Florida Agency for Health Care Administration

SFY 2015–2016 External Quality Review Technical Report

April 2017

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

Acronyms

AAAHC ..... Accreditation Association for Ambulatory Health Care
AAP ..... *Adults' Access to Preventive/Ambulatory Health Services*
ABA ..... *Adult BMI Assessment*
ACE ..... Angiotensin Converting Enzyme
ADD ..... *Follow-Up Care for Children Prescribed ADHD Medication*
ADHD ..... Attention-deficit/Hyperactivity Disorder
ADV ..... *Annual Dental Visit*
AHCA ..... Florida Agency for Health Care Administration
AIDS ..... Acquired Immunodeficiency Syndrome
ALF ..... Assisted Living Facility
AMB ..... *Ambulatory Care*
AMM ..... *Antidepressant Medication Management*
ANDP ..... Annual Network Development Plan
ANT ..... *Antenatal Steroids*
APC ..... *Use of Multiple Concurrent Antipsychotics in Children and Adolescents*
APM ..... *Metabolic Monitoring for Children and Adolescents on Antipsychotics*
ARB ..... Angiotensin Receptor Blockers
ASR ..... Achieved Savings Rebate
AWC ..... *Adolescent Well-Care Visits*
BBA ..... Balanced Budget Act of 1997
BCS ..... *Breast Cancer Screening*
BMI ..... Body Mass Index
BR ..... *Biased Rate*
CAB ..... *Call Abandonment*
CAHPS ..... Consumer Assessment of Healthcare Providers and Systems
CAP ..... *Children and Adolescents' Access to Primary Care Practitioners*
CAP ..... Corrective Action Plan
CAT ..... *Call Answer Timeliness*
CBP ..... *Controlling High Blood Pressure*
CCP ..... Cultural Competency Program
CCS ..... *Cervical Cancer Screening*
CDC ..... *Comprehensive Diabetes Care*
CDT ..... Code on Dental Procedures and Nomenclature
CEAC ..... Counties with Extreme Access Considerations
CFA ..... *Care for Adults*
CFR ..... Code of Federal Regulations
CHCUP ..... Child Health Check-Up
CHL ..... *Chlamydia Screening in Women*
CIS ..... *Childhood Immunization Status*
CLAS ..... Culturally and Linguistically Appropriate Services

CMS ..... Centers for Medicare & Medicaid Services
CMT ..... *Case Manager Training*
COA ..... *Care for Older Adults*
CPT ..... Current Procedural Terminology
CQS ..... Comprehensive Quality Strategy
CWPMHP ..... Child Welfare Prepaid Mental Health Plan
CY ..... Calendar Year
DCF ..... Florida Department of Children and Families
DEVSCR ..... *Developmental Screening in the First Three Years of Life*
DOEA ..... Department of Elder Affairs
DSS ..... Decision Support System
E & M ..... Evaluation and Management
EAPG ..... Enhanced Ambulatory Patient Grouping
EDV ..... Encounter Data Validation
EPSDT ..... Early and Periodic Screening, Diagnostic, and Treatment
EQR ..... External Quality Review
EQRO ..... External Quality Review Organization
F2F ..... *Face-to-Face Encounters*
F.A.C ..... Florida Administrative Code
FAR ..... Final Audit Report
FPC ..... *Frequency of Prenatal Care* (formerly *Prenatal Care Frequency [PCF]*)
FFS ..... Fee-for-Service
FHM ..... *Follow-Up After Hospitalization for Mental Illness*
FLEX ..... Florida Encounter Exchange
FMEA ..... Failure Modes and Effects Analysis
FMMIS ..... Florida's Medicaid Management Information System
F.S ..... Florida Statutes
HAART ..... *Highly Active Anti-Retroviral Treatment*
HbA1c ..... Hemoglobin A1c
HCFA ..... Health Care Financing Administration
HCPCS ..... Healthcare Common Procedure Coding System
HEDIS ..... Healthcare Effectiveness Data and Information Set
HIV ..... Human Immunodeficiency Virus
HIVV ..... *HIV-Related Outpatient Medical Visits*
HMO ..... Health Maintenance Organization
HP ..... Hewlett-Packard
HPV ..... *Human Papillomavirus Vaccine for Female Adolescents*
HPV ..... Human Papillomavirus
HSAG ..... Health Services Advisory Group, Inc.
HSD ..... Health Services Delivery
ICN ..... Internal Control Number

ID ..... Identification
IET ..... *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
IMA ..... *Immunizations for Adolescents*
IS ..... Information Systems
LDL-C ..... Low-density Lipoprotein Cholesterol
LO ..... Licensed Organization
LSC ..... *Lead Screening in Children*
LTC ..... Long-term Care
MA ..... Medicare Advantage
MBHO ..... Managed Behavioral Health Organization
MCO ..... Managed Care Organization
MediPass ..... Medicaid Provider Access System
MM ..... Member Months
MMA ..... Managed Medical Assistance
MMA ..... *Medication Management for People With Asthma*
MPM ..... *Annual Monitoring for Patients on Persistent Medications*
MRR ..... Medical Record Review
MRRV ..... Medical Record Review Validation
MSC ..... *Medical Assistance With Smoking and Tobacco Use Cessation*
N/A ..... *Not Applicable*
N/S ..... *Not Scored*
NB ..... *No Benefit*
NCCC ..... National Center for Cultural Competence
NCQA ..... National Committee for Quality Assurance
NDC ..... *National Drug Code*
NPI ..... National Provider Identifier
NR ..... *Not Reported*
PAHP ..... Prepaid Ambulatory Health Plan
PCCM ..... Primary Care Case Management
PCF ..... *Prenatal Care Frequency*
PCP ..... Primary Care Practitioner
PCR-AD ..... *Plan All-Cause Readmissions*
PDENT ..... *Preventive Dental Services*
PDHP ..... Prepaid Dental Health Plan
PDSA ..... Plan-Do-Study-Act
PIHP ..... Prepaid Inpatient Health Plan
PIP ..... Performance Improvement Project
PMHP ..... Prepaid Mental Health Plan
PMPM ..... Per Member Per Month
PMV ..... Performance Measure Validation
PNV ..... Provider Network Verification

PPC ..... *Prenatal and Postpartum Care*
PSN ..... Provider Service Network
Q & A ..... Question and Answer
QAIS ..... Quality Assessment and Improvement Strategy
QI ..... Quality Improvement
QM ..... Quality Management
RER ..... *Mental Health Readmission Rate*
Roadmap ..... Record of Administration, Date Management, and Processes
RRD ..... *Required Record Documentation*
SAA ..... *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
SEA ..... *Sealants*
SEAL ..... *Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk*
SFY ..... State Fiscal Year
SI ..... Study Indicator
SMC ..... *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia*
SMD ..... *Diabetes Monitoring for People with Diabetes and Schizophrenia*
SMI ..... Serious Mental Illness
SMMC ..... Statewide Medicaid Managed Care
SSD ..... *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications*
Td ..... Tetanus-Diphtheria
Tdap ..... Tetanus-Diphtheria-Pertussis
TDENT ..... *Dental Treatment Services*
TOS ..... *Timeliness of Service*
TRA ..... *Transportation Availability*
TRT ..... *Transportation Timeliness*
VLS ..... *Viral Load Suppression Among Person in HIV Medical Care*
W15 ..... *Well-Child Visits in the First 15 Months of Life*
W34 ..... *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC ..... *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*

1. Strategic Executive Summary

Overview and Scope of the External Quality Review

The Balanced Budget Act of 1997 (BBA), in accordance with the Section 1932(c) of the Social Security Act, states that "each contract with a Medicaid managed care organization shall 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 under the contract."[1]

The state fiscal year (SFY) 2015–2016 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.

This is the 10th year HSAG has produced the external quality review (EQR) report for the State of Florida. The information presented in this report does not disclose the identity of any individual, in accordance with 42 CFR §438.364(c).

This report presents findings from activities conducted in accordance with 42 CFR §438.352 and other quality activities. The data provided by AHCA were analyzed and conclusions and recommendations, as applicable, were identified as to the quality outcomes and timeliness of, and access to, care furnished to Medicaid enrollees by the Florida managed care organizations (MCOs).

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 improvement projects (PIPs) and validation of performance measures. 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 began its new three-year review cycle in SFY 2012–2013, which coincided with the implementation of the Statewide Medicaid Managed Care (SMMC) program. AHCA and the Department of Elder Affairs (DOEA) conducted readiness reviews, which included on-site reviews, of all MCOs under the new SMMC contract during SFY 2012–2013 and SFY 2013–2014. In SFY 2014–2015 AHCA monitored a segment of the federal managed care standards. AHCA began a new, three-year review cycle in SFY 2015–2016 that included various monitoring activities, as well as a partial review of the federal managed care standards.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Legislative Summary: Balanced Budget Act of 1997 Medicare and Medicaid Provisions - Sec. 1932. [42 U.S.C. 1396u–2](C)(2)(A).*

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.
- Hospital Network Adequacy Analysis—performed by HSAG.
- Child Health Check-Up (CHCUP) participation rates—data obtained from AHCA.
- Medicaid Health Plan Report Card—data obtained from AHCA.
- MCO accreditation results—data obtained from AHCA.

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 opportunities for improvement for 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.

CMS has chosen the domains of quality, access, and timeliness as keys to evaluating MCO performance. 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 final rule at 42 CFR §438.320 as follows:

> Quality, as it pertains to external quality review, means the degree to which an MCO [managed care organization] or PIHP [prepaid inpatient health plan] increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics, through provision of health services that are consistent with current professional knowledge, and interventions for performance improvement.[2]

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

Timeliness

Federal managed care regulations at 42 CFR §438.206 require the state to define its standards for timely access to care and services. These standards must take into account the urgency of the need for services. HSAG extends the definition of "timeliness" to include other federal managed care provisions that impact services to enrollees and that require timely response by the MCO/PIHP—e.g., processing expedited member grievances and appeals and providing timely follow-up care. In addition, 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 accommodate the clinical urgency of a situation." It further discusses the intent of this standard to minimize any disruption in the provision of healthcare.[3]

Access

CMS defines "access" in the final rule at 42 CFR §438.230 as follows:

> Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).

Under §438.206, availability of services means each state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs, and prepaid ambulatory health plans (PAHPs) in a timely manner. §438.68 requires that a state that contracts with an MCO or PIHP to deliver Medicaid services to develop and enforce network adequacy standards that are consistent with this section of the final rule.

Organizations Included in External Quality Review

In past years, AHCA included its various MCO, PIHP, and PAHP model types within the scope of the EQR; however, due to the SMMC transition in SFY 2014–2015, AHCA consolidated all plan types into the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) program. Under the MMA program, there are Standard plans and Specialty plans. The Specialty plans serve Medicaid enrollees with a distinct diagnosis or chronic condition.

AHCA is responsible for the administration of the Medicaid managed care program in Florida and has delegated responsibility for monitoring certain aspects of the LTC plans to DOEA. Prior technical reports have referred to health maintenance organizations (HMOs) and provider service networks (PSNs) that were identified as either Reform or Non-Reform. Reform referred to the Medicaid Reform

[3] National Committee for Quality Assurance. 2013 Standards and Guidelines for the Accreditation of Health Plans

Pilot Program that AHCA implemented in July 2006, operating under an 1115 Research and Demonstration Waiver approved by CMS. The initial waiver period was July 1, 2006, through June 30, 2011. In December 2011, CMS approved Florida's three-year waiver extension request, extending the demonstration through June 30, 2014.

In June 2013, CMS approved an amendment to the 1115 waiver, which changed the waiver from the Medicaid Reform waiver to the Medicaid Managed Medical Assistance waiver. On July 31, 2014, CMS approved a three-year waiver extension request, to extend the MMA demonstration through June 30, 2017.

For ease of reference, this report refers to the MMA Standard plans, MMA Specialty plans, and LTC plans as "plans." MMA plans include both Standard plans and Specialty plans. Throughout this report either shortened plan names or plan codes have been used when referencing a plan. Please refer to Appendix H for a comprehensive list of plan names, by plan type.

Summary of Findings, Conclusions, and Recommendations

Performance Improvement Project

During SFY 2015–2016, the MMA plans submitted four PIPs for validation, including two State-mandated topics, one additional nonclinical topic, and one additional clinical topic. For the additional clinical topic, the MMA plans were required to select a topic falling into one of three categories: a population health issue within a specific geographic area identified as in need of improvement (such as diabetes, hypertension, or asthma); integration of primary care and behavioral health; or reduction of preventable readmissions. The LTC plans submitted two PIPs for validation, including one State-mandated topic and one nonclinical topic. Comprehensive plans that offered services for both the MMA and LTC programs submitted six PIPs for validation, adhering to the PIP topic requirements for both programs. For some of the MMA Specialty plans, exceptions were made to the mandated PIP topics when the topic did not apply to the population served. The PIPs validated for SFY 2015–2016 had progressed through the Design stage (Activities I–VI) and Implementation stage (Activities VII and VIII) and reported baseline study indicator rates.

Table 1-1 displays the State-mandated PIP topics for the MMA plans and the LTC plans, as well as the status of each PIP topic.

Table 1-1—Current State-mandated PIP Topics

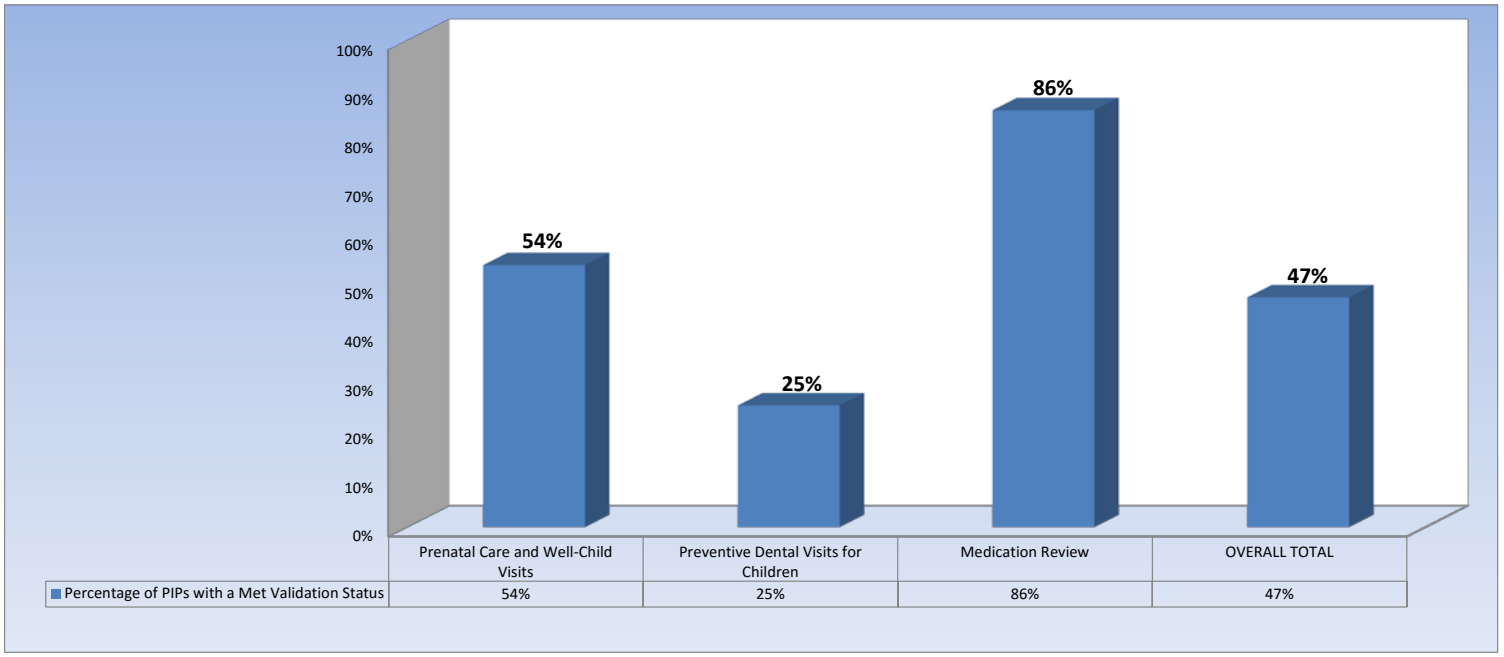
State-mandated PIP Topic	Plan Type	Status
Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	MMA	Baseline results reported
Preventive Dental Services for Children	MMA	Baseline results reported
Medication Review	LTC	Baseline results reported

Overall PIP Validation Status

HSAG validated PIPs submitted by all of the plans as required by the EQRO contract. The outcome of the validation process was an overall validation status finding for each PIP of *Met*, *Partially Met*, or *Not Met*.

Figure 1-1 displays the percentage of State-mandated PIPs achieving a *Met* overall validation status by plan type and PIP topic for PIPs submitted to AHCA on August 1, 2015, and validated by HSAG during SFY 2015–2016. Thirty-six of the 86 PIPs validated focused on one of the three State-mandated topics. The blue bars represent the percentage of PIPs with an overall validation status of *Met*.

Figure 1-1—Overall *Met* Validation Status of State-Mandated PIPs by PIP Topic



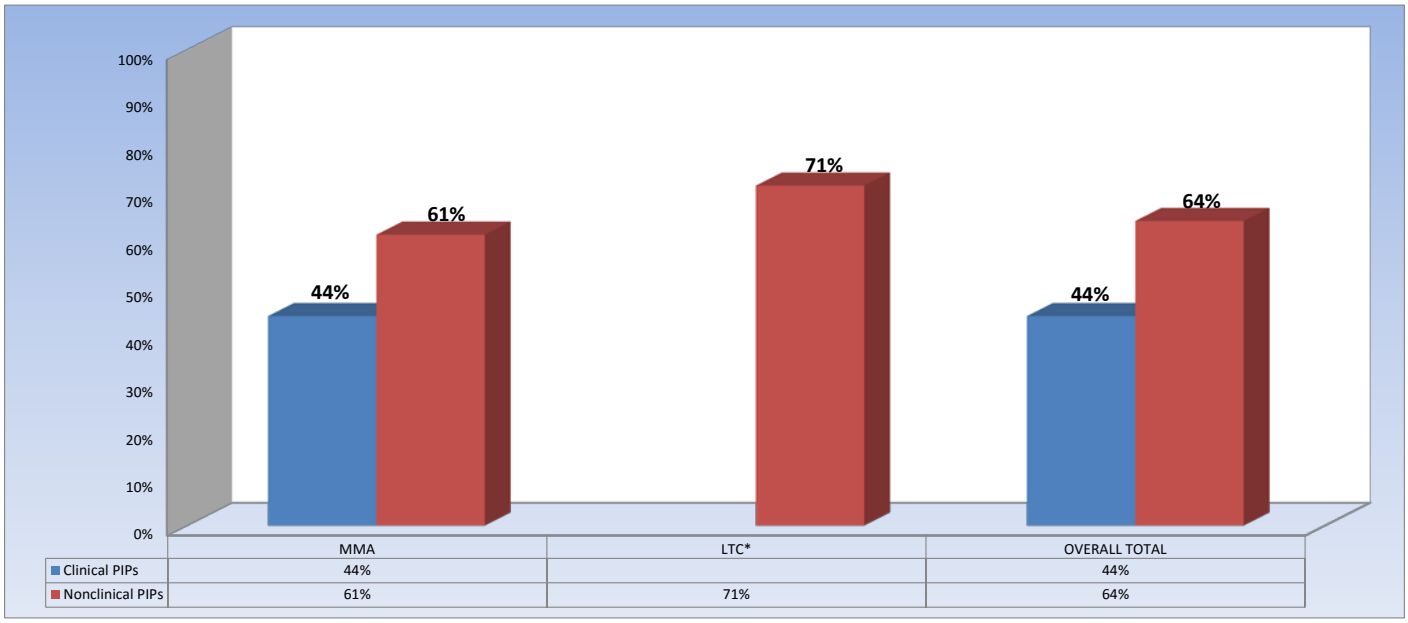
Across all State-mandated PIPs, 47 percent received an overall *Met* validation status. The percentage of PIPs receiving a *Met* validation status was highest for the *Medication Review* PIPs (86 percent). Slightly more than half (54 percent) of the *Improving Timeliness of Prenatal Care* and *Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIPs received a *Met* validation status, and only one-quarter (25 percent) of the *Preventive Dental Services for Children* PIPs received a *Met* validation status for the baseline PIP validation.

The State-mandated PIPs had progressed through the Design and Implementation stages for this year's validation; therefore, validation status was based on the study design of the PIP and the data analysis and quality improvement activities conducted for the baseline measurement period. The plans can improve their PIPs by reviewing and addressing HSAG's feedback in the PIP validation tools, reviewing the State-defined specifications for each State-mandated PIP topic, and requesting technical assistance from HSAG to address questions related to the PIP methodology and quality improvement tools and processes.

To address PIPs that did not receive a *Met* overall validation status for SFY 2015–2016, AHCA instituted an interim PIP review process and a quarterly PIP check-in process with the plans. For the interim review, AHCA instructed the plans to address all *Partially Met* and *Not Met* PIP validation scores, incorporating HSAG's validation feedback, and to submit the revised PIPs to AHCA for feedback. AHCA assessed the revised PIPs and provided further guidance to the plans, referring them to HSAG for additional technical assistance when needed. To support the plans in achieving an overall *Met* validation status across all PIP topics in future validation cycles, AHCA initiated a PIP check-in process in spring 2016. Through the check-in process, quality improvement teams from AHCA work together with each plan during quarterly one-on-one meetings to evaluate and enhance the plans' PIPs.

In addition to the 36 State-mandated PIPs referred to in Figure 1-1, HSAG validated 25 plan-selected clinical PIPs and 25 plan-selected nonclinical PIPs across the three plan types. Figure 1-2 displays the percentage of clinical and nonclinical PIPs achieving a *Met* overall validation status by plan type for the SFY 2015–2016 validation year. The blue bars represent the percentage of clinical PIPs with an overall validation status of *Met*, and the red bars represent the percentage of nonclinical PIPs with an overall validation status of *Met*.

Figure 1-2—Overall *Met* Validation Status of Plan-selected Clinical and Nonclinical PIPs by Plan Type



*HSAG did not validate any plan-selected clinical PIPs for the LTC plans for the SFY 2015–2016 validation year.

Across all plan types, 44 percent of the plan-selected clinical PIPs received an overall *Met* validation status compared to 64 percent of the plan-selected nonclinical PIPs. The pattern varied by plan type: for MMA plans, more nonclinical PIPs (61 percent) than clinical PIPs (44 percent) received a *Met* validation status. Compared to the MMA plans, the LTC plans had a greater percentage of nonclinical PIPs (71 percent) that received a *Met* validation status. The LTC plans did not submit any additional clinical PIPs for validation; therefore, only the percentage of nonclinical PIPs submitted by the LTC plans is illustrated in the figure.

As with the plans' performance on the State-mandated PIPs, the plan-selected clinical and nonclinical PIP validation results suggest room for improvement in the study designs and the quality improvement activities of the clinical and nonclinical PIPs. As the PIPs progress to the Outcomes stage, the plans should address deficiencies in the Design and Implementation stages to provide a solid foundation for achieving improvement in the study indicator rates. The plans have access to HSAG feedback and guidance in the PIP validation tools and the PIP completion instructions, and they have the opportunity to seek technical assistance from HSAG, as needed, to address any identified issues.

Recommendations

Based on the validation results across all PIPs, HSAG made observations about the design and implementation of the PIPs during the baseline measurement period. HSAG offers the following recommendations related to the validation scores in order to improve the structure and implementation of the PIPs as well as to support progress toward improved PIP outcomes in the future.

- AHCA should continue to offer and facilitate training and support opportunities to enhance the plans' capacity to implement robust quality improvement (QI) processes and strategies for their PIPs. Increasing the plans' efficacy with QI tools such as root cause analyses, key driver diagrams, process mapping, failure modes and effects analysis (FMEA), and Plan-Do-Study-Act (PDSA) cycles should help remove barriers to successfully achieving improvement in the PIP study indicators.
- The plans should accurately report the study indicator definition, including the numerator, denominator, and measurement period dates, and should align the documentation with relevant measurement specifications.
- The plans should use methodologically sound sampling techniques, when applicable, and fully document the methods used for sampling.
- The plans should correct any errors in the study indicator rate calculations that HSAG identified in the baseline PIP validation tool. Accurate study indicator rates are necessary to measure progress in improving PIP outcomes accurately during the remeasurement periods.
- The plans should ensure the use of robust QI strategies to identify and prioritize barriers and to develop interventions for the PIPs.
- The plans should use the quarterly AHCA check-in meetings as opportunities to identify and address barriers to the PIP process that may impact the ability to achieve meaningful improvement.

Performance Measure Validation

HSAG conducted performance measure validation (PMV) for measures calculated and reported by MMA Standard plans, MMA Specialty plans, and LTC plans for reporting year 2016. All measure indicator data were audited by each plan's NCQA-certified auditor; therefore, HSAG's roles in the validation of performance measures were to ensure that validation activities conducted were consistent with the CMS publication, *Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012 (CMS Performance Measure

Validation Protocol [4]); review the independent auditing process already conducted; and verify that performance measure rates were collected, reported, and calculated according to the specifications required by the State. The following sections provide a summary of the PMV findings and performance measure results for the MMA Standard and Specialty plans and LTC plans.

MMA Plans

All MMA Standard and Specialty plans were required to report 43 measures, which were grouped into nine domains (Pediatric Care, Women's Care, Living With Illness, Behavioral Health, Access/Availability of Care, and Use of Services; and three MMA Specialty Performance Measures domains: Pediatric Care, Serious Mental Illness [SMI], and Older Adult Care) (see Table 1-2). For the current measurement year, MMA plans continued to demonstrate strong performance in meeting the NCQA information systems (IS) standards. All MMA plans were fully compliant with IS standards 1, 2, 3, 5, 6, and 7. Although all MMA plans were compliant with IS Standard 1, one MMA Standard plan's vendor did not release human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) lab data, due to enrollee confidentiality concerns. As a result, this plan was unable to report the *Viral Load Suppression Among Persons in HIV Medical Care (VLS)* measure and received a *Biased Rate (BR)* audit designation for this measure.

For IS Standard 4, all but one MMA Standard plan and all but one MMA Specialty plan were fully compliant. One MMA plan that functioned as both a Standard and Specialty plan was partially compliant with this standard due to the plan not retrieving all medical record data. This plan received a *BR* audit designation for the *Antenatal Steroids (ANT)* measure because it did not use hybrid methodology as required for this measure.

Two MMA Specialty plans that provided children's services were required to report the *Developmental Screening in the First Three Years of Life (DEVSCR)* measure specific to their population. One MMA Specialty plan was required to report an additional measure *(Care for Older Adults [COA]).* One MMA Specialty plan was required to report three additional measures under the SMI domain *(Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications [SSD]), Diabetes Monitoring for People With Diabetes and Schizophrenia [SMD],* and *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia [SMC]).*

Table 1-2 below presents the 80 performance measure indicators selected for reporting year 2016 for the MMA Standard and Specialty plans, sorted by clinical domain. This table also contains the source for each measure's technical measure specifications and HSAG's assignment of the performance measures into the dimensions of quality, timeliness, and access. Cells shaded gray denote the measures for which

[4] 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: Jan 24, 2017.

AHCA established performance targets for 2016, which were generally established based on the Healthcare Effectiveness Data and Information Set (HEDIS®) [5] national Medicaid 75th percentiles.

Table 1-2—Reporting Year 2016 MMA Performance Measures and Assignments to the Quality, Timeliness, and Access Domains

Reporting Year 2016 (Calendar Year 2015) Measures	Measure Source	Quality	Timeliness	Access
Pediatric Care				
Well-Child Visits in the First 15 Months of Life (W15)—No Well-Child Visits and *Six or More Well-Child Visits*	HEDIS	✓		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	HEDIS	✓		
Childhood Immunization Status (CIS)—Combination 2 and *Combination 3*	HEDIS	✓	✓	
Lead Screening in Children (LSC)	HEDIS	✓	✓	
Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase and *Continuation and Maintenance Phase*	HEDIS	✓	✓	✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile—Total	HEDIS	✓		
Adolescent Well-Care Visits (AWC)	HEDIS	✓		
Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap/Td)	HEDIS	✓	✓	
Annual Dental Visit (ADV)—Total	HEDIS	✓		✓
Preventive Dental Services (PDENT)	CMS 416 Report			✓
Dental Treatment Services (TDENT)	CMS 416 Report			✓
Sealants (SEA)	CMS 416 Report	✓		✓
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk (SEAL)	Medicaid Child Core Set	✓		✓
Women's Care				
Cervical Cancer Screening (CCS)	HEDIS	✓		
Chlamydia Screening in Women (CHL)	HEDIS	✓		
Breast Cancer Screening (BCS)	HEDIS	✓		
Human Papillomavirus Vaccine for Female Adolescents (HPV)	HEDIS		✓	✓
Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care and *Postpartum Care*	HEDIS	✓	✓	✓
*Frequency of Ongoing Prenatal Care (FPC)—≥81 Percent of Expected Visits**	HEDIS		✓	✓
Antenatal Steroids (ANT)	Medicaid Adult Core Set	✓		
Living With Illness				
Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8%), Eye Exam (Retinal) Performed, and *Medical Attention for Nephropathy*	HEDIS	✓		
Controlling High Blood Pressure (CBP)	HEDIS	✓		
Adult BMI Assessment (ABA)	HEDIS	✓		

[5] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Reporting Year 2016 (Calendar Year 2015) Measures	Measure Source	Quality	Timeliness	Access
Medication Management for People With Asthma (MMA)—Medication Compliance 50%—Total and *Medication Compliance 75%—Total*[1]	HEDIS	✓		
Annual Monitoring for Patients on Persistent Medications (MPM)—Total	HEDIS	✓		
Plan All-Cause Readmissions (PCR-AD)—Total—18–64 Years of Age Total and *Total—65+ Years of Age Total*	Medicaid Adult Core Set	✓		
HIV-Related Outpatient Medical Visits (HIVV)—2 Visits (≥182 days)	AHCA-Defined	✓		
Highly Active Anti-Retroviral Treatment (HAART)	AHCA-Defined	✓		
Viral Load Suppression Among Persons in HIV Medical Care (VLS)—18–64 years and *65+ years*	Medicaid Adult Core Set	✓		
Medical Assistance With Smoking and Tobacco Use Cessation (MSC)—Advising Smokers and Tobacco Users to Quit—18–64 Years of Age, 65+ Years of Age, and *Total; Discussing Cessation Medications—18–64 Years of Age, 65+ Years of Age,* and *Total;* and *Discussing Cessation Strategies—18–64 Years of Age, 65+ Years of Age,* and *Total*[2]	HEDIS	✓		
Behavioral Health				
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)—Initiation of AOD Treatment—Total and *Engagement of AOD Treatment—Total*	HEDIS	✓	✓	
Follow-Up After Hospitalization for Mental Illness (FHM)—7-Day Follow-Up and *30-Day Follow-Up*	HEDIS & AHCA-Defined		✓	
Antidepressant Medication Management (AMM)—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	HEDIS	✓	✓	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	HEDIS	✓		
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Total	HEDIS	✓		
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)—Total	HEDIS	✓		
Mental Health Readmission Rate (RER)	AHCA-Defined	✓		
Access/Availability of Care				
Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–24 Months, 25 Months–6 Years, 7–11 Years, and *12–19 Years*	HEDIS			✓
Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total	HEDIS			✓
Call Answer Timeliness (CAT)	HEDIS		✓	
Transportation Availability (TRA)	AHCA-Defined			✓
Transportation Timeliness (TRT)	AHCA-Defined		✓	
Use of Services				
Ambulatory Care (AMB)—Outpatient Visits per 1,000 Member Months (MM) and *ED Visits per 1,000 MM*[3]	HEDIS			✓
MMA Specialty Performance Measures—Pediatric Care				
Developmental Screening in the First Three Years of Life (DEVSCR)—Screening in the 1st Year of Life, Screening in the 2nd Year of Life, Screening in the 3rd Year of Life, and *Screenings Total*	Medicaid Child Core Set	✓	✓	

Reporting Year 2016 (Calendar Year 2015) Measures	Measure Source	Quality	Timeliness	Access
MMA Specialty Performance Measures—SMI				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	HEDIS	✓	✓	
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	HEDIS	✓	✓	
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	HEDIS	✓	✓	
MMA Specialty Performance Measures—Older Adult Care				
Care for Older Adults (COA)—Advance Care Planning—66+ Years, Medication Review—66+ Years, Functional Status Assessment—66+ Years, and *Pain Assessment—66+ Years*	HEDIS	✓	✓	

Note: Cells shaded gray indicate measures with a 2016 performance target established by AHCA.

** indicates the MMA plans reported rates for the AHCA-defined measure, Prenatal Care Frequency (PCF), for reporting year 2015; however, this measure changed to the HEDIS Frequency of Prenatal Care (FPC) measure for reporting year 2016.*

[1] For this measure, an AHCA performance target was established only for the Medication Management for People With Asthma (MMA)—Medication Compliance 75%—Total indicator.

[2] For this measure, AHCA performance targets were established only for the Medical Assistance With Smoking and Tobacco Use Cessation (MSC)—Advising Smokers and Tobacco Users to Quit—Total, Discussing Cessation Medications—Total, and *Discussing Cessation Strategies—Total indicators.*

[3] For this measure, an AHCA performance target was established only for the Ambulatory Care (AMB)—ED Visits per 1,000 MM indicator.

A total of 53 MMA Standard performance measure indicators related to **quality** were evaluated as part of the Pediatric Care, Women's Care, Living With Illness, and Behavioral Health domains of care. AHCA performance targets were established for 34 of these measure indicators. HSAG observed the following **quality**-related performance measure results:

- For Pediatric Care, the statewide weighted average rates met or exceeded the AHCA performance targets for three of the 12 measure indicators with targets established, including *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits* and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase.*
- For Women's Care, the statewide weighted average rates did not meet the AHCA performance targets for the five measure indicators with targets established.
- For Living With Illness, the statewide weighted average rates met or exceeded the AHCA performance targets for two of the 12 measure indicators with targets established, including *Comprehensive Diabetes Care (CDC)—Medical Attention for Nephropathy* and *Annual Monitoring for Patients on Persistent Medications (MPM)—Total*.
- For Behavioral Health, the statewide weighted average rates did not meet the AHCA performance targets for the five measure indicators with targets established.

A total of 18 MMA Standard performance measure indicators related to **timeliness** were evaluated as part of the Pediatric Care, Women's Care, Behavioral Health, and Access/Availability of Care domains. AHCA performance targets were established for 16 of these measure indicators. HSAG observed the following **timeliness**-related performance measure results:

- For Pediatric Care, the statewide weighted average rates met or exceeded the AHCA performance targets for two of the six measure indicators with targets established, including *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase.*
- For Women's Care, the statewide weighted average rates did not meet the AHCA performance targets for the three measure indicators with targets established.
- For Behavioral Health, the statewide weighted average rates did not meet the AHCA performance targets for the six measure indicators with targets established.
- For Access/Availability, the statewide weighted average rate did not meet the AHCA performance target for the one measure indicator with a target established.

A total of 19 MMA Standard performance measure indicators related to **access** were evaluated as part of the Pediatric Care, Women's Care, Access/Availability of Care, and Use of Services domains. AHCA performance targets were established for 13 of these measure indicators. HSAG observed the following **access**-related performance measure results:

- For Pediatric Care, the statewide weighted average rates met or exceeded the AHCA performance targets for three of the four measure indicators with targets established, including *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase,* and *Preventive Dental Services.*
- For Women's Care, the statewide weighted average rates did not meet the AHCA performance targets for the three measure indicators with targets established.
- For Access/Availability of Care, the statewide weighted average rates did not meet the AHCA performance targets for the five measure indicators with targets established.
- For Use of Services, the statewide weighted average rate met or exceeded the AHCA performance target for the one measure indicator with a target established, *Ambulatory Care (AMB)—ED Visits per 1,000 Member Months (MM).*

In addition to the MMA Standard performance measures, two MMA Specialty plans (i.e., Children's Medical Services-S and Sunshine-S) reported 11 MMA Specialty performance measure indicators, which were all related to **quality** and **timeliness**. AHCA performance targets were established for three of these measure indicators. The reported rates for the MMA Specialty performance measures did not meet the AHCA performance targets for the three measure indicators with targets established.

The finding that only a few statewide weighted averages reaching their associated performance targets suggests opportunities for improvement in almost all domains of care.

LTC Plans

For calendar year (CY) 2015, the LTC plans were required to report two HEDIS-based and four AHCA-defined measures. Based on Final Audit Report (FAR) reviews, HSAG found that all LTC plans had

audits conducted according to NCQA HEDIS Compliance Audit policies and procedures.[6] Compliance findings pertaining to IS capability according to NCQA's IS standards were present in all reports. HSAG had no concerns with the six LTC plans' data systems and processes used for measure calculation. The LTC plans maintained the same experienced staff members for collecting and processing data for performance measure reporting. In addition, the LTC plans continued to have adequate validation processes in place to ensure data completeness and accuracy.

Table 1-3 below presents the 11 performance measure indicators selected for reporting year 2016 for the LTC plans. This table also contains the measure source for each measure and HSAG's assignment of the performance measures into the dimensions of quality, timeliness, and access. The cell shaded gray denotes the measure for which AHCA established a performance target for 2016, which was generally established based on the HEDIS national Medicaid 75th percentile.

Table 1-3—Reporting Year 2016 LTC Performance Measures and Assignments to the Quality, Timeliness, and Access Domains

Reporting Year 2016 (Calendar Year 2015) Measures	Measure Source	Quality	Timeliness	Access
Care for Adults (CFA)—Advance Care Planning—Total, Medication Review—Total, and *Functional Status Assessment—Total*	HEDIS/AHCA-Defined	✓		
Call Answer Timeliness (CAT)	HEDIS		✓	
Required Record Documentation (RRD)—701B Assessment, Plan of Care—Enrollee Participation, Plan of Care—Primary Care Physician Notification, and *Freedom of Choice Form*	AHCA-Defined	✓		
Face-to-Face Encounters (F2F)	AHCA-Defined		✓	
Case Manager Training (CMT)	AHCA-Defined		✓	
Timeliness of Services (TOS)	AHCA-Defined		✓	

Note: The cell shaded gray indicates the measure with a 2016 performance target established by AHCA.

The LTC plans reported 11 performance measure indicator rates, which were all related to **quality** and **timeliness**. AHCA performance targets were established for one of these measure indicators, *Call Answer Timeliness (CAT)*. The statewide weighted average rate for this measure did not meet the AHCA performance target established and represents an opportunity for improvement.

Review of Compliance

Due to the transition to SMMC, AHCA chose not to perform compliance reviews in SFY 2013–2014; however, readiness reviews were conducted on its MMA plans during the period of time just prior to implementation of each phase of Florida's SMMC program. AHCA's readiness review process included a desk review of numerous key documents, as well as an on-site review that included interviews and

[6] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

system demonstrations to ensure the plans met federal managed care and State requirements in 14 major standard areas.

As a result of the readiness reviews in previous years, AHCA determined that the MMA plans experienced the highest number of deficiencies in the following five categories: Administration and Management, Enrollee Materials, Grievance Systems, Prescribed Drug Services, and Provider Network. AHCA conducted desk reviews of these standards and began on-site reviews from June through October 2016.

AHCA conducted a review of compliance in SFY 2015–2016, including a review of the following standards and contract requirements:

- Access (Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, and Coverage and Authorization of Services).
- Structure and Operations (Provider Selection, Confidentiality, and Subcontractual Relationships and Delegation).
- Quality Measure and Improvement (Quality Assessment and Performance Improvement and Health Information Systems).
- Grievance System (General Requirements, Notice of Action, Handling of Grievances and Appeals, Resolution and Notification, Expedited Resolution of Appeals, Record-Keeping and Reporting Requirements, Continuation of Benefits, and Effectuation of Reversed Appeal Resolutions).
- Information Requirements.

AHCA's review of compliance included the routine assessment and evaluation of Provider Network Verification (PNV) data files; Quest ratio, time and distance reports; PDF and online directory analysis; complaints; secret shopper exercises; and Medicaid fair hearing requests.

AHCA reviewed the plans' annual network development plan (ANDP). AHCA analyzed and monitored the ANDPs for specific contract-required content and reviewed network access complaints to identify issues that conflicted with the ANDP. AHCA reviewed reported provider/group terminations and exclusions and validated these against plan submissions to the PNV file and the online directory. AHCA evaluated encounter reports to ensure the plans met the timeliness standards.

For each plan, AHCA checked notices of action and other grievance and appeal letters, as well as enrollee complaints; grievance and appeal reports; and the Denial, Reduction, Termination or Suspension of Services Report for each plan. Reviewers evaluated enrollee handbooks to ensure required information was provided in the prevalent non-English languages.

Finally, AHCA examined subcontractor agreements, including the annual monitoring schedule.

Findings, Opportunities for Improvement, and Recommendations About the Quality and Timeliness of, and Access to, Care

The following section provides a high-level summary of HSAG's findings, opportunities for improvement, and recommendations about the quality and timeliness of, and access to, care provided to Medicaid recipients based on the data provided by AHCA pertaining to compliance reviews and other monitoring activities.

Findings

AHCA conducted a review of compliance in SFY 2015–2016 that examined 18 different standards and contract requirements in five different standard categories.

As a result of these reviews, AHCA issued liquidated damages and sanctions based on the outcomes of the review of federal and State contract standards. In addition, AHCA imposed corrective action plans (CAPs) for standards that were not in compliance with federal and State contract requirements. Table 1-4 lists the CAPs that AHCA issued for each of the plans and indicates which issues AHCA identified from the year's review.

Table 1-4—FY 2015–2016 Corrective Action Plans

MMA Standard and LTC Plans												
Category	**AMG***	**BET**	**COV***	**HUM***	**MOL***	**PRS**	**CCP**	**SHP**	**SUN****	**URA***	**STW**	**Total**
Administration and Management			X			X						**2**
Covered Services	X	X							X		X	**4**
Enrollee Services and Grievances				X***							X	**3**
Finance		X				X		X				**3**
Marketing												**0**
Medicaid Fair Hearing												**0**
Provider Network	X		X	X	X	X		X	X	X	X	**9**
Quality and Utilization Management												**0**
Reporting												**0**
Total	**2**	**2**	**2**	**3**	**1**	**3**	**0**	**2**	**2**	**1**	**3**	**21**

MMA Specialty Plans												
Category	**PHC**	**CMS**	**CHA**	**FRE**	**MCC**	**SUN**						**Total**
Administration and Management		X										**1**
Covered Services		X	X									**2**
Enrollee Services and Grievances					X							**1**
Finance	X		X									**2**
Marketing												**0**
Medicaid Fair Hearing												**0**
Provider Network	X		X		X							**3**
Quality and Utilization Management												**0**
Reporting	X											**1**
Total	**3**	**2**	**3**	**0**	**2**	**0**						**10**

*This plan provides both MMA Standard and LTC services.
**Sunshine provides MMA Standard, MMA Specialty, and LTC services.
***Humana had two CAPs for the Enrollee Services and Grievances category.

Using the results AHCA provided to HSAG from the various periodic monitoring activities and reviews of compliance, HSAG organized, analyzed, and aggregated the results of the compliance activities and the required CAPs for each plan and across plans. HSAG accounted for all the CAPs as determined by AHCA that were based on individual plan compliance activities performed during SFY 2015–2016.

For the SMMC program, AHCA issued CAPs to all of the MMA Standard plans, except for one plan. For MMA Standard and LTC plans, AHCA imposed CAPs on two of the plans for the Administration and Management category. Likewise, AHCA imposed CAPs on two plans for the Enrollee Services and Grievances category. Conversely, AHCA issued CAPs on nine of the 11 plans in the Provider Network category. AHCA levied CAPs for four plans under the Covered Services category, and CAPs for three plans under the Finance category. Finally, AHCA did not issue any CAPs for the Marketing, Quality and Utilization Management, Reporting, or Medicaid Fair Hearing categories.

For the six MMA Specialty plans, AHCA issued CAPs for only four of the plans. AHCA required three CAPs for the Provider Network category. In addition, AHCA issued two CAPs for the Covered Services category. AHCA imposed only one CAP each for the Administration and Management, and the Reporting categories. AHCA issued one CAP related to the category of Enrollee Services and Grievances. AHCA did not require any CAPs for the Marketing, Medicaid Fair Hearing, and Quality and Utilization Management categories.

For the SMMC plans, AHCA did not impose any CAPs on three plans. AHCA imposed only one CAP on two plans, and two CAPs on seven plans. AHCA conducted and provided findings and results from a

structured and detailed compliance review of the Quality Improvement (QI) Plan/Program and the Cultural Competency Program (CCP), including the plan and evaluation standards. AHCA submitted information to HSAG on each plan's data from these reviews. AHCA assigned a compliance score of 100 percent to all plans reviewed under the CCP assessment. Some of the plans demonstrated strong CCP compliance while others needed to adjust their data collection or plan activities.

In terms of the QI Plan/Program standard, the majority of the plans demonstrated strong competency in performing all required activities under the program; however, some plans required enhancements of internal policies or language to properly document the activities completed.

Strengths

AHCA scored all of the plans evaluated under the CCP standard as compliant. The CCP standard required a review of several elements, including compliance with the National Culturally and Linguistically Appropriate Services (CLAS) Standards in relation to language, accessibility of services, and data collection activities. AHCA found that having all of the plans meet compliance with the cultural competency plan and evaluation was a positive step, and although some elements needed additional work, all of the elements were in full compliance.

It is also encouraging that AHCA scored the majority of the plans in the 90 percent scoring for the QI Plan/Program standard reviews. This is an indicator of high performance for the plans, demonstrating compliance with the federal and state-mandated QI requirements.

AHCA identified several deficiencies by conducting periodic and routine assessments. This is a constructive method to ensure that issues are detected in a timely manner and addressed accordingly. Although the activities are not organized by standards, these reviews allowed AHCA to continuously address problems when they occurred.

AHCA has employed a number of diverse activities that, when combined, assist in compliance reviews. The secret shopper exercises and the review of complaints were excellent mechanisms to review a plan's compliance near the time of the occurrence. AHCA used the complaints to gather information from the public, the enrollees, the provider network, and others regarding the services rendered by the plans.

Overall, AHCA devoted numerous resources to continuously monitor plans' compliance and to assess the quality of services delivered in the State through the managed care system. AHCA conducted QI Plan/Program and Cultural Competency standard reviews and a variety of monitoring activities for other areas.

Opportunities for Improvement—AHCA

HSAG found that AHCA has in effect a monitoring system addressing various requirements of the managed care program. However, the oversight activities that are consistent with federal requirements for state monitoring in §438.66 might not encompass the requirements for a review conducted within the previous three-year period to determine the plans' compliance for the standards as set forth in Subpart D and the QAPI requirements described in §438.330.

For this annual technical report, as part of the compliance documentation submitted to HSAG, AHCA included a Deeming Crosswalk (Crosswalk) developed by HSAG for SFY 2014–2015. The Crosswalk included the federal managed care standards, NCQA standards, and the SMMC core contract provisions. The Crosswalk reflects AHCA's compliance activities for some of those standards. HSAG was unable to establish if AHCA had used the EQR protocols as stated in §438.350 (e).

HSAG was unable to ascertain the methodology or process that AHCA used to ensure federal and State standards were met. For example, AHCA submitted a Crosswalk with information about how some of the standards were monitored weekly, monthly, or yearly; however, AHCA did not include an explanation as to how the standards that HSAG had established as potential deemed standards were reviewed. HSAG did not receive any indication or evidence indicated that AHCA was deeming those standards that were missing an explanation on the Crosswalk. CMS considers that states that are applying the nonduplication or deeming option are required under § 438.360(b) of the final rule to ensure that the information obtained from the accrediting organization in lieu of conducting the EQR-related activity is provided to the EQRO and included in the analysis and annual technical report required under §438.364.

AHCA only submitted individual plan reports for the CCP and QI Plan/Program standards. For all other standards, AHCA did not submit any documentation to identify the process leading to the actions that were a result of the monitoring activities. For example, AHCA submitted a table containing CAPs, sanctions, and liquidated damages for each plan; however, the evidence that substantiated the action was not submitted.

In addition, although all of the plans obtained a 100 percentage score during the CCP standard review, HSAG established that AHCA had suggested ways the plans could strengthen their CCPs. For example, AHCA identified some missing elements in the data collection segment of the demographics. AHCA established that one plan collected Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[7] and other satisfaction data, but the plan did not present the results of this information in its CCP. For another plan, AHCA determined that some elements that should be part of the plan's CCP were missing. AHCA noticed during the review that one plan focused primarily on language needs with very little attention given to race, ethnicity, or religious needs, which were an integral part of the CCP.

Opportunities for Improvement—Plans

For the review of the QI Plan/Program standard, AHCA established that even though the majority of the plans implemented a QI plan, some of the required components were not included. For example, during the reviews, AHCA determined that some elements of the QI program committee, such as a description of the members and their roles in the committee, were missing. AHCA also identified opportunities for improvement in the plans' accreditation documentation, including the documentation of accreditation when subcontracting behavioral health services.

[7] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

For some of the plans, AHCA determined that the time frames for submission of the QI plan and the QI plan communication were deficient. AHCA required the plans to revise and resubmit their QI Plans/ Programs to address these deficiencies. In addition, AHCA identified substandard compliance regarding the standard that required the plan to provide specific quality training for QI program staff serving in the QI program. Furthermore, AHCA identified that some plans did not reference the quality training developed by CMS for QI program staff.

For other standards, AHCA highlighted the following vulnerable areas from other monitoring activities:

- Maintenance of the online provider network directory.
- Continuous update of the financial reporting requirements.
- Enrollee information and enrollee materials—by not meeting time frames for providing enrollee handbooks and ID cards.
- Adequate processes for the claims and encounter systems.
- Transportation services procedures.
- Timely responses when ad hoc reports are requested by AHCA.

Recommendations

HSAG established that in accordance with 42 CFR §438.66, State Monitoring Requirements, AHCA had conducted various compliance and monitoring activities throughout SFY 2015–2016. The State recognizes these activities as initiating the first year of a three-year review cycle. HSAG recommends that in accordance with 42 CFR §438.358(b)(iii), the State conduct a comprehensive review to determine the plan's compliance with the standards in Subpart D and the quality assessment requirements.

HSAG recommends the following:

- AHCA should establish a consistent methodology when conducting periodic monitoring, and review activities to be consistent with EQR protocols to provide a uniform method of ensuring that federal and state requirements for managed care programs are met by the plans. The reviews must be comparable to the standards for EQR-related activities, and consistent with the EQR protocol in accordance with 438.452.
- AHCA should establish a consistent methodology using standard scoring to establish the threshold for compliance and score the plans as fully compliant only when all elements of the standard are present. AHCA should conduct a scheduled and complete review of activities and standards as required under 438 Subpart D. Conducting an organized and methodical compliance review will assist AHCA to not only determine performance and compliance but to identify failures in systems and to correct these in a timely manner.
- AHCA should determine which plans and which standard categories need more technical assistance to improve performance, based on information from the compliance review and monitoring that occurs throughout the year.

- AHCA's compliance review should consist of both a desk review as well as an on-site review that encompass a review of documents to ensure that the policies and procedures submitted in the desk review are operationalized at the plan level. In addition, the on-site review should include interviews with key staff members to collect data to supplement and verify what was learned in the preliminary document review and on-site document review.
- The plans should anticipate compliance reviews and maintain a checklist of compliance activities to determine internal issues with their own processes. The plans could use the federal standards as required and conduct internal risk assessments to identify and promptly address any deficiencies.
- The plans should ensure the following findings are addressed:
  - Maintenance of the online provider network directory.
  - Continuous update of the financial reporting requirements.
  - Enrollee information and enrollee materials—by meeting time frames for providing enrollee handbooks and ID cards.
  - Adequate processes for claims and encounter systems.
  - Transportation services procedures.
  - Timely responses when ad hoc reports are requested by AHCA.

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 their contracted health plans 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 in the state's overall management and oversight of its Medicaid managed care program.

During SFY 2015–2016, AHCA contracted with HSAG to conduct an encounter data validation (EDV) study. The goal of the study was to examine the extent to which encounters submitted to AHCA by its contracted SMMC plans, including MMA, Specialty, and LTC plans, collectively referred to as plans, were complete and accurate.

The SFY 2015–2016 EDV study included administrative and comparative analyses of plan-submitted encounters and a review of clinical records, plans of care and/or treatment plans, the eligibility file, and other available data sources. Additionally, the SFY 2015–2016 EDV study focused its review on a specific subset of services associated with the following categories:

- Dental services
- Therapy services (speech, occupational, and physical therapy for children under the age of 21)
- Long-term care

Encounter Data File Review Findings and Conclusions

Prior to conducting the comparative analysis and clinical record review of the EDV, HSAG conducted a preliminary review of the encounter data submitted by AHCA and the plans. This investigation evaluated general encounter counts to provide a high-level summary of the differences and variation in the quality of encounter data managed by AHCA and individual plans. Substantial differences in the volume of each of the three encounter types were observed when comparing the volume of encounters submitted by plans and AHCA. This discrepancy was mainly attributable to the duplicate records found in the encounter data submitted by AHCA. On further review, AHCA determined that the *Payer Responsibility Sequence Code* on the 2320 SBR loop of the transaction caused the "duplicated" records. The following plan submission pattern was noted:

- Plans always submit primary and secondary sequence codes and sometimes submit tertiary payer sequence codes.
- Plans always use "MC" to indicate Medicaid for all payers.
- In nearly all instances, the professional encounter submission also uses "CI" and "ZZ" in the *Claim Filing Indicator Code* field.
- Plans do not always submit payers in logical order (e.g., tertiary payers may be listed first).

Florida's Medicaid Management Information System (FMMIS) and Decision Support System (DSS) captured this information as it was submitted and stored. Since the *Payer Responsibility Sequence Code* field is a header field, it propagates to the details for each occurrence which leads to increased record counts. Since at the time of the study, there was no resolution within the data, it was determined that re-running the queries would not resolve the issue. As such, AHCA recommended moving forward with the data HSAG had received from AHCA.

A review of the encounter data volume highlighted variation in the overall and month-to-month submission of encounters by service category (i.e., dental, children's therapy, and long-term care) and source (i.e., AHCA's and plans' submitted encounters). While AHCA's encounter data showed consistently greater encounter data volume than the volume reported by the plans among all three service categories, month-to-month volume trends were relatively consistent between both data sources.

Between both children's therapy and long-term care services, required data elements such as *Primary Diagnosis Code* and *Revenue Code* were consistently complete and populated with reasonable values for most encounters reviewed for AHCA and the plans. Note that these data elements were not collected for encounters associated with dental services.

Key encounter data elements associated with situational reporting requirements (e.g., *Diagnosis Code 2*) exhibited considerable variation in the degree of completeness and validity among plans, and in relation to AHCA's encounter data. Though the importance of data elements with situational reporting requirements is minimal related to claims processing, incomplete data element results potentially impact the State's ability to identify key clinical populations and the quality of studies that rely on these data.

Comparative Analysis Findings and Conclusions

Record Completeness

The overall record omission rates for dental services varied among the three encounter types (i.e., dental, institutional, and professional), with dental encounters exhibiting the most complete data as shown by the lowest record omission rate and second lowest record surplus rate—i.e., 2.7 percent and 66.1 percent, respectively. While the overall record omission rates were generally lower for dental services among the three encounter types, the overall dental services surplus rates were extremely high, with rates greater than 50.0 percent for all three encounter types. This discrepancy was primarily due to the duplicate records submitted by AHCA. As noted earlier, the *Payer Responsibility Sequence Code* on the 2320 SBR loop of the transaction was the cause for the "duplicated" records.

Overall, between the two encounter types associated with children's therapy and long-term care services (i.e., institutional and professional), professional encounters exhibited more complete data relative to institutional encounters. While the overall record omission rates were generally low between the two encounter types for children's therapy services (4.0 percent) and long-term care services (9.6 percent), the overall surplus rates were extremely high, with rates greater than 60.0 percent for both encounter types. The high record surplus rates were attributable to the duplicated encounter records submitted by AHCA, similar to surplus rates reported for dental services.

Encounter Data Element Completeness

The level of completeness for key dental services encounter data elements was high (i.e., low overall omission and surplus rates), with the overall element omission and surplus rates of 0.0 percent for nearly all encounter data elements (i.e., *Line First Date of Service*, *Line Last Date of Service*, *Procedure Code*, and *Amount Paid*).

Children's therapy services also exhibited a high level of completeness among key data elements, with some exceptions. Key data elements such as *Primary Diagnosis Code*, *Procedure Code*, *Revenue Code*, *Line First Date of Service*, *Line Last Date of Service*, and *Amount Paid* had element omission and element surplus rates below 1 percent while provider encounter data elements exhibited less overall completeness.

Among institutional encounters associated with long-term care services, a high level of completeness was exhibited for five data elements (i.e., *Primary Diagnosis Code*, *Procedure Code*, *Revenue Code*, *Billing Provider NPI [National Provider Identifier]*, and *Amount Paid*) while a low level of completeness was shown for four data elements (i.e., *Admission Date*, *Discharge Date*, *Attending Provider ID*, and *Contract Info*). These four encounter data elements exhibited either a high level omission or surplus rate. Among encounters that could be matched between AHCA's and the plans' submitted professional encounter data for long-term care services, high levels of completeness were exhibited for nearly all of the evaluated data elements (i.e., *Line First Date of Service*, *Line Last Date of Service*, *Diagnosis Code*, *Procedure Code*, *Billing Provider NPI*, and *Amount Paid*).

Provider-related encounter data elements were most frequently associated with incomplete data. Although not critical for processing encounters received by the plans, incomplete and inaccurate provider data affect both Medicaid oversight and reporting.

Encounter Data Element Agreement

Overall, the agreement rates for dental services encounters were generally high among key encounter data elements (i.e., *Rendering Provider NPI*, *Procedure Code*, and *Tooth Number)*, with rates exceeding 95 percent agreement. This finding suggests that both sources of encounter data (i.e., AHCA and plans) exhibited the same values for dental services encounters.

Similarly, high overall agreement rates were noted for the majority of the evaluated key data elements among encounters associated with children's therapy services—e.g., *Primary Diagnosis Code*, *Procedure Code*, *Revenue Code*, *Attending Provider ID*, and *Rendering Provider NPI***.** These encounter data elements all exhibited agreement rates greater than 95.0 percent.

The overall data element agreement rate for long-term care services was mixed among key institutional and professional encounter data elements. Among institutional, long-term care service encounters that could be matched between AHCA's and the plans' submitted encounter data, high agreement rates were noted for the following fields: *Admission Date*, *Primary Diagnosis Code*, *Procedure Code*, and *Billing Provider NPI*. All reported agreement rates were greater than 95.0 percent. However, the *Attending Provider ID*, *Insurance Group Policy Number*, *Claim Filing Indicator Code*, and *Contract Info* encounter data elements showed a low degree of agreement (i.e., 0.0 percent, 56.7 percent, 62.2 percent, and 59.6 percent, respectively). Among professional, long-term care services that could be matched between AHCA's and the plans' encounter data, high agreement rates (i.e., greater than 95.0 percent), were noted in nearly all of the data elements except for the following fields: *Billing Provider NPI* (91.5 percent), *Rendering Provider NPI* (90.9 percent), *Amount Paid* (83.7 percent), *Insurance Group Policy Number* (20.0 percent), *Claim Filing Indicator Code* (56.7 percent), and *Contract Info* (64.6 percent).

Clinical Record Review Findings and Conclusions

Medical Record, Plan of Care, and Treatment Plan Submission

Overall, 114 dental, children's therapy, and long-term care sample cases per plan, or 2,508 total sample cases, were requested from 22 contracted plans. Of these sample cases, only 81.0 percent (or 2,032 cases) were submitted by the plans for inclusion in the study. The clinical documentation submission rates varied considerably among plans, with individual plan rates ranging from 23.7 percent to 100.0 percent.

Among the clinical documentation received, the rate of valid medical records received was relatively high—89.3 percent. However, the valid medical record received rate showed considerable variation among individual plans, with rates ranging from 50.6 percent to 100.0 percent. More than half of the participating plans (i.e., 13 out of 22) submitted valid medical records for more than 90.0 percent of the requested sample cases.

Of the 2,032 cases for which clinical documentation was received, HSAG expected submission of a plan of care/treatment plan for 1,546 sample cases. Only children's therapy and long-term care services required submission of a plan of care/treatment plan; dental services do not require treatment plans. Overall, of the 1,546 sample cases requiring a plan of care/treatment plan, valid documentation was received for only 55.6 percent of the cases.

The plan of care/treatment plan submission rates showed wide variation among plans, with individual rates ranging from 2.0 percent to 88.7 percent. Six plans submitted valid plans of care/treatment plans for less than 50.0 percent of the requested sample records. Overall, more than 30 percent of the plan of care/treatment plan documents were found to be invalid—i.e., documentation did not meet AHCA's approved template. Three plans submitted valid plans of care/treatment plans for less than 50.0 percent of the requested sample cases.

Encounter Data Completeness

Overall, AHCA's encounter data were supported by the clinical documentation in enrollees' medical records (i.e., low medical record omission) for dental and children's therapy services. Of the data elements reported in AHCA's encounter data, 9.5 percent or fewer were not supported in enrollees' medical records. However, medical record omission rates for long-term care encounter data elements were higher, ranging from one-quarter to one-third of the encounter data elements being unsupported by enrollees' medical records. These findings suggest that long-term care encounter data submitted to FMMIS reflect incomplete and/or inaccurate data relative to enrollees' medical records. Additional evaluation of long-term care service encounter submission is necessary to better understand the factors contributing to data discrepancies between the plans and AHCA.

Conversely, assessment of encounter data omission rates revealed that not all services documented in enrollees' medical records were submitted to or processed and stored by AHCA. The encounter data omission rates for key data elements also showed mixed results for each of the service categories assessed. The encounter data omission rates were relatively low for all encounter data elements except for *Diagnosis Code* (i.e., 16.1 percent [children's therapy] and 26.9 percent [long-term care]) and the *Procedure Code Modifier* for children's therapy services (31.0 percent). These high encounter data omission rates indicate that information found in enrollees' medical records was missing from AHCA's encounter data. Moreover, medical records with date of service discrepancies did not fully account for the omission of key data elements. This finding suggests that some data elements recorded and available in enrollees' medical records are not submitted, or are not accepted into FMMIS, thereby affecting the overall completeness of the State's encounter data system.

Medical record omission and encounter data omission rates varied among all plans and all key data elements. Omissions identified in the medical records (services found in the encounter data but not supported by the medical record) and omissions in the encounter data (services found in the medical record but not in the encounter data) suggest continued deficiencies in the completeness of AHCA's encounter data.

Encounter Data Element Accuracy

Overall, encounter data element accuracy was high among the three service categories (i.e., dental, children's therapy, and long-term care services), with all data element accuracy rates exceeding 90.0 percent except for long-term care services diagnosis codes (i.e., 86.1 percent).

While individual accuracy rates for key data elements were high, the percentage of encounters by service category (i.e., dental, children's therapy, and long-term care services) in which all evaluated data elements (i.e., *Diagnosis Code, Procedure Code,* and *Procedure Code Modifier)* were valid was only 55.5 percent, 51.0 percent, and 28.3 percent, respectively. This finding suggests that submission of encounter data elements is frequently incomplete, leading to overall inaccuracy in the representation of clinical information in the State's encounter data.

Review of Treatment Plan/Plan of Care Documentation

Among the 22 contracted plans evaluated in the study, only 14 plans had enrollees that met the eligibility criteria for children's therapy services. Of the sample of 254 children's therapy cases, only 74.0 percent (188 out of 254) were submitted with valid documentation. More than one-quarter of the plans submitted treatment plans for at least 90 percent of the requested sample cases; three plans submitted treatment plans for 50 percent or fewer of the requested sample cases. In general, treatment plans contained the appropriate signatures, included treatment plan effective dates that covered selected dates of service, and identified valid servicing providers. However, when the servicing provider, treatment plan procedures, and associated number of units were compared to enrollees' medical records, few treatment plans supported information documented in the medical records.

