IHP	5	2	40.0%
MOL	5	2	40.0%
PHC	N/A	N/A	N/A
PRE	5	0	0.0%
PRS	11	2	18.2%
SHP	3	1	33.3%
STW	13	5	38.5%
SUN	15	9	60.0%
UHP	16	7	43.8%
VHP	2	0	0.0%
VIS	2	0	0.0%
All Plans	**112**	**37**	**33.0%**

Note: N/A indicates that a rate could not be calculated for a plan; PHC submitted no medical record documentation for the study.

Appendix F. Plan Names

Table F-1 includes the list of plans that were reviewed by HSAG for PIPs. From left to right, the table includes the plan type, the full plan name, the three-to-five letter plan code that is used in tables and graphs, and the plan shortened name.

Table F-1—SFY 2013–2014 Plan-Approved Naming Convention for the PIPs

Plan Type	Full Plan Name	3-Letter Code	Shortened Name
HMO	AHF MCO of Florida, Inc. dba Positive Healthcare Florida (Non-Reform)	POS-N	Positive
HMO	AHF MCO of Florida, Inc. dba Positive Healthcare Florida (Reform)	POS-R	Positive-R
HMO	Amerigroup Community Care (Non-Reform)	AMG-N	Amerigroup
HMO	Clear Health Alliance (Non-Reform)	CHA	Clear Health
HMO	Clear Health Alliance (Reform)	CHA-R	Clear Health-R
HMO	Coventry Health Care of Florida, Inc.—Buena Vista	VIS-N	Buena Vista
HMO	Coventry Health Care of Florida, Inc. —VISTA	VSF-N	VISTA
HMO	Florida Healthcare Plus, Inc.	FHP	FL Healthcare
HMO	Florida True Health (Non-Reform)	FTH	TrueHealth
HMO	Freedom Health, Inc. (Non-Reform)	FRE-N	Freedom
HMO	Freedom Health, Inc. (Reform)	FRE-R	Freedom-R
HMO	Healthy Palm Beaches, Inc.	HPB-N	Healthy PB
HMO	Humana Family c/o Humana Medical Plan, Inc. (Non-Reform)	HUM-N	Humana
HMO	Humana Family c/o Humana Medical Plan, Inc. (Reform)	HUM-R	Humana-R
HMO	Magellan Complete Care (Non-Reform)	MCC	Magellan
HMO	Medica Health Plans of Florida (Non-Reform)	MHP-N	Medica
HMO	Medica Health Plans of Florida (Reform)	MHP-R	Medica-R
HMO	Molina Healthcare of Florida (Non-Reform)	MOL-N	Molina
HMO	Molina Healthcare of Florida (Reform)	MOL-R	Molina-R
HMO	Preferred Care Partners dba CareFlorida (Non-Reform)	CFL-N	Preferred Care
HMO	Preferred Care Partners dba CareFlorida (Reform)	CFL-R	Preferred Care-R
HMO	Preferred Medical Plan, Inc. (Non-Reform)	PRE-N	Preferred
HMO	Simply Healthcare Plans (Non-Reform)	SHP-N	Simply Healthcare
HMO	Simply Healthcare Plans (Reform)	SHP-R	Simply Healthcare-R
HMO	Sunshine State Health Plan (Non-Reform)	SUN-N	Sunshine
HMO	Sunshine State Health Plan (Reform)	SUN-R	Sunshine-R
HMO	UnitedHealthcare Community Plan (Non-Reform)	URA-N	United
HMO	UnitedHealthcare Community Plan (Reform)	URA-R	United-R
HMO	United Healthcare of Florida, Inc.—Evercare at Home	URE-N	Evercare at Home
HMO	WellCare Health Plans, Inc.—HealthEase of Florida, Inc. (Non-Reform)	HEA-N	HealthEase
HMO	WellCare Health Plans, Inc.—Staywell of Florida, Inc. (Non-Reform)	STW-N	Staywell
HMO	WellCare Health Plans, Inc.—Staywell of Florida, Inc. (Reform)	STW-R	Staywell-R