Of the 722 sample cases associated with long-term care services, only 490 plan of care documents were expected to be submitted by the plans since 232 sample cases were associated with Evaluation and Management (E & M) services. As such, plan of care documentation was not required for the selected date of service. Of the 490 sample long-term care cases, only 49.2 percent (241 out of 490) were submitted with valid documentation. Moreover, only five of the 22 plans submitted plans of care for 90 percent or more of the requested sample cases while nearly half of the plans submitted plans of care for fewer than 50 percent of the requested sample cases. In general, plans of care contained the appropriate signatures, included plan of care effective dates that covered selected dates of service, and identified valid servicing providers. However, as with treatment plans, when the servicing provider, plan of care procedures, and associated number of units were compared to enrollees' medical records, few plans of care supported information documented in the medical records.

Recommendations

Based on HSAG's review of the encounter data submitted by AHCA and the plans, HSAG identified several opportunities for continued improvement in the quality of Florida's encounter data. While some of the discrepancies noted were related to AHCA's ability to process and prepare its encounter data for evaluation, high omission, surplus, and error rates, coupled with variation between plans and encounter types, suggest systemic issues in the transmission of data between the plans and AHCA's FMMIS. To

ensure the success of future encounter data validation activities and the quality of encounter data submissions from contracted health plans, the following recommendations have been prepared to address potential opportunities for improvement.

- AHCA should continue to work with its MMIS and DSS teams to review quality control procedures to ensure the accurate production of data extracts. Through the development of standard data extraction procedures, quality controls, and process documentation, the number of errors associated with extracted data could be reduced, leading to more accurate data extractions and reporting. Moreover, the development and implementation of stored procedures can be reused for similar activities with minimal changes for future studies. Sufficient processes and training should also be put in place to ensure the 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.
  - Distributions of the data field values are reasonable.
  - Presence check (i.e., data with missing values for all records in any of the data fields).
  - Data fields were populated with reasonable values.

  The validity of data submitted for evaluation has been a consistent issue impacting reporting for several encounter data evaluation studies. HSAG recommends that AHCA convene a time-limited, post-study workgroup to identify, evaluate, and propose solutions to address ongoing quality issues. Processes to be reviewed include the communication of extraction requirements, identification of extracted fields, and defined quality control steps and processes.
- AHCA should work with its MMIS vendor to develop supplemental encounter data submission guidelines, and/or expand its existing Companion Guide to clearly define appropriate submission requirements for nonstandard data elements necessary for data processing (e.g., *Payer Responsibility Sequence Code*). Ensuring that plans submit data elements consistently and in alignment with FMMIS processing rules is critical to being able to report and process encounter data for reporting. Once guidelines are established, technical assistance calls/meetings can be scheduled to make sure all parties understand any new submission requirements.

  Additionally, AHCA should work with its MMIS and DSS data vendors to develop internal data processing routines to establish standardized programming logic to ensure plan encounter data are accurately processed.
- AHCA should review, and modify as needed, existing plan contracts to include language outlining specific requirements for submitting valid clinical record documentation (i.e., medical records, plans of care, and treatment plans) to AHCA, or its representatives, in addition to defining the requirements and submission standards for the procurement of requested clinical records. To allow for proper oversight of clinical services and care management activities, it is important to build expectations directly in contracts regarding the submission of supporting documentation. Moreover, HSAG recommends including language that allows AHCA to hold health plans accountable for

meeting submission expectations. Additionally, to ensure clinical documentation is complete and valid, modifications to the contract should include language that outlines minimum documentation requirements and expected templates for plans of care/treatment plans. The inclusion of this information ensures the availability to information critical to oversight activities**.**

- AHCA should continue to collaborate with the plans to monitor, investigate, and reconcile discrepancies in encounter data volume regularly. Although encounter data volume trends were similar between AHCA- and plan-submitted encounter data, differences in overall volume suggest potential deficiencies in the data. Results from the current study should be used to target specific encounter data to conduct data mining reviews and determine whether differences were due to failed or incomplete submissions or processing parameters associated with FMMIS.

Hospital Network Adequacy Analysis

During SFY 2015–2016, AHCA contracted with HSAG to conduct a hospital network adequacy study which focused on two main aspects of network adequacy. First, HSAG assessed compliance with bed-to-enrollee and county standards for each plan and at the statewide level. Second, HSAG compared AHCA's time and distance standards with CMS' Health Services Delivery (HSD) standards. The results of these analyses can be used as a baseline for future network adequacy analyses in Florida.

The analysis of compliance with the bed-to-enrollee and county standards indicated that the plans achieved a fairly high level of compliance with the bed-to-enrollee standards. All 14 plans included in this analysis were in compliance with the required ratios for acute care hospital beds and for fully accredited psychiatric community hospital/crisis stabilization unit/freestanding psychiatric specialty beds for adults. One-half of the plans (50 percent) were in compliance for the required ratio for fully accredited psychiatric community hospital/crisis stabilization unit/freestanding psychiatric specialty beds for children. Eleven of the 14 plans (79 percent) for which enrollment data were available appear to be in compliance with the required ratio for inpatient substance abuse detox unit beds.

The plans did not achieve the same level of compliance with the county facility standards. Four of the 14 plans met the county facility standards for 24/7 emergency service facilities, only one plan met the standard for hospitals or facilities with birth/delivery services beds, and no plans met the standard for licensed community substance abuse treatment centers. It should be noted that because certain facilities were not available in some counties, some plans could not meet the required network standards. To these plans, AHCA granted a waiver of these requirements. The facilities described above were not available, with some counties having only one facility.

The comparison of AHCA's time/distance standards with CMS' HSD standards showed that AHCA's performance standards appear to be more stringent than the HSD standards in all counties except for large metropolitan counties.

Based on the results of these analyses, HSAG offers the following recommendations:

- HSAG recommends that AHCA conduct an in-depth review of network adequacy to include the following: enrollee-to-provider ratios by provider specialty, geospatial distributional analyses of

providers' time/distance performance evaluations, and average time/distance to the nearest three providers. This type of study would establish baseline results essential to any future review of access and adequacy of Florida's provider network.

- Based on the first recommendation, AHCA should implement a time-limited work group to establish revised standards based on baseline results. These standards can target high-volume or high-profile provider types and be segmented by geographic setting. HSAG recommends reaching out to other Medicaid agencies to conduct a scan of existing standards and monitoring strategies implemented in other states. Using this information, AHCA could draw best practices in designing its own standards. These standards should incorporate distinct time and distance standards for urban versus rural counties, as these counties experience challenges unique to their urbanicity including different demographics, socioeconomic status, healthcare needs, and geography. Based on these differing characteristics, these two county types should not be held to the same standard.

Overall Assessment of Progress in Meeting Agency Goals and Priorities

During previous years, HSAG made recommendations for each of the activities that were conducted. These recommendations were made in the annual reports, or, in the case of the focused study, in the actual report. Table 1-5 is a summary of the follow up actions per activity that AHCA completed in response to HSAG's recommendations during SFY 2015–2016.

Table 1-5—HSAG Recommendations With AHCA Actions

HSAG Recommendation	AHCA Action
Performance Improvement Projects	
AHCA, with HSAG's assistance, should identify statewide goals or expected levels of performance for the study indicators in all new State-mandated PIPs.	For PIP indicators that are HEDIS measures, AHCA established the National Medicaid 75th Percentile as published by NCQA as a goal. According to the SMMC contract, AHCA required the plans to achieve a 28 percent rate for the preventive dental services measure by FFY 2015.
HSAG recommended: • The plans should align documentation of the study question, study population, and study indicators with the State-defined specifications for all State-mandated PIP topics. • The plans should accurately report the study indicator definition, including the numerator, denominator, and measurement period dates, and align the documentation with relevant measurement specifications. • The plans should use methodologically sound sampling techniques and should fully document the methods used for sampling, when applicable.	For the HSAG series of recommendations, AHCA completed the following actions: • During the May 2015 Quarterly Meeting in Tallahassee, the HSAG PIP Team provided training to the plans that focused on current quality improvement science methods. While on-site, HSAG offered technical assistance sessions to the plans on their PIPs. • During June and July 2015, HSAG continued to provide technical assistance to the plans via conference call upon request. Technical assistance included how the plans should align documentation of the study question, study population, and study

HSAG Recommendation	AHCA Action
• The plans should thoroughly describe the administrative and/or manual data collection methods used for each PIP, including manual data collection tools, when used. The documented data collection methods should clearly show how enrollees are identified for inclusion in the denominator and numerator of the study indicator(s). • The plans should ensure that the estimated administrative data completeness is accurately calculated and documented for PIPs using claims data, when applicable. Both the estimated percentage of completeness and the methods used to determine estimated completeness should be documented in the PIP.	indicators with the State-defined specifications for all State-mandated PIP topics. • On July 1, 2015, AHCA sent an email communication to the plans, providing information on upcoming, quality-related due dates and submission clarification, which included expectations for PIP submissions.
AHCA should continue to offer and facilitate training and support opportunities to enhance the plans' capacity to implement robust quality improvement (QI) processes and strategies for their PIPs. Increasing the plans' efficacy with QI tools such as root cause analyses, key driver diagrams, process mapping, failure modes and effects analysis (FMEA), and Plan-Do-Study-Act (PDSA) cycles should help remove barriers to successfully achieving improvement in the PIP study indicators.	AHCA arranged for HSAG's PIP team to give presentations on how to use the PDSA cycle for the dental PIPs during the February 2016 quarterly webinar and May 2016 on-site quarterly meeting. During March and April 2016, AHCA's Medicaid Quality Bureau staff had on-site PIP Check-in meetings with the plans individually. These meetings focused on how the plans tested interventions for their PIPs and measured their success, with an emphasis on using PDSA cycles.
Validation of Performance Measures	
During its desk review of the FARs, HSAG identified that not all LTC plans' audits were conducted following NCQA's HEDIS Compliance Audit policies and procedures. Although all performance measures were AHCA-defined measures and not HEDIS measures, HSAG agreed with AHCA that to the 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 recommended that the FAR should include a brief description of these data systems used for calculating AHCA-defined measures.	On December 17, 2015, AHCA issued a performance measure policy transmittal to the plans, providing them with information about revised performance measure and child health check-up contract requirements for the July 1, 2016, performance measure submissions and submission of the FFY 2014–2015 child health check-up report. On January 13, 2016, AHCA updated its performance measure specifications document for both LTC and MMA AHCA-defined measures. On January 6, 2016, HSAG and AHCA met to discuss the need for an improved rate template. HSAG created a new and improved template for the July 2016 performance measure reporting.

HSAG Recommendation	AHCA Action
HSAG offered the following recommendations related to the LTC plan performance measures: • Since this was the first year the LTC plans were required to report the assigned measures, LTC plan variation in performance was expected. HSAG recommended that all LTC plans and AHCA consider the rates as baseline performance from which investigation or intervention strategies could be developed to improve quality for future years. • Since the *Case Manager Training* measure suggested 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.	On December 17, 2015, AHCA issued a performance measure policy transmittal to the plans, providing them with information about revised performance measure and child health check-up contract requirements for the July 1, 2016, performance measure submissions and submission of the FFY 2014–2015 child health check-up report. On January 13, 2016, AHCA updated its performance measure specifications document for both LTC and MMA AHCA-defined measures. On January 6, 2016, HSAG and AHCA met to discuss the need for an improved rate template. HSAG created a new and improved template for the July 2016 performance measure reporting.
Compliance With Access, Structure, and Operations Standards	
Based on the data from the readiness reviews, AHCA may want to continue targeted reviews and monitoring in the following standard areas: • Administration and Management • Enrollee Materials • Grievance System • Prescribed Drug Services • Provider Network In addition, AHCA may want to provide technical assistance for the SMMC plans to assist the plans in understanding and meeting requirements in these areas.	AHCA staff members conducted desk reviews of these areas and covered several of these areas as part of their site visits to the plans from June through October 2016.
AHCA should ensure that its ongoing compliance monitoring is designed to cover all of the areas required by 42 CFR §438.358, to ensure the plans meet federal requirements and standards established by the State for access to care, structure and operations, and quality measurement and improvement.	AHCA staff compiled a list of who is monitoring all applicable areas and how they are monitored.
Validation of Encounter Data	
AHCA should work with the plans to investigate and reconcile, where necessary, identified differences in the monthly encounter data volume. Although professional and dental encounter data volume	AHCA is holding the plans accountable to submit complete and accurate encounter data. AHCA requires the plans to audit their providers via edits to the claims payment system. In addition, AHCA has

HSAG Recommendation	AHCA Action
between AHCA- and plan-submitted encounter data was similar, variation among plans and encounter types, along with differences in overall volume, suggest potential deficiencies in the data. Results from the current study can be used to target specific encounter data to conduct data mining reviews and determine whether differences are due to failed or incomplete submissions or processing parameters associated with FMMIS. Ideally, AHCA's encounter system should accurately capture all encounters—i.e., both paid and denied—to account for all encounter information transmitted between the plans and the State.	worked closely with Hewlett-Packard (HP) and the HP field representatives to provide outreach and training with the plans, focusing on encounters submitted to the State.
AHCA should continue to work with its MMIS and DSS teams to implement standard quality controls to ensure the accurate production of reports and data extracts. Through the development of standard data extraction procedures and quality controls, the number of errors associated with extracted data could be reduced, leading to the use of fewer State resources and elimination of multiple data pulls. Moreover, stored procedures can be reused with minimal changes for future studies. Sufficient processes and training should be put in place to ensure the 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., data with missing values for all records in any of the data fields). • Data fields were populated with reasonable values. As of April 2015, AHCA began exploring how encounter data are pulled from its DSS to determine how to proceed with standardizing its encounter data extraction procedures.	AHCA instituted a policy that all data requests come through the Medicaid Data Analytics Bureau. This action should result in a decrease in variances and discrepancies between reporting systems.
AHCA should review its encounter data submission standards to ensure they meet agency needs and	AHCA implemented the Enhanced Ambulatory Patient Grouping (EAPG) System. It is anticipated

HSAG Recommendation	AHCA Action
expectations. As with most Medicaid programs, it is critical that agencies evaluate and reevaluate their data needs. As federal and State reporting of plan and program performance has become increasingly important, expectations need to be modified to ensure all data suppliers are submitting the necessary data to ensure complete and accurate reporting. For example, the EDV study noted considerable variation and low levels of completeness associated with encounter data elements characterized by situational reporting requirements—e.g., secondary diagnosis codes. The omission of these fields, coupled with inconsistent reporting by the plans, suggested a lack of consistency in both the completeness and accuracy of AHCA's encounter data. To ensure the most accurate reporting, it is key that data submission guidelines clearly delineate all required encounter fields. Additionally, due to the high number of missing or inaccurate provider-related encounter data elements (e.g., *Billing Provider NPI*), continued review of plan processes for tracking and submitting provider information is critical to overall encounter data quality.	that this initiative will have a positive impact to the data requirements for outpatient claim submissions, especially related to the requirement for submitting and capturing procedure codes. In addition, the review of encounter data submission standards was being addressed through various initiatives including the FLEX (Florida Encounter Exchange) Project, expanded benefits project, NPI (National Provider Identifier) crosswalk project, and EAPG project. The FLEX project modified editing verification processes to be unique toward encounter data submissions and improving AHCA's monitoring capabilities toward plan encounter data submissions. The Expanded Benefits Project enhanced the FMMIS to identify state plan services versus enhanced benefits to include service validations that are outside Medicaid approved services and to resolve encounter rejections for NPI crosswalk mismatches as a result of multiple matches. The NPI Crosswalk Project goal resolves all of the NPI crosswalk issues, resulting in a positive provider match for all encounter data submissions. The EAPG Project includes a requirement that a procedure code must be submitted for outpatient claims/encounters. To further this effort, AHCA contracted with a vendor to assess encounter data submissions and provide recommendations for improvement.
AHCA should continue its efforts to work with the plans to explore the reasons for incomplete encounter data submissions and develop strategies to improve rates.	AHCA continued to work closely with HP and the HP field representatives to perform outreach and training with the plans, focusing on encounters submitted to the State. In addition, since September 2014, Medicaid Fiscal Agent Operations and HP Provider Support have worked together to develop an encounter data support process. This effort created an HP Operational Support Unit that specifically worked with the plans to improve encounter data submission issues including both timeliness and accuracy. This unit works with the plans through a dedicated email account, on-site plan visits, webinars, and conference calls. An issues log process was implemented to track and resolve technical and policy-related issues. AHCA hired a dedicated staff person in the Medicaid Fiscal Agent Operations Unit to support these efforts and also be a contact for the plans for encounter data submissions.

HSAG Recommendation	AHCA Action
AHCA should review, and modify as needed, existing plan contracts and encounter submission guidelines to include language outlining specific requirements for submitting complete data to AHCA. Modification to the contract or supplemental guidelines should include explicit definitions of the types of encounters to be submitted—e.g., paid, denied, other. As the ultimate payer, AHCA's encounter data system should comprise a complete record of all transactions processed and maintained by the plans and downstream contractors. In addition, to ensure complete data, contracts should specify any critical elements (e.g., provider data) needed for contract and program monitoring.	The current SMMC contract holds the plans accountable for submitting complete and accurate encounter data. To assist in this process, AHCA continued to work closely with HP and the HP field representatives to perform outreach and training with the plans, focusing on encounters submitted to the State.
AHCA should consider developing a monitoring strategy to routinely examine encounter volume. As part of a larger encounter data quality strategy or program, these metrics would help ensure timely identification of potential problems and establish expectations of contracted plans. Additionally, implementation of a performance monitoring system could lead to the development of performance standards that can be used to monitor plan performance as well as a means to monitor contract compliance. AHCA can monitor encounter volume by provider type, place of service, type of service (e.g., vision, lab), etc.	AHCA developed a monitoring strategy to routinely examine encounter volume. AHCA created the following reports to monitor encounter data: • Encounter Accuracy Trending • Encounters by Claim Type • Encounter Timeliness • Monthly Encounter Statistics Report for SMMC
AHCA should work with the plans to develop a monitoring program that requires the plans to audit provider encounter submissions for completeness and accuracy. AHCA may also want to require the plans to develop periodic provider education and training regarding encounter data submissions, 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 encounter data monitoring.	AHCA and its fiscal agent continued to work with the plans to ensure that encounter data submissions are complete and accurate. AHCA and its fiscal agent increased their efforts related to monitoring and oversight of the plans' encounter data submissions. The fiscal agent's field staff continued to provide technical assistance to all plans, especially in areas identified for improvement.

HSAG Recommendation	AHCA Action
Focused Study: Cultural Competency	
HSAG made the following recommendations: • Develop a detailed cultural competency policy that includes the minimum required elements of a Cultural Competency Plan (CCP). Consider developing a "Checklist of Required Elements" as an attachment to the policy. • Update the core contract language to refer to a CCP policy, if a policy is developed. • Require that the findings from the plan's evaluation be applied to updating the annual CCP, as necessary.	AHCA developed language and executed a contract amendment to include more specific requirements for each SMMC plan's Cultural Competency Plan and Annual Evaluation. The language for the contract amendment included more specific requirements for each SMMC plan's CCP and annual evaluation.
AHCA should consider requiring plan adherence to some, if not all, of the National CLAS Standards with clear guidance on the minimum requirements to meet each standard.	AHCA developed language for a contract amendment with more specific requirements for each SMMC Plan's CCP and annual evaluation. AHCA decided to not require that plans adhere to all of the National CLAS Standards; however, AHCA noted that a review of the 2015 CCPs indicated that 12 of the 19 plans adhered to some, if not all, of the National CLAS Standards.

2. Introduction

Background

The Balanced Budget Act of 1997 (BBA), in accordance with CFR §438.350 external quality review, requires that states ensure that a qualified EQRO perform an annual review for each contracting MCO, PIHP, PAHP, or PCCM entity (described in CFR §438.310(c)(2)). The BBA further specifies that the EQR activities be conducted in a manner consistent with the protocols established under 42 CFR §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 has progressively moved 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 Provider Access System (MediPass), a Primary Care Case Management (PCCM) program, 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, 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 SMMC program with two components: the MMA program and the LTC program.
- On June 14, 2013, CMS approved an amendment to the State's 1115 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 by region, 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 to August 2014.

- The SMMC program was successfully implemented by August 1, 2014.
- Since the initial SMMC program was implemented and as of December 2016, the plans have consolidated to 17 MMA plans (11 MMA Standard plans and six MMA Specialty plans), and six LTC plans.

The demographics of the Florida Medicaid population (excluding the fee-for-service population) as of December 2016 were as follows[8]:

- Approximately 3.1 million were enrolled in an MMA Standard plan.
- Approximately 68,400 were enrolled in an MMA Specialty plan.
- Approximately 94,000 were enrolled in an LTC plan.

The State's Comprehensive Quality Strategy

The Florida Medicaid Revised Comprehensive Quality Strategy 2013–2014 Update (also referred to as the 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."[9]

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.

[8] Agency for Health Care Administration. Florida Statewide Medicaid Monthly Enrollment Report. Available at: https://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml. Accessed on: Dec 7, 2016.

[9] 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: Dec 7, 2016.

To meet CMS requirements and State goals, AHCA contracted with HSAG to conduct EQR mandatory and optional activities for SFY 2015–2016. The assessment of these activities and recommendations that follow, as discussed in Section 3 of this report, are an integral component of AHCA's CQS. 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 CQS was the transition to SMMC. The SMMC program 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. The MMA program provides primary and acute medical assistance and related services. With both programs fully implemented, all PMHPs/CWPMHP and PDHPs were phased out.

Please refer to Appendix H for a comprehensive list of plan names, by plan type.

Purpose of the Report

The purpose of the SFY 2015–2016 External Quality Review Technical Report is to comply with the requirements as set forth under 42 CFR part 438 Managed Care Rules, which require 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.

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–H. 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 information required by the Managed Care Rules regarding the methodology for conducting EQR activities may be found in Appendix A. Appendices B, C, D, E, F, and G include plan-specific PIP, performance measure, compliance review, EDV, and network adequacy study results, respectively. Appendix H includes a comprehensive list of plan names, by plan type.

Validation of Performance Improvement Projects

MMA Plans

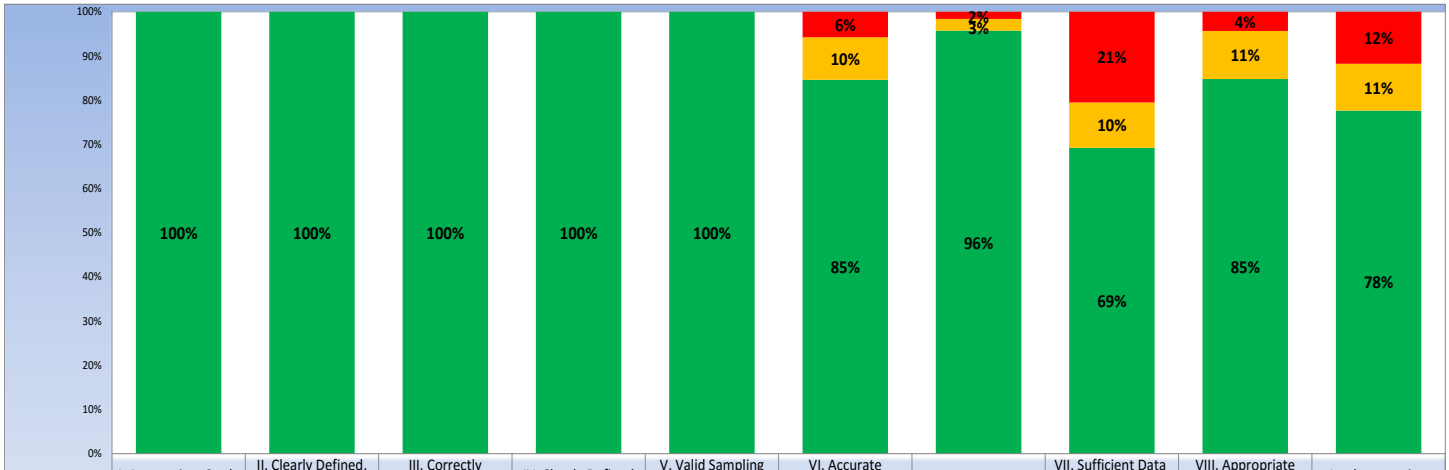
Results—PIP Validation Status

HSAG validated two State-mandated PIPs for the MMA plans during the SFY 2015–2016 validation year. The *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIP was submitted by 13 MMA Standard plans. The *Preventive Dental Services for Children* PIP was submitted by 13 MMA Standard plans and three MMA Specialty plans. A total of 29 PIPs conducted by the MMA plans focused on one of the two State-mandated PIP topics. With the PIPs having progressed through the Implementation stage, the MMA plans reported baseline study indicator results for the State-mandated PIPs in SFY 2015–2016 and HSAG validated Activities I–VIII, accordingly.

Validation Status of the State-Mandated *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIP

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 *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIP. HSAG validated 13 MMA Standard Plans' PIPs for this topic. Percentage totals may not equal 100 due to rounding.

Figure 3-1—State-Mandated PIP Validation Scores by Activity and Stage:
Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits



	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
Not Met	0%	0%	0%	0%	0%	6%	2%	21%	4%	12%
Partially Met	0%	0%	0%	0%	0%	10%	3%	10%	11%	11%
Met	100%	100%	100%	100%	100%	85%	96%	69%	85%	78%

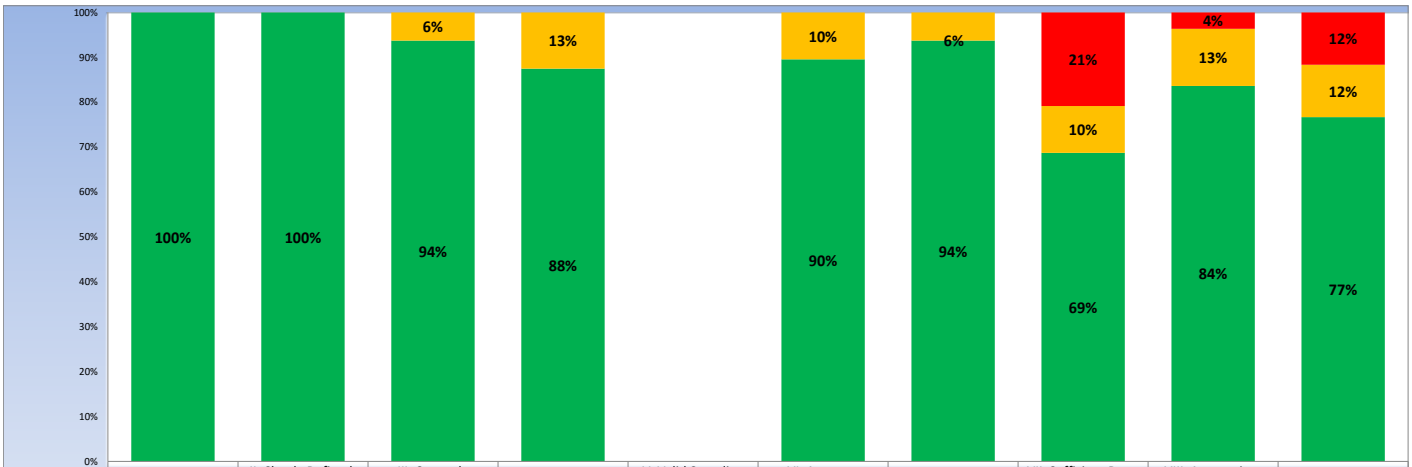
In the Design stage of the *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIP, the MMA plans had the greatest opportunities for improvement in Activity VI (Accurate Complete Data Collection), the only activity in the Design stage that did not receive a *Met* score for 100 percent of applicable evaluation elements. The greatest challenge in Activity VI was accurate documentation of estimated administrative data completeness. In this activity, 85 percent of applicable evaluation elements received a *Met* score. Across all six activities of the Design stage, 96 percent of the evaluation elements received a *Met* score, suggesting that despite some minor challenges related to data collection methods, the MMA plans used a methodologically sound study design for this State-mandated PIP. The MMA plans can address the deficiencies identified in the study design by reviewing the State-defined and HEDIS-based specifications for the PIP and addressing HSAG's feedback in the PIP validation tool.

In the Implementation stage of the PIP, 78 percent of evaluation elements received a *Met* score, suggesting substantial opportunities for improvement in this stage. The MMA plans performed better in Activity VIII (Appropriate Improvement Strategies), with 85 percent of evaluation elements being scored *Met*, compared to Activity VII (Sufficient Data Analysis and Interpretation), where only 69 percent of elements were scored *Met*. While some of the MMA plans had difficulty reporting and interpreting the baseline study indicator results accurately, the most common issue in Activity VII was a lack of documentation regarding whether the MMA plan identified factors that affected the validity of the results. The most common challenges in Activity VIII were related to conducting a thorough and methodologically sound causal/barrier analysis and prioritization of barriers. The MMA plans should address errors and omissions in Activities VII and VIII to ensure accurate outcomes measurement and effective quality improvement strategies are being used to drive improvement.

Validation Status of the State-Mandated *Preventive Dental Services for Children* PIP

Figure 3-2 displays the percentage of evaluation elements achieving a *Met*, *Partially Met*, and *Not Met* validation score by activity and stage for the *Preventive Dental Services for Children* PIP. HSAG validated a total of 16 PIPs—13 MMA Standard plan PIPs and three MMA Specialty plan PIPs—for this topic. Percentage totals may not equal 100 due to rounding.

Figure 3-2—State-Mandated PIP Validation Scores by Activity and Stage:
Preventive Dental Services for Children



	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
Not Met	0%	0%	0%	0%		0%	0%	21%	4%	12%
Partially Met	0%	0%	6%	13%		10%	6%	10%	13%	12%
Met	100%	100%	94%	88%		90%	94%	69%	84%	77%

*No data are presented for Activity V. Valid Sampling Techniques because sampling was not used for the *Preventive Dental Services for Children* PIP.

For the *Preventive Dental Services for Children* PIP, the MMA plans generally designed methodologically sound projects and received a *Met* score for 94 percent of applicable evaluation elements in the Design stage. Because data collection for the PIP was not based on sampling, Activity V (Valid Sampling Techniques) was not scored; the Design stage score was based on Activities I through IV and Activity VI. While the MMA plans demonstrated solid performance across the Design stage, they had the greatest opportunities for improvement in Activity IV (Clearly Defined Study Indicator[s]), where 88 percent of the evaluation elements received a *Met* score. The MMA plans may address deficiencies in Activity IV by reviewing the State-defined specifications for the PIP and ensuring that the PIP documentation for Activity IV clearly and accurately defines the study indicator and aligns with the State-defined specifications.

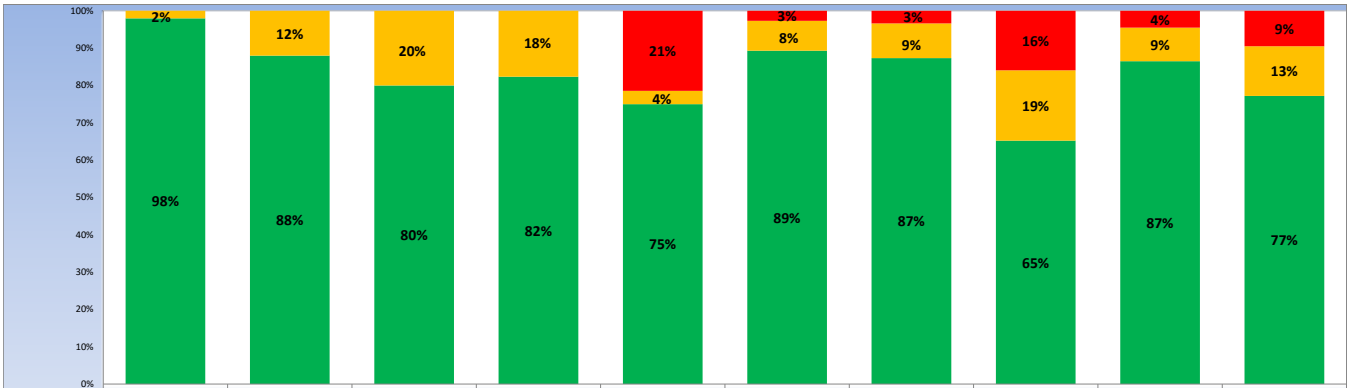
The percentage of elements receiving a *Met* score for the Implementation stage was 77 percent, suggesting the MMA plans had room for improvement in this stage. The MMA plans' performance in the Implementation stage for this PIP was similar to their performance on the *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIP. In the *Preventive Dental Services for Children* PIP, the MMA plans again performed better in Activity VIII (Appropriate Improvement Strategies) than in Activity VII (Sufficient Data Analysis and Interpretation). In Activity VIII, 84 percent of the evaluation elements were scored *Met* compared to Activity VII, where only 69 percent received a *Met* score. For the Implementation stage, the plans most commonly struggled with clear and accurate documentation of the study indicator results. Documenting whether factors were identified that affected the validity of the results was a common challenge for the plans. In Activity VIII, the most common challenges were related to conducting a thorough and methodologically sound causal/barrier analysis and prioritizing barriers. The MMA plans should refer to HSAG's feedback in the

validation tool to correct errors in reported study indicator results and validity of results. Technical assistance from HSAG is available to the plans, upon request, for PIP study design and implementation questions requiring further guidance.

Validation Status of Clinical PIPs

Figure 3-3 displays the percentage of evaluation elements achieving a *Met*, *Partially Met*, and *Not Met* validation score by activity and stage for the clinical PIPs submitted by the MMA plans. HSAG validated a total of 25 clinical PIPs submitted by the MMA plans. Percentage totals may not equal 100 due to rounding.

Figure 3-3—MMA Clinical PIP Validation Scores by Activity and 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
Not Met	0%	0%	0%	0%	21%	3%	3%	16%	4%	9%
Partially Met	2%	12%	20%	18%	4%	8%	9%	19%	9%	13%
Met	98%	88%	80%	82%	75%	89%	87%	65%	87%	77%

Across the six activities in the Design stage of the clinical PIPs, 87 percent of the evaluation elements received a *Met* score. The MMA plans demonstrated the greatest need for improvement in Activity V (Valid Sampling Techniques), where only 75 percent of the evaluation elements received a *Met* score. After Activity V, the plans had the greatest room for improvement in Activity III (Correctly Identified Study Population) and Activity IV (Clearly Defined Study Indicators), where 80 percent and 82 percent of the elements, respectively, received a *Met* score. The MMA plans should review and address HSAG's feedback in the PIP validation tool to strengthen the study design of their clinical PIPs.

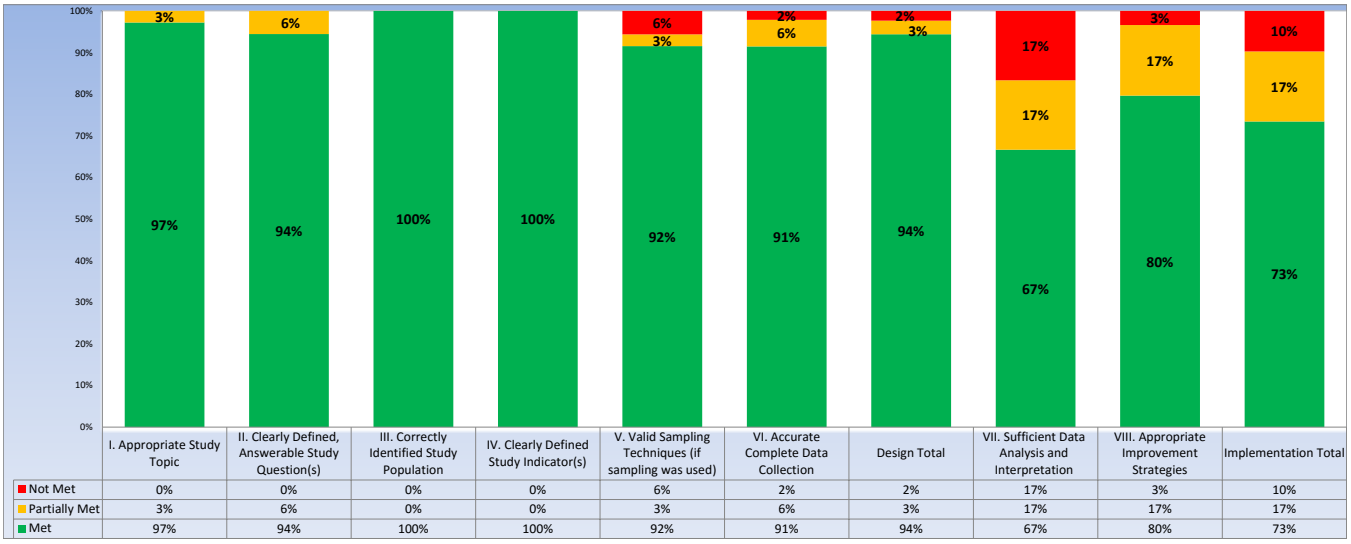
Across the two activities in the Implementation stage, 77 percent of the evaluation elements received a *Met* score. The MMA Standard plans had stronger performance in Activity VIII (Appropriate Improvement Strategies), where 87 percent of the elements received a *Met* score, compared to Activity VII (Sufficient Data Analysis and Interpretation), where only 65 percent of the elements received a *Met* score. In Activity VII, the plans had challenges in accurately documenting and interpreting study indicator results and documenting whether factors were identified that impacted the validity of the results. The greatest opportunities for improvement in Activity VIII were completing a methodologically sound causal/barrier analysis and identifying and prioritizing barriers. The plans should consult the

feedback provided in the PIP validation tool and seek technical assistance from HSAG if questions remain on improving performance in Activities VII and VIII.

Validation Status of Nonclinical PIPs

Figure 3-4 displays the percentage of evaluation elements achieving a *Met*, *Partially Met*, and *Not Met* validation score by activity and stage for the nonclinical PIPs submitted by the MMA plans. HSAG validated a total of 18 nonclinical PIPs submitted by the MMA plans. Percentage totals may not equal 100 due to rounding.

Figure 3-4—MMA Nonclinical PIP Validation Scores by Activity and 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
Not Met	0%	0%	0%	0%	6%	2%	2%	17%	3%	10%
Partially Met	3%	6%	0%	0%	3%	6%	3%	17%	17%	17%
Met	97%	94%	100%	100%	92%	91%	94%	67%	80%	73%

The MMA plans applied methodologically sound design principles to their nonclinical PIPs, as evidenced by their performance across all six activities in the Design stage, where 94 percent of the evaluation elements received a *Met* score. The percentage of evaluation elements receiving a *Met* score by activity ranged from 91 percent in Activity VI (Accurate Complete Data Collection) to 100 percent in Activities III (Correctly Identified Study Population) and IV (Clearly Defined Study Indicator[s]).

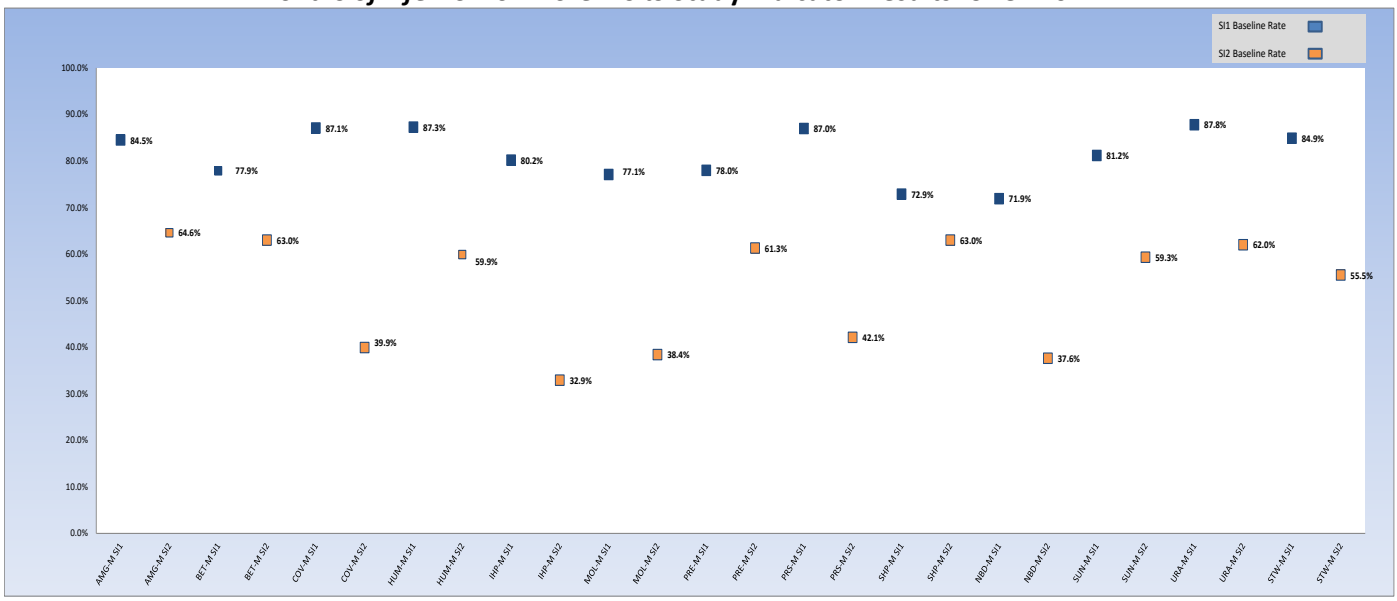
The MMA plans had greater room for improvement in the Implementation stage than in the Design stage, with only 73 percent of evaluation elements across Activities VII and VIII receiving a *Met* score. The plans performed better in Activity VIII (Appropriate Improvement Strategies), where 80 percent of evaluation elements were scored *Met* compared to Activity VII (Sufficient Data Analysis and Interpretation), where 67 percent of evaluation elements were scored *Met*. The most common areas in need of improvement included the narrative interpretation of study indicator results and identification of factors affecting the validity of the results in Activity VII, as well as the causal/barrier analysis, barrier identification, and barrier prioritization in Activity VIII. The plans should seek additional assistance, as needed, to address gaps in their data analysis and quality improvement capacity, identified by any evaluation elements that did not receive a *Met* score.

Results—Study Indicator Results

Study Indicator Results for the *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIP

Figure 3-5 displays the baseline measurement period rates reported by the MMA Standard plans for the State-mandated *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIP. There were two study indicators for this PIP: Study Indicator 1 was the rate of pregnant members who received a timely prenatal care visit and Study Indicator 2 was the rate of child members who received six or more well-child visits by 15 months of age. The baseline rates for Study Indicator 1 (SI1) are designated by the dark blue boxes plotted on the chart. The baseline rates for Study Indicator 2 (SI2) are designated by the orange boxes. The X axis is labeled with the plan name abbreviation and study indicator (SI1 or SI2) for each data point on the chart. The full name of each MMA plan and associated plan name abbreviation are presented in Appendix H.

Figure 3-5—State-Mandated *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* Study Indicator Results for CY 2014

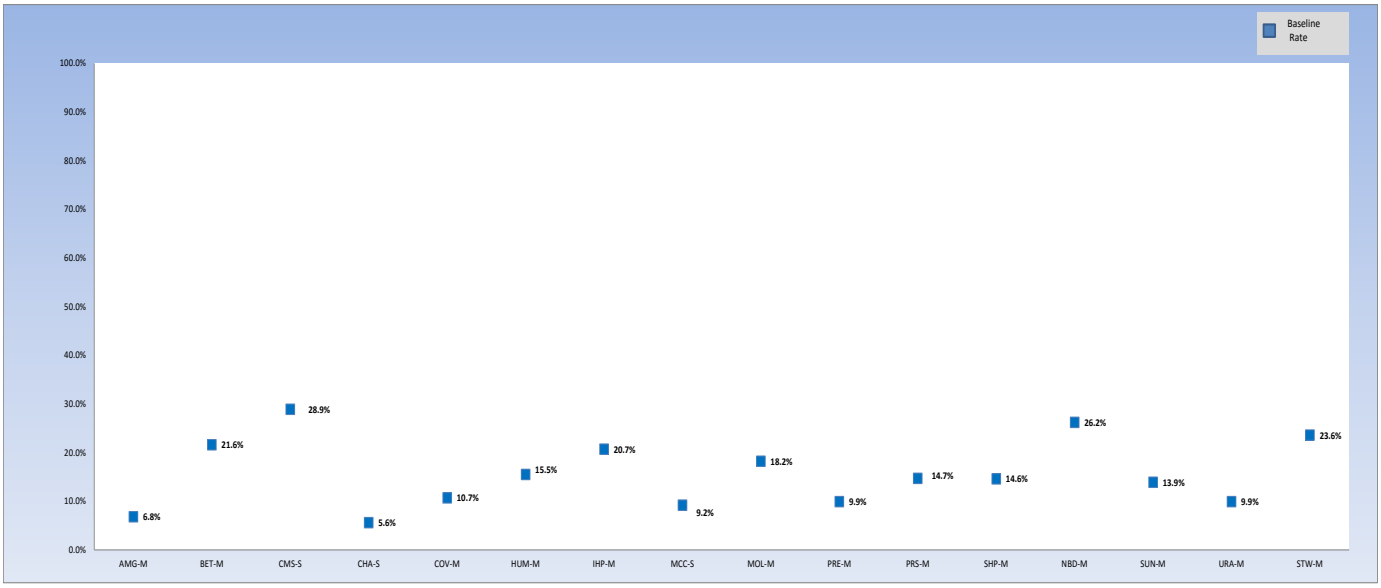


Thirteen MMA Standard plans reported baseline results for the PIP's two study indicators. Across the 13 PIPs, the plans had higher baseline rates for SI1 (timely prenatal visits—in dark blue), than SI2 (well-child visits—in orange), suggesting that, in general, the plans have more room for improvement in the rate of well-child visits in the first 15 months of life than the rate of timely prenatal visits. The baseline rates of timely prenatal visits ranged from 71.9 percent to 87.8 percent. The baseline rates of children receiving six or more well-child visits in the first 15 months of life ranged from 32.9 percent to 64.6 percent. United reported the highest baseline rate of timely prenatal visits (87.8 percent) and Amerigroup reported the highest baseline rate of children receiving six or more well-child visits in the first 15 months of life (64.6 percent).

Study Indicator Results for the *Preventive Dental Services for Children* PIP

Figure 3-6 displays the baseline measurement period rates reported by the MMA Standard and Specialty plans for the State-mandated *Preventive Dental Services for Children* PIP. There was one study indicator for the PIP, which measured the rate of child members, ages 1 to 20, who received at least one preventive dental visit during the measurement year. The baseline rate for each plan's PIP is represented by a blue box. The X axis is labeled with the plan name abbreviation for each data point on the chart. The full name of each MMA plan and associated plan name abbreviation are presented in Appendix H.

Figure 3-6—State-Mandated *Preventive Dental Services for Children* Study Indicator Results for Federal Fiscal Year (FFY) 2013–2014



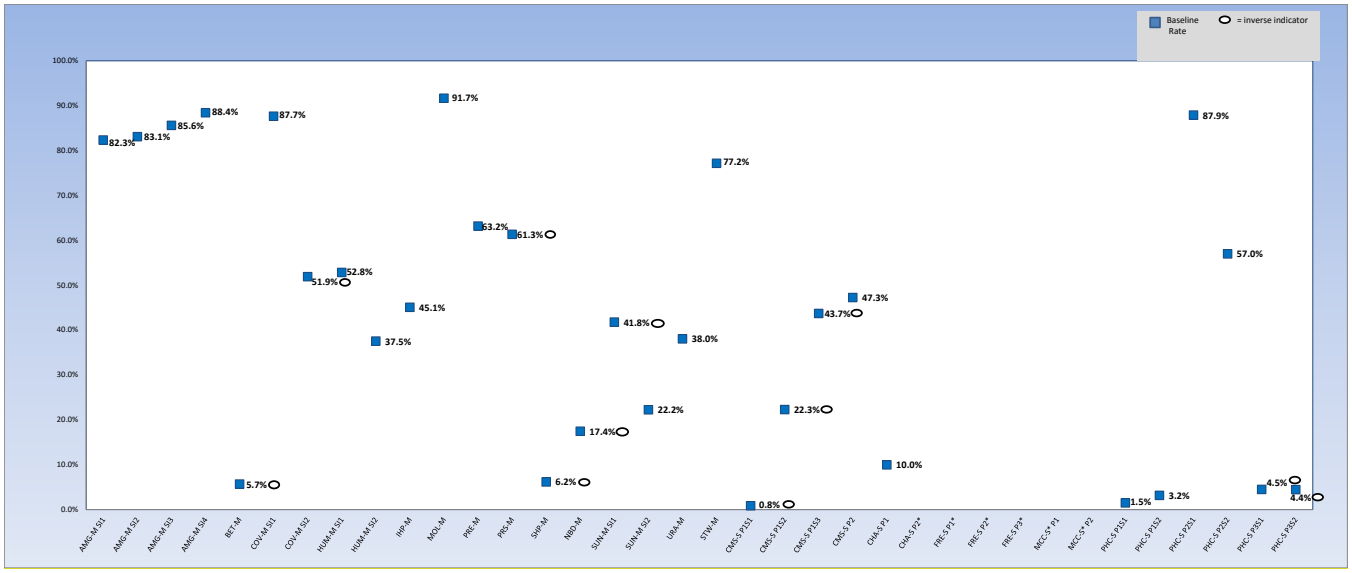
Thirteen MMA Standard plans and three MMA Specialty plans reported baseline results for the PIP's study indicator. The lowest baseline rate (5.6 percent) was reported by Clear Health-S, and the highest baseline rate (28.9 percent) was reported by Children's Medical Services-S. The baseline rates across the 16 MMA plans suggest considerable room for improvement in children's preventive dental service rates for all of the plans.

It should be noted that AHCA identified inconsistencies in the data collection and calculation processes for the *Preventive Dental Services for Children* PIP study indicator baseline rates among plans. Upon discovery of the rate calculation inconsistencies, AHCA instructed the plans to review their baseline rate data collection and calculation processes and make corrections, as needed, to ensure the correct rates were reported. Because the inconsistencies were identified after PIP validation had begun, HSAG could not incorporate the corrected rates into the SFY 2015–2016 PIP validation. HSAG will review all corrected baseline rates when they are submitted for the SFY 2016–2017 PIP validation and will revise the baseline rates reported in Figure 3-6 , as warranted, in the SFY 2016–2017 Technical Report.

Study Indicator Results for the MMA Clinical PIPs

Figure 3-7 displays the baseline measurement period rates reported by the MMA plans for the plan-selected clinical PIPs. The blue boxes on the chart represent the baseline study indicator rate reported for each study indicator. 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 plan name (i.e., SI1 for Study Indicator 1 and SI2 for Study Indicator 2). The X axis is labeled with the plan name abbreviation and SI1 or SI2 for each data point on the chart. The full name of each MMA Standard plan and associated plan name abbreviation are presented in Appendix H.

Figure 3-7—MMA Clinical PIP Study Indicator Results for CY 2014

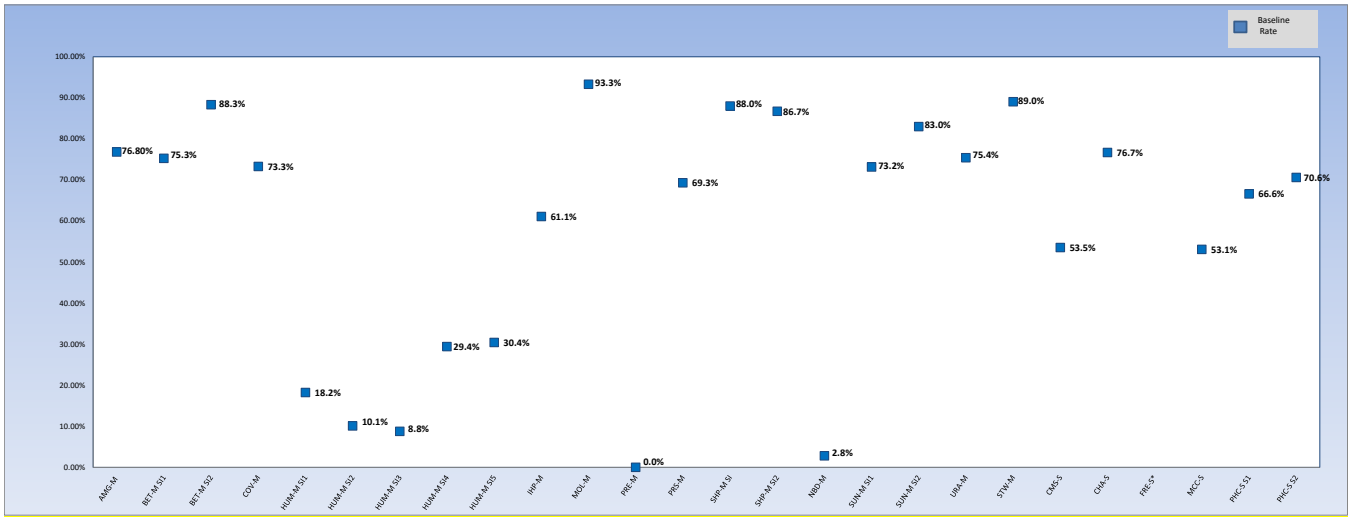


Sixteen MMA plans reported baseline results for a total of 30 clinical PIP study indicators. Two MMA plans did not report baseline results for their clinical PIPs, and one plan reported baseline results for one clinical PIP but not for its second clinical PIP; therefore, six study indicators do not have a baseline rate plotted on the chart. Eleven of the study indicators with baseline results were inverse indicators, where a lower rate is better. The baseline rates for the inverse study indicators ranged from a minimum of 0.8 percent, reported by Children's Medical Services-S, to a maximum of 61.3 percent, reported by Prestige. The baseline rates for the remaining 19 study indicators, where a higher percentage is better, ranged from a minimum of 1.5 percent, reported by Positive-S, to a maximum of 91.7 percent, reported by Molina. The wide ranges of baseline study indicator rates among the clinical PIPs suggested that there was considerable variation, by plan and PIP topic, in the opportunities for improvement in the clinical PIPs.

Study Indicator Results for the MMA Nonclinical PIPs

Figure 3-8 displays the baseline study indicator rates reported by the MMA plans for the plan-selected nonclinical PIPs. Note: 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). The X axis is labeled with the plan name abbreviation and, if applicable, SI1 or SI2 for each data point on the chart. The full name of each MMA Standard plan and associated plan name abbreviation are presented in Appendix H.

Figure 3-8—MMA Nonclinical PIP Study Indicator Results for CY 2014



Seventeen MMA plans reported baseline results for a total of 25 nonclinical PIP study indicators. One MMA plan, Freedom-S, did not report baseline results for its nonclinical PIP. The baseline study indicator rates varied widely by plan and PIP topic. While six of the baseline study indicator rates were greater than 80 percent, another five baseline rates were below 20 percent, illustrating the wide rate variation among the PIPs. Preferred reported the lowest baseline study indicator rate at 0.0 percent. Molina reported the highest baseline study indicator rate, or 93.3 percent. The wide range of baseline study indicator rates suggested that some of the nonclinical PIPs have considerably more room for improvement than others.

MCO Comparison

The SFY 2015–2016 validation results for the MMA PIPs suggest that, among the two State-mandated PIP topics, the MMA plans performed better on the *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIPs, where 54 percent of PIPs received a *Met* validation status, than on the *Preventive Dental Services for Children* PIPs, among which only 25 percent of PIPs received a *Met* validation status. The MMA plans' reported baseline study indicator results varied widely for both State-mandated PIP topics. For Study Indicator 1 (timely prenatal visits) in the *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIP, SFCCN demonstrated the greatest need for improvement, with a baseline rate of 71.9 percent. For Study Indicator 2 (well-child visits), Integral demonstrated the greatest need for

improvement, with a baseline rate of 32.9 percent. For the *Preventive Dental Services for Children* PIP, Clear Health-S demonstrated the greatest need for improvement, with a baseline study indicator rate of 5.6 percent. Children's Medical Services-S reported the highest baseline rate (28.9 percent); however, this rate still represented substantial room for improvement in the preventive dental visit rate.

For the plan-selected PIP topics, the MMA plans performed better on the nonclinical PIPs, with 61 percent of the PIPs receiving a *Met* validation status, compared to the clinical PIPs, of which 44 percent received a *Met* validation status. The baseline study indicator rates varied widely for the clinical and nonclinical plan-selected PIPs. Among the clinical PIPs, 11 of the study indicators with baseline results were inverse indicators, where a lower rate is better. Prestige reported the highest baseline rate for an inverse study indicator (61.3 percent), demonstrating the greatest need for improvement among those PIPs with inverse indicators. Of the remaining study indicators, where a higher percentage is better, the greatest need for improvement was demonstrated by Positive-S, which reported a baseline rate of 1.5 percent. Among the nonclinical plan-selected PIPs, Preferred demonstrated the greatest need for improvement, with a reported baseline study indicator rate of 0.0 percent.

Conclusions and Recommendations

During the SFY 2015–2016 validation cycle, HSAG validated the baseline measurement period of the MMA plans' PIPs though the Design and Implementation stages (Activities I through VIII). The percentage of PIPs receiving an overall *Met* validation status varied by PIP topic. Among the two State-mandated PIP topics submitted by the MMA plans, a lower percentage of the *Preventive Dental Services for Children* PIPs (25 percent) received a *Met* validation status compared to the *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIPs (54 percent). Based on the validation results, HSAG concluded that the MMA plans had considerable opportunities for improvement in the Implementation stage for the *Preventive Dental Services for Children* PIPs.

Based on the overall validation status of the additional plan-selected clinical and nonclinical PIPs submitted by the MMA plans, the plans had greater opportunities for improvement among the clinical PIPs than among the nonclinical PIPs. As summarized in Figure 1-2, the MMA plans received a *Met* overall validation status for only 44 percent of the plan-selected clinical PIPs compared to 61 percent of the nonclinical PIPs. Despite the difference in the percentage of PIPs receiving an overall *Met* validation status, the MMA plans had opportunities for improvement in the study designs and implementation of both the clinical and nonclinical plan-selected PIPs.

HSAG determined that opportunities for improvement in the Implementation stage of the PIPs existed for the MMA plans. While the PIP validation scores varied by plan PIP topic, in general the Implementation stage presented greater challenges for the plans than the Design stage. The validation scores in the Design stage suggested that, overall, the plans designed methodologically sound projects capable of accurately measuring and evaluating annual measurements of the PIP study indicators. In the Implementation stage, the plans had challenges with both Activity VII (Sufficient Data Analysis and Interpretation) and Activity VIII (Appropriate Improvement Strategies). Due to the sequential nature of the PIP process, in which one stage provides the foundation for the next stage, addressing any

opportunities for improvement in the Design and Implementation stages is critical to achieving success in the Outcomes stage.

To improve performance in the PIP Implementation stage, and subsequently in the achievement of improved outcomes, the MMA plans should ensure that robust QI strategies are used to identify and prioritize barriers and to develop interventions for each PIP. This recommendation is especially relevant to the *Preventive Dental Services for Children* PIPs, among which only 25 percent of the PIPs achieved a *Met* validation status. The MMA plans should address HSAG's feedback in the PIP validation tool and seek additional technical assistance, as needed, so that impactful strategies are being used to improve the study indicator rates.

The MMA plans should also ensure that the documentation of the PIP design, including study question, study population, and study indicators, are clearly and accurately documented, and align with the State-defined specifications for the State-mandated PIP topics. Additionally, the plans should thoroughly describe the data collection process used for each PIP, showing clearly how enrollees are identified for inclusion in the denominator and numerator of the study indicators. For PIPs relying on sampling techniques, the plans should ensure that sound sampling methods are used and documented. Finally, the plans should correct any errors in the study indicator rate calculations identified by HSAG during PIP validation. Accurate study indicator rates are necessary for an accurate measurement of progress in improving PIP outcomes during the remeasurement periods.

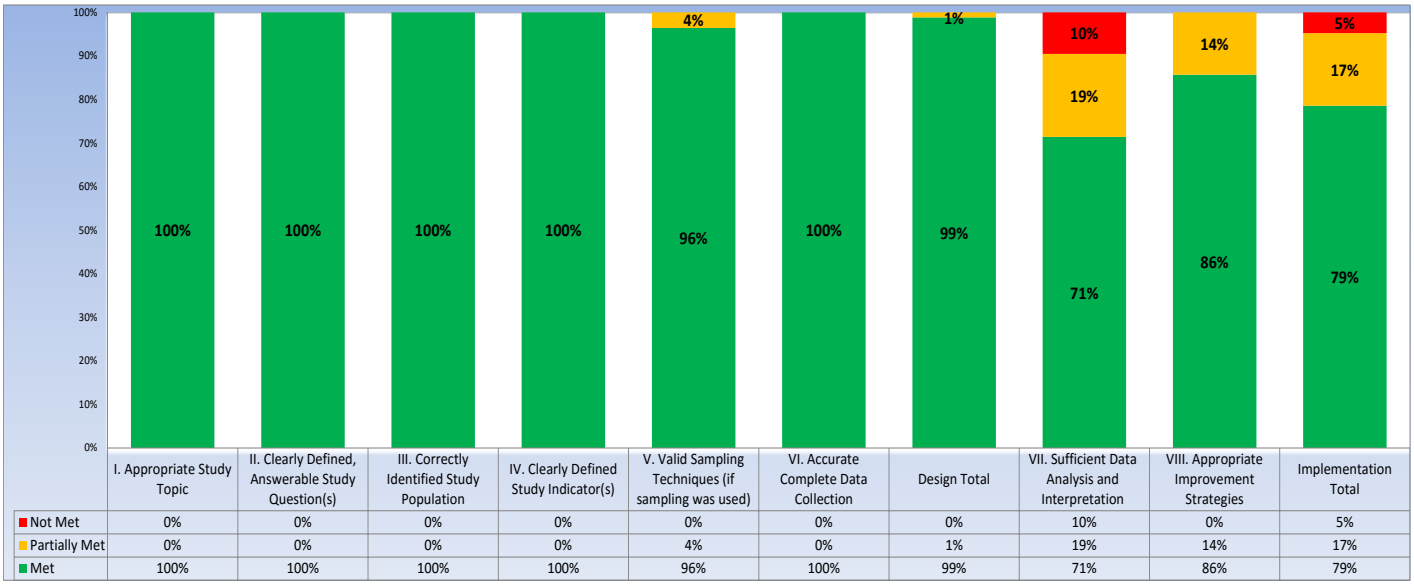
LTC Plans

Results—PIP Validation Status

Validation Status of the *Medication Review* PIP

Figure 3-9 displays the percentage of evaluation elements achieving a *Met*, *Partially Met*, and *Not Met* validation score by activity and stage for the *Medication Review* PIP. HSAG validated a total of seven LTC plan PIPs for this topic. Percentage totals may not equal 100 due to rounding.

Figure 3-9—State-Mandated PIP Validation Scores by Activity and Study Stage: *Medication Review*



	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
Not Met	0%	0%	0%	0%	0%	0%	0%	10%	0%	5%
Partially Met	0%	0%	0%	0%	4%	0%	1%	19%	14%	17%
Met	100%	100%	100%	100%	96%	100%	99%	71%	86%	79%

In the Design stage of the *Medication Review* PIP, the LTC plans demonstrated a strong application of sound scientific principles by receiving a *Met* score for 99 percent of all applicable evaluation elements across the six activities. The LTC plans received a *Met* score for 100 percent of the elements in Activities I (Appropriate Study Topic), II (Clearly Defined, Answerable Study Question), III (Correctly Identified Study Population), IV (Clearly Defined Study Indicator[s]), and VI (Accurate Complete Data Collection). Ninety-six percent of the elements in Activity V (Valid Sampling Techniques), the remaining activity in the Design stage, received a *Met* score, suggesting that the LTC plans performed well throughout the Design stage.

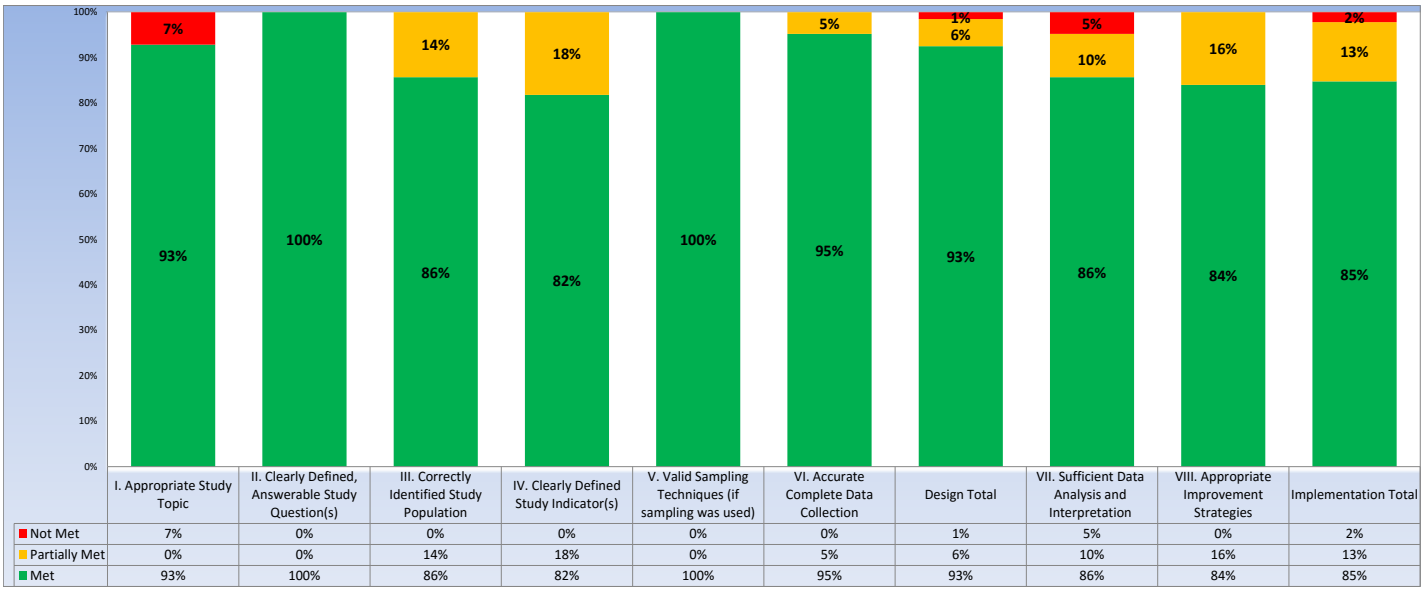
The LTC plans had greater challenges in the Implementation stage of the *Medication Review* PIP, where only 79 percent of the evaluation elements received a *Met* score. The LTC plans' performance in this stage was similar to the MMA plans' performance for the other two State-mandated PIP topics. Like the MMA plans, the LTC plans performed better in Activity VIII (Appropriate Improvement Strategies), receiving a *Met* score for 86 percent of the elements, compared to Activity VII (Sufficient Data Analysis and Interpretation), where they received a *Met* score for only 71 percent of the elements. The LTC plans' most common challenge in Activity VII was incomplete documentation of whether they identified

factors that impacted the validity of the PIP study indicator results. In Activity VIII, the LTC plans had opportunities to improve performance on conducting a thorough and methodologically sound causal/barrier analysis and prioritizing barriers.

Validation Status of the Nonclinical PIPs

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 nonclinical PIPs submitted by the LTC plans. HSAG validated seven nonclinical PIPs submitted by the LTC plans. Percentage totals may not equal 100 due to rounding.

Figure 3-10—LTC Nonclinical 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
Not Met	7%	0%	0%	0%	0%	0%	1%	5%	0%	2%
Partially Met	0%	0%	14%	18%	0%	5%	6%	10%	16%	13%
Met	93%	100%	86%	82%	100%	95%	93%	86%	84%	85%

In general, the LTC plans designed methodologically sound nonclinical PIPs and received a *Met* score for 93 percent of the applicable evaluation elements across the six activities in the Design stage. The percentage of *Met* scores by activity ranged from 82 percent in Activity IV (Clearly Defined Study Indicator[s]) to 100 percent in Activities II (Clearly Defined, Answerable Study Question[s]) and V (Valid Sampling Techniques). The most common challenge for the LTC plans in the Design stage was related to lack of clear and complete definitions for the study indicators. One LTC plan received a *Not Met* score in Activity I (Appropriate Study Topic), which led to a score of 93 percent across all LTC nonclinical PIPs for Activity I. One LTC plan received a *Not Met* score in Activity I because it did not appropriately revise the PIP's study topic in response to HSAG's recommendation in the previous year's PIP validation tool, which focused on the PIP's study design.

In the Implementation stage, across all of the nonclinical PIPs, the LTC plans received a *Met* score for 85 percent of the evaluation elements across in Activities VII (Sufficient Data Analysis and Interpretation) and VIII (Appropriate Improvement Strategies). The LTC plans performed similarly in the two individual activities, receiving a *Met* score for 86 percent of the evaluation elements in Activity

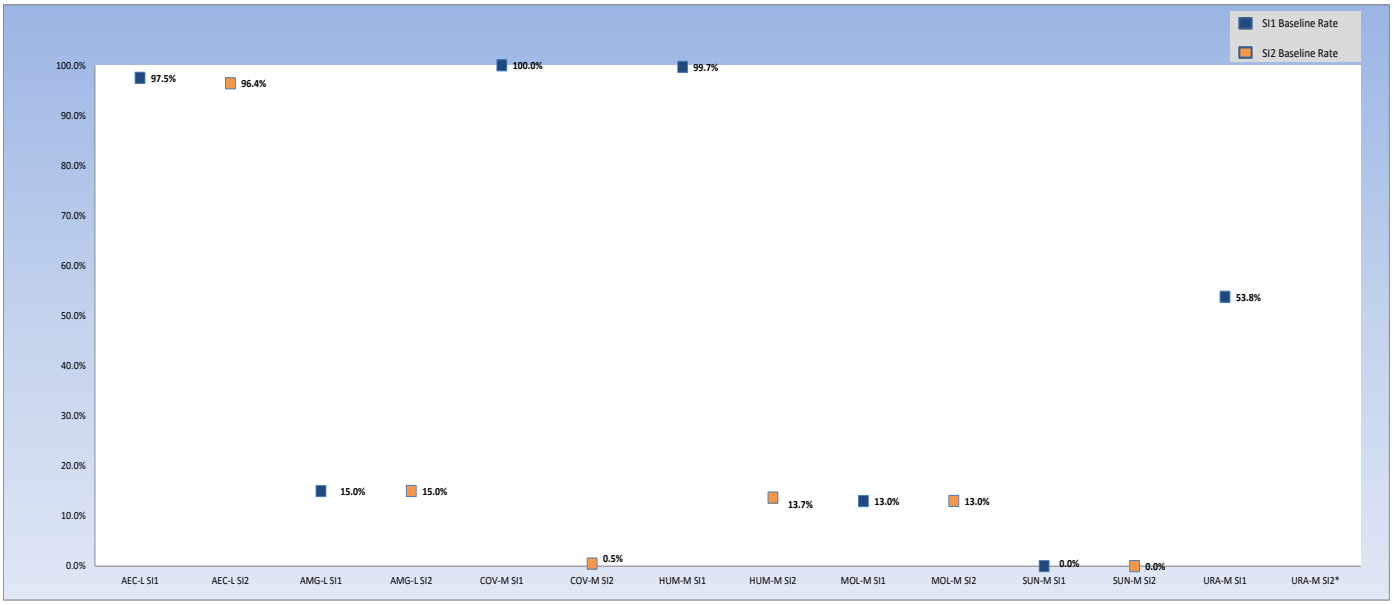
VII and for 84 percent of the elements in Activity VIII. The most common challenges for the LTC plans in the Implementation stage included insufficient documentation of whether any factors affected the study indicator results in Activity VII; and, in Activity VIII, implementing interventions that were not logically linked to identified barriers and/or study indicator outcomes. As recommended for previously discussed validation results for other PIP topics and plan types, the LTC plans should review HSAG's feedback in the PIP validation tool for those evaluation elements that did not receive a *Met* score and request technical assistance, as needed, to address identified issues and strengthen their PIP performance going forward.

Results—Study Indicator Results

Study Indicator Results for the *Medication Review* PIP

Figure 3-11 displays the baseline measurement period rates reported by the LTC plans for the State-mandated *Medication Review* PIP. There were two study indicators for this PIP: Study Indicator 1 (SI1) was the rate of members who had evidence of a medication list in the medical record, and Study Indicator 2 was the rate of members who had at least one documented medication review conducted during the measurement year. The baseline rates for SI1 are designated by the dark blue boxes plotted on the chart. The baseline rates for SI2 are designated by the orange boxes. The X axis is labeled with the plan name abbreviation and SI1 or SI2 for each data point on the chart. The full name of each LTC plan and associated plan name abbreviation are presented in Appendix H.

Figure 3-11—State-mandated *Medication Review* Study Indicator Results for CY 2014



* United Healthcare did not report a baseline rate for SI2.

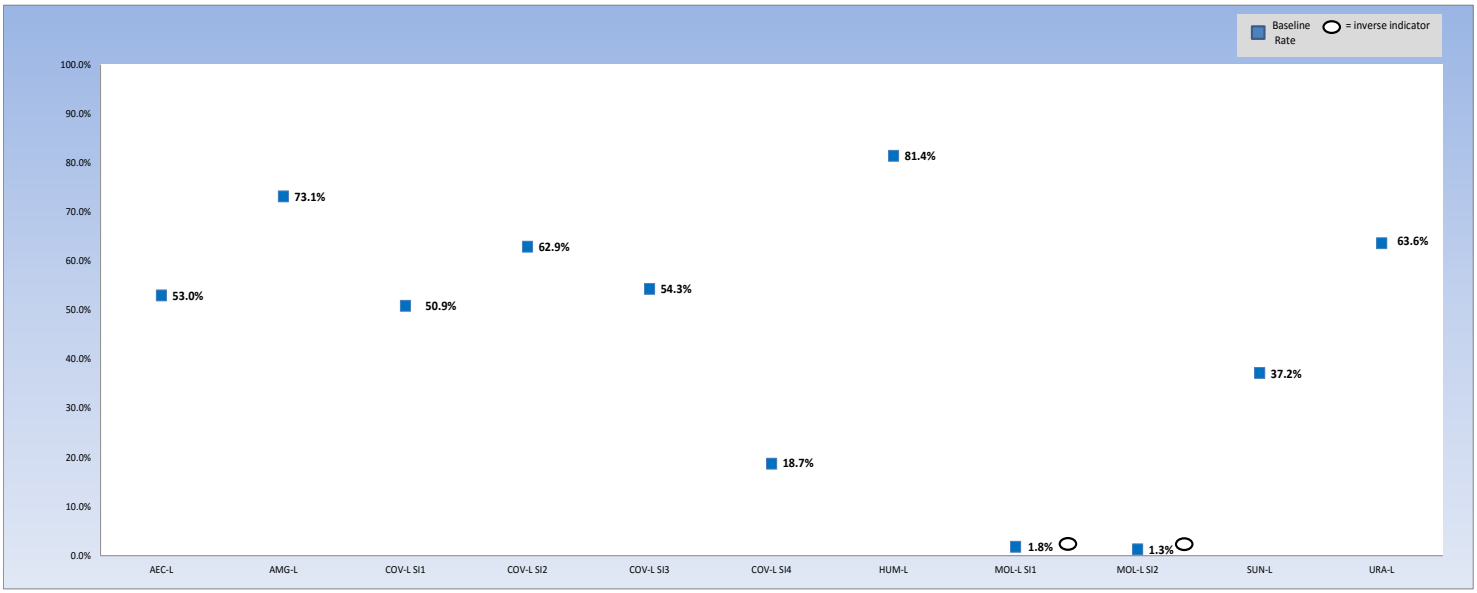
Six LTC plans reported baseline results for the PIP's two study indicators. One LTC plan, United-LTC, reported baseline results only for SI1. The reported baseline rates varied widely by plan. The three LTC plans that reported the highest rates for SI1 (evidence of a list of medications in the medical record)

were Coventry-LTC, Humana-LTC, and American Eldercare-LTC, with baseline SI1 rates of 100 percent, 99.7 percent, and 97.5 percent, respectively. American Eldercare reported the highest baseline rate (96.4 percent) for SI2 (at least one medication review). Sunshine-LTC reported baseline rates of 0.0 percent for both study indicators. The plan documented in its PIP that baseline data collection barriers prevented identification of any members who met the numerator definition for either study indicator. HSAG recommended in the PIP validation tool that Sunshine-LTC discuss the data collection issues with AHCA and seek technical assistance from HSAG, as needed, to overcome the data collection issues for future measurement periods.

Nonclinical PIP Study Indicator Results

Figure 3-12 displays the baseline study indicator results for the nonclinical PIPs submitted by the LTC plans. 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 plan name (i.e., SI1 for Study Indicator 1 and SI2 for Study Indicator 2). The full name of each LTC plan and associated plan name abbreviation is presented in Appendix H.

Figure 3-12—Nonclinical PIP Study Indicator Results for CY 2014 for LTC Plans



Seven LTC plans reported baseline results, for a total of 11 nonclinical PIP study indicators. Two of the nonclinical study indicators were inverse indicators, where a lower rate is better. The baseline rates for the two inverse study indicators reported by Molina-LTC, were 1.8 percent and 1.3 percent, respectively. The low baseline rates for Molina's two inverse study indicators suggested that there was little room for improvement in the PIP outcomes; therefore, HSAG recommended in the PIP validation tool that the plan select a new nonclinical PIP topic supported by historical data indicating a need for improvement. The baseline results for the remaining nonclinical PIP study indicators, where a higher

rate is better, ranged from a minimum of 18.7 percent, reported by Coventry-LTC, to a maximum of 81.4 percent, reported by Humana Medical Plan.

MCO Comparison

Overall, the LTC plans performed well on the Design and Implementation stages of the State-mandated *Medication Review* PIP topic, where 86 percent of the PIPs received an overall *Met* validation status. The PIP outcomes, including whether statistically significant improvement was achieved, will be evaluated during the next validation cycle, when the plans report results of the first remeasurement. The baseline rates reported for the *Medication Review* PIPs varied widely. For Study Indicator 1 (evidence of a list of medications in the medical record) Sunshine-LTC demonstrated the greatest need for improvement with a reported baseline rate of 0.0 percent, and Coventry-LTC had the least room for improvement with a reported baseline rate of 100.0 percent. For Study Indicator 2 (at least one medication review), Sunshine-LTC demonstrated the greatest opportunity for improvement with a reported baseline rate of 0.0 percent, and American Eldercare-LTC demonstrated the least room for improvement with a reported baseline rate of 96.4 percent.

Among the plan-selected nonclinical PIPs, four (71 percent) of the LTC plans' seven PIPs received a *Met* validation status. The baseline results of the LTC plans' nonclinical PIPs varied. One LTC plan, Molina-LTC used two inverse study indicators for the nonclinical PIP, where a lower rate is better. Molina-LTC's reported baseline rates for the two inverse study indicators were 1.8 percent and 1.3 percent, respectively, demonstrating little room for improvement. HSAG recommended that Molina-LTC select a new PIP topic, based on these study indicator results. Among the six remaining nonclinical PIPs, one of Coventry-LTC's four nonclinical PIP study indicators demonstrated the greatest room for improvement, with a baseline rate of 18.7 percent. Humana-LTC reported a baseline study indicator rate of 81.4 percent, demonstrating the least amount of room for improvement at baseline.

Conclusions and Recommendations

During the SFY 2015–2016 validation cycle, HSAG validated the baseline measurement period of the LTC plans' PIPs through the Design and Implementation stages (Activities I through VIII). The LTC plans submitted two types of PIPs for validation: the State-mandated *Medication Review* PIP and a plan-selected, nonclinical PIP. The percentage of PIPs receiving an overall *Met* validation status varied by PIP topic. For the State-mandated *Medication Review* PIP, 86 percent of the PIPs received a *Met* validation status. For the plan-selected nonclinical PIPs, 71 percent of the PIPs received a *Met* validation status.

HSAG determined that opportunities for improvement in the Implementation stage of the PIPs existed for LTC plans. While the PIP validation scores varied by plan, in general, the Implementation stage presented greater challenges than the Design stage. The validation scores in the Design stage suggested that, overall, the plans designed methodologically sound projects capable of accurately measuring and evaluating annual measurements of the PIP study indicators. In the Implementation stage, the plans had challenges in both Activity VII (Sufficient Data Analysis and Interpretation) and Activity VIII (Appropriate Improvement Strategies). Due to the sequential nature of the PIP process, in which one

stage provides the foundation for the next stage, addressing any opportunities for improvement in the Design and Implementation stages is critical to achieving success in the Outcomes stage.

To optimize PIP performance and support improvement of health outcomes, HSAG recommends that the LTC plans ensure that the design of each PIP is clearly and accurately documented. For State-mandated PIP topics, the study question, study population, and study indicators should align with the State-defined specifications. The plans should accurately report the study indicator definition, including the numerator, denominator, and measurement period dates, and align the documentation with relevant measurement specifications. When using sampling techniques, the plans should ensure that the sampling methods are fully documented and methodologically sound so that results can be generalized to the eligible population for the PIP. In addition to sampling techniques used, all data collection methods should be thoroughly described for each PIP, clearly demonstrating how enrollees are identified for inclusion in the denominator and numerator of the study indicators.

In the Implementation stage of the PIPs, HSAG recommends that the LTC plans correct any errors in the study indicator rate calculations that were identified by HSAG during PIP validation. Accurate study indicator rates are necessary for an accurate measurement of progress in improving PIP outcomes during the remeasurement periods. Additionally, the plans should ensure that the estimated administrative data completeness is accurately calculated and documented for PIPs, using claims data when applicable. Both the estimated percentage of completeness and the methods used to determine estimated completeness should be documented in the PIP. By addressing HSAG's feedback in the PIP validation tools and seeking technical assistance, as needed, the LTC plans will improve the implementation of PIPs and facilitate achievement of desired improvement.

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.

HSAG was contracted to perform validation of performance measures for the CY 2015 measurement period on the following three plan types: MMA Standard plans, MMA Specialty plans, and LTC plans. 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 (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 MMA Standard and Specialty plans and LTC plans during SFY 2015–2016. This section of the report includes the PMV audit findings and performance measure results for these plans. Please refer to Appendix A of this report where the PMV methodology is described in greater detail. Detailed PMV results may be found in the 2016–2017 *Performance Measure Validation Findings Report.*

MMA Plans

AHCA required that each MMA plan undergo an NCQA HEDIS Compliance Audit on the performance measures selected for reporting. These audits were performed by NCQA-licensed organizations (LOs) in 2016, on data collected during CY 2015.

Table 3-1 presents the 80 performance measure indicators selected for reporting year 2016 for the MMA Standard and Specialty plans sorted by clinical domain (i.e., Pediatric Care, Women's Care, Living With Illness, Behavioral Health, Access/Availability of Care, Use of Services, or MMA Specialty Performance Measures—Pediatric Care, Serious Mental Illness [SMI], or Older Adult Care). This table also contains the measure source for each measure and HSAG's assignment of the performance measures into the dimensions of quality, timeliness, and access. Cells shaded gray denote the measures for which AHCA established performance targets for 2016, and were generally established based on the HEDIS national Medicaid 75th percentiles.

Table 3-1—Reporting Year 2016 MMA Performance Measures and Assignments to the Quality, Timeliness, and Access Domains

Reporting Year 2016 (Calendar Year 2015) Measures	Measure Source	Quality	Timeliness	Access
Pediatric Care				
Well-Child Visits in the First 15 Months of Life (W15)—No Well-Child Visits and *Six or More Well-Child Visits*	HEDIS	✓		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	HEDIS	✓		
Childhood Immunization Status (CIS)—Combination 2 and *Combination 3*	HEDIS	✓	✓	
Lead Screening in Children (LSC)	HEDIS	✓	✓	
Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase and *Continuation and Maintenance Phase*	HEDIS	✓	✓	✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile—Total	HEDIS	✓		
Adolescent Well-Care Visits (AWC)	HEDIS	✓		
Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap/Td)	HEDIS	✓	✓	
Annual Dental Visit (ADV)—Total	HEDIS	✓		✓
Preventive Dental Services (PDENT)	CMS 416 Report			✓
Dental Treatment Services (TDENT)	CMS 416 Report			✓
Sealants (SEA)	CMS 416 Report	✓		✓
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk (SEAL)	Medicaid Child Core Set	✓		✓
Women's Care				
Cervical Cancer Screening (CCS)	HEDIS	✓		
Chlamydia Screening in Women (CHL)	HEDIS	✓		
Breast Cancer Screening (BCS)	HEDIS	✓		
Human Papillomavirus Vaccine for Female Adolescents (HPV)	HEDIS		✓	✓
Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care and *Postpartum Care*	HEDIS	✓	✓	✓
*Frequency of Ongoing Prenatal Care (FPC)—≥81 Percent of Expected Visits**	HEDIS		✓	✓
Antenatal Steroids (ANT)	Medicaid Adult Core Set	✓		
Living With Illness				
Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8%), Eye Exam (Retinal) Performed, and *Medical Attention for Nephropathy*	HEDIS	✓		
Controlling High Blood Pressure (CBP)	HEDIS	✓		
Adult BMI Assessment (ABA)	HEDIS	✓		
Medication Management for People With Asthma (MMA)—Medication Compliance 50%—Total and *Medication Compliance 75%—Total*[1]	HEDIS	✓		
Annual Monitoring for Patients on Persistent Medications (MPM)—Total	HEDIS	✓		
Plan All-Cause Readmissions (PCR-AD)—Total—18–64 Years of Age Total and *Total—65+ Years of Age Total*	Medicaid Adult Core Set	✓		
HIV-Related Outpatient Medical Visits (HIVV)—2 Visits (≥182 days)	AHCA-Defined	✓		

Reporting Year 2016 (Calendar Year 2015) Measures	Measure Source	Quality	Timeliness	Access
Highly Active Anti-Retroviral Treatment (HAART)	AHCA-Defined	✓		
Viral Load Suppression Among Persons in HIV Medical Care (VLS)—18–64 years and *65+ years*	Medicaid Adult Core Set	✓		
Medical Assistance With Smoking and Tobacco Use Cessation (MSC)—Advising Smokers and Tobacco Users to Quit—18–64 Years of Age, 65+ Years of Age, and *Total; Discussing Cessation Medications—18–64 Years of Age, 65+ Years of Age,* and *Total;* and *Discussing Cessation Strategies—18–64 Years of Age, 65+ Years of Age,* and *Total*[2]	HEDIS	✓		
Behavioral Health				
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)—Initiation of AOD Treatment—Total and *Engagement of AOD Treatment—Total*	HEDIS	✓	✓	
Follow-Up After Hospitalization for Mental Illness (FHM)—7-Day Follow-Up and *30-Day Follow-Up*	HEDIS & AHCA-Defined		✓	
Antidepressant Medication Management (AMM)—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	HEDIS	✓	✓	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	HEDIS	✓		
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Total	HEDIS	✓		
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)—Total	HEDIS	✓		
Mental Health Readmission Rate (RER)	AHCA-Defined	✓		
Access/Availability of Care				
Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–24 Months, 25 Months–6 Years, 7–11 Years, and *12–19 Years*	HEDIS			✓
Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total	HEDIS			✓
Call Answer Timeliness (CAT)	HEDIS		✓	
Transportation Availability (TRA)	AHCA-Defined			✓
Transportation Timeliness (TRT)	AHCA-Defined		✓	
Use of Services				
Ambulatory Care (AMB)—Outpatient Visits per 1,000 Member Months (MM) and *ED Visits per 1,000 MM*[3]	HEDIS			✓
MMA Specialty Performance Measures—Pediatric Care				
Developmental Screening in the First Three Years of Life (DEVSCR)—Screening in the 1st Year of Life, Screening in the 2nd Year of Life, Screening in the 3rd Year of Life, and *Screenings Total*	Medicaid Child Core Set	✓	✓	
MMA Specialty Performance Measures—SMI				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	HEDIS	✓	✓	
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	HEDIS	✓	✓	
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	HEDIS	✓	✓	

Reporting Year 2016 (Calendar Year 2015) Measures	Measure Source	Quality	Timeliness	Access
MMA Specialty Performance Measures—Older Adult Care				
Care for Older Adults (COA)—Advance Care Planning—66+ Years, Medication Review—66+ Years, Functional Status Assessment—66+ Years, and *Pain Assessment—66+ Years*	HEDIS	✓	✓	

Note: Cells shaded gray indicate the measures with a 2016 performance target established by AHCA.

** indicates the MMA plans reported rates for the AHCA-defined measure, Prenatal Care Frequency (PCF), for reporting year 2015; however, this measure changed to the HEDIS Frequency of Prenatal Care (FPC) measure for reporting year 2016.*

[1] For this measure, an AHCA performance target was established only for the Medication Management for People With Asthma (MMA)—Medication Compliance 75%—Total indicator.

[2] For this measure, AHCA performance targets were established only for the Medical Assistance With Smoking and Tobacco Use Cessation (MSC)—Advising Smokers and Tobacco Users to Quit—Total, Discussing Cessation Medications—Total, and *Discussing Cessation Strategies—Total indicators.*

[3] For this measure, an AHCA performance target was established only for the Ambulatory Care (AMB)—ED Visits per 1,000 MM indicator.

For this section of the report, performance measure results and plan comparisons are discussed by domain of care. The results sections below discuss the statewide average performance as compared to the AHCA-identified performance targets and statewide rate increases or decreases from reporting year 2015 to reporting year 2016.

Additionally, the plan comparisons sections below summarize the range in performance across the plans, plans' performance compared to the AHCA performance targets, and performance among the plans in relation to the corresponding national HEDIS benchmarks, when available. Specifically, the plan-specific rates were compared to NCQA's Quality Compass®[10] national Medicaid HMO percentiles for HEDIS 2015, which are expressed in percentiles of national performance for different measures. For comparative purposes, the plans' rates were categorized using the following star ratings:

★★★★★ = At or above the 90th percentile
★★★★ = From the 75th percentile to the 89th percentile
★★★ = From the 50th percentile to the 74th percentile
★★ = From the 25th percentile to the 49th percentile
★ = Below the national Medicaid 25th percentile

To review the plan-specific star ratings by measure, please refer to Appendix D.

[10] Quality Compass® is a registered trademark for the National Committee for Quality Assurance (NCQA).

Results—Pediatric Care

Table 3-2 displays the statewide weighted averages calculated by HSAG for reporting years 2015 and 2016 for all measures in the Pediatric Care domain. As shown with measures shaded in gray in the table, AHCA established performance targets for 13 of the 16 measures in this domain. Cells shaded in green indicate performance rates that met or exceeded AHCA's reporting year 2016 performance targets.

Table 3-2—Florida Medicaid Performance Measure Result Summary Table, Pediatric Care

Measure	Reporting Year 2015	Reporting Year 2016
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	2.79%	2.35%
Six or More Well-Child Visits	54.92%	58.26%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.45%	75.43%
Childhood Immunization Status		
Combination 2	75.12%	77.48%
Combination 3	70.61%	72.41%
Lead Screening in Children		
Lead Screening in Children	62.02%	60.50%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	49.65%	49.94%
Continuation and Maintenance Phase	63.20%	62.70%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	—	62.45%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	53.20%	52.85%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	65.06%	67.32%
Annual Dental Visit		
Total	34.24%	46.67%
Preventive Dental Services		
Preventive Dental Services	12.09%	33.01%
Dental Treatment Services		
Dental Treatment Services	5.25%	14.64%
Sealants		
Sealants	4.26%	12.85%

Measure	Reporting Year 2015	Reporting Year 2016
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	—	25.22%+

** Indicates that lower rates are better for this measure.*
+ Due to issues associated with the plan-level eligible population values for this measure, this rate was weighted by select plans' denominators, rather than the eligible populations.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report.
Gray shading indicates that AHCA established a performance target for the measure for reporting year 2016.
Green shading indicates that the performance measure rate for reporting year 2016 met or exceeded the performance target.

Statewide rates for reporting year 2016 for *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits*, *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*, and *Preventive Dental Services* met or exceeded the performance targets for reporting year 2016. Statewide rates for *Lead Screening in Children*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Immunizations for Adolescents—Combination 1(Meningococcal, Tdap/Td)*, and *Annual Dental Visit—Total* fell below AHCA's performance targets by at least 10 percentage points, indicating opportunities for improvement. The *Lead Screening in Children* statewide measure rate showed the greatest opportunity for improvement, falling approximately 19 percentage points below the AHCA performance target.

From reporting year 2015 to reporting year 2016, the statewide measure rate within this domain that increased the most was *Preventive Dental Services*, with an increase of approximately 21 percentage points, followed by *Annual Dental Visit—Total*, with an increase of approximately 12 percentage points, which indicated improved performance from the prior year in these areas.

MCO Comparison—Pediatric Care

The greatest range of plan results for reporting year 2016 was observed for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, at approximately 63 percentage points, from 74.19 percent (Clear Health-S) to 11.11 percent (CCP[11]), followed by *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*, at approximately 55 percentage points, from 54.73 percent (Staywell) to 0.00 percent (Magellan-S). For *Lead Screening in Children*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, and *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap/Td)*, no plans reached the corresponding AHCA performance target.

Sunshine-S performed best on Pediatric Care measures, with approximately 32 percent of its rates (seven of 22 rates) ranking at or above the 90th percentile. The remaining plans reported fewer than 10

[11] SFCCN changed its name to South Florida Community Care Network, DBA Community Care Plan (CCP) in SFY 2017. For the purposes of this report, CCP is used as the reference in the PMV reporting as it is based on SFY 2017 data.

percent of the rates at or above the 90th percentile. Conversely, Magellan-S demonstrated the worst performance on measures in the Pediatric Care domain, with all eight of its rates falling below the national Medicaid 25th percentile.

Results—Women's Care

Table 3-3 displays the statewide weighted averages calculated by HSAG for reporting years 2015 and 2016 for all measures in the Women's Care domain. As shown with measures shaded in gray in the table, AHCA established performance targets for five of the eight measures in this domain.

Table 3-3—Florida Medicaid Performance Measure Result Summary Table, Women's Care

Measure	Reporting Year 2015	Reporting Year 2016
Cervical Cancer Screening		
Cervical Cancer Screening	55.08%	51.27%
Chlamydia Screening in Women		
Total	60.54%+	61.80%
Breast Cancer Screening		
Breast Cancer Screening	59.39%	61.16%
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	—	21.25%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	84.01%	82.91%
Postpartum Care	59.76%	58.62%
Frequency of Ongoing Prenatal Care[1]		
≥81 Percent of Expected Visits	65.44%	66.52%
Antenatal Steroids		
Antenatal Steroids	1.65%	1.09%

[1]MMA plans reported rates for the AHCA-defined measure, Prenatal Care Frequency (PCF), for 2015; however, this measure changed to the HEDIS Frequency of Prenatal Care (FPC) for 2016. Therefore, exercise caution when comparing rates between years.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report.
+ Due to issues associated with the plan-level eligible population values for this measure, this rate was weighted by select plans' denominators rather than by the eligible populations.
Gray shading indicates that AHCA established a performance target for the measure for reporting year 2016.

At the statewide level, none of the rates in the Women's Care domain met AHCA's reporting year 2016 performance targets. Statewide rates for *Cervical Cancer Screening* and *Prenatal and Postpartum Care—Postpartum Care* fell below AHCA's performance targets by at least 10 percentage points, indicating opportunities for improvement. The *Cervical Cancer Screening* statewide measure rate showed the greatest opportunity for improvement, falling 16.61 percentage points below the AHCA performance target. The statewide rates for all seven measure indicators that were reported during reporting years 2015 and 2016 remained stable, with no rates indicating substantive improvement or decline in performance.

MCO Comparison—Women's Care

The greatest range of plan results during reporting year 2016 in the Women's Care measures was observed for *Antenatal Steroids*, at approximately 49 percentage points, from 48.72 percent (Humana) to 0.00 percent (Amerigroup, Better Health, Children's Medical Services-S, Clear Health-S, and Magellan-S), followed by *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits*, at approximately 46 percentage points, from 76.24 percent (Amerigroup) to 30.16 percent (Children's Medical Services-S). For *Cervical Cancer Screening* and *Prenatal and Postpartum Care—Postpartum Care*, no plans reached the corresponding AHCA performance target.

Coventry performed best on measures in the Women's Care domain, with approximately 44 percent of its rates (four of nine rates) ranking at or above the 90th percentile. Conversely, Children's Medical Services-S demonstrated the worst performance on measures in the Women's Care domain, with approximately 83 percent of its rates (five of six rates) falling below the national Medicaid 25th percentile.

Results—Living With Illness

Table 3-4 displays the statewide weighted averages calculated by HSAG for reporting years 2015 and 2016 for all measures in the Living With Illness domain. As denoted by the gray-shaded cells in the table, 12 of the 25 measure indicators had a performance target established by AHCA for 2016. Cells shaded in green indicate performance rates that met or exceeded AHCA's reporting year 2016 performance targets.

Table 3-4—Florida Medicaid Performance Measure Result Summary Table, Living With Illness

Measure	Reporting Year 2015	Reporting Year 2016
Comprehensive Diabetes Care[1]		
Hemoglobin A1c (HbA1c) Testing	84.51%+	81.04%
*HbA1c Poor Control (>9.0%)**	41.87%	47.81%
HbA1c Control (<8.0%)	47.83%+	43.61%
Eye Exam (Retinal) Performed	51.25%	51.06%
Medical Attention for Nephropathy	84.10%+	91.65%
Controlling High Blood Pressure		
Controlling High Blood Pressure	57.26%	50.33%
Adult BMI Assessment		
Adult BMI Assessment	85.68%+	86.68%
Medication Management for People With Asthma		
Medication Compliance 50%—Total	—	53.57%
Medication Compliance 75%—Total	—	29.90%
Annual Monitoring for Patients on Persistent Medications		
Total	91.78%	91.01%

Measure	Reporting Year 2015	Reporting Year 2016
Plan All-Cause Readmissions*		
Total—18–64 Years of Age Total	17.83%	22.82%
Total—65+ Years of Age Total	11.63%	10.52%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	28.18%	27.88%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	78.08%	65.09%
Viral Load Suppression Among Persons in HIV Medical Care		
18–64 years	10.32%	13.08%
65+ years	5.75%	8.97%
Medical Assistance With Smoking and Tobacco Use Cessation[2]		
Advising Smokers and Tobacco Users to Quit—18–64 Years of Age	—	74.18%
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	—	61.15%
Advising Smokers and Tobacco Users to Quit—Total	—	71.49%
Discussing Cessation Medications—18–64 Years of Age	—	46.45%
Discussing Cessation Medications—65+ Years of Age	—	41.30%
Discussing Cessation Medications—Total	—	45.39%
Discussing Cessation Strategies—18–64 Years of Age	—	41.74%
Discussing Cessation Strategies—65+ Years of Age	—	33.94%
Discussing Cessation Strategies—Total	—	40.13%

[1] Due to changes in the HEDIS 2016 technical specifications for this measure, exercise caution when trending rates between 2016 and prior years and when comparing HEDIS 2016 rates for this measure to performance targets derived using data reported for HEDIS 2015.
[2] Due to issues associated with the plan-level eligible population values for Medical Assistance With Smoking and Tobacco Use Cessation, MMA program unweighted averages rather than weighted averages are presented in this report for these measure indicators.
** Indicates that lower rates are better for this measure.*
[+] Due to issues associated with the plan-level eligible population values for this measure, this rate was weighted by select plans' denominators rather than by the eligible populations.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report.
Gray shading indicates that AHCA established a performance target for the measure for reporting year 2016.
Green shading indicates that the performance measure rate for reporting year 2016 met or exceeded the performance target.

Only two of 12 reporting year 2016 statewide rates in the Living With Illness domain with a performance target met or exceeded the target, including *Comprehensive Diabetes Care—Medical Attention for Nephropathy* and *Annual Monitoring for Patients on Persistent Medications—Total*. Four of the 12 indicators with performance targets had statewide rates that fell 10 percentage points or more below the performance target, including *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%), HbA1c Control (<8%), Eye Exam (Retinal) Performed,* and *Controlling High Blood Pressure*. The *Controlling High Blood Pressure* statewide measure rate showed the greatest opportunity for improvement, falling almost 15 percentage points below the AHCA performance target.

From reporting year 2015 to reporting year 2016, the statewide measure rate that increased the most was *Comprehensive Diabetes Care—Medical Attention for Nephropathy*, with an increase of approximately 8 percentage points, indicating improved performance from the prior year in this area. Conversely, the statewide rate for *Highly Active Anti-Retroviral Treatment* decreased the most from reporting year 2015 to reporting 2016 (i.e., approximately 13 percentage points), indicating opportunities for improvement.

However, it should be noted that due to changes in the HEDIS 2016 technical specifications for *Comprehensive Diabetes Care*, caution should be exercised when trending rates between 2016 and prior years and when comparing HEDIS 2016 rates to performance targets derived using data reported for HEDIS 2015.

MCO Comparison—Living With Illness

The greatest range of plan results for the Living With Illness reporting year 2016 measures was observed for *Viral Load Suppression Among Persons in HIV Medical Care—18–64 Years*, at approximately 55 percentage points, from 54.94 percent (Positive-S) to 0.00 percent (Better Health, Children's Medical Services -S, Clear Health-S, Molina, Simply, and Staywell), followed by *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, at approximately 51 percentage points, from 39.66 percent (Humana) to 90.58 percent (Magellan-S). For *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8%)*, and *Eye Exam (Retinal) Performed*, no plans reached the corresponding AHCA performance target.

In this domain, Children's Medical Services-S performed best, with all eight of its rates ranking at or above the 90th percentile. Freedom-S also performed favorably, with its one Living With Illness measure rate that was reportable and comparable to national Medicaid percentiles ranking at or above the 90th percentile. Conversely, Sunshine demonstrated the worst performance on measures in this domain, with approximately 57 percent of its rates (12 of 21 rates) falling below the national Medicaid 25th percentile.

Results—Behavioral Health

Table 3-5 displays the statewide weighted averages calculated by HSAG for reporting years 2015 and 2016 for all measures in the Behavioral Health domain. As denoted by the gray shaded cells, AHCA established a 2016 performance target for seven of the ten reported measure indicators.

Table 3-5—Florida Medicaid Performance Measure Result Summary Table, Behavioral Health

Measure	Reporting Year 2015	Reporting Year 2016
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—Total	43.74%	39.99%
Engagement of AOD Treatment—Total	6.78%	6.39%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	24.65%	35.71%

Measure	Reporting Year 2015	Reporting Year 2016
30-Day Follow-Up	38.35%	53.77%
Antidepressant Medication Management		
Effective Acute Phase Treatment	52.52%	51.85%
Effective Continuation Phase Treatment	36.61%	36.81%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[1]		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	—	59.04%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
Total	—	37.77%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*		
Total	—	1.77%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	26.82%	26.62%

[1] *Due to changes in the HEDIS 2016 technical specifications for this measure, exercise caution when trending rates between 2016 and prior years and when comparing HEDIS 2016 rates for this measure to performance targets derived using data reported for HEDIS 2015.*
** Indicates that lower rates are better for this measure.*
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report.
Gray shading indicates that AHCA established a performance target for the measure for reporting year 2016.

No statewide rates in this domain met the 2016 performance targets, indicating overall opportunities for improvement related to Behavioral Health statewide. Specifically, for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* measure indicators, the statewide rates for reporting year 2016 fell below AHCA's performance targets by approximately 21 percentage points, despite increases from reporting year 2015 by approximately 11 percentage points and 15 percentage points, respectively.

MCO Comparison—Behavioral Health

At the plan level, the greatest range of plan results for the Behavioral Health measures was observed for *Mental Health Readmission Rate,* at approximately 62 percentage points, from 0.00 percent (Children's Medical Services-S) to 62.09 (Sunshine-S), followed by *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up,* at approximately 55 percentage points, from 54.89 percent (Sunshine-S) to 0.00 percent (Positive S). No plans reached the corresponding AHCA performance target for the following measure indicators: *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Engagement of AOD Treatment—Total*, *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*, and *Adherence to Antipsychotic Medications for Individuals With Schizophrenia.*

In this domain of care, Positive-S, Magellan-S, and United each reported two rates that ranked at or above the 90th percentile, and the remaining health plans did not report any measure rates at or above the 90th percentile. Positive-S also reported the highest percentage of rates below the national Medicaid 25th percentile compared to the other health plans (71 percent [five of seven rates]).

Results—Access/Availability of Care

Table 3-6 displays the statewide weighted averages calculated by HSAG for reporting years 2015 and 2016 for all measures in the Access/Availability of Care domain. As denoted by the gray shaded cells, six of the total eight measure indicators reported for reporting year 2016 had a performance target established by AHCA.

Table 3-6—Florida Medicaid Performance Measure Result Summary Table, Access/Availability of Care

Measure	Reporting Year 2015	Reporting Year 2016
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	95.96%	94.81%
25 Months–6 Years	89.30%	88.74%
7–11 Years	88.64%	89.28%
12–19 Years	85.76%	86.28%
Adults' Access to Preventive/Ambulatory Health Services		
Total	74.11%	74.93%
Call Answer Timeliness		
Call Answer Timeliness	86.91%+	83.63%
Transportation Availability		
Transportation Availability	97.05%	98.75%
Transportation Timeliness		
Transportation Timeliness	78.13%	79.32%

Gray shading indicates that AHCA established a performance target for the measure for reporting year 2016.
+ Due to issues associated with the plan-level eligible population values for this measure, this rate was weighted by select plans' denominators rather than by the eligible populations.

No statewide rates met AHCA's reporting year 2016 performance targets. The statewide rate for *Adults' Access to Preventive/Ambulatory Health Services—Total* fell below AHCA's performance targets by about 12 percentage points, indicating the greatest opportunity for improvement related to the performance targets. The statewide rates for all seven measure indicators that were reported during reporting years 2015 and 2016 remained stable, with no rates indicating substantive improvement or decline in performance.

MCO Comparison—Access/Availability of Care

At the plan level, the greatest range of plan results for reporting year 2016 in the Access/Availability of Care domain was observed for *Transportation Timeliness*, at approximately 48 percentage points, from 91.81 (Clear Health-S) to 44.04 percent (Children's Medical Services-S), followed by *Call Answer*

Timeliness, at approximately 41 percentage points, from 95.09 percent (Humana) to 53.98 percent (Children's Medical Services-S). At least one plan exceeded the AHCA performance target for every measure in this domain.

Freedom-S performed best on measures in this domain, with two of its three rates ranking at or above the 90th percentile. Conversely, Prestige demonstrated the worst performance, with approximately 89 percent of its rates (eight of nine rates) falling below the national Medicaid 25th percentile.

Results—Use of Services

Table 3-7 displays the statewide weighted averages for reporting years 2015 and 2016 for the *Ambulatory Care—Outpatient Visits per 1,000 Member Months (MM*) and *ED Visits per 1,000 MM* measures. Of note, Use of Services data are descriptive in nature and are evaluated to monitor patterns of ED and outpatient ambulatory care utilization over time. Assessment of utilization should be based on the characteristics of the MMA plans' populations and service delivery models.

Table 3-7—Statewide Ambulatory Care Weighted Averages

Measure	Reporting Year 2015	Reporting Year 2016
AMB—Outpatient Visits per 1,000 MM	298.34	304.82
*AMB—ED Visits per 1,000 MM**	71.56	69.06

** Indicates that lower rates are better for this measure.*

Slight variation in statewide performance occurred for both measures from 2015 to 2016. The 2016 statewide rate for *Ambulatory Care—ED Visits per 1,000 MM* was compared to the performance target for 2016 (as indicated with gray shading), and the calculated rate exceeded that target (as indicated with green shading).

MCO Comparison—Use of Services

In general, both the outpatient visits and ED visits rates varied widely among MMA plans. For the *Ambulatory Care—Outpatient Visits per 1,000 MM* measure, plan rates ranged from 243.49 per 1,000 MM (Magellan-S) to 536.36 per 1,000 MM (Freedom-S). For the *Ambulatory Care—ED Visits per 1,000 MM* measure, plan rates ranged from 52.65 per 1,000 MM (Simply) to 165.43 per 1,000 MM (Positive-S). A plan's outpatient visits rate did not appear to have a relationship with its ED visits rate (e.g., plans with higher outpatient visits per 1,000 MM did not necessarily demonstrate lower rates of ED visits per 1,000 MM).

For the *Ambulatory Care—ED Visits per 1,000 MM* measure, rates for four of the reporting plans (Positive-S, Magellan-S, Clear Health-S, and Children's Medical Services-S) exceeded the 2016 performance target, indicating opportunities for improvement. Note that these four plans serve specialty conditions, so their populations may be different than other plans. Although these visits were not adjusted by the MMA plans' enrollee demographic and/or clinical characteristics, the lower value suggests better utilization.

Results—Performance Measures for MMA Specialty Plans

In addition to the MMA Standard performance measures, two MMA Specialty plans (i.e., Children's Medical Services-S and Sunshine-S) were required to report several MMA performance measures. For these two plans, one additional measure yielding four measures indicators (i.e., *Developmental Screening in the First Three Years of Life—Screening in the 1st Year of Life*, *Screening in the 2nd Year of Life*, *Screening in the 3rd Year of Life*, and *Screenings Total*) were required for reporting. Table 3-8 displays the weighted averages for reporting years 2015 and 2016 for the measures by domain: Pediatric Care, Serious Mental Illness (SMI), and Older Adult Care. Cells shaded gray indicate the measure indicators with a 2016 performance target established by AHCA.

Table 3-8—Florida Medicaid MMA Weighted Averages for MMA Specialty Performance Measures

Measure	Reporting Year 2015	Reporting Year 2016
Pediatric Care		
Developmental Screening in the First Three Years of Life		
Screening in the 1st Year of Life	—	15.22%
Screening in the 2nd Year of Life	—	22.26%
Screening in the 3rd Year of Life	—	17.25%
Screenings Total	28.41%	19.42%
Serious Mental Illness (SMI)		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	71.02%
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	—	66.25%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	—	NA
Older Adult Care		
Care for Older Adults		
Advance Care Planning—66+ Years	—	70.59%
Medication Review—66+ Years	—	88.24%
Functional Status Assessment—66+ Years	—	85.29%
Pain Assessment—66+ Years	—	85.29%

—Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report.
NA (i.e., Small Denominator) indicates that the organizations followed the specifications, but the denominator was too small (<30) to report valid rates.
Gray shading indicates that AHCA established a performance target for the measure for reporting year 2016.

The 2016 statewide MMA rates for all developmental screening measures for children under 3 years of age suggested opportunities for improvement, with the *Developmental Screening in the First Three Years of Life—Screenings Total* measure decreasing 8.99 percentage points from the previous year. Please note that while both plans reported the *Developmental Screening* measure, the MMA Specialty plans' performance measure reports indicated that they used the administrative method to calculate this measure. AHCA staff members have recently determined that calculating this measure using the Child Core Set administrative specifications (which count as one Current Procedural Terminology [CPT] code) is problematic as Florida Medicaid does not use this code.

One MMA Specialty plan, Magellan-S, serving SMI enrollees, was required to report three additional measures (*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications, Diabetes Monitoring for People With Diabetes and Schizophrenia,* and *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*). Rates related to people with schizophrenia or bipolar disorder who were taking antipsychotic medications and received a diabetes screening and those people with diabetes and schizophrenia who received diabetes monitoring were reported at 71.02 and 66.25, respectively.

An additional MMA Specialty plan, Freedom-S, providing care for Medicare-Medicaid dual eligible enrollees with chronic diseases, was required to report four additional measures (*Care for Older Adults—Advance Care Planning—66+ Years, Medication Review—66+ Years, Functional Status Assessment—66+ Years,* and *Pain Assessment—66+ Years*). Nearly 71 percent of enrollees 66 years and older received advance care planning, and medications were reviewed for over 88 percent of enrollees 66 years and older.

Conclusion and Recommendations

During SFY 2015–2016, all plans 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, all MMA Standard and Specialty plans were fully compliant with the following standards: IS 2.0 (Enrollment Data), IS 3.0 (Practitioner Data), IS 5.0 (Supplemental Data), IS 6.0 (Member Call Center Data), and IS 7.0 (Data Integration).

All MMA Specialty plans and all but one MMA Standard plan (i.e., PRS-M) were fully compliant with IS 1.0 (Medical Services Data). This plan was compliant with IS Standard 1.E for laboratory services and data processing; however, the plan's lab vendor did not release human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) lab data, due to enrollee confidentiality concerns. As a result, the plan was unable to report the *Viral Load Suppression Among Persons in HIV Medical Care* measure and received a *Biased Rate (BR)* audit designation for this measure. Further, all but one MMA Standard plan (i.e., Sunshine) and all but one MMA Specialty plan (i.e., Sunshine-S) were fully compliant with IS 4.0 (Medical Record Review Processes). These plans were partially compliant with this standard due to the plan not retrieving all medical record data for the *Antenatal Steroids* measure; therefore, since the plans did not use hybrid methodology as required for this measure, the measure was given a *BR* audit designation.

For performance measure reporting year 2015 (i.e., CY 2014), the plans transitioned from the previous managed care contracts to the MMA contracts; therefore, the plans could only report enrollees who met the continuous enrollment criteria across the old and new contracts. Nonetheless, all were able to report the rates required by AHCA. Due to changes in the Medicaid program, the 2015 statewide and plan-specific MMA rates were considered baseline rates. Reporting year 2016 represents the first full calendar year of data for all MMA plans.

Under the Pediatric Care domain, MMA plans exceeded the performance target for four measures: *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits, Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*, and *Preventive Dental Services*. Additionally, *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Childhood Immunization Status—Combination 2* and *Combination 3* rates were all within 5 percentage points of their respective targets.

For Women's Care, MMA plans performed below the AHCA performance targets for each measure in this domain for which performance targets were provided. Nonetheless, three indicators were all within 5 percentage points of their respective targets: *Chlamydia Screening in Women—Total, Breast Cancer Screening*, and *Frequency of Ongoing Prenatal Care*. Of note, this was the first year that the MMA plans reported rates for the *Human Papillomavirus Vaccine for Female Adolescents* measure, and, therefore, no performance target has been established yet for this measure.

MMA plans exceeded the AHCA performance target on two measures in the Living With Illness domain, including *Comprehensive Diabetes Care—Medical Attention for Nephropathy* and *Annual Monitoring for Patients on Persistent Medications—Total*. The *Adult BMI Assessment* and *Annual Monitoring for Patients on Persistent Medications* rates were within 5 percentage points of their respective targets.

For Behavioral Health, MMA plans performed below the AHCA performance targets. The *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Initiation of AOD Treatment—Total, Antidepressant Medication Management—Effective Acute Phase Treatment,* and *Effective Continuation Phase Treatment* rates were within 5 percentage points of their respective targets.

In the domain of Access/Availability of Care, MMA plans performed below the AHCA performance targets for each of the measures in this domain where performance targets were provided. Nonetheless, three indicators were within 5 percentage points of their respective targets: *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years,* and *7–11 Years*.

Use of Services data are descriptive in nature and are evaluated to monitor patterns of utilization over time. Assessment of utilization should be based on the characteristics of the MMA plans' populations and service delivery models. With the exception of the *Ambulatory Care (AMB)—ED Visits per 1,000 MM* measure, the measures in this domain do not lend themselves to measuring the quality of care; therefore, HSAG did not compare MMA plan performance on these measures across plans or to performance targets or national benchmarks.

With regard to the MMA Specialty performance measure results, the 2016 statewide MMA rates for all developmental screening measures for children under 3 years of age suggested opportunities for improvement. All of these measures decreased from the prior year. Of note, while two plans reported the *Developmental Screening* measure, the MMA Specialty plans' performance measure reports indicated that they used the administrative method to calculate this measure. AHCA staff members have recently determined that calculating this measure using the Child Core Set administrative specifications (which count as one CPT code) is problematic as Florida Medicaid does not use this code. Performance measure rates for Magellan-S enrollees with schizophrenia or bipolar disorder who were taking antipsychotic medications and received a diabetes screening and those people with diabetes and schizophrenia who received diabetes monitoring were reported at 71.02 and 66.25, respectively. Further, according to performance measure rates for Freedom-S, nearly 71 percent of enrollees 66 years and older received advance care planning, and medications were reviewed for over 88 percent of enrollees 66 years and older.

Overall, 40 statewide MMA rates fell below AHCA's performance targets and six exceeded the performance targets. While opportunities for improvement exist in almost all domains of care, HSAG offers the following recommendations:

- HSAG recommends that improvement efforts be focused on measures with 2016 rates falling below AHCA's performance targets by at least 10 percentage points, as listed below.
  - **Pediatric Care—***Lead Screening in Children, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total, Immunizations for Adolescents—Combination 1(Meningococcal, Tdap/Td),* and *Annual Dental Visit—Total*
  - **Women's Care—***Cervical Cancer Screening* and *Prenatal and Postpartum Care—Postpartum Care*
  - **Living With Illness—***Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Eye Exam (Retinal) Performed,* and *Controlling High Blood Pressure*
  - **Behavioral Health—***Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*
  - **Access/Availability of Care—***Adults' Access to Preventive/Ambulatory Health Services—Total*
  - **MMA Specialty Performance Measures—SMI—***Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* and *Diabetes Monitoring for People With Diabetes and Schizophrenia*
- In addition to the measures listed above, HSAG recommends that improvement efforts be focused on measures with notable performance declines from 2015 to 2016, as listed in below:
  - **Pediatric Care—***Developmental Screening in the First Three Years of Life—Screenings—Total*
  - **Living With Illness—***Highly Active Anti-Retroviral Treatment*
- HSAG recommends that MMA plans develop improvement strategies to target the measures listed above. For example, MMA plans could investigate root causes associated with low performance based on the care provided to enrollees with diabetes and thereby target improvement activities that could increase compliance on numerous indicators of care such as *Comprehensive Diabetes Care,*

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications, and *Diabetes Monitoring for People With Diabetes and Schizophrenia*.

- In addition, during the PMV process, HSAG identified an opportunity to improve clarification of specifications for the *Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk* measure. During the review, HSAG noted that the majority of MMA plans' eligible population values for this measure were identical to the denominator values. However, two plans' eligible populations were greater than the denominators. One potential reason for the differences in values could be related to the timing of when plans applied the exclusionary criteria (e.g., applying exclusions before the eligible population is identified). The specifications do not seem to clearly define the criteria that should be used to identify the eligible population for this measure (only the denominator), so it is unclear if the eligible population and denominator values should be equivalent. Further, in the rate reporting template it appears acceptable for plans to report denominator values that are less than the total eligible populations. HSAG recommends that AHCA provide clear guidance for the identification of eligible population in both the reporting requirements and template to unify reporting requirements across all participating plans for the next reporting period.

LTC Plans

Six LTC plans contracted with AHCA for providing long-term care services to their Medicaid enrollees were required to report select performance measures. For SFY 2015–2016, AHCA required the LTC plans to calculate and report six performance measures using CY 2015 data (see Table 3-9). The LTC plans underwent a performance measure review to ensure that the rates calculated and reported for these measures were valid and accurate. All LTC plans contracted external audit firms to perform the audit. All audits were conducted by NCQA-licensed organizations (LOs). AHCA intended that an NCQA HEDIS Compliance Audit be conducted to the extent possible.

Table 3-9—Reporting Year 2016 LTC Performance Measures

Reporting Year 2016 (Calendar Year 2015) Measures	Measure Source
Care for Adults (CFA)—Advance Care Planning—Total, Medication Review—Total, and *Functional Status Assessment—Total*	HEDIS/AHCA-Defined
Call Answer Timeliness (CAT)	HEDIS
Required Record Documentation (RRD)—701B Assessment, Plan of Care—Enrollee Participation, Plan of Care—Primary Care Physician Notification, and *Freedom of Choice Form*	AHCA-Defined
Face-to-Face Encounters (F2F)	AHCA-Defined
Case Manager Training (CMT)	AHCA-Defined
Timeliness of Services (TOS)	AHCA-Defined

Results

Table 3-10 displays the LTC program weighted averages for reporting years 2015 and 2016 for the measures. The *Call Answer Timeliness* measure is shaded gray to indicate that this is the only measure with a 2016 performance target established by AHCA. The 2016 performance target was not met this year; therefore, no cells are shaded green.

Table 3-10—Florida Medicaid LTC Program Weighted Averages

Measure	Reporting Year 2015	Reporting Year 2016
Care for Adults		
Advance Care Planning—18–60 Years	44.56%	35.41%
Advance Care Planning—61–65 Years	45.04%	39.02%
Advance Care Planning—66+ Years	48.69%	43.04%
Advance Care Planning—Total	48.11%	41.91%
Medication Review—18–60 Years	19.54%	37.31%
Medication Review—61–65 Years	22.83%	30.12%
Medication Review—66+ Years	23.74%	31.89%
Medication Review—Total	23.32%	34.27%
Functional Status Assessment—18–60 Years	77.42%	84.11%
Functional Status Assessment—61–65 Years	77.28%	81.87%
Functional Status Assessment—66+ Years	75.07%	84.77%
Functional Status Assessment—Total	75.40%	84.53%
Call Answer Timeliness		
Call Answer Timeliness	89.07%	77.25%
Required Record Documentation		
701B Assessment	47.96%	79.92%
Plan of Care—Enrollee Participation	61.67%	70.41%
Plan of Care—Primary Care Physician Notification	28.07%	53.52%
Freedom of Choice Form	—	68.94%
Face-to-Face Encounters		
Face-to-Face Encounters	73.55%	90.23%
Case Manager Training		
Case Manager Training	89.59%+	94.38%+
Timeliness of Services		
Timeliness of Services	49.84%+	51.11%+

— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report.
Gray shading indicates that AHCA established a performance target for the measure for reporting year 2016.
+ Due to issues associated with the plan-level eligible population values for this measure, this rate was weighted by select plans' denominators rather than by the eligible populations.

From reporting year 2015 to reporting year 2016, the statewide measure rate with the largest increase was *Required Record Documentation—701B Assessment*, with an increase of approximately 32 percentage points, followed by *Required Record Documentation—Plan of Care—Primary Care Physician Notification*, with an increase of approximately 25 percentage points, which indicated improved performance from the prior year in these areas. Conversely, *Call Answer Timeliness* demonstrated the greatest performance decline from reporting year 2015 to 2016, with a decrease of approximately 12 percentage points, and this rate did not meet AHCA's reporting year 2016 performance targets.

MCO Comparison

At the plan level, the greatest range of plan results for reporting year 2016 was observed for *Care for Adults—Advance Care Planning—Total*, at approximately 84 percentage points from 97.69 percent (Amerigroup-LTC) to 13.54 percent (Sunshine-LTC). Rates for Coventry-LTC, Humana-LTC, and United-LTC met or exceeded the performance target for *Call Answer Timeliness,* while the remaining LTC plans' rates for this measure were below the performance target.

Conclusions and Recommendations

The LTC plans were required to report the same six measures as the previous year, yielding 11 measure indicators. For the current year, HSAG identified that not all LTC plan audits were conducted following NCQA HEDIS Compliance Audit policies and procedures. Although some performance measures were AHCA-defined measures and not HEDIS measures, HSAG agreed with AHCA that, to the extent possible, NCQA HEDIS Compliance Audit policies and procedures should be followed when auditing these measures.

In terms of performance measure results, for LTC plans, only *Call Answer Timeliness* was assigned a performance target by AHCA. The 2016 rate for *Call Answer Timeliness* fell below AHCA's performance targets by nearly 12 percentage points. Therefore, HSAG offers the following recommendations:

- HSAG recommends that improvement efforts be focused on the *Call Answer Timeliness* measure as it represents the sole opportunity for improvement relative to an AHCA-defined performance target. In addition, HSAG recommends that improvement efforts be focused on measures with notable performance declines from 2015 to 2016 or measures for which rates with less than 100 percent are deemed noncompliant by AHCA. HSAG's recommended measures for targeted quality improvement activities are as follows:
  - *Case Manager Training*
  - *Care for Older Adults—Advance Care Planning—18–60 Years, 61–65 Years, 66+ Years,* and *Total*
  - *Required Record Documentation*
- Although some improvement was demonstrated in the *Case Manager Training* measure among the LTC plans, no LTC plan reported a rate of 100 percent for this measure. This measure suggests LTC

plan compliance to a mandate to report abuse, neglect, and exploitation; therefore, LTC plans with less than 100 percent performance should investigate the root cause of the noncompliance and assure proper and timely training for their case managers. Similarly, the *Required Record Documentation* measure assesses the percentage of enrollees whose records contained specific documents to be maintained by the LTC plans; therefore, a rate less than 100 percent would imply noncompliance with AHCA's expectation.

- While the 2016 statewide LTC rates were low and plan performance was diverse, eight of the 12 *Care for Older Adults* measure indicators increased from the prior year, and three of the *Required Record Documentation* measure indicators that were compared to the prior year improved.
- In addition, HSAG identified an opportunity to improve the quality assurance checks performed during the validation process for the *Case Manager Training* measure. During the review, HSAG noted that the eligible population and denominator values were not equivalent despite reporting this measure administratively, according to the technical specifications. HSAG recommends that the LTC plans' NCQA LOs perform additional quality checks during the PMV process to improve data accuracy for this measure across all participating plans for the next reporting period.
- Further, HSAG identified an opportunity to improve the clarification of specifications for the *Timeliness of Services* measure. During the review, HSAG noted that the majority of LTC plans' eligible population values for this measure were identical to the denominator values. However, two plans' eligible populations were substantially greater than the denominators. Although for this measure it is acceptable to report varying eligible populations and denominators, the difference between the two values for these plans seemed questionable. One potential reason for the vast differences in values for these two plans could be related to when plans applied the exclusionary criteria (e.g., applying exclusions after the eligible population is identified). The specifications do not clarify when enrollees (1) in an assisted living facility (ALF), nursing home facility, participant directed option, or inpatient setting, or (2) who have refused services should be excluded (i.e., whether or not such should be excluded from the eligible population and denominator). HSAG recommends that AHCA provide clear guidance for the identification of the eligible population in the reporting requirements to unify these requirements across all participating plans for the next reporting period.

Follow-Up on Prior Year Recommendations

Based on the prior review period (SFY 2014–2015), HSAG offered the following recommendations for the LTC plans:

- Although there was some improvement in the *Case Manager Training* measure among the LTC plans, not all LTC plans reported 100 percent for this measure. Since this measure suggests LTC plan compliance with a mandate to report abuse, neglect, and exploitation, LTC plans with less than 100 percent performance should investigate the root cause of the noncompliance and assure proper and timely training for their case managers.
- Of the six measures that the LTC plans were required to report for SFY 2014–2015, three were new measures as compared to SFY 2013–2014. The 2015 statewide LTC rates for these first-year measures were low, and plan performance was diverse. Specifically, the *Required Record*

Documentation measure components showed very wide plan variation in performance. Since the measure assesses the percentage of enrollees who have specific documents to be maintained by the LTC plans in their records, a rate less than 100 percent would imply failure to comply with AHCA's expectation. HSAG recommends that plans with poor performance develop corrective action plans to ensure timely remedial actions to improve care.

- Despite AHCA's expectation, not all LTC plans' audits were conducted following NCQA HEDIS Compliance Audit policies and procedures. 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 recommends that the Final Audit Report (FAR) include a brief description of these data systems used for calculating AHCA-defined measures. The FAR should also include specific compliance findings related to each IS standard.

HSAG found that for the current review period, all six LTC plans reported rates less than 100 percent for the *Case Management Training* measure. Further, rates for all six LTC plans for the *Required Record Documentation* measure indicators were less than 100 percent. HSAG also found that audits conducted for some of the LTC plans still did not follow NCQA HEDIS Compliance Audit policies and procedures. In addition, the FARs continued to show lack of information regarding the data systems that were being used to calculate some of the AHCA-defined measures.