Table F-1—SFY 2013–2014 Plan-Approved Naming Convention for the PIPs			
Plan Type	**Full Plan Name**	**3-Letter Code**	**Shortened Name**
PDHP	DentaQuest of Florida	DQT	DentaQuest
PDHP	MCNA Dental Plans	MDP	MCNA
CWPMHP	Community Based Care Partnership	CBC	CBC Partnership
PMHP	Florida Health Partners (Area 5)	FHP-5	Florida HP (A5)
PMHP	Florida Health Partners (Area 6)	FHP-6	Florida HP (A6)
PMHP	Florida Health Partners (Area 7)	FHP-7	Florida HP (A7)
PMHP	Florida Health Partners (Area 8)	FHP-8	Florida HP (A8)
PMHP	North Florida Behavioral Health Partners (Area 3)	NFHP-3	North Florida (A3)
PMHP	Jackson Health System/Public Health Trust of Dade County (Area 11)	PHT-11	Public Health Trust (A11)
PMHP	Lakeview Center dba Access Behavioral Health (Area 1)	ABH-1	Access (A1)
PMHP	Magellan Behavioral Health of Florida, Inc. (Area 2)	MAG-2	Magellan (A2)
PMHP	Magellan Behavioral Health of Florida, Inc. (Area 4)	MAG-4	Magellan (A4)
PMHP	Magellan Behavioral Health of Florida, Inc. (Area 9)	MAG-9	Magellan (A9)
PMHP	Magellan Behavioral Health of Florida, Inc. (Area 11)	MAG-11	Magellan (A11)
PSN	Better Health (Non-Reform)	BET-N	Better Health
PSN	Better Health (Reform)	BET-R	Better Health-R
PSN	Care Access PSN (Non-Reform)	CAP-N	Care Access
PSN	Children's Medical Services—Broward (Reform)	CMB-R	CMS-Broward
PSN	Children's Medical Services—Duval (Reform)	CMD-R	CMS-Duval
PSN	First Coast Advantage, LLC (Non-Reform)	UFS-N	First Coast
PSN	First Coast Advantage, LLC (Reform)	UFS-R	First Coast-R
PSN	Integral Quality Care (Non-Reform)	IQC-N	Integral
PSN	Prestige Health Choice (Non-Reform)	PRS-N	Prestige
PSN	Salubris (Non-Reform)	SAL-N	Salubris
PSN	South Florida Community Care Network (Non-Reform)	SFC-N	SFCCN
PSN	South Florida Community Care Network (Reform)	SFC-R	SFCCN-R
SIPP	Alternate Family Care	AFC	Alternate Family Care
SIPP	BayCare Behavioral Health, Inc.	BAY	BayCare
SIPP	Citrus Health Network, Inc.—CATS	CHN-C	Citrus-C
SIPP	Citrus Health Network, Inc.—RITS	CHN-R	Citrus-R
SIPP	Daniel Memorial, Inc.	DMI	Daniel Memorial
SIPP	Devereux Orlando	DXO	Devereux-O
SIPP	Jackson Memorial Hospital	JXM	Jackson
SIPP	Lakeview Center, Inc.	LCI	Lakeview
SIPP	Manatee Palms Youth Services	MPY	Manatee Palms
SIPP	Sandy Pines	SPS	Sandy Pines
SIPP	The Vines	TVS	The Vines
SIPP	University Behavioral Center	UBC	University Behavioral

Table F-2 includes the list of plans that were reviewed by HSAG for PMVs. The plans are grouped according to type. For HMOs and PSNs, from left to right, the table includes the full plan name; the plan shortened name; the three-to-five letter plan code that is used in tables and graphs; and classification (Reform, Non-Reform, or Both). For PMHPs/CWPMHP, LTC plans, and PDHPs, the full name is listed, followed by the short name and abbreviation.

Table F-2—SFY 2013–2014 Plan Approved Naming Convention for the PMVs

Plan Name	Shortened Name	Plan Abbreviation	Reform and/or Non-Reform
HMOs			
AHF MCO of Florida, Inc. dba Positive Healthcare Florida	Positive	POS	Both
Amerigroup Community Care	Amerigroup	AMG	Non-Reform
Clear Health Alliance	Clear Health	CHA	Both
Coventry Health Care of Florida, Inc.—Buena Vista	Buena Vista	VIS	Non-Reform
Coventry Health Plan of Florida, Inc.—VISTA	VISTA	VSF	Non-Reform
Florida Healthcare Plus	FL Healthcare	FHP	Non-Reform
Florida True Health	TrueHealth	FTH	Non-Reform
Freedom Health, Inc.	Freedom	FRE	Both
Healthy Palm Beaches, Inc.	Healthy PB	HPB	Non-Reform
Humana Family c/o Humana Medical Plan, Inc.	Humana	HUM	Both
Magellan Complete Care	Magellan	MCC	Reform
Medica Health Plans of Florida	Medica	MHP	Both
Molina Healthcare of Florida	Molina	MOL	Both
Preferred Care Partners dba CareFlorida	CareFlorida	CFL	Both
Preferred Medical Plan, Inc.	Preferred	PRE	Non-Reform
Simply Healthcare Plans	Simply Healthcare	SHP-N	Non-Reform
Sunshine State Health Plan	Sunshine	SUN	Both
UnitedHealthcare Community Plan	United	URA	Both
WellCare Health Plans, Inc.—HealthEase	HealthEase	HEA	Non-Reform
WellCare Health Plans, Inc.—Staywell	Staywell	STW	Both
PSNs			
Better Health	Better Health	BET	Reform
Children's Medical Services	CMS	CMS	Reform
First Coast Advantage, LLC	First Coast	UFS	Both