Review of Compliance With Access, Structure, and Operations Standards

Overview of Compliance Review Activity

In accordance with 42 CFR §438.358, which describes activities related to external quality reviews, a State Medicaid agency, its agent that is not an MCO or PIHP, or an EQRO must conduct a review within a three-year period to determine MCO and PIHP compliance with state standards. In accordance with 42 CFR §438.204(g), these standards must be as stringent as the federal Medicaid managed care standards described at 42 CFR §438 that address requirements related to access, structure and operations, and measurement and improvement.

To fulfill this requirement, in SFY 2014–2015, AHCA conducted readiness reviews of each of its SMMC plans during the period of time just prior to implementation of each phase of Florida's SMMC program. (Note: AHCA did not conduct a readiness review of Freedom-S because Freedom-S was already operating as a Dual-eligible Special Needs [D-SNP] plan and providing services in the SMMC program.) Because the SMMC program required the plans to operate under a new set of contract requirements and, in many cases, in a new geographical service area, the readiness reviews initiated a new three-year cycle of determining compliance for the Florida Medicaid plans, as required by the federal regulations.

In SFY 2015–2016, AHCA conducted various types of compliance activities. For example, AHCA focused on those areas that were problematic for the plans from the readiness reviews and other monitoring activities. These included Administration and Management, Enrollee Materials, the Grievance System, Prescribed Drug Services, the Provider Network standards, and Quality Improvement and Cultural Competency Programs. AHCA conducted desk reviews and began on-site reviews of the specific elements from June through October 2016.

AHCA used the Deeming Project information from the SFY 2014–2015 focused study to identify the review of activities to ensure compliance with federal and State requirements. In addition, AHCA conducted periodic reviews of the monitoring activities throughout the contract year. Some of the areas reviewed included Finance, Contracts, Member Services, Marketing, and Provider Network. As a consequence, AHCA issued corrective action plans (CAPs), liquidated damages, and other sanctions as identified in the SMMC contracts. In addition, AHCA used various data source methods, such as periodic and ad hoc reports, complaints, and the Provider Network Verification (PNV) system to compile information for the compliance reviews.

Objectives

AHCA's objectives for conducting the reviews were to:

- Determine if the plans satisfactorily met AHCA's requirements as specified in contract, policies, Florida law, and the Medicaid Managed Care rules (42 CFR Part 438).

- Increase AHCA's knowledge of the plans' operations and other contract implementation areas.
- Provide technical assistance or guidance on those identified areas that have been problematic in the past.
- Perform plan oversight to ensure overall contract compliance and to compare plans' performance.

Methods for Conducting the Review

AHCA conducted performance reviews of the plans based on the required standards for compliance reviews as outlined in the Medicaid Managed Care rules. These periodic reviews were based on various methodologies. AHCA included the following standards for the periodic reviews:

Access Standards

- Assurances of Adequate Capacity and Services
- Coordination and Continuity of Care
- Coverage and Authorization of Services

Structure and Operation

- Provider Selection
- Confidentiality
- Subcontractual Relationships and Delegation

Quality Measure and Improvement

- Quality Assessment and Performance Improvement Program
- Health Information Systems

Grievance System

- General Requirements
- Notice of Action
- Handling of Grievances and Appeals
- Resolution and Notification
- Expedited Resolution of Appeals
- Record-Keeping and Reporting Requirements
- Continuation of Benefits
- Effectuation of Reversed Appeal Resolutions

Information Requirements

Corrective Actions Imposed During SFY 2015–2016

When AHCA scored performance for a standard as less than fully compliant, it required the plan to complete a CAP. AHCA followed up on each plan's implementation of the CAPs and related outcomes during its ongoing monitoring and oversight activities as well as during compliance reviews. These activities determined whether the corrective actions were effective in bringing the plans back into compliance with State and federal requirements.

In addition, AHCA conducted reviews that not only resulted in CAPs, but also in liquidated damages and other sanctions in the following categories:

- Provider Network
- Finance
- Quality and Utilization Management
- Medicaid Fair Hearing
- Marketing
- Network Access
- Payment
- Administration and Management
- Covered Services
- Reporting
- Enrollee Services and Grievances

AHCA used the following subcategories to issue the CAPs, liquidated damages, and other sanctions:

- Financial
- Encounter Data
- Claims Processing
- Marketing Materials
- Enrollee Notices
- Care Coordination
- Transportation
- Provider Network
- Medical Necessity/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
- Confidentiality

AHCA submitted the compliance reviews for the plans' Quality Improvement (QI) Plan/Program and Cultural Competency Plans (CCPs) to HSAG for inclusion in this annual technical report.

AHCA's methodology to review each QI Plan/Program included the following elements:

- Item number
- Reference and source of review
- QI program/plan document used as reference for review
- Requirements—43
- *Met*, *Not Met*, *Not Applicable* (*N/A*) or *Not Scored* (*N/S*) scoring

Each requirement was individually considered to determine, based on evidence provided by the plan, if the plan met or did not meet compliance with the standard. In other words, each requirement had its own scoring criteria and in order to achieve a *Met* score, all of the elements of the requirement must meet the criteria. Plans with any *Not Met* QI Plan/Program elements were asked to revise and resubmit for AHCA's approval.

The methodology used for the Cultural Competency standard review was based on the required elements as described in the AHCA SMMC contract (under Core Contract Requirements), which provides for a CCP as follows:

> The CCP must describe how providers, Managed Care Plan employees, and systems will effectively provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes, values, affirms and respects the worth of the individual enrollees and protects and preserves the dignity of each.[12]

Each element under the requirement was measured individually. The scoring methodology was based on compliance or noncompliance with each element and included observations from the reviewer. Even though the plans all scored 100 percent compliance for the CCP standard, AHCA had suggestions for each plan, aimed at strengthening performance for this standard.

Plan-Specific Results

AHCA reviewed the plan-specific performance and compliance on 43 elements per plan for the QI Plan/Program standard and 10 elements for the Cultural Competency standard. In addition, AHCA conducted periodic monitoring activities of other federal and State contract standards and, as a consequence, imposed corrective action plans for each plan that was not in compliance with the reviewed standards. For plan comparison, HSAG calculated an average aggregate percentage for the QI

[12] Florida Agency for Health Care Administration. Attachment II—Core Contract Provisions—Effective November 15, 2016. Available at: http://www.fdhc.state.fl.us/medicaid/statewide_mc/pdf/Contracts/2016-11-15/11-15-16_Attachment_II_Gen_Amend.pdf. Accessed on: Feb 14, 2017.

Plan/Program standard by totaling the percentage scores AHCA assigned to the individual plans and dividing this total by the number of plans, resulting in 94 percent.

AHCA submitted completed reviews for the QI Plan/Program and Cultural Competency standards and submitted the results of the reviews to HSAG to be used for the annual technical report. Note: AHCA did not submit any other plan-specific reports to HSAG for inclusion in the annual technical report, but did submit a table that contained plan-specific CAPs, sanctions, and liquidated damages. Review results are displayed in the tables below.

MMA Standard Plans

Amerigroup

Findings

Table 3-11 presents the overall compliance results and the scores for each of the two categories of standards reviewed by AHCA. Scores are organized according to each category as *Met*, *Not Met*, *N/A*, and *N/S*. This table represents QI Plan/Program and Cultural Competency standards.

Table 3-11—Amerigroup Levels of Compliance With QI Plan/Program and Cultural Competency Standards

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	# *N/A* or *N/S*	Compliance Score*
I	Cultural Competency	10	10	0	0	100%
II	Quality Improvement Plan and Program	43	33	6	4	86%
Total Compliance Score						**93%**

* AHCA provided the calculated percentages for the compliance review results for each plan to HSAG, and HSAG has used the scores provided by AHCA in this report.

Total # of Elements: The total number of elements in each standard.

Table 3-11 shows that Amerigroup received a 100 percent score in the Cultural Competency standard review. AHCA recognized that the contractor had submitted a comprehensive CCP and evaluation that included the elements as required under the contractual provisions and in accordance with the applicable federal regulations.

Table 3-11 shows that Amerigroup received an 86 percent score in the QI Plan/Program standard. Of the 43 elements, 33 elements were scored *Met*, six elements were scored *Not Met*, two elements were scored *N/A*, and two elements were scored *N/S*. The percentage of compliance for this plan was impacted by two *N/S* and two *N/A* elements out of 43 elements.

AHCA identified deficiencies in the QI Plan/Program standard related to accreditation. F.S. Section 409.967(2)(e)3 requires the managed care plans to be accredited by a nationally recognized accrediting

body, or have initiated the accreditation process within one year after the contract with AHCA was executed. The plan failed to provide its accreditation status during the review period.

Similarly, the plan failed to demonstrate compliance with the standard that requires establishing a QI program committee. The contractual provision requires the plan to have designated representatives including the quality director, the grievance coordinator, the credentialing manager, and others. AHCA identified that the plan did not mention the grievance coordinator, the credentialing manager, the risk manager/infection control nurse, the enrollee advocate representative, the provider representative, or the geriatrician.

In addition, AHCA determined that the plan had inadequate communication between the governing body and the QI program committee regarding the strategic direction and the QI program.

Strengths

Amerigroup demonstrated strong performance for the CCP standard review, scoring 100 percent. Amerigroup scored as fully compliant for the element that requires a description of the plan's positions assigned within its QI program, including why each position was chosen to serve on the committee and the role each position is expected to fulfill.

Opportunities for Improvement

Amerigroup scored below the average aggregate for the plans. Amerigroup has opportunities for improvement in the following areas:

- Ensuring better documentation of its QI Plan/Program and committee structure.
- Ensuring that the strategic direction of the QI program is appropriately communicated as required.
- Cooperating with the EQRO during the external quality review activities, which included medical and case review of records.
- Ensuring that the provider network directory is maintained as required by federal and State requirements.

Corrective Actions

Amerigroup received two CAPs as an MMA Standard plan. The categories impacted were Provider Network and Covered Services. Amerigroup failed to maintain and update its provider online directory (i.e., adult psychiatry providers in Miami-Dade County). In addition, the plan neglected to comply with transportation provisions (i.e., LogistiCare).

Better Health

Findings

Table 3-12 presents the overall compliance results and the scores for each of the two categories of standards reviewed by AHCA. Scores are organized according to each category as *Met*, *Not Met*, *N/A*, and *N/S*. This table represents QI Plan/Program and Cultural Competency standards.

Table 3-12—Better Health Levels of Compliance With QI Plan/Program and Cultural Competency Standards

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	# *N/A* or *N/S*	Compliance Score*
I	Cultural Competency	10	10	0	0	100%
II	Quality Improvement Plan and Program	43	40	2	1	96%
Total Compliance Score						**98%**

* AHCA provided the calculated percentages for the compliance review results for each plan to HSAG, and HSAG has used the scores provided by AHCA in this report.

Total # of Elements: The total number of elements in each standard.

Table 3-12 shows that Better Health received a 100 percent score in the Cultural Competency standard review. AHCA recognized that the plan had covered all the required elements under its CCP. AHCA indicated that although the plan did not include its population demographics for age, gender, race/ethnicity, and language, the evaluation contained all those required elements.

Overall, for the QI Plan/Program standard review, Better Health received a 96 percent score. Of the 43 elements, Better Health was in full compliance with 40 elements. Only two elements were scored *Not Met*, and one element was scored *N/A*.

The QI Plan/Program standard review allowed AHCA to determine that although the plan had included several staff members to serve on its QI Program Committee as required, the plan failed to provide an explanation as to why those members were included and a description of their roles. AHCA also identified deficiencies related to the description of the process for selecting evaluation and study design procedures in the QI Plan/Program. Better Health mentioned the study design; however, the plan did not provide a description of the process for choosing evaluation and study design procedures.

Strengths

Better Health demonstrated strong performance for the Cultural Competency standard review, scoring 100 percent. Better Health received an overall score of 96 percent for the QI Plan/Program standard review, with only two elements scored *Not Met*.

Opportunities for Improvement

Better Health scored above the average aggregate for the plans. Better Health has opportunities for improvement in the following areas:

- Ensuring better documentation of its QI Plan/Program, explaining the QI committee's composition.
- Describing the process for selecting evaluation and study design procedures for the QI plan.
- Ensuring that all provisions for transportation services are adequately documented and implemented as required by AHCA.

Corrective Actions

Better Health received two CAPs as an MMA Standard plan. These actions were related to the Finance and Covered Services categories. The plan did not comply with transportation provisions (i.e., access to care). In addition, the plan did not file an accurate 2015 Q3 Achieved Savings Rebate (ASR) Financial Report as required by AHCA.

Coventry

Findings

Table 3-13 presents the overall compliance results and the scores for each of the two categories of standards reviewed by AHCA. Scores are organized according to each category as *Met*, *Not Met*, *N/A*, and *N/S*. This table represents QI Plan/Program and Cultural Competency standards.

Table 3-13—Coventry Levels of Compliance with QI Plan/Program and Cultural Competency Standards[1]

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	# *N/A* or *N/S*	Compliance Score*
I	Cultural Competency	10	10	0	0	100%
II	Quality Improvement Plan and Program	43	40	2	1	96%
Total Compliance Score						**98%**

[1] Coventry is contracted with AHCA for the provision of MMA Standard and LTC services. The results and data used in the analysis include performance and compliance for the two plan types combined.

* AHCA provided the calculated percentages for the compliance review results for each plan to HSAG, and HSAG has used the scores provided by AHCA in this report.

Total # of Elements: The total number of elements in each standard.

Table 3-13 shows that Coventry received a 100 percent score in the Cultural Competency standard review. However, AHCA noted in the review tool that, although Coventry provided the 2009–2013 census data for Florida related to race and ethnicity, specific enrollee demographic data were not provided in either the CCP or the evaluation document.

Overall, for the QI Plan/Program standard review, Coventry received a 96 percent score. Of the 43 elements, Coventry was in full compliance with 40 elements. Only two elements were scored *Not Met*, and one element was scored *N/A*.

For one of the elements that received a *Not Met* score, AHCA emphasized that the required QI plan must be available to the State agency as requested, and Coventry had not specifically stated this provision.

In the same category, AHCA indicated that, as required by contractual provisions, the QI plan did not state that the resumes of the QI program committee members would be made available upon AHCA's request.

Strengths

Coventry demonstrated strong performance for the Cultural Competency standard review, scoring 100 percent. Coventry received an overall score of 96 percent for the QI Plan/Program standard review, with only two elements scored *Not Met*.

Opportunities for Improvement

Coventry scored above the average aggregate for the plans. Coventry has opportunities for improvement in the following areas:

- Ensuring better documentation in its QI plan, acknowledging that the QI plan is available to AHCA if requested.
- Ensuring better documentation of its QI program committee and how the committee members' resumes are available upon AHCA's request.
- Ensuring that the claims and encounter processes are adequately addressing all AHCA requirements.

Corrective Actions

Coventry received two CAPs, one as an LTC plan and one as an MMA Standard plan. As an MMA Standard plan, Coventry failed to update the online provider directory (i.e., adult psychiatry providers in Miami-Dade County), which was related to the Provider Network category. As an LTC plan, Coventry was noncompliant with the requirement to comply with claims processing requirements, which was related to the Administration and Management category.

Humana

Findings

Table 3-14 presents the overall compliance results and the scores for each of the two categories of standards reviewed by AHCA. Scores are organized according to each category as *Met*, *Not Met*, *N/A*, and *N/S*. This table represents QI Plan/Program and Cultural Competency standards.

Table 3-14—Humana Levels of Compliance With QI Plan/Program and Cultural Competency Standards[1]

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	# *N/A* or *N/S*	Compliance Score*
I	Cultural Competency	10	10	0	0	100%
II	Quality Improvement Plan and Program	43	40	2	1	96%
Total Compliance Score						**98%**

[1] Humana is contracted with AHCA for the provision of MMA Standard and LTC services. The results and data used in the analysis include performance and compliance for the two types of plans combined.

* AHCA provided the calculated percentages for the compliance review results for each plan to HSAG, and HSAG has used the scores provided by AHCA in this report.

Total # of Elements: The total number of elements in each standard.

Table 3-14 shows that Humana received a 100 percent score in the Cultural Competency standard review. A positive overview from AHCA noted that Humana included self-reported, demographic race/ethnicity data and languages spoken by enrollees and Humana employees. According to AHCA, Humana also included data on race/ethnicity for enrollees with certain chronic health conditions. Conversely, AHCA noted that Humana collects CAHPS and other satisfaction data but did not present the results of this information in the CCP or evaluation.

Table 3-14 shows that Humana received a 96 percent score in the QI Plan/Program standard. Of the 43 elements, 40 elements were scored *Met*, two elements were scored *Not Met*, and one element was scored *N/A*.

AHCA identified that Humana had subcontracted with a managed behavioral health organization (MBHO) for the provision of behavioral health services, and as such the MBHO must be properly accredited. However, Humana failed to present proof of such accreditation. Humana also failed to mention the resumes were made available to AHCA upon request.

Strengths

Humana demonstrated strong performance for the Cultural Competency standard review, scoring 100 percent. Humana received an overall score of 96 percent for the QI Plan/Program standard review, with only two elements scored *Not Met*.

Opportunities for Improvement

Humana scored above the average aggregate for the plans. Humana has opportunities for improvement in the following areas:

- Ensuring documentation is available to demonstrate that the MBHO subcontractor has the required accreditation, and making this documentation available to AHCA during reviews and upon request.
- Ensuring better documentation of its QI committee and how the committee members' resumes are available upon AHCA's request.
- Enhancing internal processes to ensure compliance with enrollee communications and materials including the time frames as required by AHCA.

Corrective Actions

Humana received three CAPs as an MMA Standard plan. The CAPs were imposed as a result of noncompliance with two requirements related to the Enrollee Services and Grievances category and one requirement related to the Provider Network category. AHCA determined that the plan did not comply with time frames for providing enrollee handbooks, ID cards, and provider directories. In addition, the plan did not comply with enrollees' notice for denials, reductions, terminations, or suspensions of services within the time frames specified in the contract. The plan also failed to update the online provider directory (i.e., adult psychiatry providers in Miami-Dade County).

Molina

Findings

Table 3-15 presents the overall compliance results and the scores for each of the two categories of standards reviewed by AHCA. Scores are organized according to each category as *Met*, *Not Met*, *N/A*, and *N/S*. This table represents QI Plan/Program and Cultural Competency standards.

Table 3-15—Molina Levels of Compliance With QI Plan/Program and Cultural Competency Standards[1]

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	# *N/A* or *N/S*	Compliance Score*
I	Cultural Competency	10	10	0	0	100%
II	Quality Improvement Plan and Program	43	36	5	2	88%
Total Compliance Score						**94%**

[1] Molina is contracted with AHCA for the provision of MMA Standard and LTC services. The results and data used in the analysis include performance and compliance for the two types of plans combined.

* AHCA provided the calculated percentages for the compliance review results for each plan to HSAG, and HSAG has used the scores provided by AHCA in this report.

Total # of Elements: The total number of elements in each standard.

Table 3-15 shows that Molina received a 100 percent score in the Cultural Competency standard review. However, some elements that should be part of the CCP and evaluation were missing. AHCA noticed during the review that Molina focused primarily on language needs with less attention given to race, ethnicity, or religious needs, which are integral parts of the CCP.

Table 3-15 shows that Molina received an 88 percent score in the QI Plan/Program standard. Although Molina was compliant with 36 of the 43 elements, it failed to obtain compliance in five elements, and two elements were scored *N/A*.

AHCA's QI review indicated that Molina did not reference its accreditation status in its QI Plan/Program description. In addition, the plan was scored noncompliant with the element that requires the plans to maintain minutes of all QI program committee and subcommittee meetings and to make the minutes available to AHCA upon request. During the review, AHCA identified that the plan failed to mention in its QI Plan and Program Description that the meeting minutes were available for AHCA's review.

Furthermore, Molina received a negative score for the element that requires the plan to document how it makes available the required description of managed care positions assigned to the QI program to AHCA upon request. Molina was the only plan that was not in compliance with the element that requires a process to report findings from the QI plan to appropriate executive authority, staff, and departments within the plan as well as relevant stakeholders, such as participating providers. Also, the QI plan did not include how this communication would be documented for AHCA's review.

Strengths

Molina demonstrated strong performance for the Cultural Competency standard review, scoring 100 percent. Molina received the third-lowest score among all plans for the QI Plan/Program standard review.

Opportunities for Improvement

Molina scored below the average aggregate for the plans. Molina has opportunities for improvement in the following areas:

- Ensuring better documentation of the QI program committee and how the committee members' resumes are available upon AHCA's request.
- Ensuring proper documentation and availability of the QI program committee minutes and mentioning that the minutes are available upon request.
- Ensuring a process to report findings from the QI plan to appropriate parties as required.
- Ensuring that the QI plan includes how the communication of QI activities is documented for AHCA's review.
- Ensuring that the provider network directory is maintained according to federal and State requirements.

Corrective Actions

Molina received one CAP as an MMA Standard plan, which was related to the Provider Network category. AHCA determined that the plan had failed to update the online provider directory (i.e., adult psychiatry providers in Miami-Dade County).

Prestige

Findings

Table 3-16 presents the overall compliance results and the scores for each of the two categories of standards reviewed by AHCA. Scores are organized according to each category as *Met*, *Not Met*, *N/A*, and *N/S*. This table represents QI Plan/Program and Cultural Competency standards.

Table 3-16—Prestige Levels of Compliance With QI Plan/Program and Cultural Competency Standards

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	# *N/A* or *N/S*	Compliance Score*
I	Cultural Competency	10	10	0	0	100%
II	Quality Improvement Plan and Program	43	39	3	1	93%
Total Compliance Score						**97%**

* AHCA provided the calculated percentages for the compliance review results for each plan to HSAG, and HSAG has used the scores provided by AHCA in this report.

Total # of Elements: The total number of elements in each standard.

Table 3-16 shows that Prestige received a 100 percent score in the Cultural Competency standard review. AHCA recognized that Prestige has embraced the CLAS standards and had including them in its CCP.

AHCA also noted that Prestige was collecting data regarding gender, age group, race/ethnicity, and primary language—elements that are key components of the CCP.

Table 3-16 shows that Prestige received a 93 percent score in the QI Plan/Program standard. Although Prestige was compliant with 39 of the 43 elements, it failed to obtain compliance in three elements, and one element was scored *N/A*.

AHCA's QI Plan/Program standard review indicated that Prestige failed to indicate its accreditation status. Six other plans also failed to reference their accreditation status in their QI Plan/Program descriptions. In addition, Prestige failed to demonstrate the accreditation for behavioral health services.

In addition to Prestige, seven other plans failed to demonstrate compliance with the element that requires MBHOs to be accredited for the provision of behavioral health services if they are subcontracted by the plan. In addition, Prestige failed to meet the element that required the plan to document how it makes

available the required description of managed care positions assigned to the QI program to AHCA upon request.

Strengths

Prestige demonstrated strong performance for the Cultural Competency standard review, scoring 100 percent. Prestige scored 93 percent for the QI Plan/Program standard review; although below average, this score is within 7 percentage points of 100 percent compliance with this standard.

Opportunities for Improvement

Prestige scored below the average aggregate for the plans. Prestige has opportunities for improvement in the following areas:

- Ensuring better documentation of its QI program committee and how the committee members' resumes are available upon AHCA's request.
- Ensuring documentation is available to demonstrate that both Prestige and its MBHO subcontractor have the required accreditation and making this information available to AHCA during reviews and upon request.

Corrective Actions

Prestige received three CAPs as an MMA Standard plan. The issue categories were Finance, Administration and Management, and Provider Network. These CAPs were related to compliance with claims processing. AHCA identified that the plan was noncompliant with the maintenance of the Financial Surplus Requirements for Quarter Ending 3/31/2015 and failed to update the online provider directory (i.e., adult psychiatry providers in Miami-Dade County).

SFCCN

Findings

Table 3-17 presents the overall compliance results and the scores for each of the two categories of standards reviewed by AHCA. Scores are organized according to each category as *Met*, *Not Met*, *N/A*, and *N/S*. This table represents QI Plan/Program and Cultural Competency standards.

Table 3-17—SFCCN Levels of Compliance With QI Plan/Program and Cultural Competency Standards

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	# *N/A* or *N/S*	Compliance Score*
I	Cultural Competency	10	10	0	0	100%
II	Quality Improvement Plan and Program	43	40	2	1	96%
Total Compliance Score						**98%**

* AHCA provided the calculated percentages for the compliance review results for each plan to HSAG, and HSAG has used the scores provided by AHCA in this report.

Total # of Elements: The total number of elements in each standard.

Table 3-17 shows that SFCCN received a 100 percent score in the Cultural Competency standard review. However, AHCA indicated that on June 1, 2015, SFCCN submitted one document containing both the 2015–2016 CCP and the plan's annual evaluation. The evaluation was composed of two brief paragraphs, which did not cover any of the required areas. SFCCN stated that it has incorporated the CLAS standards as guidelines for furnishing culturally competent services. Although SFCCN mentioned that it collects CAHPS data and other enrollee feedback, no data were provided in either of these documents. In addition, no demographic data were included.

On July 31, 2015, AHCA requested that SFCCN submit a more comprehensive CCP annual evaluation, which was submitted to AHCA on August 13, 2015. The resubmitted evaluation document focused only on complaint and grievance reports and 2014 enrollee satisfaction survey results.

AHCA scored SFCCN as 96 percent compliant with the QI Plan/Program standard. Of the 43 elements, 40 elements were scored *Met*, two elements were scored *Not Met*, and one element was scored *N/A*. One of the elements for which SFCCN was noncompliant required the plan to indicate its accreditation status.

SFCCN failed to meet the element that requires the plan to provide specific quality training for QI program staff. Furthermore, AHCA identified that SFCCN did not reference the quality training developed by CMS for QI program staff.

In addition, AHCA's findings identified that SFCCN did not present evidence as to the accreditation needed for the behavioral health services subcontractors in accordance with State and contractual requirements.

Strengths

SFCCN demonstrated strong performance for the Cultural Competency standard review, scoring 100 percent. SFCCN scored 96 percent for the QI Plan/Program standard review, with only two elements scored as *Not Met*.

Opportunities for Improvement

SFCCN scored above the average aggregate for the plans. SFCCN has opportunities for improvement in the following areas:

- Ensuring that specific quality training includes protocols developed by CMS, is provided to QI program staff, and is documented as required.
- Ensuring documentation is available to demonstrate that the MBHO subcontractor has the required accreditation and making this information available to AHCA during reviews and upon request.

Corrective Actions

SFCCN did not receive any CAPs as an MMA Standard plan. However, AHCA imposed a sanction on this plan for failure to satisfactorily respond to an ad hoc request.

Simply

Findings

Table 3-18 presents the overall compliance results and the scores for each of the two categories of standards reviewed by AHCA. Scores are organized according to each category as *Met*, *Not Met*, *N/A*, and *N/S*. This table represents QI Plan/Program and Cultural Competency standards.

Table 3-18—Simply Levels of Compliance With QI Plan/Program and Cultural Competency Standards

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	# *N/A* or *N/S*	Compliance Score*
I	Cultural Competency	10	10	0	0	100%
II	Quality Improvement Plan and Program	43	40	2	1	96%
Total Compliance Score						**98%**

* AHCA provided the calculated percentages for the compliance review results for each plan to HSAG, and HSAG has used the scores provided by AHCA in this report.

Total # of Elements: The total number of elements in each standard.

Table 3-18 shows that Simply received a 100 percent score in the Cultural Competency standard review. AHCA noted that Simply had included all the required components in its CCP, except demographics. However, Simply did include the demographic data in the evaluation document, which is a companion document of the CCP.

For the QI Plan/Program standard, Simply was in compliance, with an overall score of 96 percent. Simply's score is above average compared to other plans' scores. Of the 43 elements, Simply scored *Not Met* in only two elements. Simply failed to meet compliance for the element that requires the QI plan to describe the process for selecting evaluation and study design procedures.

In addition, Simply failed to demonstrate compliance for the QI element that requires the plan to have a description of the managed care plan positions assigned to the QI program, including a description of why each position was chosen to serve on the committee and the role each position is expected to fulfill. AHCA determined that, although Simply mentioned the staff members included in the QI program committee, the plan omitted an explanation of why they were included and of their particular roles.

Strengths

Simply demonstrated strong performance for the Cultural Competency standard review, scoring 100 percent. Simply scored 96 percent for the QI Plan/Program standard review, with only two elements scored *Not Met*.

Opportunities for Improvement

Simply scored above the average aggregate for the plans; however, the plan has opportunities for improvement in the following areas:

- Ensuring that it has appropriate documentation demonstrating the process for selecting evaluation and study design procedures under the QI plan.
- Ensuring better documentation of the composition of its QI program committee, including an explanation of why members were included and their particular roles in the committee.
- Ensuring that the provider network directory is maintained according to federal and State requirements.

Corrective Actions

Simply received two CAPs as an MMA Standard plan. One CAP dealt with complaints related to the Finance category for failure to file an accurate 2015 Q3 ASR Financial Report. The remaining CAP, related to the Provider Network category, was due to the plan's noncompliance with the requirement to update the online provider directory (i.e., adult psychiatry providers in Miami-Dade County).

Sunshine

Findings

Table 3-19 presents the overall compliance results and the scores for each of the two categories of standards reviewed by AHCA. Scores are organized according to each category as *Met*, *Not Met*, *N/A*, and *N/S*. This table represents QI Plan/Program and Cultural Competency standards.

Table 3-19—Sunshine Levels of Compliance With QI Plan/Program and Cultural Competency Standards[1]

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	# *N/A* or *N/S*	Compliance Score*
I	Cultural Competency	10	10	0	0	100%
II	Quality Improvement Plan and Program	43	41	1	1	98%
Total Compliance Score						**99%**

[1] Sunshine is contracted with AHCA for the provision of MMA Standard, MMA Specialty, and LTC services. The results and data used in the analysis include performance and compliance for the three types of plans combined.

* AHCA provided the calculated percentages for the compliance review results for each plan to HSAG, and HSAG has used the scores provided by AHCA in this report.

Total # of Elements: The total number of elements in each standard.

Table 3-19 shows that Sunshine scored 100 percent compliance in the Cultural Competency standard review. AHCA identified several ways the plan could strengthen its CCP. AHCA identified several areas for improvement related to data collection and implementation of the CLAS standards. AHCA suggested during its review that the Sunshine QI plan and evaluation are two separate documents that contain the same information, with the exception of the material contained on page 9 of the evaluation document.

In addition, AHCA indicated that neither document contained demographics related to plan membership, providers, or plan employees. Sunshine stated that it adhered to CLAS standard principles and listed each of the standards. However, the CCP and evaluation lacked substance related to describing how the standards were implemented and evaluated. AHCA stated that Sunshine mentioned that the plan monitored the delivery of care through its CAHPS Member Satisfaction Survey and Provider Satisfaction Survey, but the evaluation document did not provide any actual survey data. Although this plan serves LTC, MMA, and child welfare populations, Sunshine did not mention the populations that it serves.

Sunshine was in compliance with 41 of the 43 QI Plan/Program standard elements reviewed, with an above-average performance of 98 percent when compared to the average aggregate for the plans. However, since one of the elements was scored *N/A*, the plan was noncompliant with only one element, which stated that if the plan subcontracts with an MBHO for the provision of behavioral health services, the MBHO must be properly accredited. Nevertheless, AHCA indicated in posterior notes that the plan had demonstrated the MBHO accreditation.

Strengths

Sunshine demonstrated strong performance for the Cultural Competency standard review, scoring 100 percent. For the QI Plan/Program standard review, Sunshine scored 98 percent, with only one element scored *Not Met* and one element scored *N/A*.

Opportunities for Improvement

Sunshine scored above the average aggregate for the plans; however, the plan has opportunities for improvement in the following areas:

- Properly documenting the CCP and evaluation to ensure compliance with the requirements.
- Ensuring documentation is available to demonstrate that the MBHO subcontractor has the required accreditation and making the documentation available to AHCA during reviews and upon request.
- Ensuring that all provisions for transportation services are adequately documented and implemented as required by AHCA.

Corrective Actions

Sunshine received two CAPs as an MMA Standard plan. One CAP dealt with complaints related to the Covered Services category as the plan failed to comply with the requirements for transportation provision (i.e., access to care). The remaining CAP fell within the Provider Network category as the plan failed to update the online provider directory (i.e., adult psychiatry providers in Miami-Dade County).

UnitedHealthcare

Findings

Table 3-20 presents the overall compliance results and the scores for each of the two categories of standards reviewed by AHCA. Scores are organized according to each category as *Met*, *Not Met*, *N/A*, and *N/S*. This table represents QI Plan/Program and Cultural Competency standards.

Table 3-20—United Levels of Compliance With QI Plan/Program and Cultural Competency Standards[1]

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	# *N/A* or *N/S*	Compliance Score*
I	Cultural Competency	10	10	0	0	100%
II	Quality Improvement Plan and Program	43	34	8	1	81%
Total Compliance Score						**91%**

[1] United is contracted with AHCA for the provision of MMA Standard and LTC services. The results and data used in the analysis include performance and compliance for the two types of plans combined.

* AHCA provided the calculated percentages for the compliance review results for each plan to HSAG, and HSAG has used the scores provided by AHCA in this report.

Total # of Elements: The total number of elements in each standard.

Table 3-20 shows that United received a 100 percent score in the Cultural Competency standard review. The review indicated that United's CCP covered all the required areas. AHCA highlighted that United did not provide AHCA with an evaluation document with its original submission in June. The evaluation document was requested on July 31, 2015, and was not received by AHCA until August 7, 2015. AHCA recognized that the evaluation provided CAHPS data, access to practitioner data, grievance and appeals data, a table which included an aggregate comparison of practitioner and member language, and data regarding the top languages requested through United's language line service.

For the QI Plan/Program standard, Table 3-20 demonstrated that United was in full compliance with 34 of the 43 elements. However, compared with its peers, United scored below the average aggregate for the plans, with 81 percent compliance. United scored *N/A* for one element and *Not Met* for eight elements. United and one other plan were the only two plans that did not mention the requirement related to cooperating with AHCA and the EQRO in the QI program description.

The plan failed to meet eight of the 43 elements. AHCA identified issues related to the requirement that the plan identify, track, review, and analyze critical incidents to identify and address potential and actual quality of care and/or health and safety issues. AHCA highlighted that during the review it was unable to find the provisions addressing critical incidents in the QI program description.

AHCA also established that the plan subcontracted with an MBHO for the provision of behavioral health services; however, the plan failed to demonstrate that, as required by the State of Florida and the contract, the MBHO must be accredited from a recognized national accreditation organization within one year of start-up and achieve full accreditation within two years of beginning operations.

As part of the QI program, plans must make the QI plan available to AHCA, as requested. During the review AHCA determined that the plan had no statement indicating that the QI plan was available, which caused the plan to fail this requirement. Other identified deficiencies included the lack of specific references to training including protocols developed by CMS regarding quality. This requirement indicates that the plan must have, at a minimum, protocols developed by CMS regarding quality.

Lastly, the QI program is required to include a description of the health management information systems that were used to support the QI program. The plan was unable to demonstrate compliance with the requirement because AHCA found that the plan did not have a description of the health management information systems that were used to support the QI program.

Strengths

United demonstrated strong performance for the Cultural Competency standard review, scoring 100 percent. For the QI Plan/Program standard review, the plan scored 81 percent, with eight elements scored *Not Met*.

Opportunities for Improvement

United scored below the average aggregate for the plans, with an 81 percent score. The plan has opportunities for improvement in the following areas:

- Ensuring that it has appropriate documentation demonstrating that it has the provisions to address critical incidents in the QI program description.
- Ensuring documentation is available to demonstrate that the MBHO subcontractor has the required accreditation and making the information available to AHCA during reviews and upon request.
- Ensuring that specific quality training includes protocols developed by CMS, is provided to QI program staff, and is documented as required.
- Ensuring better documentation in the QI plan, acknowledging that this plan is available to AHCA if requested.
- Ensuring that the provider network directory is maintained according to federal and State requirements.

Corrective Actions

As an MMA Standard plan, United received one CAP, which was related to the Provider Network category. The plan failed to update the online provider directory (i.e., adult psychiatry providers in Miami-Dade County).

Staywell

Findings

Table 3-21 presents the overall compliance results and the scores for each of the two categories of standards reviewed by AHCA. Scores are organized according to each category as *Met*, *Not Met*, *N/A*, and *N/S*. This table represents QI Plan/Program and Cultural Competency standards.

Table 3-21—Staywell Levels of Compliance With QI Plan/Program and Cultural Competency Standards

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	# *N/A* or *N/S*	Compliance Score*
I	Cultural Competency	10	10	0	0	100%
II	Quality Improvement Plan and Program	43	39	2	2	96%
Total Compliance Score						**98%**

* AHCA provided the calculated percentages for the compliance review results for each plan to HSAG, and HSAG has used the scores provided by AHCA in this report.

Total # of Elements: The total number of elements in each standard.

Table 3-21 shows that Staywell received a 100 percent score in the Cultural Competency standard review. Staywell ensured that its CCP adhered to the national CLAS standards. The plan provided demographic data in the evaluation document related to enrollee race/ethnicity and languages spoken. AHCA commented that the plan had provided demographic data on the languages spoken by enrolled providers and additionally provided a summary of language line requests for 2014.

For the QI Plan/Program standard, Staywell received a score of 96 percent, indicating compliance with 39 of the 43 elements measured. Two elements were scored *Not Met* and two were scored *N/A*. Staywell scored above average compared to its peers.

AHCA identified deficiencies in the QI Plan/Program element that, pursuant to Florida Statutes Section 409.967(2)(e)3., F.S., requires managed care plans to be accredited by a nationally recognized accrediting body, or have initiated the accreditation process within one year after the contract with AHCA was executed. The plan failed to include its accreditation status in its QI Plan/Program description. Staywell failed to meet the element that requires the plan to provide specific quality training for QI program staff, and AHCA was not able to locate specific references in the plan's QI Plan/Program description indicating that Staywell provided QI training to managed care plan enrollees.

Strengths

Staywell demonstrated strong performance for the Cultural Competency standard review, scoring 100 percent. For the QI Plan/Program standard review, the plan scored 96 percent, with only two elements scored *Not Met*.

Opportunities for Improvement

Staywell scored above the average aggregate for the plans, with a 96 percent score. The plan has opportunities for improvement in the following areas:

- Ensuring that specific quality training includes protocols developed by CMS, is provided to QI program staff, and is documented as required.
- Ensuring that documentation is available to demonstrate that the plan has the required accreditation and making this information available to AHCA during reviews and upon request.
- Ensuring that the provider network directory is maintained according to federal and State requirements.

Corrective Actions

Staywell received three CAPs as an MMA Standard plan. These CAPs were related to compliance with the Provider Network category, in that the plan failed to update the online provider directory (i.e., adult psychiatry providers in Miami-Dade County). In addition, regarding the Enrollee Services and Grievances category, the plan failed to comply with enrollee notice requirements. Related to the Covered Services category, the plan failed to coordinate discharge planning.

Specialty Plans

Positive-S

Findings

Table 3-22 presents the overall compliance results and the scores for each of the two categories of standards reviewed by AHCA. Scores are organized according to each category as *Met*, *Not Met*, *N/A*, and *N/S*. This table represents QI Plan/Program and Cultural Competency standards.

Table 3-22—Positive-S Levels of Compliance With QI Plan/Program and Cultural Competency Standards

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	# *N/A* or *N/S*	Compliance Score*
I	Cultural Competency	10	10	0	0	100%
II	Quality Improvement Plan and Program	43	37	5	1	91%
Total Compliance Score						**96%**

* AHCA provided the calculated percentages for the compliance review results for each plan to HSAG, and HSAG has used the scores provided by AHCA in this report.

Total # of Elements: The total number of elements in each standard.

Table 3-22 shows that Positive-S scored 100 percent compliance in the Cultural Competency standard. However, AHCA stated for this review that, although Positive-S indicated that the program components were developed from the CLAS standards, the standards were not documented in the CCP. The 2014 CCP evaluation listed the CLAS standards and described how each standard was met in the previous year. In addition, AHCA observed that Positive-S did not specifically mention religion or the demographic description of the membership in the QI plan, but the evaluation did include this information.

For the QI Plan/Program standard, Positive-S received an overall score of 91 percent, with five elements scored *Not Met* and one element scored *N/A*.

AHCA established that the plan subcontracted with an MBHO for the provision of behavioral health services; however, Positive-S failed to demonstrate that, as required by the State of Florida and the contract, the MBHO must be accredited from a recognized national accreditation organization within one year of start-up and achieve full accreditation within two years of beginning operations.

In addition, AHCA established that under the requirement that provides for specific QI program committee composition, related to the inclusion of an enrollee advocate representative (i.e., the managed care plan is encouraged to include multiple advocate representatives), the plan did not demonstrate compliance.

AHCA highlighted that the QI plan did not reference making the minutes of all QI program committee and subcommittee meetings available to AHCA upon request. Similarly, the plan failed to prove

compliance with the time frames, as established by AHCA, for the written QI plan, which must be submitted to AHCA within 30 days from execution of the initial contract.

Finally, the plan was not able to demonstrate compliance with the provision that requires the availability of QI program committee members' resumes upon AHCA's request.

Strengths

Positive-S demonstrated strong performance for the Cultural Competency standard review, scoring 100 percent. For the QI Plan/Program standard review, the plan scored 91 percent, with five elements scored as *Not Met*.

Opportunities for Improvement

Positive-S scored below the average aggregate for the plans. The plan has opportunities for improvement in the following areas:

- Ensuring documentation is available to demonstrate that it has the required accreditation and making this information available to AHCA during reviews and upon request.
- Ensuring better documentation of its QI program committee composition including enrollee advocate representatives.
- Ensuring proper documentation and availability of the QI program committee minutes and mentioning that the minutes are available.
- Ensuring proper documentation for compliance with the time frames for submission of the written QI plan to AHCA.
- Ensuring that the provider network directory is maintained according to federal and State requirements.

Corrective Actions

Positive-S received three CAPs as an MMA Specialty plan. These CAPs were related to the Provider Network category, in that the plan failed to update the online provider directory (i.e., adult psychiatry providers in Miami-Dade County). In addition, related to the Finance category, the plan failed to file an accurate 2015 Q4 ASR Financial Report. Related to the Marketing category, the plan failed to file accurate reports (i.e., Monthly Marketing/Public/Educational/Events Report; PNV Submission; and Enrollee Complaints, Grievances and Appeals Report).

Children's Medical Services-S

Findings

Table 3-23 presents the overall compliance results and the scores for each of the two categories of standards reviewed by AHCA. Scores are organized according to each category as *Met*, *Not Met*, *N/A*, and *N/S*. This table represents QI Plan/Program and Cultural Competency standards.

Table 3-23—Children's Medical Services-S Levels of Compliance With QI Plan/Program and Cultural Competency Standards

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	# *N/A* or *N/S*	Compliance Score*
I	Cultural Competency	10	10	0	0	100%
II	Quality Improvement Plan and Program	43	39	3	1	93%
Total Compliance Score						**97%**

* AHCA provided the calculated percentages for the compliance review results for each plan to HSAG, and HSAG has used the scores provided by AHCA in this report.

Total # of Elements: The total number of elements in each standard.

Table 3-23 demonstrates that Children's Medical Services-S scored 100 percent compliance in the Cultural Competency standard review. AHCA established that Children's Medical Services-S network covered all required areas in its CCP. The CCP document is labeled 2016, although it was submitted in 2015 for the 2015–2016 contract year. Children's Medical Services-S stated that the CCP addressed the expectations of both the National Center for Cultural Competence (NCCC) and the CLAS standards. The QI evaluation document provided data on the CAHPS questions related to cultural competency. It also provided information related to a self-evaluation and measurement of cultural and linguistic competence. However, AHCA indicated that no demographic data were reported for enrollees, providers, or plan employees in either document.

For the QI Plan/Program standard, Children's Medical Services-S had 39 elements in compliance; three elements were scored *Not Met* and one element was scored *N/A*. The plan's score of 93 percent was slightly below the average of all plans.

Regarding accreditation, the plan failed to demonstrate compliance with the requirement that it be accredited by a nationally recognized accrediting body, or have initiated the accreditation process within one year after contract execution. AHCA was not able to find documentation to demonstrate the plan's accreditation. In addition, the plan was not able to present evidence of compliance with the provision which requires that if the plan subcontracts with an MBHO for the provision of behavioral health services, the MBHO must be properly accredited.

Lastly, the plan failed to note in its QI Plan/Program description that it will make the QI plan available to AHCA, as requested.

Strengths

Children's Medical Services-S demonstrated strong performance for the Cultural Competency standard review, scoring 100 percent. The plan scored 93 percent, with 39 elements in compliance. For the QI Plan/Program standard review, the plan's score was 93 percent.

Opportunities for Improvement

Children's Medical Services-S scored slightly below the average aggregate for the plans. The plan has opportunities for improvement in the following areas:

- Ensuring documentation is available to demonstrate that it has the required accreditation and making this documentation available to AHCA during reviews and upon request.
- Ensuring better documentation in its QI plan, acknowledging that the QI plan is available to AHCA if requested.
- Ensuring documentation is available to demonstrate that the MBHO subcontractor has the required accreditation and making the documentation available to AHCA during reviews and upon request.
- Ensuring that the claims and encounter processes are adequately addressing all AHCA requirements.

Corrective Actions

Children's Medical Services-S received two CAPs as an MMA Specialty plan. These CAPs were related to the Administration and Management category, in that the plan had failed to comply with encounter data submission requirements. In addition, the Covered Services category was not met in that the plan failed to comply with care coordination and case management provisions.

Clear Health-S

Findings

Table 3-24 presents the overall compliance results and the scores for each of the two categories of standards reviewed by AHCA. Scores are organized according to each category as *Met*, *Not Met*, *N/A*, and *N/S*. This table represents QI Plan/Program and Cultural Competency standards.

Table 3-24—Clear Health-S Standards Levels of Compliance With QI Plan/Program and Cultural Competency Standards

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	# *N/A* or *N/S*	Compliance Score*
I	Cultural Competency	10	10	0	0	100%
II	Quality Improvement Plan and Program	43	40	2	1	96%
Total Compliance Score						**98%**

* AHCA provided the calculated percentages for the compliance review results for each plan to HSAG, and HSAG has used the scores provided by AHCA in this report.

Total # of Elements: The total number of elements in each standard.

Table 3-24 demonstrates that Clear Health-S received a 100 percent score in the Cultural Competency standard review. AHCA determined during the review that Clear Health-S covered all required areas in its CCP. Although the CCP did not contain an analysis of the plan's population demographics for age, gender, race/ethnicity, and language, the QI evaluation contained this information.

For the QI Plan/Program standard review, Clear Health-S received a score of 98 percent. Of the 43 elements, 40 elements were scored *Met*, two elements were scored *Not Met*, and one element was scored *N/A*. The plan's score was slightly above average compared to its peers.

AHCA recognized that the plan failed to describe the positions assigned to the QI program, including a description of why each position was chosen to serve on the QI program committee and the role each position is expected to fulfill. In addition, the QI plan must also describe the process for selecting evaluation and study design procedures; however, AHCA determined that the plan had mentioned the study design but had failed to reference the process used for choosing the evaluation and study design procedures.

Strengths

Clear Health-S demonstrated strong performance for the Cultural Competency standard review, scoring 100 percent. For the QI Plan/Program standard review, the plan scored 98 percent, with 40 elements in compliance.

Opportunities for Improvement

Clear Health-S scored slightly above the average aggregate for the plans. The plan has opportunities for improvement in the following areas:

- Ensuring that it has appropriate documentation demonstrating the process for selecting evaluation and study design procedures under the QI plan.
- Ensuring better documentation of its QI program committee composition including an explanation of why members were included and their particular roles in the committee.
- Ensuring that the provider network directory is maintained according to federal and State requirements.

Corrective Actions

Clear Health-S received three CAPs as an MMA Specialty plan. These CAPs were related to the Provider Network category, in that the plan had failed to update the online provider directory (i.e., adult psychiatry providers in Miami-Dade County). In addition, under the Covered Services category, the plan failed to comply with transportation provisions. Under the Finance category, the plan failed to file an accurate 2015 Q3 ASR Financial Report.

Freedom-S

Findings

Table 3-25 presents the overall compliance results and the scores for each of the two categories of standards reviewed by AHCA. Scores are organized according to each category as *Met*, *Not Met*, *N/A*, and *N/S*. This table represents QI Plan/Program and Cultural Competency standards.

Table 3-25—Freedom-S Levels of Compliance With QI Plan/Program and Cultural Competency Standards

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	# *N/A* or *N/S*	Compliance Score*
I	Cultural Competency	10	10	0	0	100%
II	Quality Improvement Plan and Program	43	41	0	2	100%
Total Compliance Score						**100%**

* AHCA provided the calculated percentages for the compliance review results for each plan to HSAG, and HSAG has used the scores provided by AHCA in this report.

Total # of Elements: The total number of elements in each standard.

Table 3-25 shows that Freedom-S received a 100 percent score in the Cultural Competency standard review. AHCA highlighted that the plan's CCP addressed all areas of the contract. The evaluation provided information on enrollees' language diversity based on U.S. Census Bureau data. AHCA also determined that the evaluation provided race and ethnicity information for plan enrollees, compared to State and national census data. Freedom-S additionally supplied provider network race and ethnicity data, and member services metrics for enrollees who used the language line.

For the QI Plan/Program standard review, Freedom-S performed exceptionally well, with 100 percent compliance with 41 elements under this category.

Strengths

Freedom-S demonstrated 100 percent compliance for both the Cultural Competency standard review and the QI Plan/Program standard review. Many other plans failed to meet standards related to QI components such as accreditation or the composition of the QI program. Freedom-S was able to provide enough evidence to show compliance with all the requirements reviewed.

Corrective Actions

Freedom-S did not receive any CAPs as an MMA Specialty plan during the review period.

Magellan-S

Findings

Table 3-26 presents the overall compliance results and the scores for each of the two categories of standards reviewed by AHCA. Scores are organized according to each category as *Met*, *Not Met*, *N/A*, and *N/S*. This table represents QI Plan/Program and Cultural Competency standards.

Table 3-26—Magellan-S Levels of Compliance With QI Plan/Program and Cultural Competency Standards

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	# *N/A* or *N/S*	Compliance Score*
I	Cultural Competency	10	10	0	0	100%
II	Quality Improvement Plan and Program	43	40	2	1	96%
Total Compliance Score						**98%**

* AHCA provided the calculated percentages for the compliance review results for each plan to HSAG, and HSAG has used the scores provided by AHCA in this report.

Total # of Elements: The total number of elements in each standard.

Table 3-26 shows that Magellan-S received a 100 percent score in the Cultural Competency standard review. AHCA identified that Magellan-S stated that it adopted and adheres to the CLAS standards. Although the CCP did not include demographic information, the evaluation document did. AHCA established that the evaluation contained plan staffing information related to languages spoken, as well as practitioner linguistic and ethnic make-up. Magellan-S included data regarding phone calls requesting oral translation services.

For the QI Plan/Program standard review, Magellan-S scored 96 percent, with 40 elements scored *Met*, two elements scored *Not Met*, and one element scored *N/A*.

Magellan-S failed to demonstrate compliance with the requirement that provides for the plan to maintain minutes of all QI program committee and subcommittee meetings and make the minutes available for AHCA's review upon request. AHCA indicated that there was no mention of minutes being available.

In addition, the plan failed to note in its QI Plan/Program description that it will make the QI plan available to AHCA, as requested.

Strengths

Magellan-S demonstrated strong performance for the Cultural Competency standard review, scoring 100 percent. For the QI Plan/Program standard review, the plan scored 96 percent, with 40 elements in compliance.

Opportunities for Improvement

Magellan-S scored slightly above the average aggregate for the plans. The plan has opportunities for improvement in the following areas:

- Ensuring better documentation in its QI plan, acknowledging that the QI plan is available to AHCA if requested, and submitting the QI plan in accordance with the time frames as required.
- Ensuring proper documentation and availability of the QI program committee minutes and mentioning that the minutes are available upon request.
- Ensuring that the provider network directory is maintained according to federal and State requirements.

Corrective Actions

Magellan-S received two CAPs as an MMA Specialty plan. These CAPs were related to the Provider Network category, in that the plan failed to update the online provider directory (i.e., adult psychiatry providers in Miami-Dade County). In addition, for the Enrollee Services and Grievances category, the plan failed to submit a complete and accurate Provider Complaint Report due on or before October 15, 2015.

LTC Plan

American Eldercare-LTC

Humana American Eldercare was acquired by Humana during SFY 2013 and merged with Humana on July 1, 2015. For the compliance section of this report, American Eldercare-LTC (AEC-L) will be designated as Humana American Eldercare, Inc. (Humana AEC) because during the review, Humana AEC submitted documents from Humana and AEC. For example, for the Cultural Competency standard review, Humana submitted the CCP while AEC submitted the CCP annual evaluation.

Findings

Table 3-27 presents the overall compliance results and the scores for each of the two categories of standards reviewed by AHCA. Scores are organized according to each category as *Met*, *Not Met*, *N/A*, and *N/S*. This table represents QI Plan/Program and Cultural Competency standards.

Table 3-27—Humana AEC Levels of Compliance With QI Plan/Program and Cultural Competency Standards

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	# *N/A* or *N/S*	Compliance Score*
I	Cultural Competency	10	10	0	0	100%
II	Quality Improvement Plan and Program	43	41	1	1	98%
Total Compliance Score						**99%**

* AHCA provided the calculated percentages for the compliance review results for each plan to HSAG, and HSAG has used the scores provided by AHCA in this report.

Total # of Elements: The total number of elements in each standard.

Table 3-27 shows that Humana AEC received a 100 percent score in the Cultural Competency standard review. However, AHCA emphasized that the CCP was submitted by Humana AEC, and that the CCP annual evaluation was submitted by AEC. Although the CCP stated that Humana AEC's guidance was based on federal and State laws/regulations and CLAS standards, it did not specifically align with the CLAS standards. In addition, AHCA indicated that the CCP did not specifically state religion, but the QI evaluation did. Neither the CCP nor the evaluation provided the demographic description of membership.

For the QI Plan/Program standard, Humana AEC received 98 percent compliance, with only one element scored *Not Met* and one scored *N/A*. Humana AEC's score is above average compared to its peers.

The plan did not present evidence of compliance with the provision that requires that if the plan subcontracts with an MBHO for the provision of behavioral health services, the MBHO must be properly accredited.

Strengths

Humana AEC demonstrated strong performance for the Cultural Competency standard review, scoring 100 percent. For the QI Plan/Program standard review, the plan scored 98 percent, with 41 elements in compliance.

Opportunities for Improvement

Humana AEC scored above the average aggregate for the plans; however, the plan has opportunities for improvement in the following areas:

- Ensuring documentation is available to demonstrate that its MBHO subcontractor has the required accreditation and making this documentation available to AHCA during reviews and upon request.
- Ensuring that its CCP and evaluation include the demographic description of the plan's membership.
- Enhancing internal processes to ensure compliance with the enrollee notice requirements as established by federal provisions and by AHCA.

Corrective Actions

Humana AEC received one CAP as an LTC plan. This CAP was related to noncompliance within the Enrollee Services and Grievances category. AHCA determined that the plan had failed to comply with enrollee notice requirements.

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 their contracted health 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 in the state's overall management and oversight of its Medicaid managed care program.

During SFY 2015–2016, 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 SMMC plans, including MMA, Specialty, and LTC plans, collectively referred to as plans, were complete and accurate.

The study included administrative and comparative analyses of plan-submitted encounters and a review of clinical records, plans of care and/or treatment plans, the eligibility file, and other available data sources. Additionally, the SFY 2015–2016 EDV study focused its review on a specific subset of services associated with the following categories:

- Dental services
- Therapy services (speech, occupational, and physical therapy for children under the age of 21)
- Long-term care

Encounter Data File Review

Based on the approved scope of work, HSAG worked with AHCA's EDV and DSS teams 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 study data. Data were requested for all claims/encounter records with dates of service between January 1, 2015, and June 30, 2015, that were finalized and submitted to AHCA before October 1, 2015. In addition to the file specifications, the data submission requirements also included information on the required data types (i.e., professional, dental, and institutional) and the associated required data elements. HSAG also requested AHCA to provide other supporting data files related to enrollment, demographics, and providers associated with the encounter files.

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

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

Encounter Volume Completeness and Reasonableness

Capturing, sending, and receiving encounter data has historically been difficult and costly for plans and states alike. The encounter data collection process is lengthy and has many steps where data can be lost or errors can be introduced into submitted data elements. Assessment of the completeness and accuracy of encounter data provides insight into areas that need improvement for these processes, as well as quantifying the general reliability of encounter data. These analyses were performed with the key data elements as individual units of assessment at the aggregate level for the encounter data sources (plans' encounter systems and AHCA's encounter system), and stratified by individual plans.

HSAG conducted a preliminary review of the encounter data submitted by AHCA and the plans in order to provide a high-level summary of the differences and variation in the quality of encounter data managed by AHCA and individual plans. Table E-1 in Appendix E highlights the encounter data volume submitted by AHCA and the plans. Substantial differences in the volume of each of the three encounter types were observed when comparing the volume of encounters submitted by plans and AHCA. This discrepancy was mainly attributable to the duplicate records found in the encounter data submitted by AHCA. Upon further review, AHCA determined that the *Payer Responsibility Sequence Code* on the 2320 SBR loop of the transaction caused the "duplicated" records. The following plan submission pattern was noted:

- Plans always submit primary and secondary sequence codes and sometimes submit tertiary payer sequence codes.
- Plans always use "MC" to indicate Medicaid for all payers.
- In nearly all instances, the professional encounter submission also uses "CI" and "ZZ" in the *Claim Filing Indicator Code* field.
- Plans do not always submit payers in logical order (e.g., tertiary payers may be listed first).

FMMIS and DSS captured this information as it was submitted and stored. Since the *Payer Responsibility Sequence Code* field is a header field, it propagates to the detail lines for each occurrence, which leads to increased record counts. At the time of the study, there was no resolution within the data, and it was determined that re-running the queries would not resolve the issue. As such, HSAG had to move forward with the data received from AHCA.

Examination of the volume of encounters submitted each month provided additional insight into potential problems with data completeness observed in the comparative analysis and clinical record review components of the study. Figure E-1through Figure E-3 in Appendix E provide the overall encounter volume trends over time by the plans and AHCA for each of the associated focused service categories (i.e., dental, children's therapy, and long-term care). While AHCA's encounter data showed consistently greater encounter data volume than the volume reported by the plans among all three service categories, month-to-month volume trends were relatively consistent between both data sources.

Encounter Field Completeness and Reasonableness

To determine the completeness and reasonableness of the plans' and AHCA's electronic claims/encounter data, HSAG examined the percentage of key data fields (e.g., provider NPI, diagnosis code, revenue code, NDC) that contained data and were populated with expected values. The study was restricted to specific criteria for each of the focused types of services. For example, the dental services were based on enrollees under 21 years of age with dental procedure codes. As such, since the recipient ID and the procedure codes were restricted, these fields were not evaluated if populated with expected values. For fields that were evaluated, percentages were based on all records submitted that met the specific types of services criteria, with the assumption that the encounters were in their final status as requested in the data submission requirements document. Key data fields with missing values were evaluated for completeness, but they did not contribute to calculations for accuracy (i.e., percentage missing and percentage valid). Accuracy rates were assessed based on whether submitted values were in the correct format and the data fields contained expected values (percentage valid). For example, a record in which the provider field was populated with a value of "000000000" would be considered to have a value present but not to have a valid value.

Completeness of enrollee encounters fluctuated by data source (plan-based versus AHCA-based submissions) and data element among the three encounter types assessed for the EDV, with AHCA generally submitting encounters with higher completion rates. Between children's therapy and long-term care encounter types, high levels of completeness were observed for required elements, such as *Primary Diagnosis Code* and *Revenue Code* from both data sources. Differences were observed between data sources for the completeness of provider-related data elements for essentially all encounter types; AHCA submitted encounters with consistently low percentage missing rates for provider-related fields for dental, children's therapy, and long-term care encounters, while plans submitted encounters with lower percentage missing rates for *Rendering Provider NPI* and *Billing Provider NPI* only. Diagnoses-related elements displayed similar completeness trends among encounter types (limited to children's therapy and long-term care encounters), with rates of less than 0.1 percent missing for *Primary Diagnosis Code*, but high rates of missing values for all remaining diagnosis codes. While percentage missing rates for plan-based and AHCA-based encounters were relatively equivalent for the remaining diagnosis codes in children's therapy encounters, AHCA submitted records with higher percentage missing rates for long-term care encounters.

The validity of enrollee encounters was greatly limited by high levels of missing data among encounter types for both data sources. However, it is important to note that high levels of missing data were anticipated for fields related to surgical procedure codes since these fields were not applicable in the evaluation of therapy and long-term care services. Among provider-related elements for plan-based encounters, a high level of variation was observed for plans that did not have 100.0 percent missing value rates, contributing to overall lower percentage valid rates than those observed for AHCA-based encounters. Consistently high percentage valid rates were observed for diagnoses-related data elements despite differences in the completeness of AHCA and plan-based encounters, and this trend was observed for both children's therapy and long-term care encounters.

Comparative Analysis

The comparative analysis component of the study examined the extent to which encounters submitted by the plans and maintained in FMMIS (and the data subsequently extracted and submitted by AHCA to HSAG) were accurate and complete when compared to data submitted by the plans to HSAG.

To compare the plans' and AHCA's submitted data, HSAG developed a comparable match key between the two data sources. Data fields used for professional and dental record level matching varied from plan to plan and generally included recipient identification number, internal control number (ICN), and procedure code. Data fields used for institutional record level matching included fields such as recipient identification number, ICN, and revenue center code. These data elements were concatenated to create a unique MATCHKEY, which became a unique identifier for each detail record in AHCA's and the plan's data.

This section presents the findings from the results of the comparative analysis for each of the service categories (i.e., dental, children's therapy, and long-term care) based on the encounter data (i.e., professional, dental, and institutional) maintained by the plans and AHCA.

Record Completeness

There are two aspects of record completeness—record omission and record surplus. Encounter record omission and surplus rates are summary metrics designed to evaluate discrepancies between two data sources—i.e., primary and secondary. The primary data source refers to data maintained by an organization (e.g., plan) responsible for sending data to another organization (e.g., AHCA); the data acquired by the receiving organization is referred to as the secondary data source. By comparing these two data sources (i.e., primary and secondary), the analysis yields the percentage of records contained in one source and not the other, and vice versa. As such, encounter record omission refers to the percentage of encounters reported in the primary data source that are missing from the secondary data source. For the purpose of this analysis, the omission rate identifies the percentage of encounters reported by a plan that are missing from AHCA's data. Similarly, the encounter record surplus rate refers to the percentage of encounters reported in the secondary data source (AHCA) that are missing from the primary data source (the plans).

Table 3-28 highlights the dental services results of two aspects of record completeness (i.e., encounter record omission and surplus) and describes the extent to which records are present in each data source. Dental services were reported in all three encounter types (i.e., dental, institutional, and professional). As such, results were classified by the three encounter types that are associated with each plan providing dental services.

Table 3-28—Record Omission and Surplus Rates: Dental Services Category by Plan and Encounter Type

Plan	Dental Encounters		Institutional Encounters		Professional Encounters	
	Omission	Surplus	Omission	Surplus	Omission	Surplus
AMG-L						
AMG-M	0.3%	50.9%	0.0%	50.0%	13.6%	64.7%

Plan	Dental Encounters		Institutional Encounters		Professional Encounters	
	Omission	Surplus	Omission	Surplus	Omission	Surplus
BET-M	0.0%	72.4%	0.0%	80.0%	0.0%	50.0%
CHA-S	4.3%	71.8%	NA	NA	NA	NA
CMS-S	0.2%	70.5%	0.0%	78.9%	0.0%	59.8%
COV-L						
COV-M	0.2%	56.1%	NA	NA	NA	NA
HUM-L						
HUM-M	1.2%	66.2%	0.0%	94.6%	0.0%	54.7%
MCC-S	8.3%	50.3%	NA	100.0%	0.0%	83.3%
MOL-L						
MOL-M	0.2%	72.0%	0.0%	63.6%	NA	NA
NBD-M	1.0%	55.7%	NA	NA	NA	NA
PHC-S						
PRS-M	0.0%	62.6%	0.0%	50.0%	31.4%	72.4%
SHP-M	0.0%	70.7%	0.0%	75.0%	0.0%	50.0%
STW-M	1.0%	62.3%	23.2%	67.5%	0.4%	51.7%
SUN-L						
SUN-M	8.9%	76.8%	96.2%	50.0%	0.0%	98.1%
SUN-S	7.8%	78.6%	100.0%	NA	0.0%	83.3%
URA-L						
URA-M	6.2%	54.0%	57.1%	75.0%	13.6%	61.0%
All Plans	**2.7%**	**66.1%**	**24.1%**	**74.0%**	**6.5%**	**59.4%**
Maximum	**8.9%**	**78.6%**	**100.0%**	**100.0%**	**31.4%**	**98.1%**
Minimum	**0.0%**	**50.3%**	**0.0%**	**50.0%**	**0.0%**	**50.0%**

Note: Gray shading indicates that the plan has no encounters meeting the criteria for the selected service category.
"NA" denotes there are no dental services identified from the specified encounter type.

The overall record omission rates for dental services varied across the three encounter types, with dental encounters having the lowest record omission rate of 2.7 percent, and the institutional encounters having the highest record omission rate of 24.1 percent.

Unlike the record omission rates, the overall record surplus rates were higher across all three encounter types, with rates greater than 50.0 percent. As noted in the Encounter Data File Review section of this report, the high surplus rates across all encounter types were attributed to the duplicated records from the encounter data submission from AHCA. As described earlier, the *Payer Responsibility Sequence Code* on the 2320 SBR loop of the transaction was the cause of the "duplicated" records.

Overall, the record omission rates and surplus rates varied considerably among plans for each of the encounter types.

Table 3-29—Record Omission and Surplus Rates: Children's Therapy Services Category by Plan and Encounter Type

Plan	Institutional Encounters		Professional Encounters	
	Omission	Surplus	Omission	Surplus
AMG-L				
AMG-M	9.8%	60.3%	25.7%	64.2%
BET-M	1.3%	66.6%	0.3%	62.9%
CHA-S	0.0%	50.0%	NA	NA
CMS-S	1.2%	68.2%	0.1%	61.6%
COV-L				
COV-M	0.0%	55.7%	50.0%	50.0%
HUM-L				
HUM-M	0.2%	72.2%	0.0%	67.2%
MCC-S	NA	100.0%	23.2%	66.9%
MOL-L				
MOL-M	0.3%	64.0%	1.1%	84.3%
NBD-M	0.0%	55.2%	2.8%	53.5%
PHC-S [A]	NA	100.0%	100.0%	NA
PRS-M	0.1%	61.3%	4.9%	65.3%
SHP-M	3.6%	63.4%	1.3%	66.9%
STW-M	2.7%	61.9%	3.4%	62.3%
SUN-L				
SUN-M	0.9%	55.9%	1.3%	78.5%
SUN-S	0.5%	61.4%	0.8%	79.0%
URA-L				
URA-M	70.1%	88.2%	14.1%	63.0%
All Plans	**9.9%**	**66.9%**	**4.0%**	**64.3%**
Maximum	**70.1%**	**100.0%**	**100.0%**	**84.3%**
Minimum	**0.0%**	**50.0%**	**0.0%**	**50.0%**

Note: Gray shading indicates the plan has no encounters meeting the criteria for the selected service category.
"NA" denotes there are no children's therapy services identified in the specified encounter type.
[A] The plan had fewer than 30 records with children's therapy services from both encounter types; therefore, results should be interpreted with caution.

The overall record omission rates for children's therapy services varied slightly across the two encounter types, with overall record omission rates of 9.9 percent and 4.0 percent for the institutional and professional encounters, respectively.

The overall record surplus rates for children's therapy services were higher between the two encounter types, with rates of more than 60.0 percent for both encounter types. These rates indicate that a high number of records were reported by the plans in AHCA's encounter data but were not found in the

respective records submitted by the plans to HSAG. As discussed previously, this anomaly was mainly attributed to the duplicated records in the encounter data submission from AHCA.

In general, record omission rate and surplus rate variations among plans were minimal for institutional encounters but varied considerably within the professional encounters.

Table 3-30—Record Omission and Surplus Rates: Long-term Care Services Category by Plan and Encounter Type

Plan	Institutional Encounters		Professional Encounters	
	Omission	Surplus	Omission	Surplus
AMG-L	52.1%	84.0%	6.3%	64.3%
AMG-M	13.9%	69.1%	6.1%	57.7%
BET-M	4.5%	63.6%	5.4%	69.9%
CHA-S	16.4%	73.5%	3.9%	69.7%
CMS-S	3.9%	73.6%	0.9%	73.2%
COV-L	3.9%	87.9%	3.0%	64.3%
COV-M	5.2%	60.2%	1.6%	79.5%
HUM-L	3.6%	91.9%	8.4%	74.0%
HUM-M	1.0%	79.1%	1.2%	87.8%
MCC-S	20.0%	100.0%	6.8%	61.5%
MOL-L	0.4%	78.7%	0.6%	59.8%
MOL-M	2.5%	66.5%	1.8%	60.3%
NBD-M	8.5%	60.1%	7.1%	66.4%
PHC-S	75.3%	92.2%	33.7%	61.6%
PRS-M	4.0%	75.0%	4.6%	75.0%
SHP-M	1.4%	67.5%	18.7%	70.0%
STW-M	12.4%	61.6%	1.9%	59.7%
SUN-L	10.0%	88.3%	5.8%	57.4%
SUN-M	3.0%	60.0%	52.4%	81.6%
SUN-S	1.6%	63.5%	6.0%	60.7%
URA-L	61.3%	92.0%	13.9%	54.6%
URA-M	61.4%	82.6%	17.5%	64.1%
All Plans	**25.7%**	**79.2%**	**9.6%**	**68.6%**
Maximum	**75.3%**	**100.0%**	**52.4%**	**87.8%**
Minimum	**0.4%**	**60.0%**	**0.6%**	**54.6%**

The overall record omission rates for long-term care services varied considerably between the two encounter types, with overall record omission rates of 25.7 percent and 9.6 percent for the institutional and professional encounters, respectively.

Similar to dental and children's therapy services, the overall surplus rates were relatively high between the two encounter types for long-term care services. Rates greater than 60.0 percent for both encounter types indicate that a high number of records were reported by the plans in AHCA's encounter data but were not found in the respective records submitted by the plans to HSAG. This data anomaly was mostly attributed to the duplicated records in the encounter data submission from AHCA.

Record omission rates and surplus rates varied considerably among plans for the institutional encounters, and relatively less variation was observed within the professional encounters.

Data Element Completeness

Element Omission and Surplus

Data element omission evaluates completeness based on the percentage of records with key data element values present in the plans' data systems but not in AHCA's data system. Similarly, data element surplus evaluates completeness based on the percentage of records with key data element values present in AHCA's data system but not in the plans' data systems. Data element omission and surplus found in AHCA's data system illustrates discrepancies in the completeness of AHCA's encounter data.

Table 3-31, Table 3-32, and Table 3-33 present the overall data element omission and surplus rates for each of the evaluated data elements for dental, children's therapy, and long-term care services, respectively. The plan ranges for element omission and surplus rates are also presented.

Table 3-31—Element Omission and Surplus Summary: Dental Category

Key Data Elements	Element Omission		Element Surplus	
	Overall Rate	Plan Range	Overall Rate	Plan Range
Line First Date of Service	0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%
Line Last Date of Service	0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%
Billing Provider NPI	1.7%	0.0% – 4.7%	13.4%	0.0% – 99.2%
Rendering Provider NPI	0.4%	0.0% – 2.0%	6.6%	0.0% – 100.0%
Procedure Code	0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%
Tooth Number	0.4%	0.0% – 75.2%	10.7%	0.0% – 73.0%
Amount Paid	0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%

Overall, the level of completeness for key dental services encounter data elements was high (i.e., low overall omission and surplus rates) with the overall element omission and element surplus rates of 0.0 percent for nearly all encounter data elements (*Line First Date of Service*, *Line Last Date of Service*, *Procedure Code*, and *Amount Paid*). The only exceptions were *Billing Provider NPI* (overall omission and surplus rates of 1.7 percent and 13.4 percent, respectively), *Rendering Provider NPI* (overall omission and surplus rates of 0.4 percent and 6.6 percent, respectively) and *Tooth Number* (overall omission and surplus rates of 0.4 percent and 10.7 percent, respectively).

Table 3-32—Element Omission and Surplus Summary: Children's Therapy Category

Key Data Elements		Element Omission		Element Surplus	
		Overall Rate	Plan Range	Overall Rate	Plan Range
Institutional Encounters					
Admission Date		78.4%	0.0% – 100.0%	0.0%	All plans reported 0.0%
Discharge Date		8.6%	0.0% – 78.3%	3.8%	0.0% – 80.5%
Primary Diagnosis Code		0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%
Procedure Code		0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%
Revenue Code		0.0%	All plans reported 0.0%	< 0.1%	All plans reported 0.0% except HUM-M (<0.1%)
Billing Provider NPI		0.3%	0.0% – 1.3%	28.0%	0.0% – 96.8%
Attending Provider ID		0.0%	All plans reported 0.0%	95.2%	21.0% – 100.0%
Amount Paid		0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%
Professional Encounters					
Line First Date of Service		0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%
Line Last Date of Service		0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%
Primary Diagnosis Code		0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%
Procedure Code		0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%
Billing Provider NPI		0.5%	0.0% – 8.3%	32.8%	0.0% – 64.6%
Rendering Provider NPI		5.2%	0.0% – 33.9%	11.4%	0.0% – 94.4%
Amount Paid		0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%

Encounters associated with children's therapy services also showed a high level of completeness among key data elements that were evaluated with a few exceptions. Key data elements such as *Primary Diagnosis Code*, *Procedure Code*, *Revenue Code*, *Line First Date of Service*, *Line Last Date of Service*, and *Amount Paid* had element omission and element surplus rates below 1.0 percent. Encounter data elements associated with less completeness were generally attributed to one of the provider fields. For example, the *Rendering Provider NPI* from the professional encounters exhibited overall element

omission and surplus rates of 5.2 percent and 11.4 percent, respectively, while *Billing Provider NPI* from institutional and professional encounters had surplus rates of 28.0 percent and 32.8 percent, respectively. Among institutional encounters, the *Attending Provider ID* field exhibited a surplus rate that exceeded 95.0 percent.

Table 3-33—Element Omission and Surplus Summary: Long-term Care Category

Key Data Elements	Element Omission		Element Surplus	
	Overall Rate	Plan Range	Overall Rate	Plan Range
Institutional Encounters				
Admission Date	55.3%	0.0% – 100.0%	< 0.1%	0.0% – < 0.1%
Discharge Date	21.5%	0.0% – 97.6%	8.1%	0.0% – 100.0%
Primary Diagnosis Code	0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%
Procedure Code	0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%
Revenue Code	0.0%	All plans reported 0.0%	< 0.1%	0.0% – 100.0%
Billing Provider NPI	0.4%	0.0% – 1.5%	2.1%	0.0% – 94.5%
Attending Provider ID	< 0.1%	0.0% – < 0.1%	78.5%	0.0% – 100.0%
Amount Paid	< 0.1%	0.0% – < 0.1%	< 0.1%	0.0% – 0.1%
Payer Responsibility Sequence Code	< 0.1%	0.0% – < 0.1%	9.8%	0.0% – 100.0%
Insurance Group Policy Number	1.1%	0.0% – 100.0%	12.9%	0.0% – 100.0%
Claim Filing Indicator Code	< 0.1%	0.0% – < 0.1%	7.5%	0.0% – 100.0%
Contract Info	84.8%	0.0% – 96.2%	0.1%	0.0% – 4.2%
Professional Encounters				
Line First Date of Service	0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%
Line Last Date of Service	0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%
Primary Diagnosis Code	0.0%	All plans reported 0.0%	< 0.1%	0.0% – < 0.1%
Procedure Code	0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%
Billing Provider NPI	1.8%	0.0% – 14.3%	7.0%	0.0% – 66.0%
Rendering Provider NPI	2.0%	0.0% – 8.6%	46.3%	0.0% – 97.6%
Amount Paid	0.0%	All plans reported 0.0%	< 0.1%	0.0% – 0.1%
Payer Responsibility Sequence Code	0.0%	All plans reported 0.0%	19.3%	0.0% – 100.0%
Insurance Group Policy Number	5.4%	0.0% – 100.0%	16.4%	0.0% – 100.0%

Key Data Elements	Element Omission		Element Surplus	
	Overall Rate	Plan Range	Overall Rate	Plan Range
Claim Filing Indicator Code	0.0%	All plans reported 0.0%	11.2%	0.0% – 100.0%
Contract Info	31.9%	0.0% – 81.3%	4.8%	0.0% – 67.5%

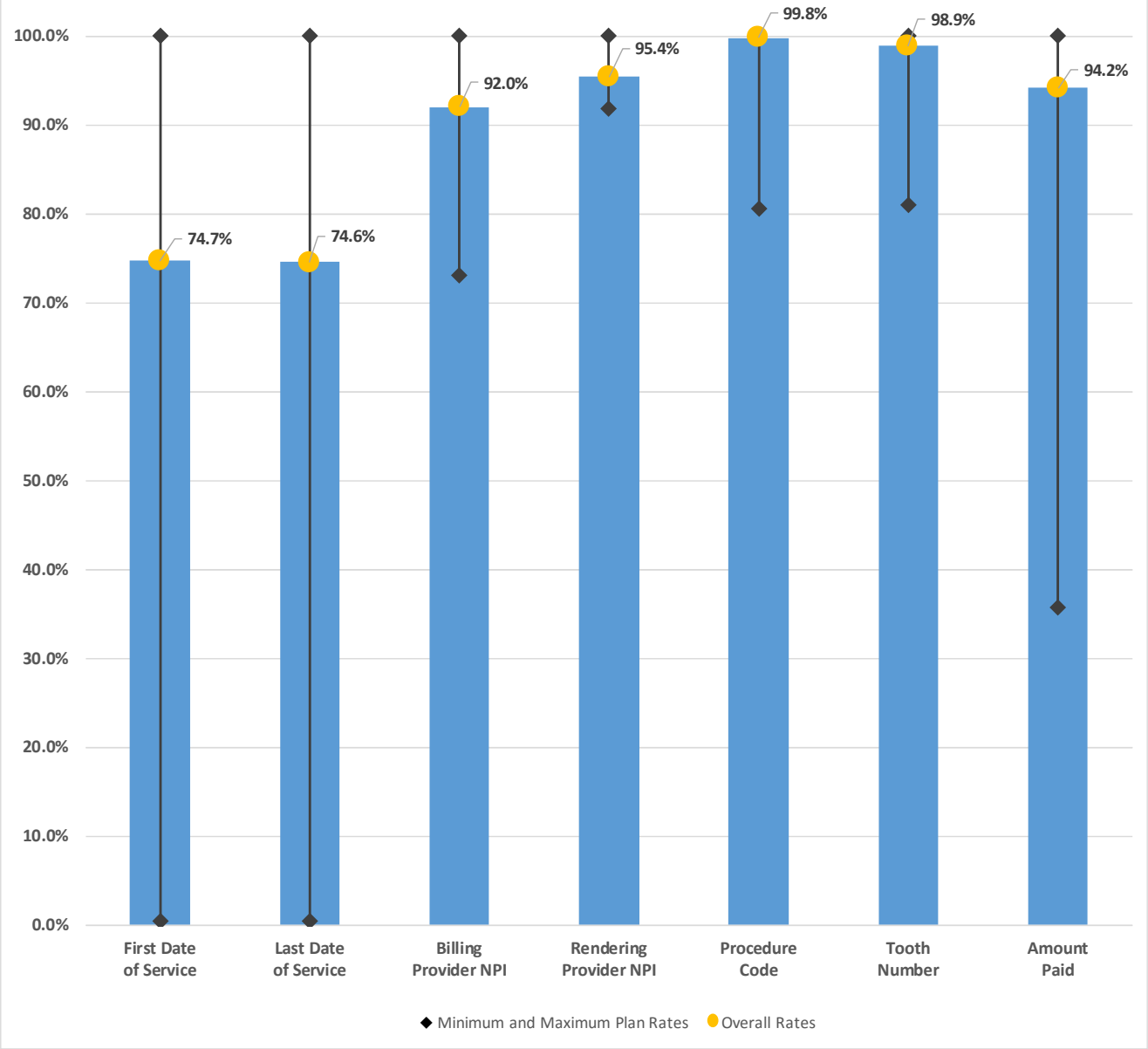
High levels of completeness were exhibited for five data elements (*Primary Diagnosis Code*, *Procedure Code*, *Revenue Code*, *Billing Provider NPI*, and *Amount Paid*) for submitted institutional encounters associated with the long-term care services, while low levels of completeness were exhibited for four data elements (*Admission Date*, *Discharge Date*, *Attending Provider ID*, and *Contract Info*), reporting either high level omission or surplus rates. Among encounters that could be matched between AHCA's and the plans' submitted professional encounter data for long-term care services, high levels of completeness were exhibited for almost half of the evaluated data elements. Three data elements (*Claim Filing Indicator Code*, *Payer Responsibility Sequence Code*, and *Insurance Group Policy Number*) displayed moderate levels of completeness, while two data elements (*Rendering Provider NPI* and *Contract Info*) displayed relatively high levels of completeness.

Data Element Agreement

Element-level agreement is limited to those records present in both data sources with values present in both data sources. Data element completeness based on element-level agreement evaluates agreement based on the percentage of records with values present in both data sources that contain the same values. Higher data element agreement rates indicate that the values populated for data elements in AHCA's submitted encounter data are more "accurate."

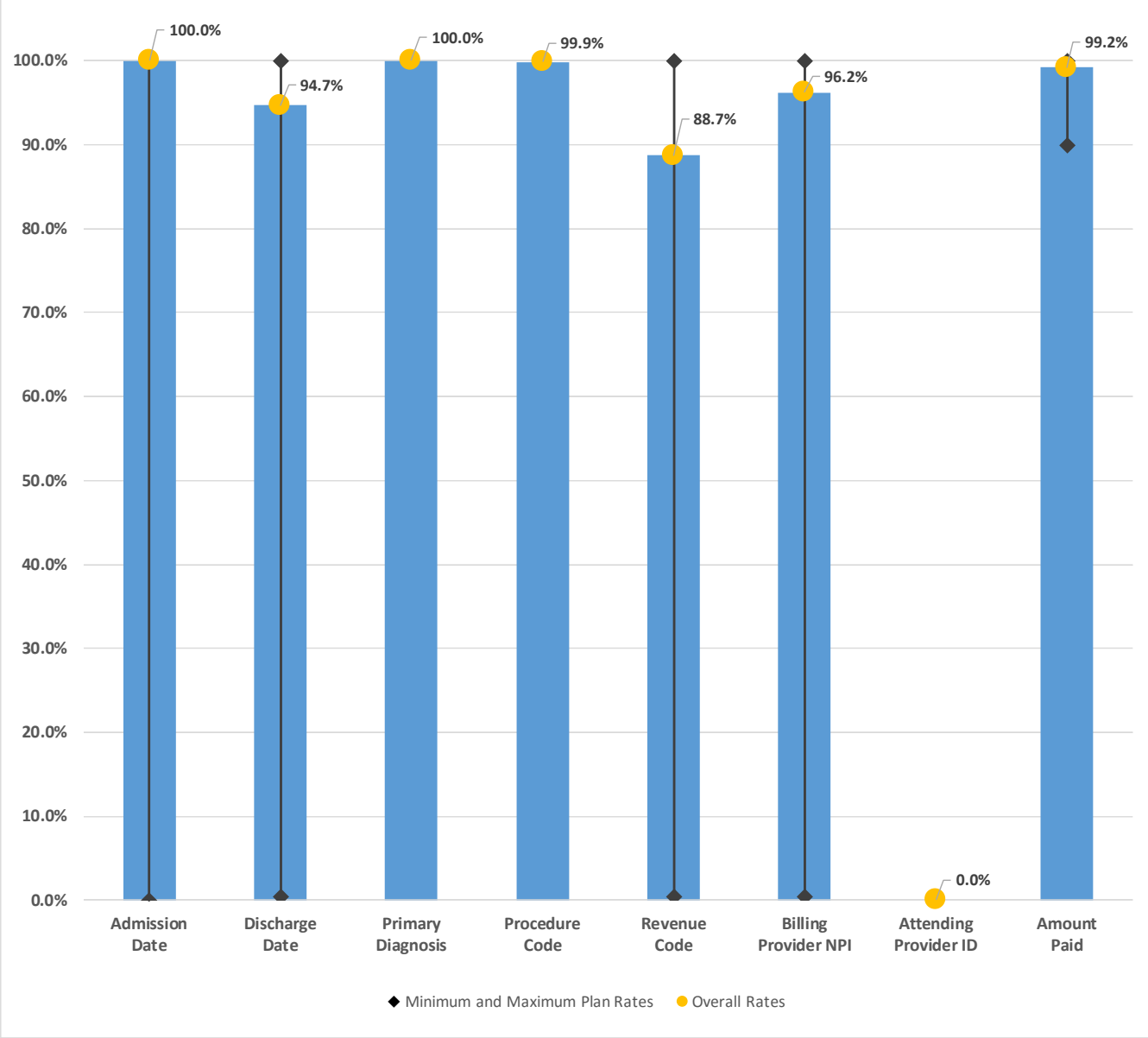
Figure 3-13 to Figure 3-17 present the overall agreement rates for each of the evaluated data elements for dental, children's therapy institutional, children's therapy professional, long-term care institutional, and long-term care professional encounters, respectively. The minimum and maximum plan element agreement rates are also presented.

Figure 3-13—Element Agreement by Key Element for Dental Encounters



Overall, data element agreement for dental services from dental encounters that could be matched between AHCA's and plans' submitted encounter data was high, with key data elements such as *Procedure Code*, *Tooth Number*, *Billing Provider NPI*, *Rendering Provider NPI*, and *Amount Paid* showing at least 90 percent agreement. This finding suggests that encounter data elements between AHCA's and plans' submitted data have the same values when populated.

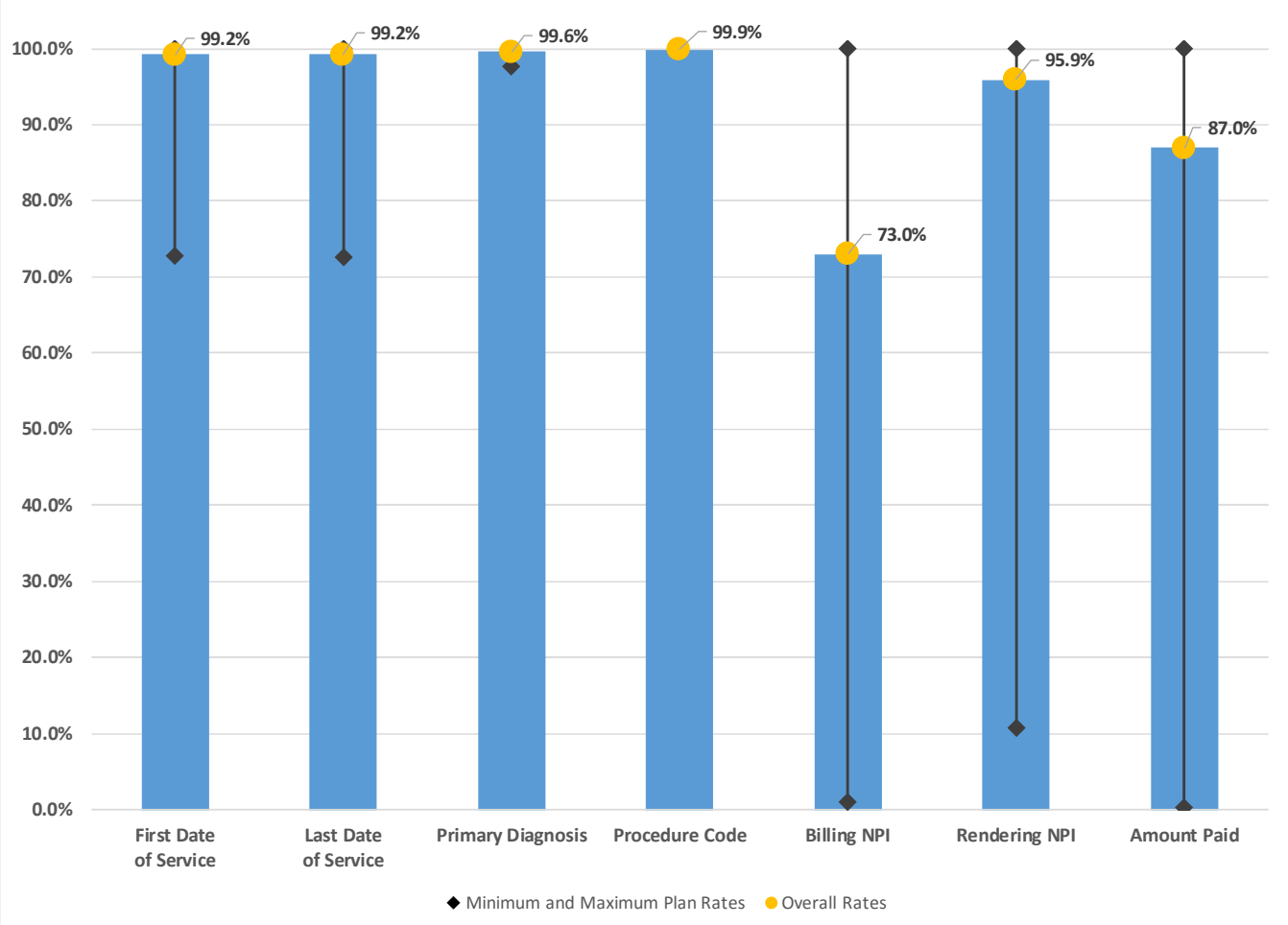
Figure 3-14—Element Agreement by Key Element for Children's Therapy From Institutional Encounters



For children's therapy services from the institutional encounters that could be matched between AHCA's encounter data and plan-submitted encounter data, high overall agreement rates were noted in the following fields: *Admission Date*, *Primary Diagnosis Code*, *Procedure Code*, *Billing Provider NPI*, and *Amount Paid*, where all reported agreement rates greater than 95.0 percent. *Revenue Code* and *Discharge Date* showed a moderate level of agreement (i.e., 88.7 percent and 94.7 percent, respectively). The data element *Attending Provider ID* showed a very low degree of agreement with an overall rate of 0.0 percent. However, an agreement rate could be reported for only one plan (URA-M) since all other plans had no matched records for which this data element was populated in both data sources to evaluate the agreement rate.

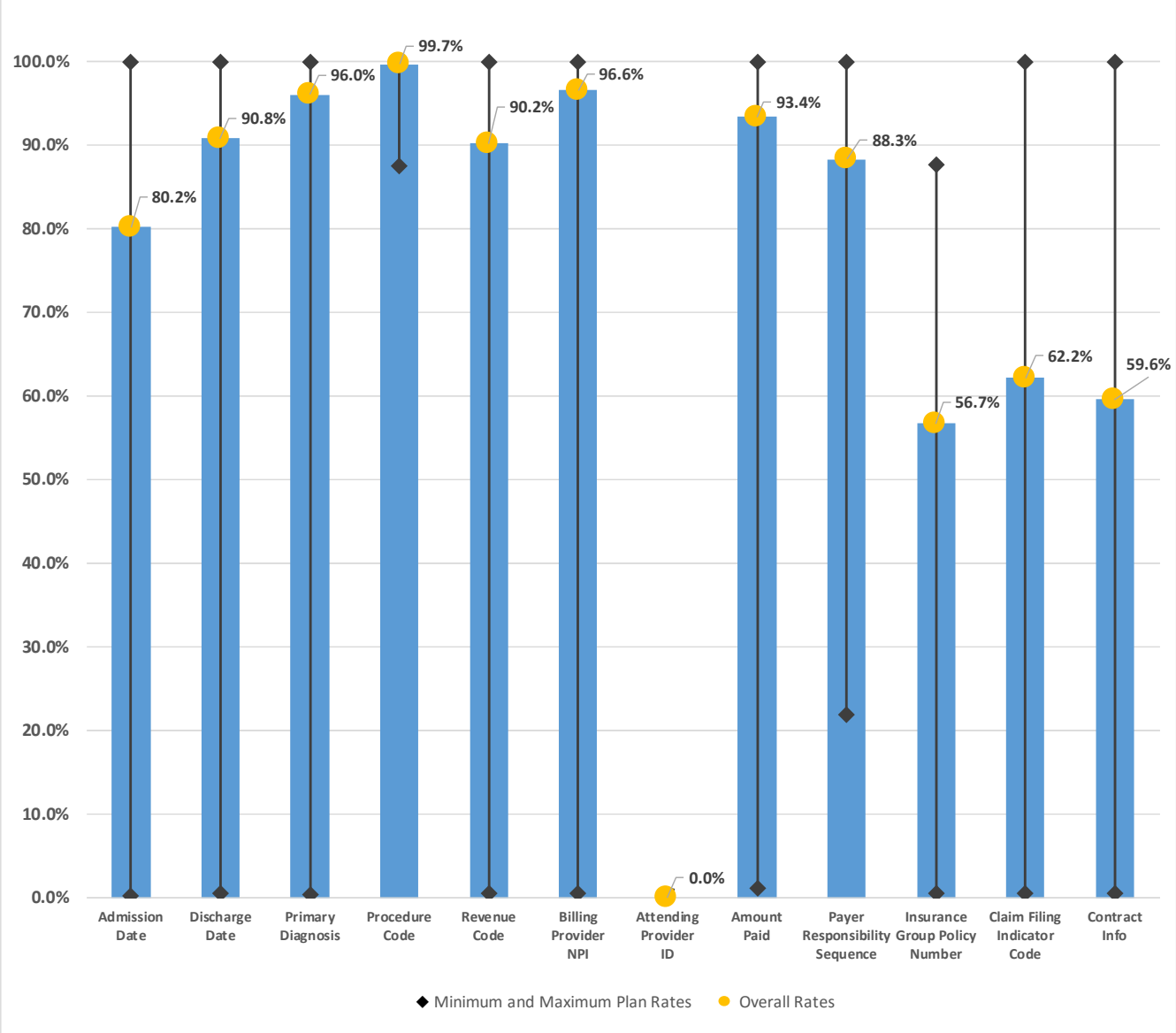
The agreement rate variations among plans for two of the data elements (*Procedure Code* and *Amount Paid*) were relatively minimal, while all plans displayed 100.0 percent agreement rates for *Primary Diagnosis Code*. The agreement rates among plans varied for data elements *Discharge Date*, *Revenue Code*, and *Billing Provider NPI*, with plan rates ranging from 0.0 percent to 100.0 percent.

Figure 3-15—Element Agreement by Key Element for Children's Therapy From Professional Encounters



Among children's therapy services from professional encounters that could be matched between AHCA's encounter data and plan submitted encounter data, high overall agreement rates were noted in the following fields: *Line First Date of Service*, *Line Last Date of Service*, *Primary Diagnosis Code*, *Procedure Code*, and *Rendering Provider NPI*, with rates greater than 95.0 percent. Data element *Amount Paid* showed a moderate level of agreement rate of 87.0 percent, while *Billing Provider NPI* showed a low level of agreement (73.0 percent).

Figure 3-16—Element Agreement by Key Element for Long-term Care From Institutional Encounters

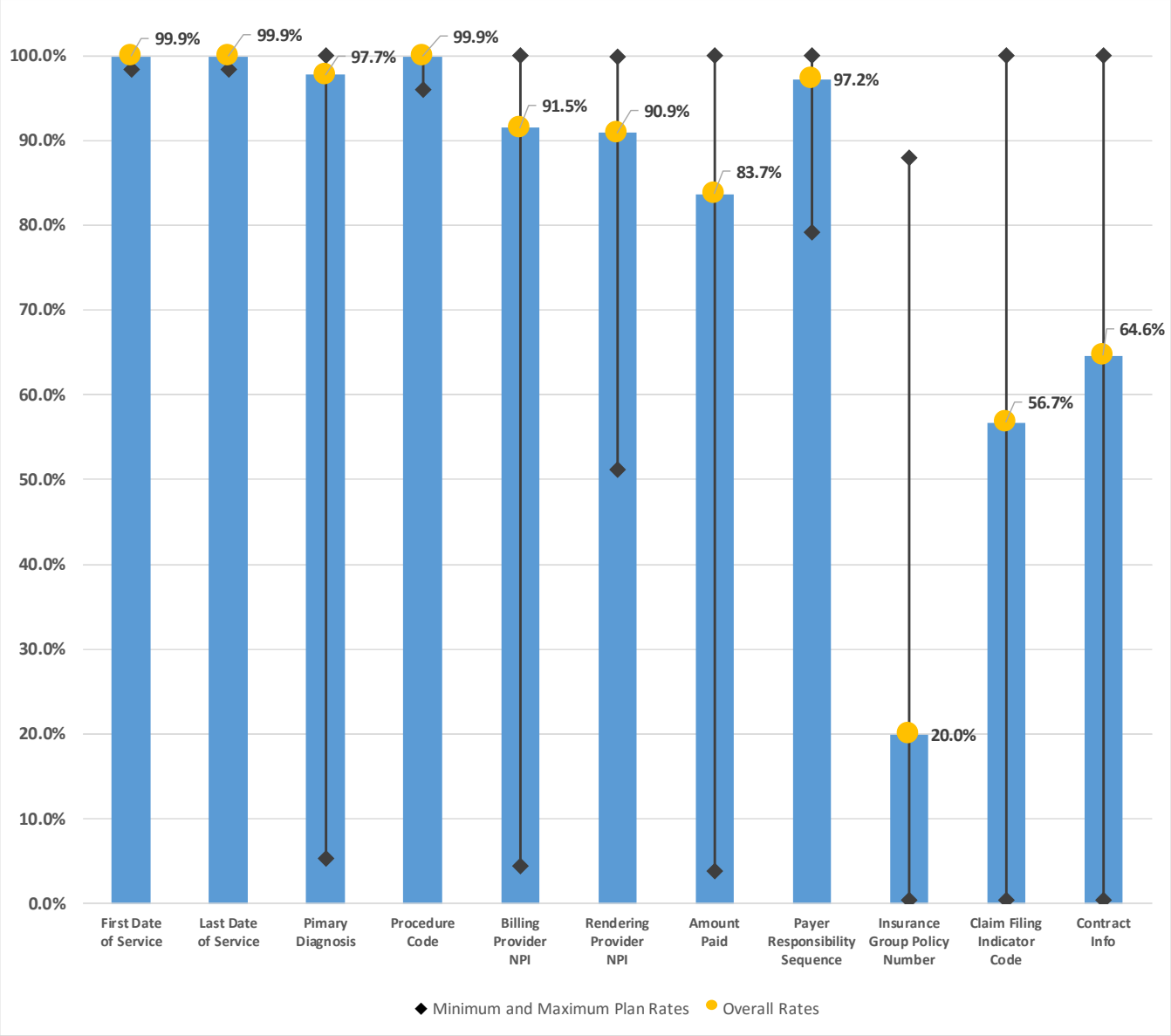


For long-term care services from the institutional encounters that could be matched between AHCA's and the plans' submitted encounter data, high agreement rates were noted for the following fields: *Primary Diagnosis Code*, *Procedure Code*, and *Billing Provider NPI*, where all displayed agreement rates of more than 95.0 percent. *Admission Date*, *Discharge Date*, *Revenue Code*, *Amount Paid*, and *Payer Responsibility Sequence Code* showed moderate levels of agreement (i.e., 80.2 percent, 90.8 percent, 90.2 percent, 93.4 percent, and 88.3 percent, respectively). The data elements *Attending Provider ID*, *Insurance Group Policy Number*, *Claim Filing Indicator Code* and *Contract Info* showed a low degree of agreement (i.e., 0.0 percent, 56.7 percent, 62.2 percent, and 59.6 percent). However, it is important to note that the *Attending Provider ID* agreement rate could be evaluated for only two plans

(URA-L and URA-M) since all other plans had no matched records for which this data element was populated in both data sources.

For long-term care services from institutional encounters, the agreement rate variations among plans for one of the data elements (*Procedure Code*) were relatively minimal, while the agreement rate varied among plans for all other data elements that were evaluated.

Figure 3-17—Element Agreement by Key Element for Long-term Care Professional Encounters



Among long-term care services from professional encounters that could be matched between AHCA's encounter data and plan-submitted encounter data, high overall agreement rates (i.e., more than 95.0

percent) were noted in nearly all of the data elements evaluated except for the following fields: *Billing Provider NPI* (91.5 percent), *Rendering Provider NPI* (90.9 percent), *Amount Paid* (83.7 percent), *Contract Info* (64.6 percent), *Claim Filing Indicator Code* (56.7 percent), and *Insurance Group Policy Number* (20.0 percent).

The agreement rate variations among plans for data elements with high overall agreement rates were generally minimal, while the agreement rates for all other data elements varied among plans.

Clinical Record Review

Clinical records (including medical and treatment-related records) are considered the "gold standard" for documenting Medicaid enrollees' access to and quality of services. The file review and comparative analysis portions of the study seek to determine the completeness and validity of AHCA's encounter data and how comparable these data are to the plans' data from which they are based, respectively. Clinical record review further assesses data quality through investigating the completeness and accuracy of AHCA's encounters compared to the information documented in the corresponding medical records of Medicaid enrollees. For long-term care enrollees, HSAG also reviewed the Plan of Care documentation as there are generally no "medical records" for individuals receiving HCBS or care in long-term care facilities (nursing homes). In addition to medical records, treatment plan documentation was also reviewed and compared to therapy-related encounters for children under the age of 21.

Enrollees' medical information was matched between data sources (AHCA encounters and physician-submitted medical records) using the unique combination of the enrollee's Medicaid ID and the identification number of the rendering provider for a specific date of service. This section presents findings from the results of the medical record review to examine the extent to which services documented in the medical record were not present in the encounter data (encounter data omission), as well as the extent to which services documented in the encounter data were not present in the enrollees' corresponding medical records (medical record omission).

Medical Record, Plan of Care, and Treatment Plan Submission

Overall, 114 dental, children's therapy, and long-term care sample cases were requested from each of the 22 contracted plans, or 2,508 total sample cases. Of these sample cases, only 81.0 percent (or 2,032 cases) were submitted by the plans for inclusion in the study. The clinical documentation submission rates varied considerably among plans, with rates ranging from 23.7 percent to 100.0 percent.

Among the clinical documentation received, the rate of valid medical records received was relatively high, 89.3 percent. The rates of valid medical records submitted showed wide variation among plans, with rates ranging from 50.6 percent to 100.0 percent. More than half of the participating plans (i.e., 13 out of 22) submitted valid medical records for more than 90.0 percent of the requested sample cases.

Of the 2,032 cases for which clinical documentation was received, HSAG expected submission of a plan of care/treatment plan for 1,546 sample cases. Only children's therapy and long-term care services required submission of a plan of care/treatment plan; dental services do not require treatment plans. The

overall submission rate of these documents was extremely low, with a submission rate of only 55.6 percent. The submission rates showed wide variation among plans, with plan rates ranging from 2.0 percent to 88.7 percent. Overall, more than 30 percent of the plan of care/treatment plan documents were found to be invalid—i.e., documentation did not meet AHCA's approved template.

Encounter Data Completeness

HSAG evaluated encounter data completeness by identifying differences between key elements of AHCA-based encounters and the corresponding medical records submitted for the analysis. These elements include *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*. Medical record omission and encounter data omission represent two aspects of encounter data completeness through their identification of vulnerabilities in the process of claims documentation and communication between providers, plans, and AHCA.

Medical record omissions occurred when an encounter data element (i.e., *Date of Service*, *Diagnosis Code*, *Procedure Code*, or *Procedure Code Modifier*) was not documented in the medical record associated with that specific AHCA encounter. Medical record omissions suggest opportunities for improvement within the provider's internal processes, such as billing processes and record documentation.

Encounter data omissions occurred when an encounter data element (i.e., *Diagnosis Code*, *Procedure Code*, or *Procedure Code Modifier*) was documented in the medical record but not found in the associated AHCA encounter. Encounter data omissions also suggest opportunities for improvement in the areas of claims submissions and/or processing routes among the providers, plans, and AHCA.

HSAG evaluated the *medical record omission* and the *encounter data omission* rates for each plan using the dates of service selected for the assessment sample. **For both rates, lower values indicate better performance.**

Table 3-34 displays the medical record and encounter data omission rates by key data element.

Table 3-34—Encounter Data Completeness Summary for the Overall Population

Key Data Elements	Medical Record Omission Rate		Encounter Data Omission Rate	
	Statewide Rate	Plan Range	Statewide Rate	Plan Range
Dental Services				
Date of Service	2.2%	0.0% – 10.0%		
Procedure Code	8.5%	0.0% – 26.6%	7.4%	0.0% – 18.8%
Children's Therapy Services				
Date of Service	0.4%	0.0% – 4.8%		
Diagnosis Code	9.5%	0.0% – 38.5%	16.1%	0.0% – 33.3%
Procedure Code	1.0%	0.0% – 9.1%	1.1%	0.0% – 5.9%

Key Data Elements	Medical Record Omission Rate		Encounter Data Omission Rate	
	Statewide Rate	Plan Range	Statewide Rate	Plan Range
Procedure Code Modifier	4.5%	0.0% – 21.1%	31.0%	3.6% – 100.0%
Long-term Care Services				
Date of Service	3.7%	0.0% – 17.5%		
Diagnosis Code	23.6%	0.0% – 46.5%	26.9%	1.8% – 50.0%
Procedure Code	22.6%	0.0% – 37.5%	6.9%	0.0% – 18.5%
Procedure Code Modifier	32.3%	0.0% – 75.0%	12.8%	0.0% – 100.0%

Assessment of enrollees' medical records showed mixed results related to medical record omission rates for each of the service categories assessed. While omission rates for dates of service associated with each of the three services identified in AHCA's encounter data were relatively low, procedure codes (except for procedure codes associated with children's therapy services), diagnosis codes, and procedure code modifiers (with the exception of procedure code modifiers associated with children's therapy services) exhibited moderate to high omission rates. Both findings suggest that key elements documented in enrollees' medical records are not always submitted or processed into FMMIS.

Assessment of encounter data omission rates revealed that not all services documented in enrollees' medical records were submitted to or processed and stored by AHCA. The encounter data omission rates for key data elements also showed mixed results for each of the service categories assessed. The encounter data omission rates were relatively low, except for diagnosis codes (from both the children's therapy and long-term care services) and procedure code modifiers from children's therapy services. The high encounter data omission rates indicate that information found in enrollees' medical records were missing from the respective AHCA encounters. Medical records with date of service discrepancies did not completely account for the omission of other key data elements. *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* omission rates varied considerably for plans as well.

Encounter Data Accuracy

Encounter data accuracy was evaluated for dates of service that existed in both AHCA's records and the submitted medical records, with values present in both data sources for the evaluated data element. HSAG assessed the accuracy of encounter data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) based on medical record documentation and support of values contained in analogous fields in AHCA's encounter data. Higher accuracy rates for each data element indicate better performance.

Table 3-35 displays the encounter data element accuracy rates associated with the three service categories.

Table 3-35—Encounter Data Element Accuracy Summary for the Overall Population

	Statewide Rate	Plan Range
Dental Services		
Procedure Code	94.7%	87.5% – 100.0%
All-Element Accuracy	55.5%	36.8% – 78.9%
Children's Therapy Services		
Diagnosis Code	92.4%	82.9% – 100.0%
Procedure Code	99.6%	95.2% – 100.0%
Procedure Code Modifier	99.2%	90.0% – 100.0%
All-Element Accuracy	51.0%	28.6% – 77.3%
Long-term Care Services		
Diagnosis Code	86.1%	54.7% – 100.0%
Procedure Code	95.9%	89.4% – 100.0%
Procedure Code Modifier	99.3%	92.9% – 100.0%
All-Element Accuracy	28.3%	13.0% – 52.2%

Overall, encounter data element accuracy was high among the three service categories, with all key data elements having accuracy rates of greater than 90.0 percent except for *Diagnosis Code* accuracy (86.1 percent) that was associated with the long-term care services. However, while individual accuracy rates for key data elements was high, the percentage of encounters by service category (i.e., dental, children's therapy, and long-term care services) in which all evaluated data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier)* were valid was only 55.5 percent, 51.0 percent, and 28.3 percent, respectively. This finding suggests that submission of encounter data elements is frequently incomplete, leading to overall inaccuracy of the clinical records contained in the State's encounter data.

Plan of Care and/or Treatment Plan Review

For long-term care and therapy-related encounters for children under the age of 21, HSAG also reviewed the plan of care/treatment plan documentation associated with these types of services. Table 3-36 displays the outcome of the review of these documents.

Table 3-36—Review of Treatment Plan/Plan of Care Summary

	Children's Therapy	Long-term Care
Expected number of treatment plans/plans of care for review	254	490
Valid treatment plans/plans of care submission	188	241
Treatment plans/plans of care documentation was signed	183	227
Selected dates of service were within the effective dates of the treatment plans/plans of care documents	178	221
Servicing providers were documented	175	216
Documented servicing providers support provider information in the medical records	158	194
Documented procedures support procedures identified in the medical records	163	192
Documented number of units support the units identified in the medical records	139	181

Among the 22 contracted plans evaluated in the study, only 14 plans had enrollees that met the eligibility criteria for the children's therapy services. Of the 254 sample children's therapy cases, only 74.0 percent (188 out of 254) were submitted with valid documentation. More than one-quarter of the plans submitted at least 90 percent of the requested documents; three plans submitted 50 percent or fewer of the requested documents. In general, the majority of the treatment plan documentation available for review contained the appropriate signatures, included treatment plan effective dates that covered selected dates of service, and identified valid servicing providers. However, when the servicing providers, treatment plan procedures, and associated number of units were compared to the enrollees' medical records, few treatment plans supported information documented in the medical records.

For a total of 722 sample cases associated with long-term care services, only 490 plans of care documents were expected to be submitted by the plans since 232 sample cases were associated with E & M services. As such, plan of care documentation was not required for the selected dates of service. Of the 490 sample long-term care cases, only 49.2 percent (241 out of 490) were submitted with valid documentation. Moreover, only five of the 22 plans submitted plans of care for 90 percent or more of the requested sample cases, while nearly half of the plans submitted plans of care for fewer than 50 percent of the requested sample cases. In general, the majority of the plan of care documentation available for review contained appropriate signatures, included plan of care effective dates that covered selected dates

of service, and identified valid servicing providers. However, as with treatment plans, when the servicing providers, plan of care procedures, and associated number of units were compared to the enrollees' medical records, few plans of care supported information documented in the medical records.

Recommendations

Based on HSAG's review of the encounter data submitted by AHCA and the plans, HSAG identified several opportunities for continued improvement in the quality of Florida's encounter data. While some of the discrepancies noted were related to AHCA's ability to process and prepare its encounter data for evaluation, high omission, surplus, and error rates, coupled with variation between plans and encounter types, suggest systemic issues in the transmission of data between the plans and AHCA's MMIS. To ensure the success of future encounter data validation activities and the quality of encounter data submissions from contracted health plans, the following recommendations have been prepared to address potential opportunities for improvement.

- AHCA should continue to work with its MMIS and DSS teams to review quality control procedures to ensure the accurate production of data extracts. Through the development of standard data extraction procedures, quality controls, and process documentation, the number of errors associated with extracted data could be reduced leading to more accurate data extractions and reporting. Moreover, the development and implementation of stored procedures can be reused for similar activities with minimal changes for future studies. Sufficient processes and training should also be put in place to ensure the 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.
  - Distributions of the data field values are reasonable.
  - Presence check (i.e., data with missing values for all records in any of the data fields).
  - Data fields were populated with reasonable values.
  - The validity of data submitted for evaluation has been a consistent issue affecting reporting for several encounter data evaluation studies. HSAG recommends that AHCA convene a time-limited, post-study workgroup to identify, evaluate, and propose solutions to address ongoing quality issues. Processes to be reviewed include the communication of extraction requirements, identification of extracted fields, and defined quality control steps and processes.
- AHCA should work with its MMIS vendor to develop supplemental encounter data submission guidelines, and/or expand its existing Companion Guide to clearly define appropriate submission requirements for nonstandard data elements necessary for data processing (e.g., *Payer Responsibility Sequence Code*). Ensuring that plans submit data elements consistently and in alignment with FMMIS processing rules is critical to being able to report and process encounter data for reporting.

Once guidelines are established, technical assistance calls/meetings can be scheduled to make sure all parties understand any new submission requirements.

Additionally, AHCA should work with its MMIS and DSS data vendors to develop internal data processing routines to establish standardized programming logic to ensure plan encounter data are accurately processed.

- AHCA should review, and modify as needed, existing plan contracts to include language outlining specific requirements for submitting valid clinical record documentation (i.e., medical records, plans of care, and treatment plans) to AHCA, or its representatives, in addition to defining the requirements and submission standards for the procurement of requested clinical records. To allow for proper oversight of clinical services and care management activities, it is important to build expectations directly in contracts regarding the submission of supporting documentation. Moreover, HSAG recommends including language that allows AHCA to hold health plans accountable for meeting submission expectations. Additionally, to ensure clinical documentation is complete and valid, modifications to the contract should include language that outlines minimum documentation requirements and expected templates for plans of care/treatment plans. The inclusion of this information ensures the availability to information critical to oversight activities**.**

- AHCA should continue to collaborate with the plans to monitor, investigate, and reconcile, discrepancies in encounter data volume regularly. Although encounter data volume trends were similar between AHCA- and plan-submitted encounter data, differences in overall volume suggest potential deficiencies in the data. Results from the current study should be used to target specific encounter data to conduct data mining reviews and determine whether differences were due to failed or incomplete submissions or processing parameters associated with FMMIS.

Hospital Network Adequacy Analysis

Phase 1 Report

Bed-to-enrollee ratio and county facility standard results are reported at the plan level and the statewide level. Plan level results are presented in Table F-1 to Table F-27 in Appendix F. The statewide level results are summarized below.

Bed-to-Enrollee Ratios

All 14 plans (100 percent) for which enrollment data were available appear to be in compliance with the required ratio for acute care hospital beds. Eleven of the 14 plans (79 percent) for which enrollment data were available appear to be in compliance with the required ratio for inpatient substance abuse detox unit beds The other three plans (Clear Health, Magellan, and Positive) do not have contracted beds for inpatient substance abuse detox unit beds. All 14 plans (100 percent) appear to be in compliance with the required ratio for fully accredited psychiatric community hospital/crisis stabilization unit/freestanding psychiatric specialty hospital beds for adults, whereas only seven of the 14 plans (50 percent) appear to be in compliance with the required ratio for fully accredited psychiatric community hospital/crisis stabilization unit/freestanding psychiatric specialty hospital beds for children. Amerigroup, Better Health, Humana, Prestige, SFCCN, Staywell, and Sunshine each have contracted beds but are not in compliance with the required ratio for fully accredited psychiatric community hospital/crisis stabilization unit/freestanding psychiatric specialty hospital beds for children. The bed-to-enrollee ratio results are shown in Table 3-37.

Table 3-37—Bed-to-Enrollee Ratios for Hospital Providers by Plan

County	Enrollment[1]	Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds			
						Adult		Child	
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)
Amerigroup	344,254	14,500	1:23	393	1:875	961	1:358	104	1:3310
Better Health	95,347	10,433	1:9	299	1:318	528	1:180	26	1:3667
Clear Health	9,234	42,087	1:0	0	NR	2,169	1:4	239	1:38
Coventry	51,837	6,167	1:8	145	1:357	660	1:78	64	1:809
Humana	329,370	21,418	1:15	927	1:355	1,647	1:199	144	1:2287
Magellan	41,909	37,170	1:1	0	NR	3,110	1:13	357	1:117
Molina	296,284	22,394	1:13	1,032	1:287	1,453	1:203	196	1:1511
Positive	1,824	6,088	1:0	0	NR	770	1:2	88	1:20
Prestige	313,672	16,524	1:18	1,038	1:302	938	1:334	109	1:2877
SFCCN	42,691	3,386	1:12	189	1:225	312	1:136	18	1:2371
Simply	81,304	5,228	1:15	145	1:560	616	1:131	64	1:1270

County	Enrollment[1]	Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds			
						Adult		Child	
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)
Staywell	694,020	28,117	1:24	721	1:962	1725	1:402	212	1:3273
Sunshine	427,215	30,329	1:14	1,344	1:317	1,433	1:298	116	1:3682
United	276,861	21,270	1:13	428	1:646	1,728	1:160	206	1:1343
TOTAL	3,005,822	265,111	1:11	6,661	1:451	18,050	1:166	1,943	1:1547

[1] Children's Medical Services was not included because the county-level enrollment data were not available

County Facility Standards

One of the 14 plans (7 percent) for which enrollment data were available appears to have met the facility standards for hospitals or facilities with birth/delivery service beds. SFCCN was the only plan that met the standard, with two or more facilities in each county served. Four of the 14 plans (29 percent) for which enrollment data were available appear to have met the facility standards for 24/7 emergency service facilities (Coventry, Positive, SFCCN, and Simply) in every county served. None of the 14 plans (0 percent) for which enrollment data were available appear to have met the facility standards for licensed community substance abuse treatment centers. The county facility standard results are shown in Table 3-38.

Table 3-38—County Facility Standards for Hospital Providers by Plan

County	Enrollment[1]	County Facility Standards					
		Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
		No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Amerigroup	344,254	36	9 of 13	52	9 of 13	3	0 of 13
Better Health	95,347	28	5 of 6	37	5 of 6	2	0 of 6
Clear Health	9,234	120	25 of 60	172	32 of 60	5	0 of 60
Coventry	51,837	12	1 of 2	19	2 of 2	1	0 of 2
Humana	329,370	54	10 of 17	77	13 of 17	5	0 of 17
Magellan	41,909	106	18 of 40	151	22 of 40	12	0 of 40
Molina	296,284	69	15 of 34	94	19 of 34	6	0 of 34
Positive	1,824	11	2 of 3	18	3 of 3	2	0 of 3
Prestige	313,672	51	12 of 55	79	20 of 55	2	0 of 55
SFCCN	42,691	7	1 of 1	10	1 of 1	0	0 of 1

County	Enrollment[1]	County Facility Standards					
		Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
		No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Simply	81,304	10	1 of 2	17	2 of 2	1	0 of 2
Staywell	694,020	75	18 of 57	118	26 of 57	7	0 of 57
Sunshine	427,215	87	18 of 49	133	25 of 49	4	0 of 49
United	276,861	57	11 of 29	84	15 of 29	8	0 of 29
TOTAL	3,005,822	723	146 of 368	1,061	194 of 368	58	0 of 309

[1] Children's Medical Services was not included because the county-level enrollment data were not available

Phase 2 Report

CMS' HSD and AHCA time/distance standards are reported at the plan level and the State-wide level. Plan level results are presented in Table G-1 to Table G-11 in Appendix G, and the statewide level results are summarized below. These standards represent the minimum performance requirements for average distance (in miles) and travel time (in minutes) for an enrollee to reach the nearest provider, by geographic grouping. The "Difference" columns shown in Table G-1 to Table G-11 in Appendix G are calculated as the difference between the HSD and AHCA distance and time standards. **Red** font illustrates when AHCA's time/distance standards are greater, or less stringent, than those listed in the HSD tables. These standards will have negative differences while positive differences imply that the AHCA standard is more stringent than the HSD standard.

Drive Time Standards

AHCA's minimum performance standards for travel time are generally more stringent than the performance standards outlined in CMS' HSD tables. The urban drive time standard set by AHCA is less stringent than the standards described in the HSD tables in 14 percent of the counties, while in 86 percent of the counties the AHCA drive time standard is more stringent than the HSD drive time standards by an average of 12 minutes. AHCA's drive time standards are less stringent than the CMS HSD standards in five urban counties (i.e., Pinellas, Hillsborough, Orange, Broward, and Miami-Dade). In those five counties, the HSD standard is a 20-minute drive time compared to AHCA's standard of a 30-minute drive time. Table 3-39 summarizes the urban drive time standards by region.

Table 3-39—Drive Time Standards for Acute Hospitals by Region for Urban Counties

Region	No. of Counties	Urban — Drive Time (in Minutes)			
		HSD Standard Range*	AHCA Standard Range*	Average Distance	No. of Counties AHCA More Stringent Than HSD
Region 01	3	45	30	15	3 of 3
Region 02	2	45	30	15	2 of 2
Region 03	6	45	30	15	6 of 6
Region 04	6	45	30	15	6 of 6
Region 05	2	20–45	30	3	1 of 2
Region 06	3	20–45	30	7	2 of 3
Region 07	4	20–45	30	9	3 of 4
Region 08	4	45	30	15	4 of 4
Region 09	4	45	30	15	4 of 4
Region 10	1	20	30	-10	0 of 1
Region 11	1	20	30	-10	0 of 1

* The range represents the range of standards for the counties in the region. If only one number is presented, the standard was the same for all counties in the region.

The rural drive time standard set by AHCA is more stringent than the HSD standard in all rural counties. The AHCA rural drive time standard exceeds the HSD drive time standard by an average of nearly 43 minutes. Table 3-40 summarizes the rural drive time standards by region.

Table 3-40—Drive Time Standards for Acute Hospitals by Region for Rural Counties

Region	No. of Counties	Rural — Drive Time (in Minutes)			
		HSD Standard Range*	AHCA Standard Range*	Average Distance	No. of Counties AHCA More Stringent Than HSD
Region 01	1	80	30	50	1 of 1
Region 02	12	75–110	30	49	12 of 12
Region 03	10	75–80	30	48	10 of 10
Region 04	1	75	30	45	1 of 1
Region 05	0	-	-	-	-
Region 06	2	75–80	30	48	2 of 2
Region 07	0	-	-	-	-
Region 08	3	75–80	30	47	3 of 3
Region 09	1	80	30	50	1 of 1
Region 10	0	-	-	-	-
Region 11	1	80	30	50	1 of 1

* The range represents the range of standards for the counties in the region. If only one number is presented, the standard was the same for all counties in the region

Distance Standards

AHCA's minimum performance standards for distance are generally more stringent than the performance standards outlined in CMS' HSD tables. The urban distance standard set by AHCA is less stringent than those outlined in the HSD tables in 14 percent of the urban counties, and AHCA's standard is within the HSD distance standard by an average of seven miles for these counties. AHCA's distance standards are less stringent than the CMS HSD standards in five urban counties (i.e., Pinellas, Hillsborough, Orange, Broward, and Miami-Dade). In those five counties, the HSD standard is 10 miles compared to AHCA's standard of 20 miles. Table 3-41 summarizes the urban distance standards by region.

Table 3-41—Distance Standards for Acute Hospitals by Region for Urban Counties

Region	No. of Counties	Urban — Distance (in Miles)			
		HSD Standard Range*	AHCA Standard Range*	Average Distance	No. of Counties AHCA More Stringent Than HSD
Region 01	3	30	20	10	3 of 3
Region 02	2	30	20	10	2 of 2
Region 03	6	30	20	10	6 of 6
Region 04	6	30	20	10	6 of 6
Region 05	2	10–30	20	0	1 of 2
Region 06	3	10–30	20	3	2 of 3
Region 07	4	10–30	20	5	3 of 4
Region 08	4	30	20	10	4 of 4
Region 09	4	30	20	10	4 of 4
Region 10	1	10	20	-10	0 of 1
Region 11	1	10	20	-10	0 of 1

* The range represents the range of standards for the counties in the region. If only one number is presented, the standard was the same for all counties in the region.

The rural distance standard set by AHCA is also more stringent than the standard in the HSD table for all rural counties by an average of 36 miles. Table 3-42 summarizes the rural distance standards by region.

Table 3-42—Distance Standards for Acute Hospitals by Region for Rural Counties

Region	No. of Counties	Rural — Distance (in Miles)			
		HSD Standard Range*	AHCA Standard Range*	Average Distance	No. of Counties AHCA More Stringent Than HSD
Region 01	1	60	20	40	1 of 1
Region 02	12	60–100	20	43	12 of 12

Region	No. of Counties	Rural — Distance (in Miles)			
		HSD Standard Range*	AHCA Standard Range*	Average Distance	No. of Counties AHCA More Stringent Than HSD
Region 03	10	60	20	40	10 of 10
Region 04	1	60	20	40	1 of 1
Region 05	0	-	-	-	-
Region 06	2	60	20	40	2 of 2
Region 07	0	-	-	-	-
Region 08	3	60	20	40	3 of 3
Region 09	1	60	20	40	1 of 1
Region 10	0	-	-	-	-
Region 11	1	60	20	40	1 of 1

* The range represents the range of standards for the counties in the region. If only one number is presented, the standard was the same for all counties in the region

Conclusions and Recommendations

The results of this hospital network adequacy analysis demonstrated that all 14 plans were in compliance with the bed-to-enrollee standards for acute care hospital beds and fully accredited psychiatric community hospital/crisis stabilization unit/freestanding psychiatric specialty hospital beds for adults. Most of the plans (79 percent) were in compliance with the required bed-to-enrollee ratio for inpatient substance abuse detox unit beds, and one-half of the plans were in compliance for fully accredited psychiatric community hospital/crisis stabilization unit/freestanding psychiatric specialty hospital beds for children.

While the plans achieved a high level of compliance with the bed-to-enrollee ratio standards, their compliance with the county facility standards did not achieve an equally high level. Four of the 14 plans met the county facility standards for 24/7 emergency service facilities, only one plan met the standard for hospitals or facilities with birth/delivery services beds, and no plans met the standard for licensed community substance abuse treatment centers.

Based on the distribution of time and distance results, AHCA's performance standards appear to be more stringent than the HSD standards in all regions except for those regions with a high number of large metropolitan counties.

HSAG offers the following recommendations based on the findings of this analysis:

- While the current study provides insight into potential access issues related to the location of Medicaid enrollees relative to the plans' provider networks, the lack of enrollee- and provider-level data makes generalizations difficult. HSAG recommends that AHCA conduct an in-depth review of network adequacy to include the following: enrollees-to-provider ratios by provider specialty, geospatial distributional analyses of providers' time/distance performance evaluations, and average

time/distance to the nearest three providers. This type of study would establish baseline results essential to any future review of access and adequacy of Florida's provider network.

- Based on the first recommendation, AHCA should implement a time-limited work group to establish revised standards based on baseline results. These standards can target high-volume or high-profile provider types and be segmented by geographic setting. HSAG recommends reaching out to other Medicaid agencies to conduct a scan of existing standards and monitoring strategies implemented in other states. Using this information, AHCA could draw best practices in designing its own standards.
- These standards should incorporate distinct time and distance standards for urban versus rural counties. Urban and rural counties experience challenges unique to their urbanicity including different demographics, socioeconomic status, healthcare needs, and geography. Based on these differing characteristics, these two county types should not be held to the same standard.

Child Health Check-Up (CHCUP) Participation Rates

States are responsible for providing Early and Periodic Screening, Diagnostic, 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 80 percent of those enrolled in the program for at least eight months. The State also requires the health plans to meet a participation goal of 80 percent. Plans that do not achieve the 80 percent screening and participation goals may be required to submit a corrective action plan to the State and are subject to liquidated damages. The most recent (October 1, 2014, to September 30, 2015) CHCUP screening rate across plans (using plan-reported data only including managed care enrollees) was 89 percent, and the participation rate was 70 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.

The first Medicaid Health Plan Report Card was based on HEDIS 2014 data (i.e., CY 2013 data reported in 2014). 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 second annual Medicaid Health Plan Report Card, published in December 2015, is based on HEDIS 2015 data (i.e., CY 2014 data reported in 2015) and includes plan performance data for services provided under previous contracts with AHCA and new MMA contracts, as the MMA program was implemented between May and August 2014.