Table F-2—SFY 2013–2014 Plan Approved Naming Convention for the PMVs			
First Coast Advantage Central	First Coast Central	CEN	Non-Reform
Integral Quality Care	Integral	IQC	Non-Reform
Prestige Health Choice	Prestige	PRS	Non-Reform
Salubris	Salubris	SAL	Non-Reform
South Florida Community Care Network	SFCCN	SFC	Both
PMHPs/CWPMHP	**Shortened Name**		**Plan Abbreviation**
Florida Health Partners (Area 5)	Florida HP (A5)		FHP-5
Florida Health Partners (Area 6)	Florida HP (A6)		FHP-6
Florida Health Partners (Area 7)	Florida HP (A7)		FHP-7
Florida Health Partners (Area 8)	Florida HP (A8)		FHP-8
Jackson Health System/Public Health Trust of Dade County (Area 11)	Public Health Trust (A11)		PHT-11
Lakeview Center dba Access Behavioral Health (Area 1)	Access (A1)		ABH-1
Magellan Behavioral Health of Florida, Inc. (Area 2)	Magellan (A2)		MAG-2
Magellan Behavioral Health of Florida, Inc. (Area 4)	Magellan (A4)		MAG-4
Magellan Behavioral Health of Florida, Inc. (Area 9)	Magellan (A9)		MAG-9
Magellan Behavioral Health of Florida, Inc. (Area 11)	Magellan (A11)		MAG-11
North Florida Behavioral Health Partners (Area 3)	North Florida (A3)		NFHP-3
LTC Plans	**Shortened Name**		**Plan Abbreviation**
American Eldercare, Inc.	American Eldercare-LTC		AEC-L
Amerigroup Community Care	Amerigroup-LTC		AMG-L
Coventry Health Care of Florida, Inc.	Coventry-LTC		COV-L
Humana Medical Plan, Inc.	Humana-LTC		HUM-L
Molina HealthCare of Florida, Inc.	Molina-LTC		MOL-L
Sunshine State Health Plan, Inc.	Sunshine-LTC		SUN-L
United HealthCare of Florida, Inc.	United-LTC		URA-L
PDHPs	**Shortened Name**		**Plan Abbreviation**
DentaQuest of Florida	DentaQuest		DQT
MCNA Dental Plans	MCNA		MDP

Table F-3 displays the list of plans that were reviewed by HSAG for the EDV activities, including a subset of plans evaluated in the Medical Record Review. The plans are grouped according to type showing the plan name followed by the abbreviation.

Table F-3—SFY 2013–2014 Plan Approved Naming Convention for the EDV Reports	
Plan Name	**Plan Abbreviation**
Prepaid Dental Health Plans	
DentaQuest	DTQ
MCNA Dental Plan	MDP
Prepaid Mental Health Plans	
Access Behavioral Health	ABH
Florida Health Partners	FHP
Magellan Behavioral Health of Florida	MBH
Child Welfare Prepaid Mental Health Plan	
Community Based Care Partnership	CBC
Specialty Plans	
Clear Health Alliance (Simply)	CHA
Positive HealthCare*	PHC
Managed Care Plans	
Amerigroup*	AMG
Better Health, LLC	BET
Buena Vista*	VIS
First Coast Advantage Central, LLC	FCA
Freedom*	FRE
Healthease*	HEA
Humana Family*	HUM
Integral*	IHP
Molina Healthcare of Florida, Inc.*	MOL
Preferred Medical Plan, Inc.*	PRE
Prestige Health Choice*	PRS
Simply Healthcare Plans, Inc.*	SHP
Staywell*	STW
Sunshine*	SUN
United Evercare / United Healthcare Plan *	UHP
Vista Healthplan of South Florida*	VHP
* Indicates those plans that were included in the Medical Record Review	