The third annual Medicaid Health Plan Report Card, published in October 2016, is based on HEDIS 2016 data (i.e., CY 2015 data reported in 2016) and includes plan performance data for service provided under the MMA plan contracts. Plans are compared against national Medicaid benchmarks published by

NCQA, using a 5-star rating scale. 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).

AHCA will continue to make improvements to the report card to make it more useful to consumers.

Plan Accreditation Results

As a condition of participation in the SMMC program, all plans are required to be accredited by NCQA, Accreditation Association for Ambulatory Health Care (AAAHC), or another nationally recognized accrediting body, or have initiated the accreditation process within one year after their contract with AHCA is executed. All plans participating in the SMMC program are accredited (eight with NCQA, nine with AAAHC).

Validation of Performance Improvement Projects

Objectives

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 clinical care as well as 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 enrollee satisfaction. As one of the mandatory EQR activities required under the BBA, HSAG validated the PIPs through an independent review process that followed CMS' *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[13] 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 between June and September 2015. The plans submitted baseline study indicator results during this validation cycle, and the PIPs had progressed through the Design and Implementation stages.

[13] 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. 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 19, 2013.

Technical Methods of Data Collection/Analysis

The methodology HSAG used to validate the PIPs was based on CMS's protocol cited above.

HSAG, in collaboration with AHCA, developed a summary form to document the PIP process. This form was completed by each plan and submitted to HSAG for review and validation. The PIP Summary Form standardized the process for submitting information regarding the PIPs and assured that all CMS protocol requirements were addressed.

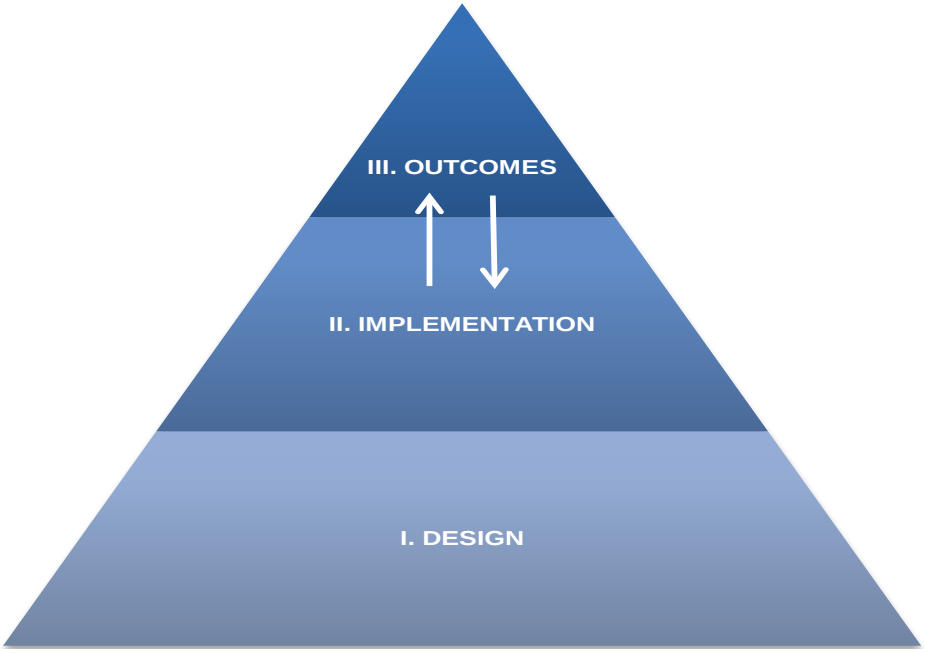
HSAG obtained the data needed to conduct the PIP validation from the plans' PIP Summary Forms. These forms provided detailed information about each plan's PIPs related to the activities completed by the plan and evaluated by HSAG for the SFY 2015–2016 validation cycle.

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 development of the study topic, question, population, indicators, sampling, and data collection. To implement successful improvement strategies, a strong study design is necessary.

Figure A-1—PIP Stages



Once the study design is established, the PIP process moves into the Implementation stage. This stage includes data analysis and implementation of improvement strategies. During this stage, the plan analyzes its data, identifies barriers to performance, and develops interventions to improve outcomes. The implementation of effective improvement strategies is necessary to improve PIP outcomes. The final stage is Outcomes, which is the evaluation of real and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when outcomes exhibit statistical improvement over the baseline rate and sustain the improvement with a subsequent measurement period. This stage is the culmination of the previous two stages. If the study outcomes do not improve, the plan's responsibility is to investigate the data it collected to ensure it had correctly identified the barriers and implemented targeted interventions to address the identified barriers. If it had not, the plan would revise its interventions and collect additional data to re-measure and evaluate outcomes for improvement. This process becomes cyclical until sustained improvement is achieved.

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),* Version 2.0, September 1, 2012 (CMS Performance Measure Validation Protocol). More specifically, HSAG performed PMV to determine if performance measure rates were collected, reported, and calculated according to the specifications required by the State.

For MMA Standard and Specialty plans (collectively referred to as "plans" in this section), AHCA required that the plans undergo an NCQA HEDIS Compliance Audit on the performance measures selected for reporting. All measure indicator data were audited by each plan's NCQA-certified auditor; therefore, 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. However, since some of the measures required to be reported are HEDIS measures, AHCA intended that an NCQA HEDIS Compliance Audit be conducted to the extent possible. Based on the FAR reviews, HSAG found that for the current year, all LTC plans' audits followed CMS protocol and, to the extent possible, aligned with NCQA's HEDIS Compliance Audit policies and procedures.

Description of Data Obtained

Since the plan audits were performed by NCQA-licensed organizations (LOs) during SFY 2015–2016, 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 these plans during SFY 2016–2017. In general, three primary data sources were used to conduct the PMV audits: the Roadmap, FAR, and measure rates provided by the plans.

Technical Methods of Data Collection/Analysis

HSAG followed two technical methods: one method for the MMA Standard and Specialty plans and one method for the LTC plans. For the MMA plans, HSAG received each plan's performance measure report and FAR from AHCA and detailed audit findings generated by the LOs. Since important documents are used and/or generated by the plans and 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.

MMA Plans

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

Table A-1—Key PMV Steps Performed by HSAG for MMA Plans

PMV Step	Associated Activities Performed by HSAG
Pre-On-Site Visit Call/Meeting	HSAG verified that the LOs addressed key 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 Roadmap components.
Software Vendor	If an MMA plan used a software vendor to produce measure rates, HSAG assessed whether or not the MMA plan contracted with a vendor that calculates and produces rates 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 HEDIS measures was not used, the LOs reviewed the MMA plan's programming language for HEDIS measures. For all non-HEDIS measures, HSAG ensured that the LOs reviewed the plan's programming language. 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 performance measure reporting match with the primary data source. This step occurs to determine the validity of the source data used to generate the measure rates.
Supplemental Data Validation	If the MMA plan used any supplemental data for reporting, the LO was to validate the supplemental data according to NCQA's guidelines. HSAG verified whether or not the LO was following the NCQA-required approach while validating the supplemental database.
Convenience Sample Validation	HSAG verified that, as part of the medical record review validation (MRRV) process, the LOs identified whether or not the MMA plan was required to prepare a convenience sample, and if not, whether specific reasons were documented.

PMV Step	Associated Activities Performed by HSAG
Medical Record Review Validation (MRRV)	HSAG examined whether or not the LOs performed a re-review of a random sample of medical records based on NCQA MRRV protocol to ensure the reliability and validity of the data collected.
Health Plan Quality Indicator Data File Review	The MMA 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. HSAG evaluated whether there was any documentation in the FAR to show that the LOs performed a review of the health plan quality indicator data file.

LTC Plans

For the LTC plans, HSAG obtained a list of the performance measures specified in the SMMC Program contract that were required for validation. Additionally, the measure definitions, measure specifications, and the reporting format were reviewed by HSAG prior to HSAG's PMV activities.

HSAG prepared a documentation request for each LTC plan's FAR and performance measure report. The performance measure report contained all rates calculated and reported by the LTC plan. According to AHCA's reporting requirements, these rates were also audited by the LTC plan's auditor.

HSAG conducted a desk review of the FARs and the performance measure reports. The desk review included the following validation activities:

- Verify that key audit elements were performed by the plan's auditor to ensure the audit was conducted in compliance with CMS protocol and, where possible, NCQA policies and procedures.
- Examine evidence that the auditors completed a thorough review of the Roadmap components associated with calculating and reporting performance measures outlined by AHCA.
- Identify that, regarding plans for which an NCQA HEDIS Compliance Audit was performed, the Information System (IS) standards (systems, policies, and procedures) applicable for performance measure reporting were reviewed and results were documented by the auditor.
- Evaluate the auditor's description and audit findings regarding data systems and processes associated with performance measure production for plans where NCQA HEDIS Compliance Audit procedures were not referenced in the FAR.

HSAG also validated the LTC plans' reporting of the audited rates in the performance measure reports, focusing on the following verification components:

- Compare the audit designation results listed in the FAR to the actual rates reported in the performance measure report to ensure that the designation is appropriately applied.
- Assess the accuracy of the rate calculated based on the denominator and numerator for each measure.
- Evaluate data reasonableness for measures with similar eligible populations.
- Assess the extent to which all data elements are reported according to the requirements listed in the AHCA Health Plan Report Guide.

Encounter Data Validation

During SFY 2015–2016, 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 SMMC plans, including MMA, Specialty, and Long-term Care (collectively referred to as "plans" in this section) were complete and accurate.

Objectives

The SFY 2015–2016 EDV study included administrative and comparative analyses of plan-submitted encounters, and a review of clinical records, plans of care and/or treatment plans, the eligibility file, and other available data sources. Additionally, the SFY 2015–2016 EDV study focused its review on a specific subset of services associated with the following categories:

- Dental services
- Therapy services (speech, occupational, and physical therapy for children under the age of 21)
- Long-term care

To assess the quality of the encounters associated with the service categories above, the SFY 2015–2016 EDV study included two evaluation components: (1) administrative and comparative data analysis of encounter data, and (2) a clinical record, plan of care, and/or treatment plan review. Combined, these approaches addressed the following study objectives:

- Determine the extent to which encounters maintained in Florida's Medicaid Management Information System (FMMIS) (and the data subsequently extracted and submitted by AHCA to HSAG) are accurate and complete when compared to data maintained by the plans.
- The completeness and accuracy of the plans' encounter data stored in FMMIS through clinical record, plan of care, and/or treatment plan review.

Description of Data Obtained

Based on activities defined in CMS' protocol for encounter data validation[14] (i.e., analyses of plan electronic encounter data for accuracy and completeness), the comparative data analysis evaluates the extent to which encounters submitted by the plans and maintained in FMMIS (and the data subsequently extracted and submitted by AHCA to HSAG) are accurate and complete when compared to data submitted by the plans to HSAG. The comparative analysis examined the encounters that are identified

[14] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 4 Validation of Encounter Data Reported by the MCO*. Protocol 4. Version 2.0. September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-4.pdf. Accessed on: Feb 21, 2017.

as dental, children's therapy, or long-term care categories with dates of service between January 1, 2015, and June 30, 2015.

The comparative analysis involved three key steps:

- Development of a data submission requirements document outlining encounter data submission requirements for AHCA and the plans including technical assistance sessions.
- Conducting a file review of submitted encounter data from AHCA and the plans.
- Conducting a comparative analysis of the encounter data.

HSAG prepared and submitted data submission requirement documents to AHCA and the plans in December 2015. These documents included a brief description of the SFY 2015–2016 EDV study, a description of the review period, requested encounter data types, required data elements, and the procedures for submitting the requested files. The encounter data fields requested by HSAG included key data elements to be evaluated in the EDV study. AHCA and the plans were requested to submit all encounter data records with dates of service between January 1, 2015, and June 30, 2015, and submitted to AHCA before October 1, 2015, to HSAG for processing. The requested data were limited to encounters in their final status and excluded encounters associated with interim adjustment history.

HSAG conducted multiple technical assistance sessions with AHCA and the plans to facilitate accurate and timely submission of data. For the plans, HSAG held two technical assistance sessions after distributing the data submission requirements documents, allowing the plans time to review and prepare any questions in advance of the sessions. During these technical assistance sessions, HSAG's EDV team introduced the SFY 2015–2016 EDV study and reviewed the data submission requirements to ensure that all questions related to data preparation and extraction were addressed. Following the completion of the technical assistance sessions, HSAG provided a question and answer (Q&A) document to the plans that addressed plan-specific questions during the sessions as well as questions sent via email. The plans were given approximately one month to extract and prepare the requested files for submission to HSAG. Similarly, HSAG met regularly with AHCA staff to review the data request documents to address any questions related to the submission of data to HSAG.

Technical Methods of Data Collection/Analysis

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 either within AHCA's data or the plans' data. HSAG also conducted multiple technical assistance sessions with AHCA and the plans to facilitate the accurate and timely submission of data.

The final sets of encounter files received from the plans and AHCA were used to examine the extent to which the data extracted and submitted 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.

Preliminary File Review

Following receipt of AHCA's and the plans' encounter data submissions, HSAG conducted a preliminary file review to determine whether any data issues existed that warranted resubmission. In addition to verifying all encounter data were submitted according to the requested file layouts, the preliminary file review evaluated the following indicators:

- **Percentage Present**—*required data fields were present on the file and have information in those fields.*
- **Percentage Valid**—*data fields were of the required type—e.g., numeric fields have numbers, character fields have characters.*
- **Percentage Valid Values**—*the values contained the expected values—e.g., valid ICD-9 codes in the diagnosis field.*

Based on the results of the preliminary file review, any major discrepancies, anomalies, or issues identified in the encounter data submissions were communicated to the affected plan or agency, which was subsequently required to resubmit data, when necessary.

Comparative Analysis

The comparative analysis evaluated the extent to which the values populated for key encounter data elements in AHCA's data matched those in the encounter data submitted by the plans. The current study focused on three types of services (i.e., dental, children's therapy, and long-term care), and these services were identified from either dental, institutional, or professional claims/encounters. As such, the comparative analysis was categorized by these types of encounters for each of the focused service categories. Additionally, the comparative analysis was divided into two analytic components. First, for each of the focused service categories, HSAG assessed record-level encounter data completeness using the following metrics:

- **Record Omission**—*the number and percentage of records present in the files submitted by the plans that were not found in the files submitted by AHCA.*
- **Record Surplus**—*the number and percentage of records present in the files submitted by AHCA but not in the files submitted by the plans.*

Second, based on the number of records present in both data sources, HSAG further examined the completeness and accuracy of the following key data elements: *Date of Service*, *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier*, *Provider Information*, *Revenue Code*, *National Drug Code (NDC)*, and *Amount Paid*. This analysis focused on an element-level comparison between both sources of data and addressed the following metrics:

- **Element Omission**—*the number and percentage of records with values present in the files submitted by the plans but not in the files submitted by AHCA (element omission).*
- **Element Surplus**—*the number and percentage of records with values present in the files submitted by AHCA but not in the files submitted by the plans (element surplus).*
- **Element Agreement**—*the number and percentage of records with exactly the same values in the files submitted by AHCA and the files submitted by the plans (element agreement). The evaluation of the element agreement was limited to those records with values present in both AHCA's and plans' submitted files.*

Clinical Record Review

Description of Data Obtained

Clinical records (including medical and treatment-related records) are considered the "gold standard" for documenting Medicaid enrollees' access to and quality of services. For LTC enrollees, HSAG reviewed the Plan of Care document as there are generally no "medical records" for individuals receiving HCBS or care in LTC facilities (nursing homes). In addition to medical records, Treatment Plan documentation was also reviewed and compared to therapy-related services.

The second component of the EDV study assessed the completeness and accuracy of AHCA encounters through a review of these clinical record documents.

Table A-2 displays the data elements evaluated in the clinical record review for each of the specific services associated with the three focused areas (i.e., dental, therapies, and LTC) that were included in the clinical record review component of the study.

Table A-2—Key Data Elements for Clinical Record Review

Key Data Fields	Dental	Therapy	LTC
Date of Service (including): • Date of admission • Date of discharge • First date of service • Last date of service	√	√	√
Diagnosis Code		√	√
CPT/CDT/HCPCS Code/Surgical Procedure Code/Modifier	√	√	√

To evaluate whether the LTC and therapy services reported in selected encounters are supported by enrollees' plans of care and/or treatment plans, HSAG reviewed plan documentation for alignment with authorization dates, scheduled services, units of service, and service providers.

To be eligible for the clinical record review, an enrollee must have been enrolled in a plan as of June 30, 2015, and must have had at least one visit during the study period (January 1, 2015–June 30, 2015). In addition, the enrollee must have been continuously enrolled in the same plan between January 1, 2015, and June 30, 2015, with no gaps. Additionally, enrollees selected for the therapy and dental reviews must have been under the age of 21.

Technical Methods of Data Collection/Analysis

Encounter data, enrollment data, and provider data from AHCA were used in the comparative analysis to select the record review samples. HSAG employed a two-stage stratified sampling design to ensure that (1) an enrollee's record was selected only once, and (2) that the number of encounters included in the final sample covered the targeted encounter types and were approximately proportional to the distribution of all encounters. First, HSAG identified all enrollees by encounter type per plan and determined the required sample size of each encounter type based on the total distribution of users. HSAG then randomly selected the enrollees from each encounter type based on the required sample size. Once sample enrollees were selected, HSAG identified all encounters associated with applicable encounter types for these enrollees. From these encounters, one date of service was randomly selected as the final sampled encounter per sampled enrollee. The final sample used in the evaluation consisted of 57 cases randomly selected across the three encounter types per plan, or 1,254 total cases. An additional 100 percent oversample (or 57 cases per plan) was sampled to replace records not procured.

Prior to clinical record procurement, HSAG sent an introduction letter to each participating plan outlining the scope of the second component of the EDV study and outlined the clinical record procurement procedures for the study. In order to maximize its procurement rate, HSAG also conducted two technical assistance sessions with the participating plans. During these technical assistance sessions, HSAG reviewed the scope of the project and procurement protocols.

Upon receiving the sample list, the plans were responsible for coordinating the clinical record procurement process with their contracted providers. HSAG worked with the plans to monitor the submission of the records from their targeted providers.

Concurrent with the record procurement activities, HSAG trained its review staff on the specific study protocols and conducted interrater reliability and rater-to-standard testing. All reviewers had to achieve at least a 95 percent accuracy rate before they were allowed to review clinical records and continue collecting data for the study.

During the clinical record review, trained HSAG reviewers first verified whether the sampled date of service could be found in the enrollee's medical record. If the date of service did not match the State's encounter data, the reviewers identified the date of service as a *medical record omission*. After evaluating the selected date of service, the reviewers then examined the services provided on the selected date of service and validated the key encounter data elements (including the plan of care and/or treatment plan documents). All findings were entered into an electronic clinical record abstraction tool to ensure data integrity.

Clinical Record, Plan of Care, and/or Treatment Plan Review Indicators

Once the abstraction was completed, HSAG's analysts exported the abstraction data from the electronic tool, reviewed the data, and conducted analyses for each plan. HSAG developed four study indicators to report the clinical record review results:

- **Medical Record Omission**—the percentage of dates of service identified in the electronic encounter data that were not found in the enrollees' medical records. HSAG also calculated this rate for the other key data elements in Table A-2.
- **Encounter Data Omission**—the percentage of key data elements from enrollees' medical records that were not found in the electronic encounter data.
- **Coding Accuracy**—the percentage of diagnosis codes, procedure codes, and procedure code modifiers associated with validated dates of service from the electronic encounter data that were correctly coded based on the enrollees' medical records.
- **Overall Accuracy**—the percentage of dates of service with all data elements coded correctly among all the validated dates of service from the electronic encounter data.

In addition to the clinical-related indicators, based on reviews of the plans of care and treatment plans, the findings included an evaluation of whether the LTC and therapy services documented for the selected dates of service were supported by the plans of care and/or treatment plans.

Hospital Network Adequacy Analysis

Phase 1

Introduction

During SFY 2015–2016, AHCA requested that HSAG conduct a targeted network adequacy review of hospitals in the SMMC program. AHCA requested that HSAG perform the following tasks in two phases. The first phase had the following tasks:

1. Compare network data from each of the SMMC plans (plans) to the licensure source data.
2. Identify discrepancies in each plan's network data and provide a report to AHCA describing the results.
3. Conduct a comparative analysis of bed-to-enrollee ratios and county facility standards by region and by county for each plan.

AHCA noted discrepancies between hospital network data the plans report weekly and the licensing data reported by the Division of Health Facility Regulation, AHCA, and the Florida Department of Children and Families (DCF). AHCA recognized that Florida's geography, locations of providers and enrollees, and provider workforce levels were all key elements that could be used for network development. AHCA's goal was to use this project as a first step in developing an approach for an EQRO network adequacy review that aligns with the CMS proposed rule, if and when the rule is finalized.

Description of Data Obtained

AHCA provided HSAG with hospital data files, and access to and training for the Florida Provider Network Verification (PNV) System. After training was completed, HSAG downloaded the following files from the PNV portal:

- Provider Network Verification File Specification—Version 2.1.1
- Provider Network Verification (PNV) Portal Florida User Guide V 0.0.03
- SMMC Panel Roster Report Layout
- Provider/Group/Hospital (PG) files

In addition to the PNV files downloaded, HSAG used the FloridaHealthFinder.gov database and http://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspxconducted data look-up on each contracted hospital, which included information on the number of total licensed beds, acute care beds, adult psychiatric beds, adult substance abuse beds, and child psychiatric beds.

Technical Methods of Data Collection/Analysis

To begin the analysis, HSAG (1) compared network data for each of the plans to the licensure source data, and (2) identified discrepancies in the plan network data. This analysis was conducted using the following licensed bed types:

- Acute Care Hospital
- Hospital or Facility With Birth/Delivery Services
- 24/7 Emergency Service Facility
- Licensed Community Substance Abuse Treatment Center[15]
- Inpatient Substance Abuse Detox Unit
- Fully Accredited Psychiatric Community Hospital (Adult) or Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital
- Fully Accredited Psychiatric Community Hospital (Child) or Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital

Upon completion of the data look-up activity, HSAG aggregated these data into a single data file for evaluation.

HSAG performed comparative data analyses between AHCA's licensing data in FloridaHealthFinder.gov and each plan's reported hospital network data in PNV. The key data elements that were used to evaluate the data were:

- Hospital ID (Medicaid ID)
- Hospital Name
- Facility Type
- Number of Licensed Beds
- Address (including street address, city, ZIP code, county, and region)

These data were then compared to each plan's submitted reports.

To conduct these comparative analyses, the hospital provider data and plan enrollment data were merged with the hospital network data collected and used by HSAG to generate bed-to-enrollee ratios and county facility standards by region and by county for each plan. Plans missing enrollment data were excluded from the supplemental analysis as valid bed-to-enrollee ratios could not be established. Additionally, HSAG implemented data management procedures to clean, process, and prepare the data files to generate comparisons between plan performance and AHCA's standards. These procedures included a manual review and assignment of facility and bed counts across counties where erroneous or mislabeled data were identified. Both the bed-to-enrollee and county facility counts were compared to AHCA standards.

[15] Licensed Community Substance Abuse Treatment Centers are not inpatient facilities and will not be included in this analysis.

Phase 2

Introduction

The tasks for the second phase of the targeted network adequacy review of hospitals in the SMMC program include:

1. Compare the CY 2016 Medicare Advantage (MA) Health Services Delivery (HSD) Reference file standards to the AHCA urban/rural network standards.
2. Identify the differences in the two sets of standards and provide a report to AHCA describing the results.

Description of Data Obtained

To complete the time/distance analyses, HSAG obtained county-specific performance standards for acute care hospitals listed in the CMS HSD tables. These HSD tables consist of county-specific time and distance standards that outline the (1) minimum number of providers/facilities, (2) maximum travel time, and (3) maximum travel distance. When these standards are met, counties are said to provide "adequate" access to a given provider/facility. County type is assigned based on the population size and density parameters of individual counties listed in Table A-3. A county must meet both the population and density thresholds to be included in any county type. Counties fall into one of five designations: Large Metro, Metro, Micro, Rural, or Counties with Extreme Access Considerations (CEAC).

Table A-3—HSD Table Population and Density Parameters

	Populations	Density
Large Metro	≥1,000,000	≥1,000/mi^2
	500,000–999,999	≥1,500/mi^2
	Any	≥5000/mi^2
Metro	≥1,000,000	10–999.9/mi^2
	500,000–999,999	10–1,499.9/mi^2
	200,000–499,999	10–4,999.9/mi^2
	50,000–199,999	100–4,999.9/mi^2
	10,000–49,999	1,000–4,999.9/mi^2
	≥1,000,000	10–999.9/mi^2
Micro	50,000–199,999	10–99.9/mi^2
	10,000–49,999	50–999.9/mi^2
Rural	10,000–49,999	10–49.9/mi^2
	<10,000	10–4,999.9/mi^2
CEAC	Any	<10/mi^2

Technical Methods of Data Collection/Analysis

AHCA network standards follow a different methodology for categorizing geographic areas and calculating time/distance standards than the CMS HSD network follows. To make comparisons between AHCA network standards and the CMS HSD network, HSAG performed several data transformations including:

1. Re-categorization of geographic areas: While AHCA's standards are limited to two general geographic areas (i.e., Urban versus Rural), CMS uses a more detailed categorization system involving five classifications (i.e., Large Metro, Metro, Micro, Rural, and CEAC). For this study, HSAG categorized Large Metro and Metro designations as Urban and the remaining CMS categories as Rural.
2. Region assignment: Using a crosswalk developed in collaboration with AHCA, HSAG mapped CMS HSD county information to specific Florida Medicaid regions for aggregate regional analyses.

HSAG cleaned, processed, and prepared the HSD tables to generate comparisons between the HSD regional and county performance standards and AHCA's time/distance standards. HSAG then evaluated whether AHCA's time and distance standards were more stringent (less than), equal to, or less stringent (greater than) the regional and county performance standards (as reported in the HSD tables).

Results are presented by region and county, stratified based on urban and rural county designations. Both the travel time (in minutes) and travel distance (in miles) standards from the HSD tables are reported along with the difference (plus or minus) from the AHCA standard.

Travel time and distance standards in the HSD tables represent the minimum performance requirements for average distance (in miles) and travel time (in minutes) for an enrollee to reach the nearest provider in each geographic grouping. To prepare results at the regional level for the State of Florida, HSAG assigned each county to a region in accordance with AHCA's SMMC Region Map.

It is important to note that, compared to AHCA county designations, the CMS HSD tables account for more specific geographic mapping of counties (i.e., Large Metro, Metro, Micro, Rural, and CEAC). In addition, the CMS HSD tables have more varied times and distances to account for different environmental conditions in geographic areas. Table A-4 displays the AHCA and HSD standards required for time and distance for acute care hospitals.

Table A-4—AHCA and HSD Requirements*

	Urban County		Rural County	
	Maximum Distance (Miles)	Maximum Travel Time (Minutes)	Maximum Distance (Miles)	Maximum Travel Time (Minutes)
AHCA	20	30	20	30
HSD*				
Large Metro	10	20		

	Urban County		Rural County	
	Maximum Distance (Miles)	Maximum Travel Time (Minutes)	Maximum Distance (Miles)	Maximum Travel Time (Minutes)
Metro	30	45		
Micro			60	80
Rural			60	75
CEAC			100	110

* The time/distance results in the HSD tables are not mapped to Urban or Rural designation. As such, HSAG mapped each of the five geographic designations identified by CMS as follows: *Micro*, *Rural*, and *CEAC* geographic settings were categorized as Rural while *Large Metro* and *Metro* designations were categorized as Urban.

Appendix B. MCO PIP Validation Results

Table B-1 includes the following information for each MMA plan's 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—MMA Plans[16]

Plan Name	PIP Topic	Validation Scores and Status
AHF MCO of Florida, Inc., d/b/a Positive Healthcare, Inc.	*7 and 30 Day Follow-up After a Hospitalization for a Mental Illness*	*93% / 88% / Partially Met*
	Improving Rates of CD4 and Viral Load Testing	*100% /100% / Met*
	Improving Satisfaction with Cultural and Language Services for People Living with HIV/AIDS	*94% / 90% / Partially Met*
	Reducing Avoidable Emergency Department Visits	*100% / 100% / Met*
Amerigroup Community Care	*Improving Overall Member Satisfaction*	*95% / 91% / Partially Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*100% / 100% / Met*
	Improving Use of Appropriate Medications for People with Asthma	*92% / 100% / Met*
	Preventive Dental Services for Children	*93% / 88% / Partially Met*
Better Health	*Improve Member Satisfaction*	*89% / 100% / Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*87% / 92% / Partially Met*
	Preventive Dental Services for Children	*87% / 89% / Partially Met*
	Reduce All-Cause Hospital Readmissions Within 30 Days	*80% / 89% / Partially Met*

[16] The plan names are from the 2015–2016 Florida Annual Performance Improvement Project Validation Summary Report.

Plan Name	PIP Topic	Validation Scores and Status
Children's Medical Services Network	*Decreasing Behavioral Health Readmission Rates*	*80% / 88% / Partially Met*
	Improving Call Center Timeliness	*67% / 63% / Partially Met*
	Preventive Dental Services for Children	*69% / 71% / Partially Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*94% / 89% / Not Met*
Clear Health Alliance	*Behavioral Health Screening of CHA Members by a PCP*	*94% / 100% / Met*
	Improve Member Satisfaction	*86% / 100% / Met*
	Improving the Percentage of Enrollees Receiving 2 or More HIV-Related Outpatient Medical Visits at Least 182 Days Apart	*38% / 29% / Not Met*
	Preventive Dental Services for Children	*87% / 88% / Partially Met*
Coventry Health Care of Florida, Inc.	*Improving Member Management of Diabetes*	*92% / 86% / Partially Met*
	Improving Member Satisfaction	*100% / 100% / Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*93% / 88% / Not Met*
	Preventive Dental Services for Children	*92% / 86% / Not Met*
Freedom Health, Inc.	*Care for Older Adults (COA)—Advance Care Planning*	*62% / 50% / Not Met*
	Comprehensive Diabetes Care (CDC)—HbA1c Poor Control > 9%	*57% / 40% / Not Met*
	Comprehensive Diabetes Care (CDC)—HbA1c Testing	*52% / 30% / Not Met*
	Plan All-Cause Readmissions (PCR-AD)	*71% / 75% / Partially Met*
Humana Medical Plan, Inc.	*Electronic Health Record with Meaningful Use*	*100% / 100% / Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*100% / 100% / Met*
	Integrating Primary Care and Behavioral Health in Antidepressant Medication Management	*100% / 100% / Met*
	Preventive Dental Services for Children	*100% / 100% / Met*

Plan Name	PIP Topic	Validation Scores and Status
Integral Quality Care	*Cervical Cancer Screening*	*100% / 100% / Met*
	Improving Enrollee Satisfaction (Child) with Health Plan Services—Access to Care	*93% / 100% / Met*
	Improving Timeless of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*94% / 100% / Met*
	Preventive Dental Services for Children	*93% / 88% / Not Met*
Magellan Complete Care	*Improving Diabetes Screening Rates for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	*100% / 100% / Met*
	Increase the Rate of Adult Member's Overall Satisfaction (CAHPS)	*95% / 100% / Met*
	Plan All-Cause Readmissions (PCR-AD)	*100% / 100% / Met*
	Preventive Dental Services for Children	*93% / 100% / Met*
Molina Healthcare of Florida, Inc.	*Improving the Rate of Asthmatic Children Using Controller Medications*	*93% / 88% / Not Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*91% / 100% / Met*
	Practitioner Satisfaction	*96% / 100% / Met*
	Preventive Dental Services for Children	*93% / 88% / Not Met*
Preferred Medical Plan, Inc.	*Continuity and Coordination of Care of High-Risk Members with Co-Existing Medical and Mental Health Disorders*	*59% / 67% / Not Met*
	Improving Timeless of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*100% / 100% / Met*
	Preventive Dental Services for Children	*87% / 88% / Not Met*
	Use of Appropriate Medications for People with Asthma	*100% / 100% / Met*

Plan Name	PIP Topic	Validation Scores and Status
Prestige Health Choice	*Improve Rates for HbA1c Testing and Compliance Among Diabetics*	*74% / 55% / Not Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*100% / 100% / Met*
	Overall Health Plan Rating Via CAHPS® 5.0H Adult Medicaid Survey	*100% / 100% / Met*
	Preventive Dental Services for Children	*93% / 88% / Partially Met*
Simply Healthcare Plans, Inc.	*Improve Member Satisfaction*	*95% / 100% / Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*87% / 91% / Partially Met*
	Preventive Dental Services for Children	*93% / 100% / Met*
	Reduce All-Cause Hospital Readmissions Within 30 Days	*88% / 100% / Met*
South Florida Community Care Network	*Improving the Number of Health Risk Assessment*	*69% / 71% / Partially Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*61% / 55% / Not Met*
	Preventive Dental Services for Children	*62% / 86% / Partially Met*
	Reducing Preventable Readmissions for Enrollees with Diabetes	*36% / 14% / Not Met*
Sunshine State Health Plan, Inc.	*Comprehensive Diabetic Care—Duval County*	*82% / 78% / Partially Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*90% / 90% / Partially Met*
	Member Satisfaction	*80% / 70% / Partially Met*
	Preventive Dental Services for Children	*69% / 57% / Partially Met*

Plan Name	PIP Topic	Validation Scores and Status
United Healthcare of Florida, Inc.	*Annual Diabetic Retinal Eye Exam*	*95% / 100% / Met*
	Call Answer Timeliness and Call Abandonment (CAT-CAB)	*92% / 100% / Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*95% / 100% / Met*
	Preventive Dental Services	*87% / 100% / Met*
Wellcare d/b/a Staywell Health Plan of Florida, Inc.	*Call Answer Timeliness*	*85% / 100% / Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*78% / 82% / Not Met*
	Improving Well-Child Visit Rates for Children Residing in Pine Hills Community	*88% / 88% / Partially Met*
	Preventive Dental Services for Children	*73% / 63% / Not Met*

Table B-2 includes the following information for each LTC plan: 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—LTC Plans[17]

Plan Name	PIP Topic	Validation Scores and Status
American Eldercare, Inc.	*Medication Review*	*93% / 100% / Met*
	Person Centered Care Plan	*93% / 100% / Met*
Amerigroup Community Care	*Improving the Number of Members with Advance Directives*	*100% / 100% / Met*
	Medication Review	*95% / 100% / Met*
Coventry Health Care of Florida, Inc.	*Medication Review*	*100% / 100% / Met*
	Timeliness of Services for the Long Term Care Program	*100% / 100% / Met*
Humana Medical Plan, Inc.	*Advanced Care Planning*	*100% / 100% / Met*
	Medication Review	*100% / 100% / Met*
Molina Healthcare of Florida, Inc.	*Medication Review*	*92% / 100% / Met*
	Reduction of Home and Community Based Service Recipients Transferred to Nursing Homes	*75% / 50% / Not Met*
Sunshine State Health Plan, Inc.	*Medication Review*	*75% / 80% / Partially Met*
	Timeliness of Services	*67% / 50% / Partially Met*
United Healthcare of Florida, Inc.	*Documentation of an Advance Directive*	*86% / 100% / Met*
	Medication Review	*92% / 100% / Met*

[17] The plan names are from the 2015–2016 Florida Annual Performance Improvement Project Validation Summary Report.

Appendix C. PIP Study Indicator Rates

Table C-1—Clinical PIP Baseline Study Indicator Rates for MMA Plans

Plan Name	PIP Topic	Study Indicator	Rate
Amerigroup	*Improving Use of Appropriate Medications for People with Asthma*	The percent of members 5–64 years of age who have been identified as having persistent asthma and who were appropriately prescribed medication during the measurement period in Region 5.	82.3%
		The percent of members 5–64 years of age who have been identified as having persistent asthma and who were appropriately prescribed medication during the measurement period in Region 6.	83.1%
		The percent of members 5–64 years of age who have been identified as having persistent asthma and who were appropriately prescribed medication during the measurement period in Region 7.	85.6%
		The percent of members 5–64 years of age who have been identified as having persistent asthma and who were appropriately prescribed medication during the measurement period in Region 11.	88.4%
Better Health	*Reduce All-Cause Hospital Readmissions Within 30 Days*	The percentage of acute inpatient stays for enrollees during the measurement year that were followed by an acute readmission within 30 days for any diagnosis, for enrollees 0 to 64 years of age.	5.7%
Children's Medical Services-S	*Decreasing Behavioral Health Readmission Rates*	The rate of children who are admitted to an inpatient facility for a mental or behavioral health issue.	0.8%
		The rate of children who are readmitted to an inpatient facility (meaning admitted and readmitted during the same period) for a mental or behavioral health issue.	22.3%
		The rate of children who are readmitted for a mental of behavioral health issue more than twice (meaning admitted and readmitted two or more times during the same period, for a total of three or more admissions) to an inpatient facility.	43.7%
Clear Health-S	*Behavioral Health Screening of CHA Members by a PCP*	The percentage of CHA enrollees who received an annual behavioral health screen by their PCP.	10.0%

Plan Name	PIP Topic	Study Indicator	Rate
	Improving the Percentage of Enrollees Receiving 2 or More HIV-Related Outpatient Medical Visits at Least 182 Days Apart	The percentage of enrollees diagnosed with HIV/AIDS who were seen on an outpatient basis by a physician, physician assistant, or advanced registered nurse practitioner for two HIV- related medical visits at least 182 days apart within the measurement year.	NR[18]
Coventry	*Improving Member Management of Diabetes*	The percentage of enrollees who had an HbA1c test performed during the measurement year.	87.7%
		The percentage of enrollees who showed poor glycemic control (HbA1c test result >9%).	51.9%
Freedom-S	*Comprehensive Diabetes Care (CDC)—HbA1c Poor Control > 9%*	The percentage of plan enrollees 18–75 years of age with a diagnosis of diabetes (Type I and Type II) who had HbA1c poor control > 9% during the measurement year.	NR
	Comprehensive Diabetes Care (CDC)—HbA1c Testing	The percentage of plan enrollees 18–75 years of age with a diagnosis of diabetes (Type I and Type II) who had HbA1c testing during the measurement year.	NR
	Plan All-Cause Readmissions (PCR-AD)	The percentage of plan enrollees less than 65 years of age with an unplanned acute readmission for any diagnosis within 30 days of being discharged from an acute inpatient hospital stay.	NR
Humana	*Integrating Primary Care and Behavioral Health in Antidepressant Medication Management*	The percentage of eligible enrollees who remained on an antidepressant medication treatment for at least 84 days during the measurement year.	52.8%
		The percentage of eligible enrollees who remained on an antidepressant medication treatment for at least 180 days during the measurement year.	37.5%
Integral	*Cervical Cancer Screening*	The percentage of women ages 21–64 assigned to Healthcare Network of Southwest Florida who had a cervical cytology performed every three years or women ages 30–64 who had a cervical cytology/human papillomavirus (HPV) co-testing every five years.	45.1%

[18] NR: Baseline not reported for this validation cycle.

Plan Name	PIP Topic	Study Indicator	Rate
Magellan-S	*Improving Diabetes Screening Rates for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	The percentage of members with schizophrenia or bipolar disorder, using antipsychotic medications, who complete a diabetes screening in Regions 10 and 11.	NR
	Plan All-Cause Readmissions (PCR-AD)	Percentage of members who had an acute inpatient stay followed by an unplanned acute readmission for any medical or behavioral health diagnosis within 30 days.	NR
Molina	*Improving the Rate of Asthmatic Children Using Controller Medications*	The percentage of asthmatic children 5 to 18 years of age who were dispensed at least one prescription for an asthma controller medication during the measurement year.	91.7%
Positive-S	*7 and 30 Day Follow-up After a Hospitalization for a Mental Illness*	The percent of acute care facility discharges for enrollees hospitalized for a mental health diagnosis, discharged to the community and seen on an outpatient basis by a mental health practitioner within seven days.	1.5%
		The percent of acute care facility discharges for enrollees hospitalized for a mental health diagnosis, discharged to the community and seen on an outpatient basis by a mental health practitioner within 30 days.	3.2%
	Improving Rates of CD4 and Viral Load Testing	The percentage of stable members who get at least two CD4 and viral load tests during the measurement year.	87.9%
		The percentage of members with a detectable VL in the previous two years, receiving at least three CD4 and viral load tests during the measurement year.	57.0%
	Reducing Avoidable Emergency Room Visits	Percentage of avoidable emergency department visits for plan enrollees during the measurement year.	4.5%
		Percentage of avoidable emergency department visits with ICD 9 codes selected for persons living with HIV/AIDS.	4.4%
Preferred	*Use of Appropriate Medications for People with Asthma*	The percentage of enrollees 5 to 64 years of age during the measurement year residing in Miami Dade and Monroe counties who were identified as	63.2%

Plan Name	PIP Topic	Study Indicator	Rate
		having persistent asthma and were appropriately prescribed medication during the measurement year.	
Prestige	*Improve Rates for HbA1c Testing and Compliance Among Diabetics*	The percentage of diabetic enrollees 18 to 50 years of age who had an HbA1c test result > 9 or were missing an HbA1c test result within the measurement year.	61.3%
SFCCN	*Reducing Preventable Readmissions for Enrollees with Diabetes*	The percentage of members age 21 and older with diabetes (type 1 and type 2) with a hospital admission for diabetes/diabetes related care and who were readmitted within 30 days with the same or similar diagnosis	17.4%
Simply	*Reduce All-Cause Hospital Readmissions Within 30 Days*	The percentage of acute inpatient stays followed by an acute readmission for any diagnosis within 30 days for enrollees 0 to 64 years of age during the measurement year.	6.2%
Staywell	*Improving Well-Child Visit Rates for Children Residing in Pine Hills Community*	The percent of children 3–6 years of age residing in Pine Hills Community who had at least one well-child visit with a PCP during the measurement period.	77.2%
Sunshine	*Comprehensive Diabetic Care—Duval County*	The percentage of enrollees 18–75 years of age with diabetes, residing in Duval County, who had one or more HbA1c levels of greater than 9 during the measurement year. (inverse indicator)	41.8%
		The percentage of enrollees 18–75 years of age with diabetes, residing in Duval County, who had one or more LDL-C level of less than 100mg/dl during the measurement year.	22.2%
United	*Annual Diabetic Retinal Eye Exam*	The percentage of diabetic enrollees 18–75 years of age, residing in Region 4, who had a diabetic retinal eye exam during the measurement year or a negative result for retinopathy the year prior.	38.0%

Table C-2—Nonclinical PIP Baseline Study Indicator Rates for MMA Plans

Plan Name	PIP Topic	Study Indicator	Rate
Amerigroup	*Improving Overall Member Satisfaction*	The percent of enrollees who respond 8, 9, or 10 on Question #35, "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?"	76.8%
Better Health	*Improve Member Satisfaction*	The percentage of enrollees who responded to the overall plan satisfaction CAHPS 5.0 Adult survey question with a score of 8 or higher.	75.3%
		The percentage of enrollees who responded to the overall plan satisfaction CAHPS 5.0 Child survey question with a score of 8 or higher.	88.3%
Children's Medical Services-S	*Improving Call Center Timeliness*	The percentage of calls received during the measurement year that were answered by a live voice within 30 seconds.	53.5%
Clear Health-S	*Improve Member Satisfaction*	The percentage of enrollees who responded to the overall plan satisfaction CAHPS 5.0 question, who had a score of 8 or higher.	76.7%
Coventry	*Improving Member Satisfaction*	The percentage of eligible enrollees who responded with a score of 8 or higher to the overall plan satisfaction CAHPS 5.0 Survey question.	73.3%
Freedom-S	*Care for Older Adults (COA)—Advance Care Planning*	The percentage of enrollees 66 years of age and older as of December 31 of the measurement year who had evidence of advance care planning during the measurement year.	NR
Humana	*Electronic Health Record with Meaningful Use*	The percentage of eligible providers in Region 11 who reported using an Electronic Health Record in a meaningful use manner.	18.2%
		The percentage of eligible providers in Region 10 who reported using an Electronic Health Record in a meaningful use manner.	10.1%
		The percentage of eligible providers in Region 9 who reported using an Electronic Health Record in a meaningful use manner.	8.8%

Plan Name	PIP Topic	Study Indicator	Rate
		The percentage of eligible providers in Region 6 who reported using an Electronic Health Record in a meaningful use manner.	29.4%
		The percentage of eligible providers in Region 1 who reported using an Electronic Health Record in a meaningful use manner.	30.4%
Integral	*Improving Enrollee Satisfaction (Child) with Health Plan Services—Access to Care*	Percentage of CAHPS Child survey respondents who received services during the measurement year and answered "Always" to the question, "In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?"	61.1%
Magellan-S	*Increase the Rate of Adult Member's Overall Satisfaction (CAHPS)*	The percentage of CAHPS adult survey respondents who respond to the question, "How would you rate your health plan" with a score of 9 or 10.	53.1%
Molina	*Practitioner Satisfaction*	The percentage of practitioners surveyed who responded "very satisfied" or "somewhat satisfied" to overall satisfaction with Molina.	93.3%
Preferred	*Continuity and Coordination of Care for High-Risk Members with Co-Existing Medical and Mental Health Disorders*	The percentage of enrollees 18 years of age and older with at least one high risk medical condition that were prescribed at least one medication for their high risk medical condition and psychotropic medication whose treatment record contained evidence of coordination of care.	0.0%
Prestige	*Overall Health Plan Rating Via CAHPS® 5.0H Adult Medicaid Survey*	The percentage of enrollees that responded to the CAHPS 5.0H Adult Medicaid Survey on Rating of Health Plan with a rank of 8, 9, or 10 out of a 10-point scale.	69.3%
Positive-S	*Improving Satisfaction with Cultural and Language Services for People Living with HIV/AIDS*	The percentage of enrollees who report usually or always receiving health care services in a language they could understand.	66.6%
		The percentage of enrollees who report usually or always feeling that the health care staff was sensitive to their cultural needs.	70.6%

Plan Name	PIP Topic	Study Indicator	Rate
SFCCN	*Improving the Number of Health Risk Assessments*	The percentage of returned and completed health risk assessments for new members.	2.8%
Simply	*Improve Member Satisfaction*	The percentage of adult enrollees who responded with a score of 8 or higher to the overall plan satisfaction CAHPS 5.0 survey question.	88.0%
		The percentage of child enrollees who responded with a score of 8 or higher to the overall plan satisfaction CAHPS 5.0 survey question.	86.7%
Staywell	*Call Answer Timeliness*	The percentage of calls received by the plan's Member Services call center (during operating hours) during the measurement year that were answered by a live voice within 30 seconds.	89.0%
Sunshine	*Member Satisfaction*	The percentage of enrollees who responded to the CAHPS 5.0 Survey Question 35 with a score of 8 or higher.	73.2%
		The percentage of enrollees who responded to the CAHPS 5.0 Survey Question 36 with a score of 8 or higher.	83.0%
United	*Call Answer Timeliness and Call Abandonment (CAT-CAB)*	The percentage of calls answered by a live voice within 30 seconds.	75.4%

Table C-3—Nonclinical PIP Baseline Study Indicator Rates for LTC Plans

Plan Name	PIP Topic	Study Indicator	Rate
American Eldercare-LTC	*Person-Centered Care Plan*	The percentage of enrollees who have at least four person-centered care plan updates documented.	53.0%
Amerigroup-LTC	*Improving the Number of Members with Advance Directives*	The percentage of enrollees who have evidence of advanced care planning in their case records during the measurement year.	73.1%
Coventry-LTC	*Timeliness of Services for the Long Term Care Program*	The percentage of newly enrolled members who received home health services, adult day care and/or home-delivered meals within 8 business days from the effective date of enrollment.	50.9%
		The percentage of newly enrolled members who received home health services within 8 business days from the effective date of enrollment.	62.9%
		The percentage of newly enrolled members who received adult day care services within 8 business days from the effective date of enrollment.	54.3%
		The percentage of newly enrolled members who received home-delivered meal services within 8 business days from the effective date of enrollment.	18.7%
Humana-LTC	*Advanced Care Planning*	The percentage of eligible enrollees that have advance care planning.	81.4%
Molina-LTC	*Reduction of Home and Community-Based Service Recipients Transferred to Nursing Homes*	The percentage of eligible enrollees who received home and community based services within three days of enrollment and were transferred to a nursing home.	1.8%
		The percentage of eligible enrollees who did not receive home and community based services within three days of enrollment and were transferred to a nursing home.	1.3%
Sunshine-LTC	*Timeliness of Services*	Newly enrolled (eligible) LTC members who receive home health services, or adult day health, or home-delivered meals within 3 calendar days from the effective date of enrollment.	37.2%
United-LTC	*Documentation of an Advance Directive*	The percentage of eligible enrollees who complete an Advance Directive during the measurement year.	63.6%

Appendix D. MCO Performance Measure Results

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

MMA Standard/Specialty Plans

This section represents the Florida Medicaid 2016 performance measure results by domain of care compared to the NCQA Quality Compass national Medicaid percentiles for HEDIS 2015 (where applicable). With the exception of the *Ambulatory Care* measures, wherein the values represent the number of outpatient or ED visits per 1,000 member months (MM), all values are shown as percentages. The results in this report are rounded to the second decimal place. For all tables presented in this appendix, the following legend applies to the Performance Level Analysis and Reporting Year 2016 Rate columns:

Symbols in the Performance Level Analysis Column

Symbol		Definition
★★★★★	=	At or above the National Medicaid 90th Percentile
★★★★	=	At or above the National Medicaid 75th Percentile but below the National Medicaid 90th Percentile
★★★	=	At or above the National Medicaid 50th Percentile but below the National Medicaid 75th Percentile
★★	=	At or above the National Medicaid 25th Percentile but below the National Medicaid 50th Percentile
★	=	Below the National Medicaid 25th Percentile
—	=	Indicates that the performance level analysis was not determined because the measure did not have an applicable benchmark.

Abbreviations Used in the Reporting Year 2016 Rate Column

Abbreviation		Definition
NA	=	*Small Denominator*. The organization followed the specifications, but the denominator was too small (<100 for CAHPS-based measures and <30 for all other measures) to report a valid rate.
NB	=	*No Benefit*. The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	=	*Not Reported*. The organization chose not to report the measure.
BR	=	*Biased Rate*. The calculated rate was materially biased.

Amerigroup Performance Measure Results

Table D-1 contains the MMA performance measure rates and performance level analysis results for Amerigroup for reporting year 2016 (CY 2015).

Table D-1—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: Amerigroup

Amerigroup Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★★★	1.25%
One Well-Child Visit	★	1.00%
Two Well-Child Visits	★★	2.51%
Three Well-Child Visits	★	3.76%
Four Well-Child Visits	★	7.02%
Five Well-Child Visits	★	12.03%
Six or More Well-Child Visits	★★★★	72.43%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	★★★★	78.78%
Childhood Immunization Status		
Combination 2	★★★★	80.79%
Combination 3	★★★★	77.08%
Lead Screening in Children		
Lead Screening in Children	★★	67.36%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★★★	52.53%
Continuation and Maintenance Phase	★★★★★	67.06%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★★	73.84%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★	55.56%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	★★	72.92%
Annual Dental Visit		
2–3 Years	★	25.57%
4–6 Years	★★	50.45%
7–10 Years	★★	58.81%
11–14 Years	★★	51.68%
15–18 Years	★★	46.00%

Amerigroup Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
19–20 Years	—	29.29%
Total	★★	48.27%
Preventive Dental Services		
Preventive Dental Services	—	33.76%
Dental Treatment Services		
Dental Treatment Services	—	15.17%
Sealants		
Sealants	—	13.16%
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	—	31.47%
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★★★	64.49%
Chlamydia Screening in Women		
16–20 Years	★★★★	60.55%
21–24 Years	★★★★	71.65%
Total	★★★★	63.68%
Breast Cancer Screening		
Breast Cancer Screening	★★★	63.22%
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	★★★★	29.47%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★★★	86.12%
Postpartum Care	★★★	64.24%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★★★★	76.24%
Antenatal Steroids		
Antenatal Steroids	—	0.00%
Living With Illness		
Comprehensive Diabetes Care[1]		
Hemoglobin A1c (HbA1c) Testing	★★★	88.84%
*HbA1c Poor Control (>9.0%)**	★★★	40.00%
HbA1c Control (<8.0%)	★★★	49.07%
Eye Exam (Retinal) Performed	★★★	54.88%
Medical Attention for Nephropathy	★★★★★	94.65%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★★★★	67.41%

Amerigroup Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Adult BMI Assessment		
Adult BMI Assessment	★★★	89.12%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years	★★	46.32%
Medication Compliance 50%—Ages 12–18 Years	★★	43.36%
Medication Compliance 50%—Ages 19–50 Years	★	50.38%
Medication Compliance 50%—Ages 51–64 Years	★	65.52%
Medication Compliance 50%—Total	★	46.30%
Medication Compliance 75%—Ages 5–11 Years	★★	19.71%
Medication Compliance 75%—Ages 12–18 Years	★★	19.82%
Medication Compliance 75%—Ages 19–50 Years	★	22.14%
Medication Compliance 75%—Ages 51–64 Years	★	41.38%
Medication Compliance 75%—Total	★	20.62%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★★	93.23%
Annual Monitoring for Members on Digoxin	★★★	56.99%
Annual Monitoring for Members on Diuretics	★★★★★	93.30%
Total	★★★★★	92.85%
Plan All-Cause Readmissions*		
Total—18–64 Years of Age Total	—	19.33%
Total—65+ Years of Age Total	—	29.05%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	29.11%
≥2 Visits	—	68.84%
1 Visit	—	14.73%
0 Visits	—	16.44%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	76.87%
Viral Load Suppression Among Persons in HIV Medical Care		
18–64 years	—	18.33%
65+ years	—	NA
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—Total	NA	NA
Discussing Cessation Medications—18–64 Years of Age	—	NA
Discussing Cessation Medications—65+ Years of Age	—	NA
Discussing Cessation Medications—Total	NA	NA

Amerigroup Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Discussing Cessation Strategies—18–64 Years of Age	—	40.00%
Discussing Cessation Strategies—65+ Years of Age	—	NA
Discussing Cessation Strategies—Total	★★	40.00%
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	★★★	43.81%
Initiation of AOD Treatment—18+ Years	★★★	39.34%
Initiation of AOD Treatment—Total	★★★	39.96%
Engagement of AOD Treatment—13–17 Years	★★	8.98%
Engagement of AOD Treatment—18+ Years	★	5.85%
Engagement of AOD Treatment—Total	★	6.28%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	—	45.34%
30-Day Follow-Up	—	64.09%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★★	53.65%
Effective Continuation Phase Treatment	★★★	38.36%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[1]		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★★	62.36%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	—	NA
6–11 Years	—	26.69%
12–17 Years	—	39.78%
Total	—	34.62%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*		
1–5 Years	—	NA
6–11 Years	—	0.56%
12–17 Years	—	1.23%
Total	—	0.96%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	37.60%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★★★	96.82%
25 Months–6 Years	★★★	91.04%

Amerigroup Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
7–11 Years	★★	90.65%
12–19 Years	★★	88.29%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	73.35%
45–64 Years	★★★	88.06%
65 Years and Older	★★★★	90.49%
Total	★	78.17%
Call Answer Timeliness		
Call Answer Timeliness	★★★	88.43%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	87.43%
Use of Services		
Ambulatory Care—Total		
Outpatient Visits—Total	—	311.64
ED Visits—Total	—	66.42

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2016 rates for this measure to performance targets derived using data reported for HEDIS 2015.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report. This symbol may also indicate that the performance level analysis was not determined because the measure did not have an applicable benchmark.
NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For reporting year 2016 rates designated NA, the performance level analysis value was also NA.
2016 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Of the 71 measure indicator rates reported by Amerigroup that were comparable to national Medicaid benchmarks, approximately 24 percent of Amerigroup's rates (17 rates) ranked at or above the national Medicaid 75th percentile, with approximately 8 percent (six rates) ranking at or above the national Medicaid 90th percentile. Conversely, approximately 44 percent of Amerigroup's rates (31 rates) fell below the national 50th Medicaid percentile, with approximately 21 percent (15 rates) falling below the national 25th Medicaid percentile.

Better Health Performance Measure Results

Table D-2 contains the MMA performance measure rates and performance level analysis results for Better Health for reporting year 2016 (CY 2015).

Table D-2—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: Better Health

Better Health Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★★★	0.97%
One Well-Child Visit	★★	1.46%
Two Well-Child Visits	★	1.70%
Three Well-Child Visits	★	3.16%
Four Well-Child Visits	★	7.06%
Five Well-Child Visits	★	12.41%
Six or More Well-Child Visits	★★★★	73.24%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	★★★	77.37%
Childhood Immunization Status		
Combination 2	★★	73.48%
Combination 3	★★	67.64%
Lead Screening in Children		
Lead Screening in Children	★★	70.32%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★★	41.38%
Continuation and Maintenance Phase	★★★	52.94%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★	67.15%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★	57.66%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	★★★	73.97%
Annual Dental Visit		
2–3 Years	★	26.07%
4–6 Years	★★	49.56%
7–10 Years	★★	53.19%
11–14 Years	★★	47.71%
15–18 Years	★★	38.99%

Better Health Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
19–20 Years	—	24.02%
Total	★★	43.77%
Preventive Dental Services		
Preventive Dental Services	—	33.08%
Dental Treatment Services		
Dental Treatment Services	—	13.75%
Sealants		
Sealants	—	12.62%
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	—	13.94%
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★★	56.20%
Chlamydia Screening in Women		
16–20 Years	★★★★	59.26%
21–24 Years	★★★	66.67%
Total	★★★	61.63%
Breast Cancer Screening		
Breast Cancer Screening	★★	53.61%
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	★★	19.46%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★★	78.59%
Postpartum Care	★★	60.34%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★★	62.04%
Antenatal Steroids		
Antenatal Steroids	—	0.00%
Living With Illness		
Comprehensive Diabetes Care[1]		
Hemoglobin A1c (HbA1c) Testing	★	79.08%
*HbA1c Poor Control (>9.0%)**	★★	43.55%
HbA1c Control (<8.0%)	★★	46.47%
Eye Exam (Retinal) Performed	★	38.44%
Medical Attention for Nephropathy	★★★★★	89.78%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★★★	58.39%

Better Health Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Adult BMI Assessment		
Adult BMI Assessment	★★★	88.81%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years	★	35.00%
Medication Compliance 50%—Ages 12–18 Years	★★	46.75%
Medication Compliance 50%—Ages 19–50 Years	★	55.56%
Medication Compliance 50%—Ages 51–64 Years	NA	NA
Medication Compliance 50%—Total	★	44.28%
Medication Compliance 75%—Ages 5–11 Years	★	15.71%
Medication Compliance 75%—Ages 12–18 Years	★★★	23.38%
Medication Compliance 75%—Ages 19–50 Years	★	30.56%
Medication Compliance 75%—Ages 51–64 Years	NA	NA
Medication Compliance 75%—Total	★	22.51%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★★	93.33%
Annual Monitoring for Members on Digoxin	NA	NA
Annual Monitoring for Members on Diuretics	★★★★	91.65%
Total	★★★★★	92.27%
Plan All-Cause Readmissions*		
Total—18–64 Years of Age Total	—	21.86%
Total—65+ Years of Age Total	—	8.39%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	29.76%
≥2 Visits	—	72.02%
1 Visit	—	14.88%
0 Visits	—	13.10%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	54.76%
Viral Load Suppression Among Persons in HIV Medical Care		
18–64 years	—	0.00%
65+ years	—	NA
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—Total	NA	NA
Discussing Cessation Medications—18–64 Years of Age	—	NA
Discussing Cessation Medications—65+ Years of Age	—	NA
Discussing Cessation Medications—Total	NA	NA

Better Health Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Discussing Cessation Strategies—18–64 Years of Age	—	NA
Discussing Cessation Strategies—65+ Years of Age	—	NA
Discussing Cessation Strategies—Total	NA	NA
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	★	24.16%
Initiation of AOD Treatment—18+ Years	★★	33.63%
Initiation of AOD Treatment—Total	★	32.51%
Engagement of AOD Treatment—13–17 Years	★★	10.74%
Engagement of AOD Treatment—18+ Years	★	5.06%
Engagement of AOD Treatment—Total	★	5.74%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	—	31.53%
30-Day Follow-Up	—	46.60%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★	48.65%
Effective Continuation Phase Treatment	★★	33.45%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[1]		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★	49.58%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	—	NA
6–11 Years	—	29.27%
12–17 Years	—	33.78%
Total	—	33.33%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*		
1–5 Years	—	NA
6–11 Years	—	NA
12–17 Years	—	2.04%
Total	—	2.41%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	24.43%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★★	95.15%
25 Months–6 Years	★★★	89.43%

Better Health Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
7–11 Years	★	87.71%
12–19 Years	★	81.69%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	64.24%
45–64 Years	★	83.21%
65 Years and Older	★	71.79%
Total	★	70.68%
Call Answer Timeliness		
Call Answer Timeliness	★★★★★	94.87%
Transportation Availability		
Transportation Availability	—	99.99%
Transportation Timeliness		
Transportation Timeliness	—	88.62%
Use of Services		
Ambulatory Care—Total		
Outpatient Visits—Total	—	278.43
ED Visits—Total	—	67.59

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2016 rates for this measure to performance targets derived using data reported for HEDIS 2015.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report. This symbol may also indicate that the performance level analysis was not determined because the measure did not have an applicable benchmark.
NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For reporting year 2016 rates designated NA, the performance level analysis value was also NA.
2016 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Of the 67 measure indicator rates reported by Better Health that were comparable to national Medicaid benchmarks, approximately 10 percent of Better Health's rates (seven rates) ranked at or above the national Medicaid 75th percentile, with approximately 6 percent (four rates) ranking at or above the national Medicaid 90th percentile. Conversely, approximately 70 percent of Better Health's rates (47 rates) fell below the national 50th Medicaid percentile, with approximately 36 percent (24 rates) falling below the national 25th Medicaid percentile.

CCP[19] Performance Measure Results

Table D-3 contains the MMA performance measure rates and performance level analysis results for CCP for reporting year 2016 (CY 2015).

Table D-3—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: CCP

CCP Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★★	2.21%
One Well-Child Visit	★★★	1.99%
Two Well-Child Visits	★★	2.43%
Three Well-Child Visits	★	3.31%
Four Well-Child Visits	★★★	11.04%
Five Well-Child Visits	★★★★	20.97%
Six or More Well-Child Visits	★★	58.06%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	★★★★	81.45%
Childhood Immunization Status		
Combination 2	★★★	75.65%
Combination 3	★★★	71.63%
Lead Screening in Children		
Lead Screening in Children	★★★	72.36%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★★	42.32%
Continuation and Maintenance Phase	★★	40.37%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★	11.11%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★	50.93%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	★★★	77.26%
Annual Dental Visit		
2–3 Years	★★	30.46%
4–6 Years	★	48.47%

[19] SFCCN changed its name to South Florida Community Care Network, DBA Community Care Plan (CCP) in SFY 2017. For the purposes of this report, CCP is used as the reference in the PMV reporting as it is based on SFY 2017 data.

CCP Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
7–10 Years	★★	53.59%
11–14 Years	★★	46.40%
15–18 Years	★★	38.72%
19–20 Years	—	20.35%
Total	★★	44.67%
Preventive Dental Services		
Preventive Dental Services	—	33.88%
Dental Treatment Services		
Dental Treatment Services	—	11.93%
Sealants		
Sealants	—	10.99%
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	—	17.92%
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★	40.27%
Chlamydia Screening in Women		
16–20 Years	★★★	56.30%
21–24 Years	★★★	62.35%
Total	★★★	57.80%
Breast Cancer Screening		
Breast Cancer Screening	★★★	60.16%
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	★	16.40%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★★	82.12%
Postpartum Care	★★	59.38%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★★	67.99%
Antenatal Steroids		
Antenatal Steroids	—	NA
Living With Illness		
Comprehensive Diabetes Care[1]		
Hemoglobin A1c (HbA1c) Testing	★★	84.01%
*HbA1c Poor Control (>9.0%)**	★★	43.69%
HbA1c Control (<8.0%)	★★	46.40%
Eye Exam (Retinal) Performed	★	40.99%
Medical Attention for Nephropathy	★★★★★	90.77%

CCP Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Controlling High Blood Pressure		
Controlling High Blood Pressure	★	49.44%
Adult BMI Assessment		
Adult BMI Assessment	★★	80.79%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years	★	42.50%
Medication Compliance 50%—Ages 12–18 Years	★★★	51.22%
Medication Compliance 50%—Ages 19–50 Years	NA	NA
Medication Compliance 50%—Ages 51–64 Years	NA	NA
Medication Compliance 50%—Total	★	46.55%
Medication Compliance 75%—Ages 5–11 Years	★	15.83%
Medication Compliance 75%—Ages 12–18 Years	★	14.63%
Medication Compliance 75%—Ages 19–50 Years	NA	NA
Medication Compliance 75%—Ages 51–64 Years	NA	NA
Medication Compliance 75%—Total	★	17.82%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★★	93.38%
Annual Monitoring for Members on Digoxin	NA	NA
Annual Monitoring for Members on Diuretics	★★★★★	92.70%
Total	★★★★★	92.03%
Plan All-Cause Readmissions*		
Total—18–64 Years of Age Total	—	24.01%
Total—65+ Years of Age Total	—	17.65%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	29.77%
≥2 Visits	—	71.76%
1 Visit	—	15.27%
0 Visits	—	12.98%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	91.60%
Viral Load Suppression Among Persons in HIV Medical Care		
18–64 years	—	27.70%
65+ years	—	NA
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—Total	NA	NA
Discussing Cessation Medications—18–64 Years of Age	—	NA

CCP Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Discussing Cessation Medications—65+ Years of Age	—	NA
Discussing Cessation Medications—Total	NA	NA
Discussing Cessation Strategies—18–64 Years of Age	—	NA
Discussing Cessation Strategies—65+ Years of Age	—	NA
Discussing Cessation Strategies—Total	NA	NA
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	★	20.34%
Initiation of AOD Treatment—18+ Years	★★★★	43.10%
Initiation of AOD Treatment—Total	★★★	39.33%
Engagement of AOD Treatment—13–17 Years	★	5.08%
Engagement of AOD Treatment—18+ Years	★	3.37%
Engagement of AOD Treatment—Total	★	3.65%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	—	28.46%
30-Day Follow-Up	—	48.45%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★★★	56.49%
Effective Continuation Phase Treatment	★★★★	47.33%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[1]		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★★	61.64%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	—	NA
6–11 Years	—	NA
12–17 Years	—	NA
Total	—	37.78%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*		
1–5 Years	—	NA
6–11 Years	—	NA
12–17 Years	—	NA
Total	—	0.00%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	29.05%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		

CCP Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
12–24 Months	★	93.11%
25 Months–6 Years	★★★	89.01%
7–11 Years	★★	91.25%
12–19 Years	★	86.10%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	48.70%
45–64 Years	★	71.01%
65 Years and Older	★	77.04%
Total	★	57.33%
Call Answer Timeliness		
Call Answer Timeliness	★★★★	89.32%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	88.67%
Use of Services		
Ambulatory Care—Total		
Outpatient Visits—Total	—	263.40
ED Visits—Total	—	61.04

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2016 rates for this measure to performance targets derived using data reported for HEDIS 2015.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report. This symbol may also indicate that the performance level analysis was not determined because the measure did not have an applicable benchmark.
NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For reporting year 2016 rates designated NA, the performance level analysis value was also NA.
2016 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Of the 65 measure indicator rates reported by CCP that were comparable to national Medicaid benchmarks, approximately 15 percent of CCP's rates (10 rates) ranked at or above the national Medicaid 75th percentile, with approximately 6 percent (four rates) ranking at or above the national Medicaid 90th percentile. Conversely, approximately 58 percent of CCP's rates (38 rates) fell below the national 50th Medicaid percentile, with approximately 34 percent (22 rates) falling below the national 25th Medicaid percentile.

Children's Medical Services-S Performance Measure Results

Table D-4 contains the MMA performance measure rates and performance level analysis results for Children's Medical Services-S for reporting year 2016 (CY 2015).

Table D-4—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: Children's Medical Services-S

Children's Medical Services-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★★	2.85%
One Well-Child Visit	★★	1.58%
Two Well-Child Visits	★★★★	5.06%
Three Well-Child Visits	★★★★	7.91%
Four Well-Child Visits	★★★★★	17.41%
Five Well-Child Visits	★★★★	23.42%
Six or More Well-Child Visits	★	41.77%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	★★	71.42%
Childhood Immunization Status		
Combination 2	★	66.79%
Combination 3	★	61.66%
Lead Screening in Children		
Lead Screening in Children	★	57.33%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★★	42.93%
Continuation and Maintenance Phase	★★★	53.55%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★	52.55%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★	55.63%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	★★	64.85%
Annual Dental Visit		
2–3 Years	★	26.34%
4–6 Years	★	46.88%
7–10 Years	★★	54.08%
11–14 Years	★★	49.62%

Children's Medical Services-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
15–18 Years	★★	43.85%
19–20 Years	—	31.38%
Total	★★	46.43%
Preventive Dental Services		
Preventive Dental Services	—	32.37%
Dental Treatment Services		
Dental Treatment Services	—	15.52%
Sealants		
Sealants	—	9.13%
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	—	0.00%
Women's Care		
Chlamydia Screening in Women		
16–20 Years	★	41.16%
21–24 Years	NA	NA
Total	★	41.16%
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	★★	18.35%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★	57.14%
Postpartum Care	★	49.21%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★	30.16%
Antenatal Steroids		
Antenatal Steroids	—	0.00%
Living With Illness		
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years	★★★★★	77.38%
Medication Compliance 50%—Ages 12–18 Years	★★★★★	78.47%
Medication Compliance 50%—Ages 19–50 Years	★★★★★	76.71%
Medication Compliance 50%—Ages 51–64 Years	NA	NA
Medication Compliance 50%—Total	★★★★★	77.80%
Medication Compliance 75%—Ages 5–11 Years	★★★★★	59.24%
Medication Compliance 75%—Ages 12–18 Years	★★★★★	57.53%
Medication Compliance 75%—Ages 19–50 Years	★★★★★	60.27%
Medication Compliance 75%—Ages 51–64 Years	NA	NA
Medication Compliance 75%—Total	★★★★★	58.59%

Children's Medical Services-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	33.57%
≥2 Visits	—	71.79%
1 Visit	—	13.93%
0 Visits	—	14.29%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	78.35%
Viral Load Suppression Among Persons in HIV Medical Care		
18–64 years	—	0.00%
65+ years	—	NA
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	★	34.52%
Initiation of AOD Treatment—18+ Years	★★★★	44.12%
Initiation of AOD Treatment—Total	★★★	38.82%
Engagement of AOD Treatment—13–17 Years	★	2.98%
Engagement of AOD Treatment—18+ Years	★	5.15%
Engagement of AOD Treatment—Total	★	3.95%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	—	38.04%
30-Day Follow-Up	—	62.75%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	—	46.00%
6–11 Years	—	41.02%
12–17 Years	—	44.20%
Total	—	43.02%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*		
1–5 Years	—	1.96%
6–11 Years	—	1.99%
12–17 Years	—	3.85%
Total	—	3.06%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	0.00%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★★★★	97.89%
25 Months–6 Years	★★★★★	94.58%

Children's Medical Services-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
7–11 Years	★★★★★	97.58%
12–19 Years	★★★★★	96.80%
Call Answer Timeliness		
Call Answer Timeliness	★	53.98%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	44.04%
Use of Services		
Ambulatory Care—Total		
Outpatient Visits—Total	—	450.33
ED Visits—Total	—	75.08
MMA Specialty Performance Measures—Pediatric Care		
Developmental Screening in the First Three Years of Life		
Screening in the 1st Year of Life	—	13.79%
Screening in the 2nd Year of Life	—	19.82%
Screening in the 3rd Year of Life	—	15.70%
Screenings Total	—	17.52%

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2016 rates for this measure to performance targets derived using data reported for HEDIS 2015.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report. This symbol may also indicate that the performance level analysis was not determined because the measure did not have an applicable benchmark.
NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For reporting year 2016 rates designated NA, the performance level analysis value was also NA.
2016 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Of the 47 measure indicator rates reported by Children's Medical Services-S that were comparable to national Medicaid benchmarks, approximately 36 percent of the plan's rates (17 rates) ranked at or above the national Medicaid 75th percentile, with approximately 26 percent (12 rates) ranking at or above the national Medicaid 90th percentile. Conversely, approximately 55 percent of the plan's rates (26 rates) fell below the national 50th Medicaid percentile, with approximately 34 percent (16 rates) falling below the national 25th Medicaid percentile.

Clear Health-S Performance Measure Results

Table D-5 contains the MMA performance measure rates and performance level analysis results for Clear Health-S for reporting year 2016 (CY 2015).

Table D-5—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: Clear Health-S

Clear Health-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	NA	NA
One Well-Child Visit	NA	NA
Two Well-Child Visits	NA	NA
Three Well-Child Visits	NA	NA
Four Well-Child Visits	NA	NA
Five Well-Child Visits	NA	NA
Six or More Well-Child Visits	NA	NA
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	NA	NA
Childhood Immunization Status		
Combination 2	NA	NA
Combination 3	NA	NA
Lead Screening in Children		
Lead Screening in Children	NA	NA
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	NA	NA
Continuation and Maintenance Phase	NA	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★★	74.19%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★	45.45%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	NA	NA
Annual Dental Visit		
2–3 Years	NA	NA
4–6 Years	NA	NA
7–10 Years	NA	NA
11–14 Years	NA	NA
15–18 Years	NA	NA

Clear Health-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
19–20 Years	—	NA
Total	★	26.74%
Preventive Dental Services		
Preventive Dental Services	—	13.69%
Dental Treatment Services		
Dental Treatment Services	—	4.78%
Sealants		
Sealants	—	7.55%
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	—	8.33%
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★★	58.15%
Chlamydia Screening in Women		
16–20 Years	NA	NA
21–24 Years	★★★★	72.06%
Total	★★★★★	73.26%
Breast Cancer Screening		
Breast Cancer Screening	★★	52.14%
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	NA	NA
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★	72.73%
Postpartum Care	★	43.64%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★	44.55%
Antenatal Steroids		
Antenatal Steroids	—	0.00%
Living With Illness		
Comprehensive Diabetes Care[1]		
Hemoglobin A1c (HbA1c) Testing	★	73.48%
*HbA1c Poor Control (>9.0%)**	★	54.74%
HbA1c Control (<8.0%)	★★	40.15%
Eye Exam (Retinal) Performed	★	33.33%
Medical Attention for Nephropathy	★★★	84.67%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★	32.60%

Clear Health-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Adult BMI Assessment		
Adult BMI Assessment	★★★★	90.02%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years	NA	NA
Medication Compliance 50%—Ages 12–18 Years	NA	NA
Medication Compliance 50%—Ages 19–50 Years	NA	NA
Medication Compliance 50%—Ages 51–64 Years	NA	NA
Medication Compliance 50%—Total	★★★★★	75.00%
Medication Compliance 75%—Ages 5–11 Years	NA	NA
Medication Compliance 75%—Ages 12–18 Years	NA	NA
Medication Compliance 75%—Ages 19–50 Years	NA	NA
Medication Compliance 75%—Ages 51–64 Years	NA	NA
Medication Compliance 75%—Total	★★★★★	58.33%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★★	98.26%
Annual Monitoring for Members on Digoxin	NA	NA
Annual Monitoring for Members on Diuretics	★★★★★	97.19%
Total	★★★★★	97.58%
Plan All-Cause Readmissions*		
Total—18–64 Years of Age Total	—	30.99%
Total—65+ Years of Age Total	—	11.90%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	35.23%
≥2 Visits	—	75.19%
1 Visit	—	13.94%
0 Visits	—	10.87%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	57.33%
Viral Load Suppression Among Persons in HIV Medical Care		
18–64 years	—	0.00%
65+ years	—	0.00%
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—Total	★★★★★	90.63%
Discussing Cessation Medications—18–64 Years of Age	—	NA
Discussing Cessation Medications—65+ Years of Age	—	NA
Discussing Cessation Medications—Total	★★★★★	63.35%

Clear Health-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Discussing Cessation Strategies—18–64 Years of Age	—	NA
Discussing Cessation Strategies—65+ Years of Age	—	NA
Discussing Cessation Strategies—Total	★★★★★	57.81%
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	NA	NA
Initiation of AOD Treatment—18+ Years	★★★★	43.58%
Initiation of AOD Treatment—Total	★★★★	43.53%
Engagement of AOD Treatment—13–17 Years	NA	NA
Engagement of AOD Treatment—18+ Years	★	3.89%
Engagement of AOD Treatment—Total	★	3.89%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	—	21.49%
30-Day Follow-Up	—	28.97%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★	49.48%
Effective Continuation Phase Treatment	★★★	36.98%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[1]		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★	54.66%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	—	NA
6–11 Years	—	NA
12–17 Years	—	NA
Total	—	NA
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*		
1–5 Years	—	NA
6–11 Years	—	NA
12–17 Years	—	NA
Total	—	NA
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	42.56%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	NA	NA
25 Months–6 Years	★	71.79%

Clear Health-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
7–11 Years	NA	NA
12–19 Years	NA	NA
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★★★★	85.79%
45–64 Years	★★★★	90.46%
65 Years and Older	★★	85.04%
Total	★★★★★	88.85%
Call Answer Timeliness		
Call Answer Timeliness	★★★★★	94.31%
Transportation Availability		
Transportation Availability	—	99.97%
Transportation Timeliness		
Transportation Timeliness	—	91.81%
Use of Services		
Ambulatory Care—Total		
Outpatient Visits—Total	—	351.70
ED Visits—Total	—	111.88

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2016 rates for this measure to performance targets derived using data reported for HEDIS 2015.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report. This symbol may also indicate that the performance level analysis was not determined because the measure did not have an applicable benchmark.
NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For reporting year 2016 rates designated NA, the performance level analysis value was also NA.
2016 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Of the 38 measure indicator rates reported by Clear Health-S that were comparable to national Medicaid benchmarks, approximately 45 percent of the plan's rates (17 rates) ranked at or above the national Medicaid 75th percentile, with approximately 29 percent (11 rates) ranking at or above the national Medicaid 90th percentile. Conversely, approximately 47 percent of the plan's rates (18 rates) fell below the national 50th Medicaid percentile, with approximately 32 percent (12 rates) falling below the national 25th Medicaid percentile.

Coventry Performance Measure Results

Table D-6 contains the MMA performance measure rates and performance level analysis results for Coventry for reporting year 2016 (CY 2015).

Table D-6—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: Coventry

Coventry Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★★	2.68%
One Well-Child Visit	★★	1.46%
Two Well-Child Visits	★	1.70%
Three Well-Child Visits	★★★	6.08%
Four Well-Child Visits	★★★	11.44%
Five Well-Child Visits	★★	15.57%
Six or More Well-Child Visits	★★★	61.07%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	★★★★	82.62%
Childhood Immunization Status		
Combination 2	★★	71.78%
Combination 3	★★	67.88%
Lead Screening in Children		
Lead Screening in Children	★★	68.86%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★	28.57%
Continuation and Maintenance Phase	NA	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★★	70.06%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★	56.51%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	★★★	76.32%
Annual Dental Visit		
2–3 Years	★★	28.73%
4–6 Years	★	48.82%
7–10 Years	★★	52.83%
11–14 Years	★★	46.99%
15–18 Years	★★	38.96%

Coventry Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
19–20 Years	—	26.48%
Total	★★	44.27%
Preventive Dental Services		
Preventive Dental Services	—	31.13%
Dental Treatment Services		
Dental Treatment Services	—	18.83%
Sealants		
Sealants	—	11.96%
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	—	0.00%
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★★★	61.22%
Chlamydia Screening in Women		
16–20 Years	★★★★★	69.82%
21–24 Years	★★★★★	74.50%
Total	★★★★★	70.96%
Breast Cancer Screening		
Breast Cancer Screening	★★★★	67.12%
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	★★★★	29.68%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★★★★★	93.02%
Postpartum Care	★★★	67.33%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★★★	72.32%
Antenatal Steroids		
Antenatal Steroids	—	NA
Living With Illness		
Comprehensive Diabetes Care[1]		
Hemoglobin A1c (HbA1c) Testing	★★★	86.62%
*HbA1c Poor Control (>9.0%)**	★★★	41.12%
HbA1c Control (<8.0%)	★★★	48.91%
Eye Exam (Retinal) Performed	★★	48.66%
Medical Attention for Nephropathy	★★★★★	95.13%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★★★	59.95%

Coventry Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Adult BMI Assessment		
Adult BMI Assessment	★★★★	90.57%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years	★★★	50.98%
Medication Compliance 50%—Ages 12–18 Years	★★★★	54.84%
Medication Compliance 50%—Ages 19–50 Years	NA	NA
Medication Compliance 50%—Ages 51–64 Years	NA	NA
Medication Compliance 50%—Total	★★	52.38%
Medication Compliance 75%—Ages 5–11 Years	★★	22.55%
Medication Compliance 75%—Ages 12–18 Years	★	16.13%
Medication Compliance 75%—Ages 19–50 Years	NA	NA
Medication Compliance 75%—Ages 51–64 Years	NA	NA
Medication Compliance 75%—Total	★	21.77%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★★	93.16%
Annual Monitoring for Members on Digoxin	NA	NA
Annual Monitoring for Members on Diuretics	★★★★★	93.32%
Total	★★★★★	92.88%
Plan All-Cause Readmissions*		
Total—18–64 Years of Age Total	—	20.04%
Total—65+ Years of Age Total	—	11.54%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	24.56%
≥2 Visits	—	63.16%
1 Visit	—	22.81%
0 Visits	—	14.04%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	83.64%
Viral Load Suppression Among Persons in HIV Medical Care		
18–64 years	—	40.00%
65+ years	—	NA
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—Total	NA	NA
Discussing Cessation Medications—18–64 Years of Age	—	NA
Discussing Cessation Medications—65+ Years of Age	—	NA
Discussing Cessation Medications—Total	NA	NA

Coventry Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Discussing Cessation Strategies—18–64 Years of Age	—	NA
Discussing Cessation Strategies—65+ Years of Age	—	NA
Discussing Cessation Strategies—Total	NA	NA
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	★★	40.32%
Initiation of AOD Treatment—18+ Years	★	30.09%
Initiation of AOD Treatment—Total	★	31.67%
Engagement of AOD Treatment—13–17 Years	★★	12.90%
Engagement of AOD Treatment—18+ Years	★	2.95%
Engagement of AOD Treatment—Total	★	4.49%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	—	28.70%
30-Day Follow-Up	—	49.44%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★★	53.05%
Effective Continuation Phase Treatment	★★★	37.20%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[1]		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★	57.02%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	—	NA
6–11 Years	—	NA
12–17 Years	—	NA
Total	—	51.52%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*		
1–5 Years	—	NA
6–11 Years	—	NA
12–17 Years	—	NA
Total	—	NA
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	19.88%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★★	95.50%
25 Months–6 Years	★★★	90.59%

Coventry Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
7–11 Years	★★	90.73%
12–19 Years	★	85.68%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	67.14%
45–64 Years	★	83.03%
65 Years and Older	★	78.64%
Total	★	72.73%
Call Answer Timeliness		
Call Answer Timeliness	★★	78.77%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	90.64%
Use of Services		
Ambulatory Care—Total		
Outpatient Visits—Total	—	315.26
ED Visits—Total	—	61.48

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2016 rates for this measure to performance targets derived using data reported for HEDIS 2015.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report. This symbol may also indicate that the performance level analysis was not determined because the measure did not have an applicable benchmark.
NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For reporting year 2016 rates designated NA, the performance level analysis value was also NA.
2016 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Of the 64 measure indicator rates reported by Coventry that were comparable to national Medicaid benchmarks, approximately 22 percent of Coventry's rates (14 rates) ranked at or above the national Medicaid 75th percentile, with approximately 13 percent (eight rates) ranking at or above the national Medicaid 90th percentile. Conversely, approximately 53 percent of Coventry's rates (34 rates) fell below the national 50th Medicaid percentile, with approximately 22 percent (14 rates) falling below the national 25th Medicaid percentile.

Freedom-S Performance Measure Results

Table D-7 contains the MMA performance measure rates and performance level analysis results for Freedom-S for reporting year 2016 (CY 2015).

Table D-7—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: Freedom-S

Freedom-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Women's Care		
Breast Cancer Screening		
Breast Cancer Screening	NA	NA
Living With Illness		
Comprehensive Diabetes Care[1]		
Hemoglobin A1c (HbA1c) Testing	NA	NA
*HbA1c Poor Control (>9.0%)**	NA	NA
HbA1c Control (<8.0%)	NA	NA
Eye Exam (Retinal) Performed	NA	NA
Medical Attention for Nephropathy	NA	NA
Controlling High Blood Pressure		
Controlling High Blood Pressure	NA	NA
Adult BMI Assessment		
Adult BMI Assessment	NA	NA
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	NA	NA
Annual Monitoring for Members on Digoxin	NA	NA
Annual Monitoring for Members on Diuretics	NA	NA
Total	★★★★★	100.00%
Plan All-Cause Readmissions*		
Total—18–64 Years of Age Total	—	NA
Total—65+ Years of Age Total	—	NA
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	NA
≥2 Visits	—	NA
1 Visit	—	NA
0 Visits	—	NA
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	NA
Viral Load Suppression Among Persons in HIV Medical Care		
18–64 years	—	NA
65+ years	—	NA

Freedom-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—Total	NA	NA
Discussing Cessation Medications—18–64 Years of Age	—	NA
Discussing Cessation Medications—65+ Years of Age	—	NA
Discussing Cessation Medications—Total	NA	NA
Discussing Cessation Strategies—18–64 Years of Age	—	NA
Discussing Cessation Strategies—65+ Years of Age	—	NA
Discussing Cessation Strategies—Total	NA	NA
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	NA	NA
Initiation of AOD Treatment—18+ Years	NA	NA
Initiation of AOD Treatment—Total	NA	NA
Engagement of AOD Treatment—13–17 Years	NA	NA
Engagement of AOD Treatment—18+ Years	NA	NA
Engagement of AOD Treatment—Total	NA	NA
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	—	NA
30-Day Follow-Up	—	NA
Antidepressant Medication Management		
Effective Acute Phase Treatment	NA	NA
Effective Continuation Phase Treatment	NA	NA
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	NA
Access/Availability of Care		
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	NA	NA
45–64 Years	NA	NA
65 Years and Older	★★★★★	97.06%
Total	★★★★★	95.24%
Call Answer Timeliness		
Call Answer Timeliness	★★★	88.90%
Transportation Availability		
Transportation Availability	—	100.00%

Freedom-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Transportation Timeliness		
Transportation Timeliness	—	91.67%
Use of Services		
Ambulatory Care—Total		
Outpatient Visits—Total	—	536.36
ED Visits—Total	—	62.81
MMA Specialty Performance Measures—Older Adult Care		
Care for Older Adults		
Advance Care Planning—66+ Years	—	70.59%
Medication Review—66+ Years	—	88.24%
Functional Status Assessment—66+ Years	—	85.29%
Pain Assessment—66+ Years	—	85.29%

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2016 rates for this measure to performance targets derived using data reported for HEDIS 2015.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report. This symbol may also indicate that the performance level analysis was not determined because the measure did not have an applicable benchmark.
NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For reporting year 2016 rates designated NA, the performance level analysis value was also NA.
2016 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Of the four measure indicator rates reported by Freedom-S that were comparable to national Medicaid benchmarks, three of the plan's rates ranked at or above the national Medicaid 90th percentile. The remaining measure rate ranked at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

Humana Performance Measure Results

Table D-8 contains the MMA performance measure rates and performance level analysis results for Humana for reporting year 2016 (CY 2015).

Table D-8—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: Humana

Humana Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★★	2.51%
One Well-Child Visit	★★★★	3.02%
Two Well-Child Visits	★★★★	4.77%
Three Well-Child Visits	★★★	5.78%
Four Well-Child Visits	★★★	10.55%
Five Well-Child Visits	★	10.80%
Six or More Well-Child Visits	★★★	62.56%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	★★★	74.89%
Childhood Immunization Status		
Combination 2	★★★	79.32%
Combination 3	★★★	73.72%
Lead Screening in Children		
Lead Screening in Children	★★	68.86%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★	38.67%
Continuation and Maintenance Phase	★★★	51.04%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★★	68.89%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★	55.19%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	★★	72.99%
Annual Dental Visit		
2–3 Years	★★	28.79%
4–6 Years	★★	50.52%
7–10 Years	★★	55.45%
11–14 Years	★★	49.58%
15–18 Years	★★	41.95%

Humana Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
19–20 Years	—	25.98%
Total	★★	46.10%
Preventive Dental Services		
Preventive Dental Services	—	33.68%
Dental Treatment Services		
Dental Treatment Services	—	15.42%
Sealants		
Sealants	—	13.31%
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	—	27.58%
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★★	54.68%
Chlamydia Screening in Women		
16–20 Years	★★★★	58.80%
21–24 Years	★★★	66.76%
Total	★★★	61.53%
Breast Cancer Screening		
Breast Cancer Screening	★★★★★	71.44%
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	★★	18.98%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★★★	85.82%
Postpartum Care	★★★	67.53%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★★	69.59%
Antenatal Steroids		
Antenatal Steroids	—	48.72%
Living With Illness		
Comprehensive Diabetes Care[1]		
Hemoglobin A1c (HbA1c) Testing	★	81.27%
*HbA1c Poor Control (>9.0%)**	★★★	39.66%
HbA1c Control (<8.0%)	★★★	49.88%
Eye Exam (Retinal) Performed	★★★	61.07%
Medical Attention for Nephropathy	★★★★★	93.92%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★★★	60.38%

Humana Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Adult BMI Assessment		
Adult BMI Assessment	★★★★	90.83%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years	★	38.10%
Medication Compliance 50%—Ages 12–18 Years	★	36.47%
Medication Compliance 50%—Ages 19–50 Years	★★	57.89%
Medication Compliance 50%—Ages 51–64 Years	NA	NA
Medication Compliance 50%—Total	★	43.49%
Medication Compliance 75%—Ages 5–11 Years	★★	19.58%
Medication Compliance 75%—Ages 12–18 Years	★	9.41%
Medication Compliance 75%—Ages 19–50 Years	★★★★	42.11%
Medication Compliance 75%—Ages 51–64 Years	NA	NA
Medication Compliance 75%—Total	★	22.49%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★	88.95%
Annual Monitoring for Members on Digoxin	★★	49.57%
Annual Monitoring for Members on Diuretics	★★★	89.22%
Total	★★★	88.58%
Plan All-Cause Readmissions*		
Total—18–64 Years of Age Total	—	24.14%
Total—65+ Years of Age Total	—	11.53%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	0.00%
≥2 Visits	—	47.11%
1 Visit	—	16.93%
0 Visits	—	35.97%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	62.46%
Viral Load Suppression Among Persons in HIV Medical Care		
18–64 years	—	1.30%
65+ years	—	4.92%
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—Total	NA	NA
Discussing Cessation Medications—18–64 Years of Age	—	NA
Discussing Cessation Medications—65+ Years of Age	—	NA
Discussing Cessation Medications—Total	NA	NA

Humana Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Discussing Cessation Strategies—18–64 Years of Age	—	NA
Discussing Cessation Strategies—65+ Years of Age	—	NA
Discussing Cessation Strategies—Total	NA	NA
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	★	30.86%
Initiation of AOD Treatment—18+ Years	★★	33.46%
Initiation of AOD Treatment—Total	★	33.29%
Engagement of AOD Treatment—13–17 Years	★★	13.43%
Engagement of AOD Treatment—18+ Years	★	4.52%
Engagement of AOD Treatment—Total	★	5.08%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	—	38.74%
30-Day Follow-Up	—	56.84%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★★	54.34%
Effective Continuation Phase Treatment	★★★	38.69%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[1]		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★★	61.85%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	—	NA
6–11 Years	—	38.17%
12–17 Years	—	34.86%
Total	—	35.73%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*		
1–5 Years	—	NA
6–11 Years	—	1.54%
12–17 Years	—	2.22%
Total	—	1.98%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	19.85%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★	93.89%
25 Months–6 Years	★★	88.34%

Humana Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
7–11 Years	★★★	91.60%
12–19 Years	★★	87.99%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	70.75%
45–64 Years	★★★	88.28%
65 Years and Older	★★★★★	93.40%
Total	★★	81.67%
Call Answer Timeliness		
Call Answer Timeliness	★★★★★	95.09%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	86.87%
Use of Services		
Ambulatory Care—Total		
Outpatient Visits—Total	—	337.39
ED Visits—Total	—	67.42

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2016 rates for this measure to performance targets derived using data reported for HEDIS 2015.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report. This symbol may also indicate that the performance level analysis was not determined because the measure did not have an applicable benchmark.
NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For reporting year 2016 rates designated NA, the performance level analysis value was also NA.
2016 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Of the 68 measure indicator rates reported by Humana that were comparable to national Medicaid benchmarks, approximately 13 percent of Humana's rates (nine rates) ranked at or above the national Medicaid 75th percentile, with approximately 6 percent (four rates) ranking at or above the national Medicaid 90th percentile. Conversely, approximately 49 percent of Humana's rates (33 rates) fell below the national 50th Medicaid percentile, with approximately 19 percent (13 rates) falling below the national 25th Medicaid percentile.

Magellan-S Performance Measure Results

Table D-9 contains the MMA performance measure rates and performance level analysis results for Magellan-S for reporting year 2016 (CY 2015).

Table D-9—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: Magellan-S

Magellan-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	NA	NA
One Well-Child Visit	NA	NA
Two Well-Child Visits	NA	NA
Three Well-Child Visits	NA	NA
Four Well-Child Visits	NA	NA
Five Well-Child Visits	NA	NA
Six or More Well-Child Visits	NA	NA
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	NA	NA
Childhood Immunization Status		
Combination 2	NR	NR
Combination 3	NR	NR
Lead Screening in Children		
Lead Screening in Children	NR	NR
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★	0.00%
Continuation and Maintenance Phase	NA	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★	50.61%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★	23.26%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	★	26.11%
Annual Dental Visit		
2–3 Years	NA	NA
4–6 Years	NA	NA
7–10 Years	★	39.21%
11–14 Years	★	32.64%
15–18 Years	★	28.66%
19–20 Years	—	19.25%

Magellan-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Total	★	29.01%
Preventive Dental Services		
Preventive Dental Services	—	17.05%
Dental Treatment Services		
Dental Treatment Services	—	9.28%
Sealants		
Sealants	—	6.66%
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	—	0.00%
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★	22.11%
Chlamydia Screening in Women		
16–20 Years	★★★★	57.71%
21–24 Years	★★★	65.16%
Total	★★★	60.19%
Breast Cancer Screening		
Breast Cancer Screening	NR	NR
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	★	1.52%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★	59.37%
Postpartum Care	★	32.60%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★	32.60%
Antenatal Steroids		
Antenatal Steroids	—	0.00%
Living With Illness		
Comprehensive Diabetes Care[1]		
Hemoglobin A1c (HbA1c) Testing	★	75.20%
*HbA1c Poor Control (>9.0%)**	★	90.58%
HbA1c Control (<8.0%)	★	7.50%
Eye Exam (Retinal) Performed	★	31.87%
Medical Attention for Nephropathy	★★★★★	90.02%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★	39.17%
Adult BMI Assessment		
Adult BMI Assessment	NR	NR

Magellan-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years	NA	NA
Medication Compliance 50%—Ages 12–18 Years	NA	NA
Medication Compliance 50%—Ages 19–50 Years	NA	NA
Medication Compliance 50%—Ages 51–64 Years	NA	NA
Medication Compliance 50%—Total	NA	NA
Medication Compliance 75%—Ages 5–11 Years	NA	NA
Medication Compliance 75%—Ages 12–18 Years	NA	NA
Medication Compliance 75%—Ages 19–50 Years	NA	NA
Medication Compliance 75%—Ages 51–64 Years	NA	NA
Medication Compliance 75%—Total	NA	NA
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★	89.60%
Annual Monitoring for Members on Digoxin	NA	NA
Annual Monitoring for Members on Diuretics	★★★★	89.69%
Total	★★★★	89.54%
Plan All-Cause Readmissions*		
Total—18–64 Years of Age Total	—	39.24%
Total—65+ Years of Age Total	—	38.82%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	0.00%
≥2 Visits	—	33.77%
1 Visit	—	16.88%
0 Visits	—	49.35%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	57.14%
Viral Load Suppression Among Persons in HIV Medical Care		
18–64 years	—	NA
65+ years	—	NA
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years of Age	—	79.17%
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—Total	★★★	79.34%
Discussing Cessation Medications—18–64 Years of Age	—	47.50%
Discussing Cessation Medications—65+ Years of Age	—	NA
Discussing Cessation Medications—Total	★★★	47.93%
Discussing Cessation Strategies—18–64 Years of Age	—	42.86%
Discussing Cessation Strategies—65+ Years of Age	—	NA

Magellan-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Discussing Cessation Strategies—Total	★★★	43.33%
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	★★★★	52.38%
Initiation of AOD Treatment—18+ Years	★★★★★	49.70%
Initiation of AOD Treatment—Total	★★★★★	49.91%
Engagement of AOD Treatment—13–17 Years	★★	8.63%
Engagement of AOD Treatment—18+ Years	★	5.10%
Engagement of AOD Treatment—Total	★	5.38%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	—	26.28%
30-Day Follow-Up	—	46.94%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★	46.74%
Effective Continuation Phase Treatment	★★	32.37%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[1]		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★	52.01%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	—	NA
6–11 Years	—	26.39%
12–17 Years	—	32.41%
Total	—	31.21%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*		
1–5 Years	—	NA
6–11 Years	—	1.83%
12–17 Years	—	2.00%
Total	—	1.96%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	32.23%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	NA	NA
25 Months–6 Years	NA	NA
7–11 Years	NA	NA
12–19 Years	NA	NA

Magellan-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	72.85%
45–64 Years	★	81.52%
65 Years and Older	★	63.62%
Total	★	75.98%
Call Answer Timeliness		
Call Answer Timeliness	★★★	87.88%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	84.12%
Use of Services		
Ambulatory Care—Total		
Outpatient Visits—Total	—	243.49
ED Visits—Total	—	157.17
MMA Specialty Performance Measures—SMI		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Med		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	★	71.02%
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	★★	66.25%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2016 rates for this measure to performance targets derived using data reported for HEDIS 2015.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report. This symbol may also indicate that the performance level analysis was not determined because the measure did not have an applicable benchmark.
NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For reporting year 2016 rates designated NA, the performance level analysis value was also NA.
NR indicates that the rate was designated Not Reported because the organization chose not to report the measure. For reporting year 2016 rates designated NR, the performance level analysis value was also NR.
2016 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Of the 44 measure indicator rates reported by Magellan-S that were comparable to national Medicaid benchmarks, approximately 16 percent of the plan's rates (seven rates) ranked at or above the national Medicaid 75th percentile, with approximately 7 percent (three rates) ranking at or above the national Medicaid 90th percentile. Conversely, approximately 68 percent of the plan's rates (30 rates) fell below the national 50th Medicaid percentile, with approximately 59 percent (26 rates) falling below the national 25th Medicaid percentile.

Molina Performance Measure Results

Table D-10 contains the MMA performance measure rates and performance level analysis results for Molina for reporting year 2016 (CY 2015).

Table D-10—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: Molina

Molina Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★	3.09%
One Well-Child Visit	★★★	1.99%
Two Well-Child Visits	★★★	3.53%
Three Well-Child Visits	★	2.65%
Four Well-Child Visits	★★	9.27%
Five Well-Child Visits	★★★★★	24.94%
Six or More Well-Child Visits	★★	54.53%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	★★★	75.89%
Childhood Immunization Status		
Combination 2	★★	75.22%
Combination 3	★★★	71.68%
Lead Screening in Children		
Lead Screening in Children	★★	70.35%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★★★	52.92%
Continuation and Maintenance Phase	NA	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★	56.47%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★	55.63%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	★★	68.79%
Annual Dental Visit		
2–3 Years	★★	32.81%
4–6 Years	★★	54.50%
7–10 Years	★★	61.71%
11–14 Years	★★	53.24%
15–18 Years	★★	44.05%

Molina Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
19–20 Years	—	27.97%
Total	★★	50.68%
Preventive Dental Services		
Preventive Dental Services	—	39.72%
Dental Treatment Services		
Dental Treatment Services	—	17.35%
Sealants		
Sealants	—	13.95%
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	—	0.00%
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★	52.23%
Chlamydia Screening in Women		
16–20 Years	★★★★	58.31%
21–24 Years	★★★★	69.84%
Total	★★★	61.79%
Breast Cancer Screening		
Breast Cancer Screening	★★	53.91%
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	★★	18.98%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★★	81.72%
Postpartum Care	★★	59.59%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★★	65.01%
Antenatal Steroids		
Antenatal Steroids	—	2.20%
Living With Illness		
Comprehensive Diabetes Care[1]		
Hemoglobin A1c (HbA1c) Testing	★★★	86.75%
*HbA1c Poor Control (>9.0%)**	★	61.15%
HbA1c Control (<8.0%)	★	32.23%
Eye Exam (Retinal) Performed	★★	49.23%
Medical Attention for Nephropathy	★★★★★	90.73%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★	45.53%

Molina Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Adult BMI Assessment		
Adult BMI Assessment	★★	80.13%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years	★★★	50.00%
Medication Compliance 50%—Ages 12–18 Years	NA	NA
Medication Compliance 50%—Ages 19–50 Years	NA	NA
Medication Compliance 50%—Ages 51–64 Years	NA	NA
Medication Compliance 50%—Total	★★	49.43%
Medication Compliance 75%—Ages 5–11 Years	★★	20.00%
Medication Compliance 75%—Ages 12–18 Years	NA	NA
Medication Compliance 75%—Ages 19–50 Years	NA	NA
Medication Compliance 75%—Ages 51–64 Years	NA	NA
Medication Compliance 75%—Total	★	20.69%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★	90.94%
Annual Monitoring for Members on Digoxin	★★★★★	70.27%
Annual Monitoring for Members on Diuretics	★★★★★	92.24%
Total	★★★★	91.32%
Plan All-Cause Readmissions*		
Total—18–64 Years of Age Total	—	23.70%
Total—65+ Years of Age Total	—	29.18%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	25.75%
≥2 Visits	—	66.17%
1 Visit	—	16.47%
0 Visits	—	17.37%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	83.80%
Viral Load Suppression Among Persons in HIV Medical Care		
18–64 years	—	0.00%
65+ years	—	NA
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—Total	★	40.24%
Discussing Cessation Medications—18–64 Years of Age	—	NA
Discussing Cessation Medications—65+ Years of Age	—	NA
Discussing Cessation Medications—Total	★	25.00%

Molina Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Discussing Cessation Strategies—18–64 Years of Age	—	NA
Discussing Cessation Strategies—65+ Years of Age	—	NA
Discussing Cessation Strategies—Total	★	19.51%
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	★	29.03%
Initiation of AOD Treatment—18+ Years	★★	34.80%
Initiation of AOD Treatment—Total	★★	34.25%
Engagement of AOD Treatment—13–17 Years	★	4.84%
Engagement of AOD Treatment—18+ Years	★	3.26%
Engagement of AOD Treatment—Total	★	3.41%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	—	31.43%
30-Day Follow-Up	—	51.37%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★★	55.80%
Effective Continuation Phase Treatment	★★★	39.62%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[1]		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★★	64.77%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	—	NA
6–11 Years	—	24.29%
12–17 Years	—	37.36%
Total	—	31.58%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*		
1–5 Years	—	NA
6–11 Years	—	2.04%
12–17 Years	—	2.48%
Total	—	2.27%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	0.53%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★	94.05%
25 Months–6 Years	★★★	88.54%

Molina Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
7–11 Years	★★	89.22%
12–19 Years	★	84.01%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	67.05%
45–64 Years	★	84.34%
65 Years and Older	★	73.66%
Total	★	72.54%
Call Answer Timeliness		
Call Answer Timeliness	★	63.98%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	85.59%
Use of Services		
Ambulatory Care—Total		
Outpatient Visits—Total	—	301.35
ED Visits—Total	—	66.43

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2016 rates for this measure to performance targets derived using data reported for HEDIS 2015.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report. This symbol may also indicate that the performance level analysis was not determined because the measure did not have an applicable benchmark.
NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For reporting year 2016 rates designated NA, the performance level analysis value was also NA.
2016 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Of the 66 measure indicator rates reported by Molina that were comparable to national Medicaid benchmarks, approximately 14 percent of Molina's rates (nine rates) ranked at or above the national Medicaid 75th percentile, with approximately 6 percent (four rates) ranking at or above the national Medicaid 90th percentile. Conversely, approximately 67 percent of Molina's rates (44 rates) fell below the national 50th Medicaid percentile, with approximately 32 percent (21 rates) falling below the national 25th Medicaid percentile.

Positive-S Performance Measure Results

Table D-11 contains the MMA performance measure rates and performance level analysis results for Positive-S for reporting year 2016 (CY 2015).

Table D-11—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: Positive-S

Positive-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	NA	NA
One Well-Child Visit	NA	NA
Two Well-Child Visits	NA	NA
Three Well-Child Visits	NA	NA
Four Well-Child Visits	NA	NA
Five Well-Child Visits	NA	NA
Six or More Well-Child Visits	NA	NA
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	NA	NA
Childhood Immunization Status		
Combination 2	NA	NA
Combination 3	NA	NA
Lead Screening in Children		
Lead Screening in Children	NA	NA
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	NA	NA
Continuation and Maintenance Phase	NA	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	NA	NA
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	NA	NA
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	NA	NA
Annual Dental Visit		
2–3 Years	NA	NA
4–6 Years	NA	NA
7–10 Years	NA	NA
11–14 Years	NA	NA
15–18 Years	NA	NA

Positive-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
19–20 Years	—	NA
Total	NA	NA
Preventive Dental Services		
Preventive Dental Services	—	2.33%
Dental Treatment Services		
Dental Treatment Services	—	2.33%
Sealants		
Sealants	—	NA
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	—	NA
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★★	55.23%
Chlamydia Screening in Women		
16–20 Years	NA	NA
21–24 Years	NA	NA
Total	NA	NA
Breast Cancer Screening		
Breast Cancer Screening	NA	NA
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	NA	NA
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	NA	NA
Postpartum Care	NA	NA
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	NA	NA
Antenatal Steroids		
Antenatal Steroids	—	NA
Living With Illness		
Comprehensive Diabetes Care[1]		
Hemoglobin A1c (HbA1c) Testing	★	72.73%
*HbA1c Poor Control (>9.0%)**	★	51.87%
HbA1c Control (<8.0%)	★★	41.71%
Eye Exam (Retinal) Performed	★	22.46%
Medical Attention for Nephropathy	★★★★★	89.84%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★	48.29%

Positive-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Adult BMI Assessment		
Adult BMI Assessment	NA	NA
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years	NA	NA
Medication Compliance 50%—Ages 12–18 Years	NA	NA
Medication Compliance 50%—Ages 19–50 Years	NA	NA
Medication Compliance 50%—Ages 51–64 Years	NA	NA
Medication Compliance 50%—Total	NA	NA
Medication Compliance 75%—Ages 5–11 Years	NA	NA
Medication Compliance 75%—Ages 12–18 Years	NA	NA
Medication Compliance 75%—Ages 19–50 Years	NA	NA
Medication Compliance 75%—Ages 51–64 Years	NA	NA
Medication Compliance 75%—Total	NA	NA
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★★	97.50%
Annual Monitoring for Members on Digoxin	NA	NA
Annual Monitoring for Members on Diuretics	★★★★★	98.53%
Total	★★★★★	97.95%
Plan All-Cause Readmissions*		
Total—18–64 Years of Age Total	—	20.23%
Total—65+ Years of Age Total	—	NA
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	22.14%
≥2 Visits	—	52.05%
1 Visit	—	21.20%
0 Visits	—	26.76%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	68.84%
Viral Load Suppression Among Persons in HIV Medical Care		
18–64 years	—	54.94%
65+ years	—	22.22%
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years of Age	—	70.45%
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—Total	★	71.01%
Discussing Cessation Medications—18–64 Years of Age	—	46.92%
Discussing Cessation Medications—65+ Years of Age	—	NA
Discussing Cessation Medications—Total	★★★	47.06%

Positive-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Discussing Cessation Strategies—18–64 Years of Age	—	44.53%
Discussing Cessation Strategies—65+ Years of Age	—	NA
Discussing Cessation Strategies—Total	★★★	44.78%
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	NA	NA
Initiation of AOD Treatment—18+ Years	★	28.29%
Initiation of AOD Treatment—Total	★	28.29%
Engagement of AOD Treatment—13–17 Years	NA	NA
Engagement of AOD Treatment—18+ Years	★	1.97%
Engagement of AOD Treatment—Total	★	1.97%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	—	0.00%
30-Day Follow-Up	—	NA
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★★★★	66.67%
Effective Continuation Phase Treatment	★★★★★	60.00%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[1]		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★	40.54%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	—	NA
6–11 Years	—	NA
12–17 Years	—	NA
Total	—	NA
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*		
1–5 Years	—	NA
6–11 Years	—	NA
12–17 Years	—	NA
Total	—	NA
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	8.57%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	NA	NA
25 Months–6 Years	NA	NA

Positive-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
7–11 Years	NA	NA
12–19 Years	NA	NA
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★★	80.75%
45–64 Years	★★	86.28%
65 Years and Older	★	72.82%
Total	★★★	83.90%
Call Answer Timeliness		
Call Answer Timeliness	★★	84.66%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	75.84%
Use of Services		
Ambulatory Care—Total		
Outpatient Visits—Total	—	432.43
ED Visits—Total	—	165.43

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2016 rates for this measure to performance targets derived using data reported for HEDIS 2015.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report. This symbol may also indicate that the performance level analysis was not determined because the measure did not have an applicable benchmark.
NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For reporting year 2016 rates designated NA, the performance level analysis value was also NA.
2016 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Of the 25 measure indicator rates reported by Positive-S that were comparable to national Medicaid benchmarks, approximately 24 percent of the plan's rates (six rates) ranked at or above the national Medicaid 90th percentile. None of the rates ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile. Conversely, approximately 64 percent of the plan's rates (16 rates) fell below the national 50th Medicaid percentile, with approximately 44 percent (11 rates) falling below the national 25th Medicaid percentile.

Prestige Performance Measure Results

Table D-12 contains the MMA performance measure rates and performance level analysis results for Prestige for reporting year 2016 (CY 2015).

Table D-12—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: Prestige

Prestige Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★	4.63%
One Well-Child Visit	★★★	2.31%
Two Well-Child Visits	★★★	3.47%
Three Well-Child Visits	★★★★	7.18%
Four Well-Child Visits	★	7.41%
Five Well-Child Visits	★★★	18.52%
Six or More Well-Child Visits	★★	56.48%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	★★★	72.22%
Childhood Immunization Status		
Combination 2	★★★	77.21%
Combination 3	★★	70.93%
Lead Screening in Children		
Lead Screening in Children	★	54.88%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★★★	50.00%
Continuation and Maintenance Phase	★★★★★	66.98%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★	58.80%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★	51.85%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	★	63.43%
Annual Dental Visit		
2–3 Years	★	25.33%
4–6 Years	★	47.04%
7–10 Years	★★	53.10%
11–14 Years	★★	47.25%
15–18 Years	★★	40.44%

Prestige Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
19–20 Years	—	25.57%
Total	★★	43.62%
Preventive Dental Services		
Preventive Dental Services	—	29.51%
Dental Treatment Services		
Dental Treatment Services	—	13.25%
Sealants		
Sealants	—	11.07%
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	—	0.00%
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★	46.84%
Chlamydia Screening in Women		
16–20 Years	★★★	56.40%
21–24 Years	★★★★	68.34%
Total	★★★	60.72%
Breast Cancer Screening		
Breast Cancer Screening	★	50.43%
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	★★★	22.45%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★	66.44%
Postpartum Care	★	48.38%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★	54.17%
Antenatal Steroids		
Antenatal Steroids	—	NA
Living With Illness		
Comprehensive Diabetes Care[1]		
Hemoglobin A1c (HbA1c) Testing	★★	85.95%
*HbA1c Poor Control (>9.0%)**	★★	48.37%
HbA1c Control (<8.0%)	★★	41.01%
Eye Exam (Retinal) Performed	★★	52.12%
Medical Attention for Nephropathy	★★★★★	92.48%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★	43.43%

Prestige Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Adult BMI Assessment		
Adult BMI Assessment	★★★	85.38%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years	★★	46.19%
Medication Compliance 50%—Ages 12–18 Years	★	39.08%
Medication Compliance 50%—Ages 19–50 Years	★	45.83%
Medication Compliance 50%—Ages 51–64 Years	NA	NA
Medication Compliance 50%—Total	★	45.33%
Medication Compliance 75%—Ages 5–11 Years	★★★	26.67%
Medication Compliance 75%—Ages 12–18 Years	★★	21.84%
Medication Compliance 75%—Ages 19–50 Years	★	20.83%
Medication Compliance 75%—Ages 51–64 Years	NA	NA
Medication Compliance 75%—Total	★★	25.82%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★	89.65%
Annual Monitoring for Members on Digoxin	★★★★★	61.98%
Annual Monitoring for Members on Diuretics	★★★	89.05%
Total	★★★	89.03%
Plan All-Cause Readmissions*		
Total—18–64 Years of Age Total	—	18.73%
Total—65+ Years of Age Total	—	17.83%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	28.14%
≥2 Visits	—	62.34%
1 Visit	—	17.75%
0 Visits	—	19.91%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	84.07%
Viral Load Suppression Among Persons in HIV Medical Care		
18–64 years	—	BR
65+ years	—	BR
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—Total	NA	NA
Discussing Cessation Medications—18–64 Years of Age	—	NA
Discussing Cessation Medications—65+ Years of Age	—	NA
Discussing Cessation Medications—Total	NA	NA

Prestige Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Discussing Cessation Strategies—18–64 Years of Age	—	NA
Discussing Cessation Strategies—65+ Years of Age	—	NA
Discussing Cessation Strategies—Total	NA	NA
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	★	29.41%
Initiation of AOD Treatment—18+ Years	★★★	38.90%
Initiation of AOD Treatment—Total	★★★	38.20%
Engagement of AOD Treatment—13–17 Years	★★	13.15%
Engagement of AOD Treatment—18+ Years	★★	7.92%
Engagement of AOD Treatment—Total	★★	8.31%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	—	17.26%
30-Day Follow-Up	—	36.27%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★★★	56.39%
Effective Continuation Phase Treatment	★★★	39.73%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[1]		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★★	63.64%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	—	NA
6–11 Years	—	27.16%
12–17 Years	—	35.29%
Total	—	32.04%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*		
1–5 Years	—	NA
6–11 Years	—	0.00%
12–17 Years	—	1.08%
Total	—	0.64%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	20.23%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★	92.58%
25 Months–6 Years	★	84.51%

Prestige Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
7–11 Years	★	80.37%
12–19 Years	★	76.19%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	68.67%
45–64 Years	★	84.59%
65 Years and Older	★	81.59%
Total	★	73.54%
Call Answer Timeliness		
Call Answer Timeliness	★★★	85.47%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	82.22%
Use of Services		
Ambulatory Care—Total		
Outpatient Visits—Total	—	244.21
ED Visits—Total	—	63.43

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2016 rates for this measure to performance targets derived using data reported for HEDIS 2015.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report. This symbol may also indicate that the performance level analysis was not determined because the measure did not have an applicable benchmark.
NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For reporting year 2016 rates designated NA, the performance level analysis value was also NA.
BR indicates that the rate was designated Biased Rate because the calculated rate was materially biased. For reporting year 2016 rates designated BR, the performance level analysis value was also BR.
2016 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Of the 68 measure indicator rates reported by Prestige that were comparable to national Medicaid benchmarks, approximately 10 percent of Prestige's rates (seven rates) ranked at or above the national Medicaid 75th percentile, with approximately 4 percent (three rates) ranking at or above the national Medicaid 90th percentile. Conversely, approximately 62 percent of Prestige's rates (42 rates) fell below the national 50th Medicaid percentile, with approximately 35 percent (24 rates) falling below the national 25th Medicaid percentile.

Simply Performance Measure Results

Table D-13 contains the MMA performance measure rates and performance level analysis results for Simply for reporting year 2016 (CY 2015).

Table D-13—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: Simply

Simply Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★★	1.95%
One Well-Child Visit	★★★	1.95%
Two Well-Child Visits	★★	2.68%
Three Well-Child Visits	★★★	5.60%
Four Well-Child Visits	★★	8.52%
Five Well-Child Visits	★★	17.76%
Six or More Well-Child Visits	★★★	61.56%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	★★★★	79.08%
Childhood Immunization Status		
Combination 2	★★★	76.16%
Combination 3	★★	68.37%
Lead Screening in Children		
Lead Screening in Children	★★	71.29%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★★	42.04%
Continuation and Maintenance Phase	NA	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★	60.58%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★	55.47%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	★★	72.26%
Annual Dental Visit		
2–3 Years	★	26.52%
4–6 Years	★★	49.68%
7–10 Years	★★	57.99%
11–14 Years	★★	51.95%
15–18 Years	★★	41.72%

Simply Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
19–20 Years	—	29.50%
Total	★★	46.79%
Preventive Dental Services		
Preventive Dental Services	—	38.07%
Dental Treatment Services		
Dental Treatment Services	—	17.89%
Sealants		
Sealants	—	13.16%
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	—	14.89%
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★★	55.47%
Chlamydia Screening in Women		
16–20 Years	★★★★	63.00%
21–24 Years	★★★	61.41%
Total	★★★★	62.71%
Breast Cancer Screening		
Breast Cancer Screening	★★★★	70.00%
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	★★★★	30.90%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★★★	86.62%
Postpartum Care	★★	55.47%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★★	66.18%
Antenatal Steroids		
Antenatal Steroids	—	0.42%
Living With Illness		
Comprehensive Diabetes Care[1]		
Hemoglobin A1c (HbA1c) Testing	★	76.89%
*HbA1c Poor Control (>9.0%)**	★★	45.50%
HbA1c Control (<8.0%)	★★★	48.18%
Eye Exam (Retinal) Performed	★	38.44%
Medical Attention for Nephropathy	★★★★★	88.32%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★★★	59.12%

Simply Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Adult BMI Assessment		
Adult BMI Assessment	★★★	86.86%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years	NA	NA
Medication Compliance 50%—Ages 12–18 Years	NA	NA
Medication Compliance 50%—Ages 19–50 Years	NA	NA
Medication Compliance 50%—Ages 51–64 Years	NA	NA
Medication Compliance 50%—Total	★★★	56.14%
Medication Compliance 75%—Ages 5–11 Years	NA	NA
Medication Compliance 75%—Ages 12–18 Years	NA	NA
Medication Compliance 75%—Ages 19–50 Years	NA	NA
Medication Compliance 75%—Ages 51–64 Years	NA	NA
Medication Compliance 75%—Total	★★	28.07%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★★	92.76%
Annual Monitoring for Members on Digoxin	★	48.10%
Annual Monitoring for Members on Diuretics	★★★★★	93.33%
Total	★★★★★	92.46%
Plan All-Cause Readmissions*		
Total—18–64 Years of Age Total	—	19.75%
Total—65+ Years of Age Total	—	12.91%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	34.86%
≥2 Visits	—	83.49%
1 Visit	—	7.34%
0 Visits	—	9.17%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	64.22%
Viral Load Suppression Among Persons in HIV Medical Care		
18–64 years	—	0.00%
65+ years	—	NA
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—Total	NA	NA
Discussing Cessation Medications—18–64 Years of Age	—	NA
Discussing Cessation Medications—65+ Years of Age	—	NA
Discussing Cessation Medications—Total	NA	NA

Simply Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Discussing Cessation Strategies—18–64 Years of Age	—	NA
Discussing Cessation Strategies—65+ Years of Age	—	NA
Discussing Cessation Strategies—Total	NA	NA
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	★★★	44.19%
Initiation of AOD Treatment—18+ Years	★	26.78%
Initiation of AOD Treatment—Total	★	28.39%
Engagement of AOD Treatment—13–17 Years	★	8.14%
Engagement of AOD Treatment—18+ Years	★	2.25%
Engagement of AOD Treatment—Total	★	2.80%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	—	28.75%
30-Day Follow-Up	—	47.60%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★★	55.34%
Effective Continuation Phase Treatment	★★★	39.47%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[1]		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★★	61.23%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	—	NA
6–11 Years	—	NA
12–17 Years	—	58.43%
Total	—	59.32%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*		
1–5 Years	—	NA
6–11 Years	—	NA
12–17 Years	—	0.00%
Total	—	0.00%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	31.56%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★★	95.20%
25 Months–6 Years	★★★★	91.25%

Simply Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
7–11 Years	★	88.66%
12–19 Years	★	83.13%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	72.70%
45–64 Years	★★★	89.35%
65 Years and Older	★	77.01%
Total	★	79.17%
Call Answer Timeliness		
Call Answer Timeliness	★★★★★	94.44%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	89.52%
Use of Services		
Ambulatory Care—Total		
Outpatient Visits—Total	—	347.73
ED Visits—Total	—	52.65

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2016 rates for this measure to performance targets derived using data reported for HEDIS 2015.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report. This symbol may also indicate that the performance level analysis was not determined because the measure did not have an applicable benchmark.
NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For reporting year 2016 rates designated NA, the performance level analysis value was also NA.
2016 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Of the 61 measure indicator rates reported by Simply that were comparable to national Medicaid benchmarks, approximately 18 percent of Simply's rates (11 rates) ranked at or above the national Medicaid 75th percentile, with approximately 8 percent (five rates) ranking at or above the national Medicaid 90th percentile. Conversely, approximately 52 percent of Simply's rates (32 rates) fell below the national 50th Medicaid percentile, with approximately 23 percent (14 rates) falling below the national 25th Medicaid percentile.

Staywell Performance Measure Results

Table D-14 contains the MMA performance measure rates and performance level analysis results for Staywell for reporting year 2016 (CY 2015).

Table D-14—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: Staywell

Staywell Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★★★	1.47%
One Well-Child Visit	★★	1.47%
Two Well-Child Visits	★★	2.70%
Three Well-Child Visits	★★★	5.65%
Four Well-Child Visits	★★★	10.57%
Five Well-Child Visits	★★★★	21.38%
Six or More Well-Child Visits	★★	56.76%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	★★★	74.70%
Childhood Immunization Status		
Combination 2	★★★	78.50%
Combination 3	★★★	73.83%
Lead Screening in Children		
Lead Screening in Children	★	51.12%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★★★★	54.73%
Continuation and Maintenance Phase	★★★★★	71.38%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★	61.73%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★	53.56%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	★★	65.96%
Annual Dental Visit		
2–3 Years	★★	27.58%
4–6 Years	★★	50.23%
7–10 Years	★★	57.75%
11–14 Years	★★	52.12%
15–18 Years	★★	45.93%

Staywell Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
19–20 Years	—	28.26%
Total	★★	48.28%
Preventive Dental Services		
Preventive Dental Services	—	36.90%
Dental Treatment Services		
Dental Treatment Services	—	16.69%
Sealants		
Sealants	—	15.44%
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	—	45.34%
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★	53.33%
Chlamydia Screening in Women		
16–20 Years	★★★★	58.06%
21–24 Years	★★★★	69.41%
Total	★★★	61.57%
Breast Cancer Screening		
Breast Cancer Screening	★★★	63.15%
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	★★	19.22%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★★★	85.43%
Postpartum Care	★★	56.78%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★★	68.34%
Antenatal Steroids		
Antenatal Steroids	—	NA
Living With Illness		
Comprehensive Diabetes Care[1]		
Hemoglobin A1c (HbA1c) Testing	★★★	87.34%
*HbA1c Poor Control (>9.0%)**	★★★	41.94%
HbA1c Control (<8.0%)	★★	47.64%
Eye Exam (Retinal) Performed	★★★	56.08%
Medical Attention for Nephropathy	★★★★★	95.04%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★	44.44%

Staywell Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Adult BMI Assessment		
Adult BMI Assessment	★★★	85.87%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years	★★	46.27%
Medication Compliance 50%—Ages 12–18 Years	★★	45.52%
Medication Compliance 50%—Ages 19–50 Years	★★	57.97%
Medication Compliance 50%—Ages 51–64 Years	★★★	74.74%
Medication Compliance 50%—Total	★★	48.00%
Medication Compliance 75%—Ages 5–11 Years	★★	21.15%
Medication Compliance 75%—Ages 12–18 Years	★★	21.84%
Medication Compliance 75%—Ages 19–50 Years	★★	31.16%
Medication Compliance 75%—Ages 51–64 Years	★★	46.32%
Medication Compliance 75%—Total	★	23.03%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★	91.82%
Annual Monitoring for Members on Digoxin	★★★	57.75%
Annual Monitoring for Members on Diuretics	★★★★★	91.92%
Total	★★★★	91.49%
Plan All-Cause Readmissions*		
Total—18–64 Years of Age Total	—	22.38%
Total—65+ Years of Age Total	—	16.82%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	23.83%
≥2 Visits	—	64.26%
1 Visit	—	16.98%
0 Visits	—	18.76%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	85.58%
Viral Load Suppression Among Persons in HIV Medical Care		
18–64 years	—	0.00%
65+ years	—	NA
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years of Age	—	76.72%
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—Total	★★	76.23%
Discussing Cessation Medications—18–64 Years of Age	—	46.09%
Discussing Cessation Medications—65+ Years of Age	—	NA
Discussing Cessation Medications—Total	★★	45.45%

Staywell Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Discussing Cessation Strategies—18–64 Years of Age	—	39.13%
Discussing Cessation Strategies—65+ Years of Age	—	NA
Discussing Cessation Strategies—Total	★	38.02%
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	★★	40.46%
Initiation of AOD Treatment—18+ Years	★★★	40.14%
Initiation of AOD Treatment—Total	★★★	40.17%
Engagement of AOD Treatment—13–17 Years	★★	9.63%
Engagement of AOD Treatment—18+ Years	★★	6.60%
Engagement of AOD Treatment—Total	★	6.92%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	—	37.18%
30-Day Follow-Up	—	53.35%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★	48.96%
Effective Continuation Phase Treatment	★★★	34.27%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[1]		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★	60.60%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	—	21.25%
6–11 Years	—	26.23%
12–17 Years	—	35.66%
Total	—	31.55%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*		
1–5 Years	—	0.00%
6–11 Years	—	1.21%
12–17 Years	—	2.05%
Total	—	1.66%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	20.39%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★★	95.68%
25 Months–6 Years	★★★	88.91%

Staywell Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
7–11 Years	★★	88.97%
12–19 Years	★	86.82%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	70.78%
45–64 Years	★★	87.30%
65 Years and Older	★★★★	90.35%
Total	★	75.98%
Call Answer Timeliness		
Call Answer Timeliness	★★	80.65%
Transportation Availability		
Transportation Availability	—	94.07%
Transportation Timeliness		
Transportation Timeliness	—	68.34%
Use of Services		
Ambulatory Care—Total		
Outpatient Visits—Total	—	311.72
ED Visits—Total	—	72.42

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2016 rates for this measure to performance targets derived using data reported for HEDIS 2015.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report. This symbol may also indicate that the performance level analysis was not determined because the measure did not have an applicable benchmark.
NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For reporting year 2016 rates designated NA, the performance level analysis value was also NA.
2016 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Of the 73 measure indicator rates reported by Staywell that were comparable to national Medicaid benchmarks, approximately 14 percent of Staywell's rates (10 rates) ranked at or above the national Medicaid 75th percentile, with approximately 5 percent (four rates) ranking at or above the national Medicaid 90th percentile. Conversely, approximately 58 percent of Staywell's rates (42 rates) fell below the national 50th Medicaid percentile, with approximately 12 percent (nine rates) falling below the national 25th Medicaid percentile.

Sunshine Performance Measure Results

Table D-15 contains the MMA performance measure rates and performance level analysis results for Sunshine for reporting year 2016 (CY 2015).

Table D-15—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: Sunshine

Sunshine Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★	4.09%
One Well-Child Visit	★★★	2.40%
Two Well-Child Visits	★★★★	5.29%
Three Well-Child Visits	★★★★	7.69%
Four Well-Child Visits	★★★★	12.26%
Five Well-Child Visits	★★★★★	25.72%
Six or More Well-Child Visits	★	42.55%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	★★★	73.16%
Childhood Immunization Status		
Combination 2	★★★	76.44%
Combination 3	★★	70.67%
Lead Screening in Children		
Lead Screening in Children	★★	63.70%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★★★	51.05%
Continuation and Maintenance Phase	★★★★	60.71%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★	57.69%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★	47.47%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	★	62.50%
Annual Dental Visit		
2–3 Years	★★	27.38%
4–6 Years	★	48.63%
7–10 Years	★★	55.02%
11–14 Years	★★	48.46%
15–18 Years	★★	42.42%

Sunshine Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
19–20 Years	—	24.01%
Total	★★	45.28%
Preventive Dental Services		
Preventive Dental Services	—	27.70%
Dental Treatment Services		
Dental Treatment Services	—	10.96%
Sealants		
Sealants	—	9.72%
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	—	NA
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★	43.52%
Chlamydia Screening in Women		
16–20 Years	★★★★	62.90%
21–24 Years	★★★★	71.68%
Total	★★★★	65.70%
Breast Cancer Screening		
Breast Cancer Screening	★★	53.13%
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	★★	18.51%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★★	82.51%
Postpartum Care	★	54.61%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★★	65.96%
Antenatal Steroids		
Antenatal Steroids	—	BR
Living With Illness		
Comprehensive Diabetes Care[1]		
Hemoglobin A1c (HbA1c) Testing	★	66.59%
*HbA1c Poor Control (>9.0%)**	★	57.08%
HbA1c Control (<8.0%)	★	39.68%
Eye Exam (Retinal) Performed	★	45.94%
Medical Attention for Nephropathy	★★★	84.22%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★	37.02%

Sunshine Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Adult BMI Assessment		
Adult BMI Assessment	★★★	84.62%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years	★	42.86%
Medication Compliance 50%—Ages 12–18 Years	★	37.15%
Medication Compliance 50%—Ages 19–50 Years	★★★	59.69%
Medication Compliance 50%—Ages 51–64 Years	★★	71.64%
Medication Compliance 50%—Total	★	44.76%
Medication Compliance 75%—Ages 5–11 Years	★	16.77%
Medication Compliance 75%—Ages 12–18 Years	★	14.58%
Medication Compliance 75%—Ages 19–50 Years	★	27.13%
Medication Compliance 75%—Ages 51–64 Years	★★	47.76%
Medication Compliance 75%—Total	★	18.93%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★★	92.13%
Annual Monitoring for Members on Digoxin	★★★	57.27%
Annual Monitoring for Members on Diuretics	★★★★★	92.25%
Total	★★★★★	91.74%
Plan All-Cause Readmissions*		
Total—18–64 Years of Age Total	—	20.20%
Total—65+ Years of Age Total	—	3.79%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	21.81%
≥2 Visits	—	58.31%
1 Visit	—	16.32%
0 Visits	—	25.37%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	66.06%
Viral Load Suppression Among Persons in HIV Medical Care		
18–64 years	—	20.05%
65+ years	—	NA
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—Total	NA	NA
Discussing Cessation Medications—18–64 Years of Age	—	NA
Discussing Cessation Medications—65+ Years of Age	—	NA
Discussing Cessation Medications—Total	NA	NA

Sunshine Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Discussing Cessation Strategies—18–64 Years of Age	—	NA
Discussing Cessation Strategies—65+ Years of Age	—	NA
Discussing Cessation Strategies—Total	NA	NA
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	NB	NB
Initiation of AOD Treatment—18+ Years	NB	NB
Initiation of AOD Treatment—Total	NB	NB
Engagement of AOD Treatment—13–17 Years	NB	NB
Engagement of AOD Treatment—18+ Years	NB	NB
Engagement of AOD Treatment—Total	NB	NB
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	—	37.81%
30-Day Follow-Up	—	49.03%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★	47.00%
Effective Continuation Phase Treatment	★★	32.67%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[1]		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★★	62.55%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	—	NA
6–11 Years	—	37.26%
12–17 Years	—	45.96%
Total	—	42.86%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*		
1–5 Years	—	NA
6–11 Years	—	0.41%
12–17 Years	—	1.81%
Total	—	1.30%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	29.87%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★	93.69%
25 Months–6 Years	★★	87.60%

Sunshine Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
7–11 Years	★	86.99%
12–19 Years	★	82.21%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	63.28%
45–64 Years	★	78.38%
65 Years and Older	★	61.59%
Total	★	66.13%
Call Answer Timeliness		
Call Answer Timeliness	★★	78.46%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	84.74%
Use of Services		
Ambulatory Care—Total		
Outpatient Visits—Total	—	278.78
ED Visits—Total	—	65.64

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2016 rates for this measure to performance targets derived using data reported for HEDIS 2015.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report. This symbol may also indicate that the performance level analysis was not determined because the measure did not have an applicable benchmark.
NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For reporting year 2016 rates designated NA, the performance level analysis value was also NA.
NB indicates that the rate was designated No Benefit because the organization did not offer the health benefit required by the measure. For reporting year 2016 rates designated NB, the performance level analysis value was also NB.
BR indicates that the rate was designated Biased Rate because the calculated rate was materially biased. For reporting year 2016 rates designated BR, the performance level analysis value was also BR.
2016 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Of the 64 measure indicator rates reported by Sunshine that were comparable to national Medicaid benchmarks, approximately 19 percent of Sunshine's rates (12 rates) ranked at or above the national Medicaid 75th percentile, with approximately 6 percent (four rates) ranking at or above the national Medicaid 90th percentile. Conversely, approximately 67 percent of Sunshine's rates (43 rates) fell below the national 50th Medicaid percentile, with approximately 39 percent (25 rates) falling below the national 25th Medicaid percentile.

Sunshine-S Performance Measure Results

Table D-16 contains the MMA performance measure rates and performance level analysis results for Sunshine-S for reporting year 2016 (CY 2015).

Table D-16—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: Sunshine-S

Sunshine-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★★	1.89%
One Well-Child Visit	★★	1.14%
Two Well-Child Visits	★★★	4.17%
Three Well-Child Visits	★★★★	7.95%
Four Well-Child Visits	★★★★★	21.97%
Five Well-Child Visits	★★★★★	33.71%
Six or More Well-Child Visits	★	29.17%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	★★★★	82.10%
Childhood Immunization Status		
Combination 2	★★★	79.09%
Combination 3	★★	70.55%
Lead Screening in Children		
Lead Screening in Children	★★	62.37%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★★	45.27%
Continuation and Maintenance Phase	★★	38.81%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★	38.94%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★★	63.53%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	★	61.56%
Annual Dental Visit		
2–3 Years	★★★	40.82%
4–6 Years	★★★★★	77.22%
7–10 Years	★★★★★	77.78%
11–14 Years	★★★★★	74.14%
15–18 Years	★★★★★	73.57%

Sunshine-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
19–20 Years	—	28.10%
Total	★★★★★	69.04%
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	—	NA
Women's Care		
Chlamydia Screening in Women		
16–20 Years	★★★★★	71.65%
21–24 Years	NA	NA
Total	★★★★★	71.65%
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	★	11.05%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★	60.99%
Postpartum Care	★	44.68%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★	40.43%
Antenatal Steroids		
Antenatal Steroids	—	BR
Living With Illness		
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years	NA	NA
Medication Compliance 50%—Ages 12–18 Years	NA	NA
Medication Compliance 50%—Ages 19–50 Years	NA	NA
Medication Compliance 50%—Ages 51–64 Years	NA	NA
Medication Compliance 50%—Total	NA	NA
Medication Compliance 75%—Ages 5–11 Years	NA	NA
Medication Compliance 75%—Ages 12–18 Years	NA	NA
Medication Compliance 75%—Ages 19–50 Years	NA	NA
Medication Compliance 75%—Ages 51–64 Years	NA	NA
Medication Compliance 75%—Total	NA	NA
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	NA
≥2 Visits	—	NA
1 Visit	—	NA
0 Visits	—	NA
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	NA
Viral Load Suppression Among Persons in HIV Medical Care		

Sunshine-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
18–64 years	—	NA
65+ years	—	NA
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	NB	NB
Initiation of AOD Treatment—18+ Years	NB	NB
Initiation of AOD Treatment—Total	NB	NB
Engagement of AOD Treatment—13–17 Years	NB	NB
Engagement of AOD Treatment—18+ Years	NB	NB
Engagement of AOD Treatment—Total	NB	NB
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	—	54.89%
30-Day Follow-Up	—	66.79%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[1]		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NA	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	—	NA
6–11 Years	—	44.80%
12–17 Years	—	52.66%
Total	—	50.12%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*		
1–5 Years	—	NA
6–11 Years	—	0.96%
12–17 Years	—	2.26%
Total	—	1.86%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	62.09%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★★★★	98.05%
25 Months–6 Years	★★★★★	93.26%
7–11 Years	★★★	92.49%
12–19 Years	★★★★	92.56%
Call Answer Timeliness		
Call Answer Timeliness	★★	78.46%

Sunshine-S Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	80.74%
Use of Services		
Ambulatory Care—Total		
Outpatient Visits—Total	—	309.20
ED Visits—Total	—	61.39
MMA Specialty Performance Measures—Pediatric Care		
Developmental Screening in the First Three Years of Life		
Screening in the 1st Year of Life	—	15.84%
Screening in the 2nd Year of Life	—	26.29%
Screening in the 3rd Year of Life	—	20.25%
Screenings Total	—	22.54%

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2016 rates for this measure to performance targets derived using data reported for HEDIS 2015.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report. This symbol may also indicate that the performance level analysis was not determined because the measure did not have an applicable benchmark.
NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For reporting year 2016 rates designated NA, the performance level analysis value was also NA.
NB indicates that the rate was designated No Benefit because the organization did not offer the health benefit required by the measure. For reporting year 2016 rates designated NB, the performance level analysis value was also NB.
BR indicates that the rate was designated Biased Rate because the calculated rate was materially biased. For reporting year 2016 rates designated BR, the performance level analysis value was also BR.
2016 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Of the 33 measure indicator rates reported by Sunshine-S that were comparable to national Medicaid benchmarks, approximately 45 percent of the plan's rates (15 rates) ranked at or above the national Medicaid 75th percentile, with approximately 30 percent (10 rates) ranking at or above the national Medicaid 90th percentile. Conversely, approximately 39 percent of the plan's rates (13 rates) fell below the national 50th Medicaid percentile, with approximately 21 percent (seven rates) falling below the national 25th Medicaid percentile.

United Performance Measure Results

Table D-17 contains the MMA performance measure rates and performance level analysis results for United for reporting year 2016 (CY 2015).

Table D-17—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: United

United Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★★★	1.29%
One Well-Child Visit	★★★	2.32%
Two Well-Child Visits	★★★	3.61%
Three Well-Child Visits	★	3.61%
Four Well-Child Visits	★★	8.51%
Five Well-Child Visits	★★	17.27%
Six or More Well-Child Visits	★★★	63.40%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	★★★	76.90%
Childhood Immunization Status		
Combination 2	★★★	77.37%
Combination 3	★★★	72.75%
Lead Screening in Children		
Lead Screening in Children	★	56.04%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★★★	49.92%
Continuation and Maintenance Phase	★★★★	62.73%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★★	68.24%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★	50.85%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	★★	64.27%
Annual Dental Visit		
2–3 Years	★	22.67%
4–6 Years	★	45.11%
7–10 Years	★★	52.53%
11–14 Years	★★	46.89%
15–18 Years	★★	39.35%

United Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
19–20 Years	—	25.80%
Total	★★	42.70%
Preventive Dental Services		
Preventive Dental Services	—	30.51%
Dental Treatment Services		
Dental Treatment Services	—	13.43%
Sealants		
Sealants	—	13.48%
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	—	32.77%
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★	50.24%
Chlamydia Screening in Women		
16–20 Years	★★★	53.16%
21–24 Years	★★★	66.16%
Total	★★★	57.52%
Breast Cancer Screening		
Breast Cancer Screening	★★★	58.71%
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	★★	20.44%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★★★	87.56%
Postpartum Care	★★	60.98%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★★	66.10%
Antenatal Steroids		
Antenatal Steroids	—	NA
Living With Illness		
Comprehensive Diabetes Care[1]		
Hemoglobin A1c (HbA1c) Testing	★★	83.45%
*HbA1c Poor Control (>9.0%)**	★★	44.77%
HbA1c Control (<8.0%)	★★	43.80%
Eye Exam (Retinal) Performed	★★	52.31%
Medical Attention for Nephropathy	★★★★★	93.92%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★	48.42%

United Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Adult BMI Assessment		
Adult BMI Assessment	★★★	86.11%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years	★★★	51.02%
Medication Compliance 50%—Ages 12–18 Years	★★★	49.65%
Medication Compliance 50%—Ages 19–50 Years	★★★★★	74.51%
Medication Compliance 50%—Ages 51–64 Years	NA	NA
Medication Compliance 50%—Total	★★★	53.76%
Medication Compliance 75%—Ages 5–11 Years	★★★	28.98%
Medication Compliance 75%—Ages 12–18 Years	★★★	25.17%
Medication Compliance 75%—Ages 19–50 Years	★★★★★	50.98%
Medication Compliance 75%—Ages 51–64 Years	NA	NA
Medication Compliance 75%—Total	★★★	31.18%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★★	92.58%
Annual Monitoring for Members on Digoxin	★	44.44%
Annual Monitoring for Members on Diuretics	★★★★★	92.68%
Total	★★★★★	92.07%
Plan All-Cause Readmissions*		
Total—18–64 Years of Age Total	—	19.73%
Total—65+ Years of Age Total	—	7.10%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	18.08%
≥2 Visits	—	55.61%
1 Visit	—	10.53%
0 Visits	—	33.87%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	87.91%
Viral Load Suppression Among Persons in HIV Medical Care		
18–64 years	—	45.57%
65+ years	—	NA
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—Total	NA	NA
Discussing Cessation Medications—18–64 Years of Age	—	NA
Discussing Cessation Medications—65+ Years of Age	—	NA
Discussing Cessation Medications—Total	NA	NA

United Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
Discussing Cessation Strategies—18–64 Years of Age	—	NA
Discussing Cessation Strategies—65+ Years of Age	—	NA
Discussing Cessation Strategies—Total	NA	NA
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	★★★★★	64.65%
Initiation of AOD Treatment—18+ Years	★★★★	47.28%
Initiation of AOD Treatment—Total	★★★★★	48.79%
Engagement of AOD Treatment—13–17 Years	★★★★	24.77%
Engagement of AOD Treatment—18+ Years	★★	8.75%
Engagement of AOD Treatment—Total	★★★	10.13%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	—	52.32%
30-Day Follow-Up	—	68.97%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★★	53.74%
Effective Continuation Phase Treatment	★★★	39.33%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[1]		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★★	65.28%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	—	NA
6–11 Years	—	35.16%
12–17 Years	—	41.63%
Total	—	39.24%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*		
1–5 Years	—	NA
6–11 Years	—	0.66%
12–17 Years	—	1.29%
Total	—	1.03%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	22.21%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★★	94.87%
25 Months–6 Years	★★★	89.03%

United Reporting Year 2016 Measure	Performance Level Analysis	Reporting Year 2016 Rate
7–11 Years	★★	89.75%
12–19 Years	★★	87.83%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	70.56%
45–64 Years	★★	86.06%
65 Years and Older	★	75.04%
Total	★	75.31%
Call Answer Timeliness		
Call Answer Timeliness	★★★★	91.54%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	82.18%
Use of Services		
Ambulatory Care—Total		
Outpatient Visits—Total	—	326.77
ED Visits—Total	—	71.49

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2016 rates for this measure to performance targets derived using data reported for HEDIS 2015.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2015 rate is not presented in this report. This symbol may also indicate that the performance level analysis was not determined because the measure did not have an applicable benchmark.
NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For reporting year 2016 rates designated NA, the performance level analysis value was also NA.
2016 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Of the 68 measure indicator rates reported by United that were comparable to national Medicaid benchmarks, approximately 19 percent of United's rates (13 rates) ranked at or above the national Medicaid 75th percentile, with approximately 12 percent (eight rates) ranking at or above the national Medicaid 90th percentile. Conversely, approximately 41 percent of United's rates (28 rates) fell below the national 50th Medicaid percentile, with approximately 15 percent (10 rates) falling below the national 25th Medicaid percentile.

LTC Plans

This section represents the Florida Medicaid reporting year 2016 performance measure results for the LTC plans. Of note, rates for the *Call Answer Timeliness (CAT)* measure were presented with comparisons to national benchmarks in Appendix E of the previous year's report (i.e., star ratings results); however, the *CAT* measure results are compared to the performance target for 2016 in Section 4 of this report, and star ratings for the *CAT* measure are not presented in this section. For all tables presented in this appendix, the following legend applies to the reporting year 2016 rate columns:

Acronym	Definition
NA	*Small Denominator.* The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Amerigroup-LTC Performance Measure Results

Table D-18 contains the LTC performance measure rates for Amerigroup-LTC for reporting year 2016 (CY 2015).

Table D-18—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: Amerigroup-LTC

Amerigroup-LTC Reporting Year 2016 Measure	Reporting Year 2016 Rate
Care for Adults	
Advance Care Planning—18–60 Years	96.88%
Advance Care Planning—61–65 Years	NA
Advance Care Planning—66+ Years	97.91%
Advance Care Planning—Total	97.69%
Medication Review—18–60 Years	NA
Medication Review—61–65 Years	NA
Medication Review—66+ Years	NA
Medication Review—Total	71.21%
Functional Status Assessment—18–60 Years	93.75%
Functional Status Assessment—61–65 Years	NA
Functional Status Assessment—66+ Years	96.07%
Functional Status Assessment—Total	96.06%
Call Answer Timeliness	
Call Answer Timeliness	88.43%
Required Record Documentation	
701B Assessment	81.48%
Plan of Care—Enrollee Participation	88.19%
Plan of Care—Primary Care Physician Notification	88.89%
Freedom of Choice Form	90.74%
Face-to-Face Encounters	
Face-to-Face Encounters	84.84%
Case Manager Training	
Case Manager Training	96.05%
Timeliness of Services	
Timeliness of Services	63.51%

NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<30) to report a valid rate.

Amerigroup-LTC's *Care for Adults* performance measure results showed that approximately 9.8 out of 10 enrollees had advance care planning, approximately 7.1 out of 10 enrollees received a medication review, and approximately 9.6 out of 10 enrollees had a functional status assessment.

For the *Call Answer Timeliness* measure, approximately 8.8 out of 10 calls from Amerigroup-LTC enrollees were answered by a live voice within 30 seconds.

Amerigroup-LTC's *Required Record Documentation* performance measure results showed that approximately 8.1 out of 10 enrollees' records contained documentation of an annual 701B assessment within 365 days of the previous level of care determination, approximately 8.8 out of 10 enrollees' records contained a plan of care signed by the enrollee or the enrollee's representative, approximately 8.9 out of 10 enrollees' records indicated that the plan of care was sent to the primary care physician within 10 business days of development for new enrollees or the anniversary of the effective date for established enrollees, and approximately 9.1 out of 10 enrollees' records contained a completed Freedom of Choice Form signed by the enrollee or the enrollee's representative.

Based on the *Face-to-Face Encounters* measure rate, approximately 8.5 out of 10 Amerigroup-LTC enrollees had a face-to-face encounter with a care/case manager every three months.

For the *Case Manager Training* measure, approximately 9.6 out of 10 Amerigroup-LTC case managers received training on the mandate to report abuse, neglect, and exploitation.

Approximately 6.4 out of 10 newly enrolled members received services within five business days of enrollment according to Amerigroup-LTC's *Timeliness of Services* performance measure results.

Coventry-LTC Performance Measure Results

Table D-19 contains the LTC performance measure rates for Coventry-LTC for reporting year 2016 (CY 2015).

Table D-19—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: Coventry-LTC

Coventry-LTC Reporting Year 2016 Measure	Reporting Year 2016 Rate
Care for Adults	
Advance Care Planning—18–60 Years	70.45%
Advance Care Planning—61–65 Years	85.29%
Advance Care Planning—66+ Years	78.76%
Advance Care Planning—Total	78.44%
Medication Review—18–60 Years	87.04%
Medication Review—61–65 Years	80.00%
Medication Review—66+ Years	84.15%
Medication Review—Total	84.22%
Functional Status Assessment—18–60 Years	87.50%
Functional Status Assessment—61–65 Years	NA
Functional Status Assessment—66+ Years	82.44%
Functional Status Assessment—Total	82.89%
Call Answer Timeliness	
Call Answer Timeliness	97.86%
Required Record Documentation	
701B Assessment	87.78%
Plan of Care—Enrollee Participation	89.56%
Plan of Care—Primary Care Physician Notification	82.67%
Freedom of Choice Form	76.89%
Face-to-Face Encounters	
Face-to-Face Encounters	77.57%
Case Manager Training	
Case Manager Training	97.65%
Timeliness of Services	
Timeliness of Services	54.25%

NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<30) to report a valid rate.

Coventry-LTC's *Care for Adults* performance measure results showed that approximately 7.8 out of 10 enrollees had advance care planning, approximately 8.4 out of 10 enrollees received a medication review, and approximately 8.3 out of 10 enrollees had a functional status assessment.

For the *Call Answer Timeliness* measure, approximately 9.8 out of 10 calls from Coventry-LTC enrollees were answered by a live voice within 30 seconds.

Coventry-LTC's *Required Record Documentation* performance measure results showed that approximately 8.8 out of 10 enrollees' records contained documentation of an annual 701B assessment within 365 days of the previous level of care determination, approximately nine out of 10 enrollees' records contained a plan of care signed by the enrollee or the enrollee's representative, approximately 8.3 out of 10 enrollees' records indicated that the plan of care was sent to the primary care physician within 10 business days of development for new enrollees or the anniversary of the effective date for established enrollees, and approximately 7.7 out of 10 enrollees' records contained a completed Freedom of Choice Form signed by the enrollee or the enrollee's representative.

Based on the *Face-to-Face Encounters* measure rate, approximately 7.8 out of 10 Coventry-LTC enrollees had a face-to-face encounter with a care/case manager every three months.

For the *Case Manager Training* measure, approximately 9.8 out of 10 Coventry-LTC case managers received training on the mandate to report abuse, neglect, and exploitation.

Approximately 5.4 out of 10 newly enrolled members received services within five business days of enrollment according to Coventry-LTC's *Timeliness of Services* performance measure results.

Humana-LTC Performance Measure Results

Table D-20 contains the LTC performance measure rates for Humana-LTC for reporting year 2016 (CY 2015).

Table D-20—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: Humana-LTC

Humana-LTC Reporting Year 2016 Measure	Reporting Year 2016 Rate
Care for Adults	
Advance Care Planning—18–60 Years	66.03%
Advance Care Planning—61–65 Years	66.17%
Advance Care Planning—66+ Years	65.78%
Advance Care Planning—Total	65.83%
Medication Review—18–60 Years	81.82%
Medication Review—61–65 Years	NA
Medication Review—66+ Years	84.62%
Medication Review—Total	81.25%
Functional Status Assessment—18–60 Years	87.68%
Functional Status Assessment—61–65 Years	86.65%
Functional Status Assessment—66+ Years	86.59%
Functional Status Assessment—Total	86.68%
Call Answer Timeliness	
Call Answer Timeliness	96.28%
Required Record Documentation	
701B Assessment	83.58%
Plan of Care—Enrollee Participation	94.41%
Plan of Care—Primary Care Physician Notification	74.09%
Freedom of Choice Form	90.66%
Face-to-Face Encounters	
Face-to-Face Encounters	92.77%
Case Manager Training	
Case Manager Training	92.97%
Timeliness of Services	
Timeliness of Services	62.44%

NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<30) to report a valid rate.

Humana-LTC's *Care for Adults* performance measure results showed that approximately 6.6 out of 10 enrollees had advance care planning, approximately 8.1 out of 10 enrollees received a medication review, and approximately 8.7 out of 10 enrollees had a functional status assessment.

For the *Call Answer Timeliness* measure, approximately 9.6 out of 10 calls from Humana-LTC enrollees were answered by a live voice within 30 seconds.

Humana-LTC's *Required Record Documentation* performance measure results showed that approximately 8.4 out of 10 enrollees' records contained documentation of an annual 701B assessment within 365 days of the previous level of care determination, approximately 9.4 out of 10 enrollees' records contained a plan of care signed by the enrollee or the enrollee's representative, approximately 7.4 out of 10 enrollees' records indicated that the plan of care was sent to the primary care physician within 10 business days of development for new enrollees or the anniversary of the effective date for established enrollees, and approximately 9.1 out of 10 enrollees' records contained a completed Freedom of Choice Form signed by the enrollee or the enrollee's representative.

Based on the *Face-to-Face Encounters* measure rate, approximately 9.3 out of 10 Humana-LTC enrollees had a face-to-face encounter with a care/case manager every three months.

For the *Case Manager Training* measure, approximately 9.3 out of 10 Humana-LTC case managers received training on the mandate to report abuse, neglect, and exploitation.

Approximately 6.2 out of 10 newly enrolled members received services within five business days of enrollment according to Humana-LTC's *Timeliness of Services* performance measure results.

Molina-LTC Performance Measure Results

Table D-21 contains the LTC performance measure rates for Molina-LTC for reporting year 2016 (CY 2015).

Table D-21—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: Molina-LTC

Molina-LTC Reporting Year 2016 Measure	Reporting Year 2016 Rate
Care for Adults	
Advance Care Planning—18–60 Years	74.36%
Advance Care Planning—61–65 Years	NA
Advance Care Planning—66+ Years	88.86%
Advance Care Planning—Total	88.08%
Medication Review—18–60 Years	NA
Medication Review—61–65 Years	NA
Medication Review—66+ Years	NA
Medication Review—Total	NA
Functional Status Assessment—18–60 Years	95.00%
Functional Status Assessment—61–65 Years	NA
Functional Status Assessment—66+ Years	97.03%
Functional Status Assessment—Total	96.91%
Call Answer Timeliness	
Call Answer Timeliness	63.98%
Required Record Documentation	
701B Assessment	92.20%
Plan of Care–Enrollee Participation	95.81%
Plan of Care–Primary Care Physician Notification	78.37%
Freedom of Choice Form	91.39%
Face-to-Face Encounters	
Face-to-Face Encounters	62.79%
Case Manager Training	
Case Manager Training	84.51%
Timeliness of Services	
Timeliness of Services	36.71%

NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<30) to report a valid rate.

Molina-LTC's *Care for Adults* performance measure results showed that approximately 8.8 out of 10 enrollees had advance care planning and approximately 9.7 out of 10 enrollees had a functional status assessment.

For the *Call Answer Timeliness* measure, approximately 6.4 out of 10 calls from Molina-LTC enrollees were answered by a live voice within 30 seconds.

Molina-LTC's *Required Record Documentation* performance measure results showed that approximately 9.2 out of 10 enrollees' records contained documentation of an annual 701B assessment within 365 days of the previous level of care determination, approximately 9.6 out of 10 enrollees' records contained a plan of care signed by the enrollee or the enrollee's representative, approximately 7.8 out of 10 enrollees' records indicated that the plan of care was sent to the primary care physician within 10 business days of development for new enrollees or the anniversary of the effective date for established enrollees, and approximately 9.1 out of 10 enrollees' records contained a completed Freedom of Choice Form signed by the enrollee or the enrollee's representative.

Based on the *Face-to-Face Encounters* measure rate, approximately 6.3 out of 10 Molina-LTC enrollees had a face-to-face encounter with a care/case manager every three months.

For the *Case Manager Training* measure, approximately 8.5 out of 10 Molina-LTC case managers received training on the mandate to report abuse, neglect, and exploitation.

Approximately 3.7 out of 10 newly enrolled members received services within five business days of enrollment according to Molina-LTC's *Timeliness of Services* performance measure results.

Sunshine-LTC Performance Measure Results

Table D-22 contains the LTC performance measure rates for Sunshine-LTC for reporting year 2016 (CY 2015).

Table D-22—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: Sunshine-LTC

Sunshine-LTC Reporting Year 2016 Measure	Reporting Year 2016 Rate
Care for Adults	
Advance Care Planning—18–60 Years	13.14%
Advance Care Planning—61–65 Years	11.76%
Advance Care Planning—66+ Years	13.75%
Advance Care Planning—Total	13.54%
Medication Review—18–60 Years	42.93%
Medication Review—61–65 Years	39.32%
Medication Review—66+ Years	51.11%
Medication Review—Total	42.92%
Functional Status Assessment—18–60 Years	87.26%
Functional Status Assessment—61–65 Years	84.51%
Functional Status Assessment—66+ Years	83.83%
Functional Status Assessment—Total	84.44%
Call Answer Timeliness	
Call Answer Timeliness	74.17%
Required Record Documentation	
701B Assessment	84.67%
Plan of Care—Enrollee Participation	65.21%
Plan of Care—Primary Care Physician Notification	35.04%
Freedom of Choice Form	67.88%
Face-to-Face Encounters	
Face-to-Face Encounters	92.81%
Case Manager Training	
Case Manager Training	98.21%
Timeliness of Services	
Timeliness of Services	32.78%

Sunshine-LTC's *Care for Adults* performance measure results showed that approximately 1.4 out of 10 enrollees had advance care planning, approximately 4.3 out of 10 enrollees received a medication review, and approximately 8.4 out of 10 enrollees had a functional status assessment.

For the *Call Answer Timeliness* measure, approximately 7.4 out of 10 calls from Sunshine-LTC enrollees were answered by a live voice within 30 seconds.

Sunshine-LTC's *Required Record Documentation* performance measure results showed that approximately 8.5 out of 10 enrollees' records contained documentation of an annual 701B assessment within 365 days of the previous level of care determination, approximately 6.5 out of 10 enrollees' records contained a plan of care signed by the enrollee or the enrollee's representative, approximately 3.5 out of 10 enrollees' records indicated that the plan of care was sent to the primary care physician within 10 business days of development for new enrollees or the anniversary of the effective date for established enrollees, and approximately 6.8 out of 10 enrollees' records contained a completed Freedom of Choice Form signed by the enrollee or the enrollee's representative.

Based on the *Face-to-Face Encounters* measure rate, approximately 9.3 out of 10 Sunshine-LTC enrollees had a face-to-face encounter with a care/case manager every three months.

For the *Case Manager Training* measure, approximately 9.8 out of 10 Sunshine-LTC case managers received training on the mandate to report abuse, neglect, and exploitation.

Approximately 3.3 out of 10 newly enrolled members received services within five business days of enrollment according to Sunshine-LTC's *Timeliness of Services* performance measure results.

United-LTC Performance Measure Results

Table D-23 contains the LTC performance measure rates for United-LTC for reporting year 2016 (CY 2015).

Table D-23—Florida Medicaid Reporting Year 2016 (CY 2015) Results Summary Table: United-LTC

United-LTC Reporting Year 2016 Measure	Reporting Year 2016 Rate
Care for Adults	
Advance Care Planning—18–60 Years	30.16%
Advance Care Planning—61–65 Years	NA
Advance Care Planning—66+ Years	35.49%
Advance Care Planning—Total	34.55%
Medication Review—18–60 Years	7.58%
Medication Review—61–65 Years	NA
Medication Review—66+ Years	8.33%
Medication Review—Total	8.27%
Functional Status Assessment—18–60 Years	65.15%
Functional Status Assessment—61–65 Years	NA
Functional Status Assessment—66+ Years	69.14%
Functional Status Assessment—Total	67.88%
Call Answer Timeliness	
Call Answer Timeliness	91.60%
Required Record Documentation	
701B Assessment	49.64%
Plan of Care—Enrollee Participation	26.52%
Plan of Care—Primary Care Physician Notification	42.34%
Freedom of Choice Form	21.17%
Face-to-Face Encounters	
Face-to-Face Encounters	89.96%
Case Manager Training	
Case Manager Training	91.36%
Timeliness of Services	
Timeliness of Services	70.41%

NA indicates that the rate was designated Small Denominator because the organization followed the specifications but the denominator was too small (<30) to report a valid rate.

United-LTC's *Care for Adults* performance measure results showed that approximately 3.5 out of 10 enrollees had advance care planning, approximately 0.8 out of 10 enrollees received a medication review, and approximately 6.8 out of 10 enrollees had a functional status assessment.

For the *Call Answer Timeliness* measure, approximately 9.2 out of 10 calls from United-LTC enrollees were answered by a live voice within 30 seconds.

United-LTC's *Required Record Documentation* performance measure results showed that approximately five out of 10 enrollees' records contained documentation of an annual 701B assessment within 365 days of the previous level of care determination, approximately 2.7 out of 10 enrollees' records contained a plan of care signed by the enrollee or the enrollee's representative, approximately 4.2 out of 10 enrollees' records indicated that the plan of care was sent to the primary care physician within 10 business days of development for new enrollees or the anniversary of the effective date for established enrollees, and approximately 2.1 out of 10 enrollees' records contained a completed Freedom of Choice Form signed by the enrollee or the enrollee's representative.

Based on the *Face-to-Face Encounters* measure rate, approximately nine out of 10 United-LTC enrollees had a face-to-face encounter with a care/case manager every three months.

For the *Case Manager Training* measure, approximately 9.1 out of 10 United-LTC case managers received training on the mandate to report abuse, neglect, and exploitation.

Approximately seven out of 10 newly enrolled members received services within five business days of enrollment according to United-LTC's *Timeliness of Services* performance measure results.

Encounter Volume Completeness and Reasonableness

Encounter Data Volume

Table E-1 displays the encounter data volume submitted by AHCA and the plans. The table highlights the number of records by each source as well as the difference in counts between the two sources.

Table E-1—Encounter Data Submission by Plan and AHCA (January 1, 2015 – June 30, 2015)

Plan	Institutional			Professional			Dental		
	Records Submitted		Volume Difference	Records Submitted		Volume Difference	Records Submitted		Volume Difference
	AHCA	Plan		AHCA	Plan		AHCA	Plan	
AMG-L	156,082	53,609	102,473	1,566,023	603,579	962,444	1,590	747	843
AMG-M	3,926,562	1,520,327	2,406,235	8,956,750	4,142,505	4,814,245	1,090,018	538,308	551,710
BET-M	1,005,314	338,876	666,438	2,946,944	1,009,831	1,937,113	544,938	150,534	394,404
CHA-S	422,142	134,119	288,023	670,582	245,250	425,332	22,818	6,420	16,398
CMS-S	1,782,884	519,268	1,263,616	6,234,885	2,082,574	4,152,311	411,616	122,084	289,532
COV-L	360,650	60,053	300,597	472,754	175,442	297,312	130	47	83
COV-M	484,834	205,626	279,208	1,198,662	547,933	650,729	127,862	56,075	71,787
HUM-L	350,866	43,858	307,008	1,174,696	337,081	837,615	NA	NA	-
HUM-M	6,271,311	1,610,389	4,660,922	19,663,932	3,917,479	15,746,453	1,067,269	367,118	700,151
MCC-S	901,830	310,308	591,522	2,043,761	908,388	1,135,373	57,924	32,710	25,214
MOL-L	249,421	55,386	194,035	629,210	254,770	374,440	110	34	76
MOL-M	1,763,602	606,848	1,156,754	4,417,540	1,400,307	3,017,233	786,766	221,035	565,731
NBD-M	337,596	155,915	181,681	962,952	371,279	591,673	145,104	64,700	80,404
PHC-S	24,628	19,148	5,480	94,348	86,069	8,279	NA	NA	-
PRS-M	2,276,772	581,799	1,694,973	7,168,685	2,497,799	4,670,886	743,576	277,653	465,923
SHP-M	917,316	322,772	594,544	3,285,864	1,172,006	2,113,858	459,192	133,696	325,496
STW-M	7,754,299	3,228,407	4,525,892	18,439,343	7,463,916	10,975,427	2,663,358	1,017,431	1,645,927
SUN-L	539,197	199,310	339,887	4,082,778	1,697,167	2,385,611	7,220	1,423	5,797
SUN-M	3,542,196	1,405,503	2,136,693	9,615,692	3,527,025	6,088,667	2,369,630	593,663	1,775,967
SUN-S	149,250	53,929	95,321	947,880	372,142	575,738	386,428	89,604	296,824
URA-L	1,169,730	390,024	779,706	931,443	533,785	397,658	448	195	253
URA-M	5,058,432	2,607,278	2,451,154	8,762,196	4,812,367	3,949,829	962,428	465,537	496,891
All Plans	**39,444,914**	**14,422,752**	**25,022,162**	**104,266,920**	**38,158,694**	**66,108,226**	**11,848,425**	**4,139,014**	**7,709,411**

Table E-2 provides a general overview of the average utilization per enrollee by plan from January 1, 2015–June 30, 2015, for dental, children's therapy, and long-term care service categories.

Table E-2—Encounter Data Overview

Plan	Average Number of Enrollees Under 21 per Month[1]	Dental		Children's Therapy		Average Number of Enrollees per Month[1]	Long-term Care	
		Total Number of Encounters[2]	Total Encounters PMPM[3]	Total Number of Encounters	Total Encounters PMPM		Total Number of Encounters	Total Encounters PMPM
AMG-L[4, 5]	0	NA	NA	NA	NA	4,594	380,120	13.79
AMG-M	246,960	112,935	0.08	73,754	0.05	328,876	469,912	0.24
BET-M	68,150	25,310	0.06	21,007	0.05	91,021	103,433	0.19
CHA-S	253	39	0.03	31	0.02	9,214	24,605	0.45
CMS-S	63,698	32,158	0.08	629,646	1.65	63,698	539,946	1.41
COV-L[4, 5]	1	0	0	0	0	4,624	133,804	4.82
COV-M	31,133	11,629	0.06	1,474	0.01	46,126	34,848	0.13
HUM-L[4, 5]	2	0	0	0	0	4,665	229,391	8.20
HUM-M	191,042	79,288	0.07	41,333	0.04	298,698	549,011	0.31
MCC-S	12,700	3,678	0.05	451	0.01	40,189	196,112	0.81
MOL-L[4, 5]	1	0	0	0	0	5,537	219,308	6.60
MOL-M	117,921	65,183	0.09	31,958	0.05	161,324	241,259	0.25
NBD-M	34,051	13,030	0.06	18,986	0.09	42,371	39,571	0.16
PHC-S[4]	38	1	0.00	3	0.01	1,808	3,400	0.31
PRS-M	203,961	89,445	0.07	47,037	0.04	300,962	307,297	0.17
SHP-M	47,392	22,563	0.08	79,343	0.28	83,649	133,199	0.27
STW-M	492,775	208,682	0.07	141,720	0.05	667,069	872,593	0.22
SUN-L[4, 5]	15	2	0.02	0	0	33,698	1,389,896	6.87
SUN-M	284,657	114,994	0.07	82,997	0.05	409,216	533,914	0.22
SUN-S	21,165	18,965	0.15	10,921	0.09	21,165	179,179	1.41
URA-L[4, 5]	6	8	0.24	0	0	19,789	333,829	2.81
URA-M	168,600	61,485	0.06	141,910	0.14	265,919	698,829	0.44
All Plans	**1,984,497**	**859,395**	**0.07**	**1,322,571**	**0.11**	**2,848,396**	**7,613,456**	**0.45**

[1] The average number of enrollees was calculated by dividing the total number of member months by six, in order to align with the number of months in the encounter data for the review period of January 1, 2015, through June 30, 2015.

[2] An encounter was defined by a unique combination of plan, recipient ID, provider identification, and date of service.

[3] The total encounters per member per month (PMPM) rate was calculated by dividing the total number of encounters by the total member months.

[4] These plans provided no dental services during the study period. While they provided no dental services during the study period, a small number of encounters were reported in AHCA's encounter submission; therefore, rates should be interpreted with caution.

[5] These plans have no encounters that are associated with therapy services for children under the age of 21.

Monthly Variations of Encounters for Dates of Service by Service Category

Figure E-1, Figure E-2, and Figure E-3 illustrate the overall encounter data volume trends over time by the plans and AHCA for dental, therapy and long-term care encounters, respectively. Neither the plans nor AHCA consistently used the unique control number to indicate unique encounters; consequently, an encounter was defined by a unique combination of plan, recipient ID, provider identification number, and date of service.

Figure E-1—Monthly Variations in the Dental Category by Plan and AHCA

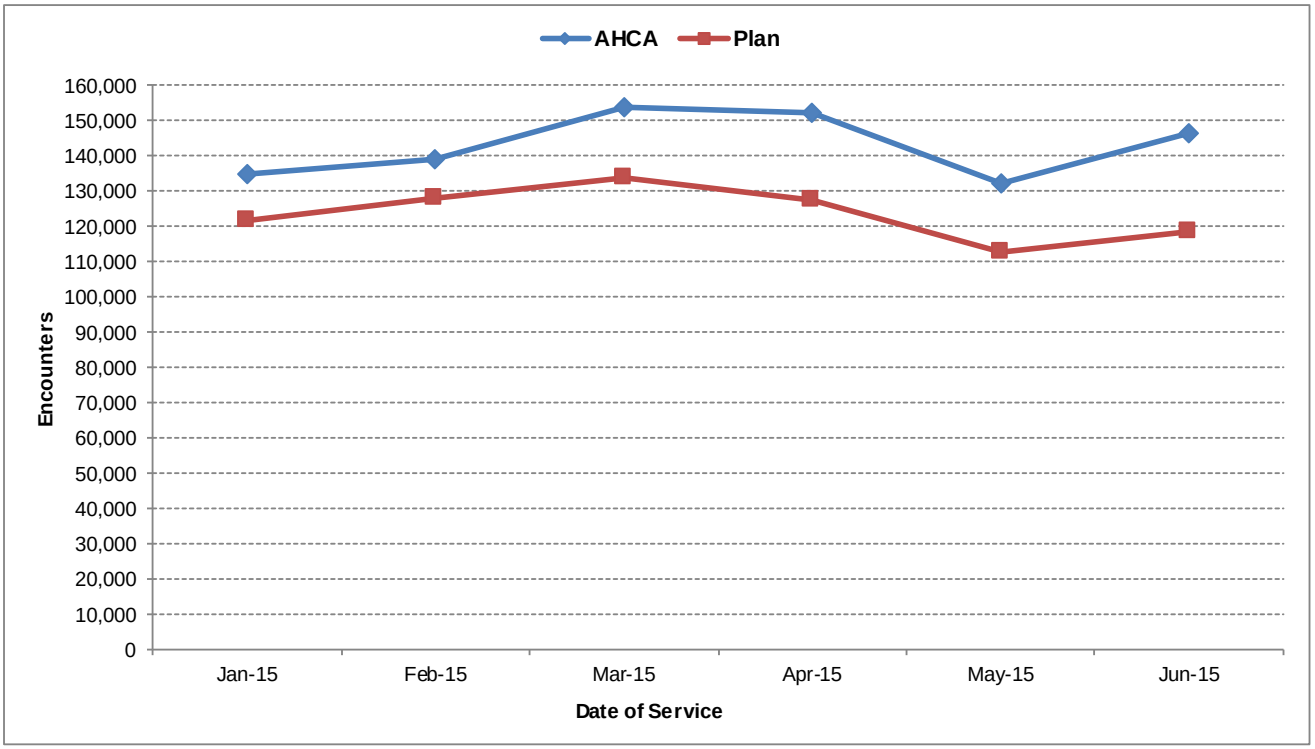


Figure E-2—Monthly Variations in the Children's Therapy Category by Plan and AHCA

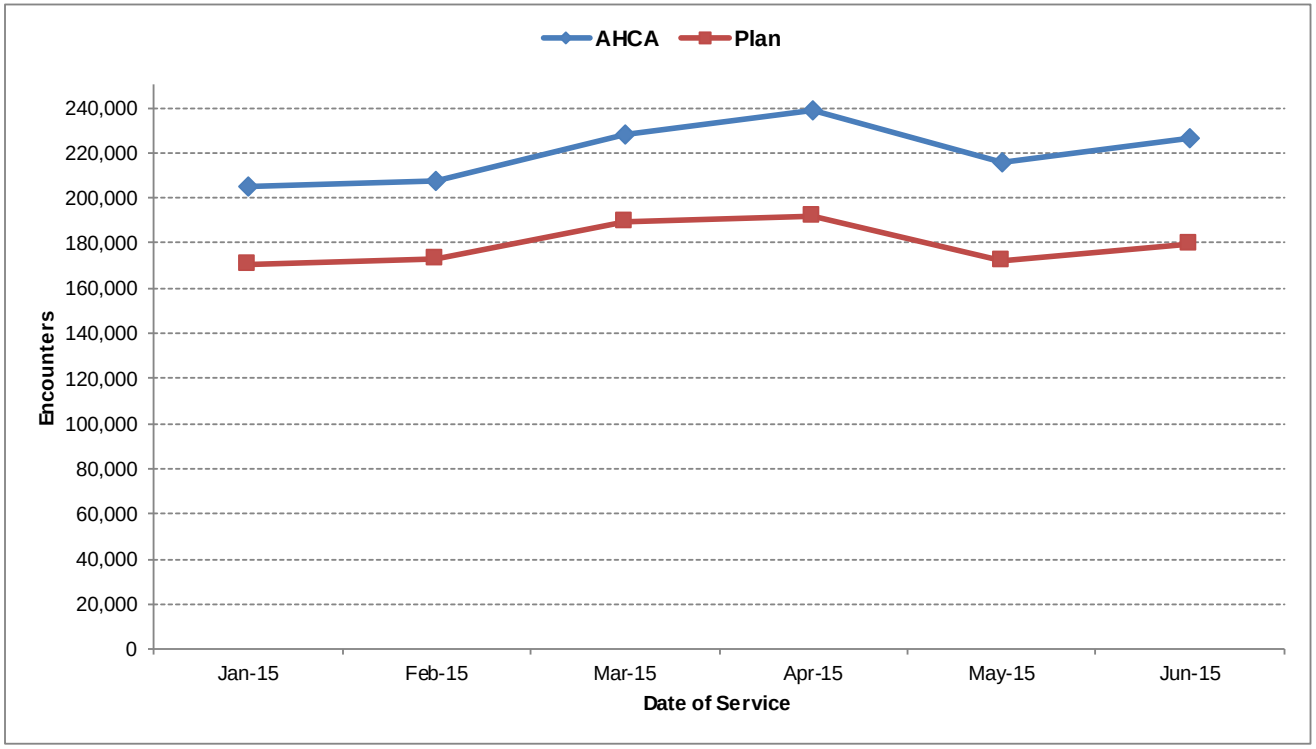
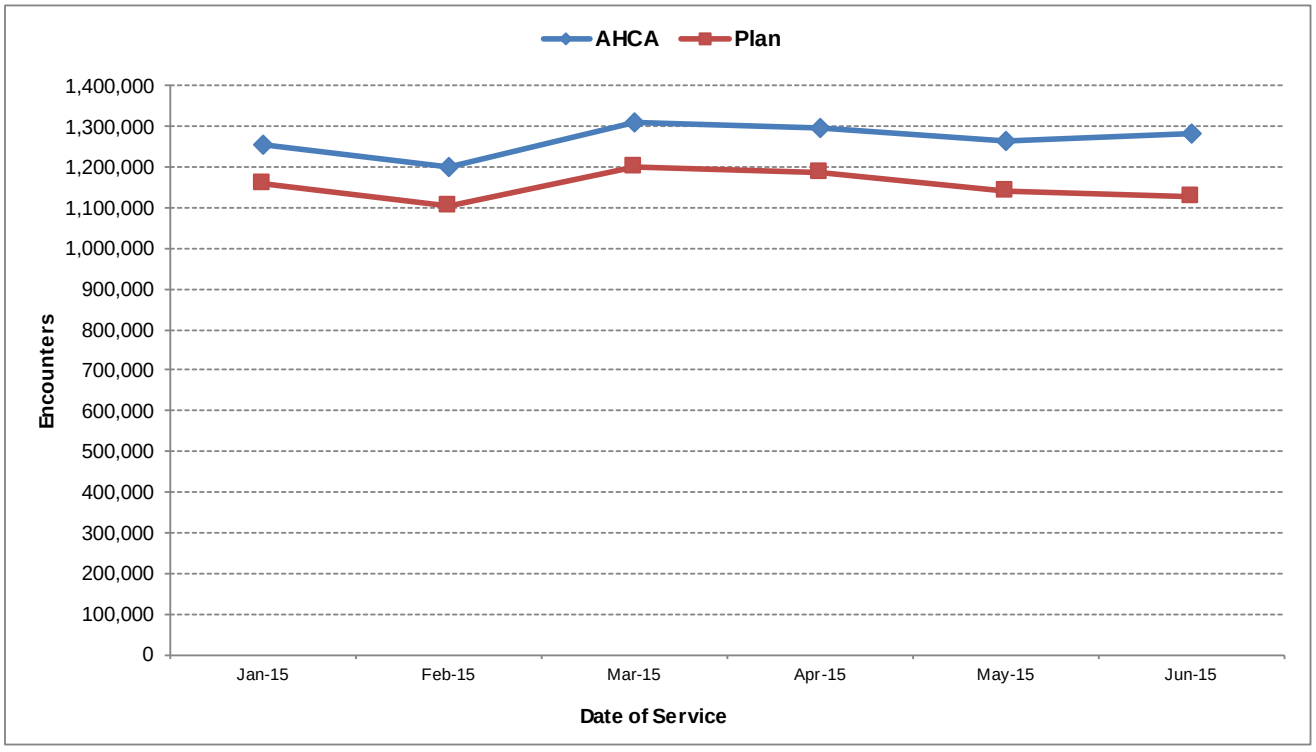


Figure E-3—Monthly Variations in the Long-term Care Category by Plan and AHCA



Encounter Field Completeness and Reasonableness

Table E-3 shows the data fields and the associated acceptable ranges or values for each of the service categories included in this study.

Table E-3—Valid Ranges or Values for the Data Field Completeness Analyses

Field	Format	Valid Ranges or Values	Analyses Applied		
			Dental Category	Children's Therapy Category	Long-term Care Category
Principal/ Primary Diagnosis	Character	ICD-9 Manual		√	√
Additional Diagnoses (12)	Character	ICD-9 Manual		√	√
Surgical Codes 1 – 6	Character	ICD-9 Manual		√	√
NDC	Character	Medi-Span database		√	√
Revenue Codes	Character	UB-04 Revenue Code Manual		√	√
Billing Provider (ID and NPI)	Character	State-supplied provider file	√	√	√
Rendering Provider (ID and NPI)	Character	State-supplied provider file	√	√	√
Attending Provider NPI	Character	State-supplied provider file		√	√
Referring Provider (ID and NPI)	Character	State-supplied provider file		√	√

Note: Gray blank cells indicate that the data field values were not applicable for the associated service category; therefore, they were not evaluated.

Dental Encounter Field Reasonableness and Completeness

Table E-4 shows the percentage missing and valid rates for key data fields for encounters associated with the dental services for data extracted from the plans' and AHCA's encounter systems.

Table E-4—Completeness (Percentage Missing) and Accuracy (Percentage Valid) for Key Dental Services Data Elements by Plan and AHCA

	Billing Provider ID[A]		Billing Provider NPI[A]		Rendering Provider ID[A, B]		Rendering Provider NPI[A, B]		Referring Provider ID[A, B]		Referring Provider NPI[A, B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
Plan												
AMG-L												
AMG-M	100.0%	NA	0.0%	96.5%	100.0%	NA	0.0%	99.4%	100.0%	NA	100.0%	NA
BET-M	100.0%	NA	< 0.1%	86.2%	100.0%	NA	48.8%	99.8%	100.0%	NA	> 99.9%	100.0%
CHA-S	100.0%	NA	0.0%	100.0%	100.0%	NA	37.9%	100.0%	100.0%	NA	100.0%	NA
CMS-S	100.0%	NA	> 99.9%	100.0%	100.0%	NA	< 0.1%	98.3%	100.0%	NA	> 99.9%	100.0%
COV-L												
COV-M	100.0%	NA	0.0%	98.6%	100.0%	NA	100.0%	NA	100.0%	NA	100.0%	NA
HUM-L												
HUM-M	100.0%	NA	0.0%	87.2%	100.0%	NA	< 0.1%	98.5%	100.0%	NA	100.0%	NA
MCC-S	0.5%	89.3%	0.0%	93.1%	0.8%	97.0%	0.0%	98.2%	100.0%	NA	100.0%	NA
MOL-L												
MOL-M	100.0%	NA	0.0%	91.7%	100.0%	NA	0.0%	98.3%	100.0%	NA	100.0%	NA
NBD-M	100.0%	NA	0.0%	92.1%	100.0%	NA	0.0%	99.6%	100.0%	NA	100.0%	NA
PHC-S	100.0%	NA	0.0%	100.0%	100.0%	NA	0.0%	100.0%	100.0%	NA	100.0%	NA
PRS-M	100.0%	NA	0.0%	99.5%	100.0%	NA	0.0%	99.5%	100.0%	NA	100.0%	NA
SHP-M	100.0%	NA	0.0%	93.9%	100.0%	NA	47.1%	97.3%	100.0%	NA	> 99.9%	100.0%
STW-M	0.0%	0.0%	0.0%	96.7%	100.0%	NA	11.3%	99.5%	100.0%	NA	> 99.9%	100.0%
SUN-L	100.0%	NA	0.0%	100.0%	100.0%	NA	0.0%	100.0%	100.0%	NA	100.0%	NA
SUN-M	100.0%	NA	0.0%	88.5%	100.0%	NA	< 0.1%	99.4%	100.0%	NA	> 99.9%	100.0%
SUN-S	100.0%	NA	0.0%	90.8%	100.0%	NA	< 0.1%	99.7%	100.0%	NA	100.0%	NA
URA-L	100.0%	NA	100.0%	NA	0.0%	0.0%	0.0%	87.1%	100.0%	NA	100.0%	NA
URA-M	99.8%	18.4%	99.7%	99.9%	< 0.1%	36.2%	0.0%	98.5%	> 99.9%	100.0%	> 99.9%	100.0%
AHCA												
AMG-L												
AMG-M	1.0%	96.7%	1.2%	97.5%	< 0.1%	96.7%	0.1%	98.6%	> 99.9%	100.0%	> 99.9%	100.0%
BET-M	3.4%	98.9%	3.4%	91.1%	14.2%	98.8%	14.2%	96.3%	> 99.9%	100.0%	> 99.9%	100.0%
CHA-S	0.0%	100.0%	0.0%	97.7%	12.0%	100.0%	12.0%	98.7%	100.0%	NA	100.0%	NA
CMS-S	5.8%	98.0%	5.8%	94.9%	3.4%	98.9%	4.2%	97.0%	99.9%	99.6%	99.9%	98.8%
COV-L												

	Billing Provider ID[A]		Billing Provider NPI[A]		Rendering Provider ID[A, B]		Rendering Provider NPI[A, B]		Referring Provider ID[A, B]		Referring Provider NPI[A, B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
COV-M	0.4%	99.4%	0.4%	94.0%	0.4%	99.4%	0.4%	94.0%	100.0%	NA	100.0%	NA
HUM-L												
HUM-M	4.0%	99.5%	4.2%	93.0%	0.1%	99.5%	0.4%	94.3%	> 99.9%	100.0%	> 99.9%	100.0%
MCC-S	1.3%	99.0%	1.4%	95.3%	0.0%	98.8%	0.1%	97.0%	> 99.9%	100.0%	> 99.9%	100.0%
MOL-L												
MOL-M	2.8%	99.6%	2.8%	94.8%	< 0.1%	99.9%	0.1%	92.3%	> 99.9%	100.0%	> 99.9%	100.0%
NBD-M	1.4%	98.3%	1.4%	92.3%	< 0.1%	100.0%	< 0.1%	97.8%	100.0%	NA	100.0%	NA
PHC-S	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	100.0%	NA	100.0%	NA
PRS-M	0.0%	99.6%	< 0.1%	97.4%	1.6%	99.6%	1.6%	97.3%	> 99.9%	100.0%	> 99.9%	100.0%
SHP-M	1.7%	99.7%	1.8%	95.0%	11.8%	99.7%	12.0%	97.1%	> 99.9%	100.0%	> 99.9%	100.0%
STW-M	2.3%	99.2%	2.4%	96.6%	0.2%	99.3%	0.3%	97.7%	> 99.9%	99.0%	> 99.9%	100.0%
SUN-L	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	100.0%	NA	100.0%	NA
SUN-M	6.8%	98.8%	6.8%	95.6%	0.4%	99.4%	0.6%	96.9%	> 99.9%	66.7%	> 99.9%	100.0%
SUN-S	4.9%	99.2%	4.9%	93.3%	0.2%	99.5%	0.4%	97.3%	100.0%	NA	100.0%	NA
URA-L	7.3%	100.0%	7.3%	72.5%	7.3%	100.0%	7.3%	72.5%	100.0%	NA	100.0%	NA
URA-M	0.4%	98.8%	0.5%	95.9%	1.1%	98.8%	1.2%	95.8%	> 99.9%	100.0%	> 99.9%	100.0%

[A] *Missing* (i.e., percentage missing) and *Valid* (i.e., percentage valid) are based on different denominators; therefore, the percentages will not sum to 100 percent. *Validity* can only be assessed for records where values are present.
[B] *Rendering Provider* (ID and NPI), and *Referring Provider* (ID and NPI) fields are situational (i.e., not required for every encounter transaction).
"NA" denotes all records had missing values for this data element; therefore, validity could not be assessed.
Gray shading indicates no dental services to assess.

Children's Therapy Encounter Field Reasonableness and Completeness

Table E-5, Table E-6, and Table E-7 show the percentage missing and valid rates for key data fields for encounters associated with children's therapy services for data extracted from the plans' and AHCA's encounter systems.

Table E-5—Completeness (Percentage Missing) and Accuracy (Percentage Valid) for Key Children's Therapy Category Data Elements by Plan and AHCA

	Primary Diagnosis Code		Diagnosis Code 2[A, B]		Diagnosis Code 3[A, B]		Diagnosis Code 4[A,B]		Diagnosis Code 5 – Diagnosis Code 12[A,B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
Plan										
AMG-L										
AMG-M	0.0%	> 99.9%	43.2%	100.0%	79.4%	> 99.9%	91.6%	100.0%	93.1%	100.0%
BET-M	0.0%	100.0%	75.2%	100.0%	93.0%	100.0%	98.9%	100.0%	100.0%	NA
CHA-S	0.0%	100.0%	47.5%	100.0%	47.5%	100.0%	100.0%	NA	NA	NA
CMS-S	< 0.1%	99.6%	66.8%	99.9%	84.2%	99.7%	92.5%	99.8%	85.0%	100.0%
COV-L										
COV-M	0.0%	100.0%	8.4%	100.0%	78.1%	100.0%	89.7%	100.0%	99.3%	100.0%
HUM-L										
HUM-M	0.0%	> 99.9%	45.0%	> 99.9%	83.4%	100.0%	94.4%	100.0%	97.5%	100.0%
MCC-S	0.0%	100.0%	59.4%	100.0%	80.6%	100.0%	96.5%	100.0%	NA	NA
MOL-L										
MOL-M	0.0%	100.0%	56.9%	100.0%	81.6%	100.0%	93.7%	100.0%	92.6%	100.0%
NBD-M	0.0%	98.9%	86.4%	99.1%	97.5%	100.0%	99.3%	100.0%	82.4%	100.0%
PHC-S	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	NA	NA
PRS-M	0.0%	> 99.9%	59.9%	> 99.9%	86.5%	100.0%	96.0%	100.0%	96.4%	100.0%
SHP-M	0.0%	99.9%	66.9%	99.4%	89.9%	99.7%	99.0%	100.0%	100.0%	NA
STW-M	0.0%	100.0%	52.5%	100.0%	80.9%	100.0%	92.0%	100.0%	89.4%	100.0%
SUN-L										
SUN-M	0.0%	100.0%	51.7%	100.0%	80.8%	100.0%	92.4%	100.0%	100.0%	NA
SUN-S	0.0%	100.0%	58.4%	100.0%	84.4%	100.0%	94.8%	100.0%	100.0%	NA
URA-L	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
URA-M	0.0%	> 99.9%	62.3%	> 99.9%	89.0%	99.9%	96.2%	99.9%	96.5%	100.0%
AHCA										
AMG-L										
AMG-M	0.0%	> 99.9%	43.1%	100.0%	78.8%	100.0%	91.2%	100.0%	93.2%	100.0%
BET-M	0.0%	100.0%	75.7%	100.0%	92.3%	100.0%	98.7%	100.0%	97.1%	100.0%
CHA-S	0.0%	100.0%	47.5%	100.0%	47.5%	100.0%	100.0%	NA	NA	NA
CMS-S	0.0%	99.6%	67.1%	99.8%	84.7%	99.8%	93.0%	99.9%	87.3%	100.0%
COV-L										

	Primary Diagnosis Code		Diagnosis Code 2[A, B]		Diagnosis Code 3[A, B]		Diagnosis Code 4[A,B]		Diagnosis Code 5 – Diagnosis Code 12[A,B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
COV-M	0.0%	100.0%	7.0%	100.0%	80.4%	100.0%	92.4%	100.0%	99.4%	100.0%
HUM-L										
HUM-M	0.0%	> 99.9%	46.2%	100.0%	83.8%	100.0%	94.7%	100.0%	97.4%	100.0%
MCC-S	0.0%	100.0%	39.8%	100.0%	67.1%	100.0%	85.7%	100.0%	91.3%	100.0%
MOL-L										
MOL-M	0.0%	100.0%	63.5%	100.0%	85.9%	100.0%	95.7%	100.0%	93.8%	100.0%
NBD-M	0.0%	98.9%	89.4%	98.9%	97.6%	100.0%	99.3%	100.0%	94.2%	100.0%
PHC-S	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	100.0%	NA	100.0%	NA
PRS-M	0.0%	> 99.9%	63.4%	> 99.9%	87.0%	100.0%	96.2%	100.0%	96.1%	100.0%
SHP-M	0.0%	99.9%	71.4%	99.7%	92.2%	99.7%	99.2%	100.0%	98.1%	100.0%
STW-M	0.0%	100.0%	53.4%	100.0%	82.4%	100.0%	92.8%	100.0%	91.0%	100.0%
SUN-L										
SUN-M	0.0%	100.0%	62.6%	100.0%	86.3%	100.0%	94.8%	100.0%	92.4%	100.0%
SUN-S	0.0%	100.0%	64.9%	100.0%	87.0%	100.0%	96.4%	100.0%	95.8%	100.0%
URA-L										
URA-M	0.0%	100.0%	65.4%	100.0%	90.3%	100.0%	97.0%	100.0%	96.0%	100.0%

[A] *Missing* (i.e., percentage missing) and *Valid* (i.e., percentage valid) are based on different denominators; therefore, the percentages will not sum to 100 percent. *Validity* can only be assessed for records where values are present.
[B] *Diagnosis Code 2* through *Diagnosis Code 12* fields are situational (i.e., not required for every encounter transaction).
"NA" denotes all records had missing values for this data element; therefore, validity could not be assessed.
Gray shading indicates no children's therapy services to assess.

Table E-6—Completeness (Percentage Missing) and Accuracy (Percentage Valid) for Key Children's Therapy Category Data Elements by Plan and AHCA (cont.)

	Rendering Provider ID[A, B]		Rendering Provider NPI[A, B]		Billing Provider ID[A, B]		Billing Provider NPI[A, B]		Attending Provider ID[A, B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
Plan										
AMG-L										
AMG-M	100.0%	NA	6.9%	97.2%	100.0%	NA	< 0.1%	97.4%	100.0%	NA
BET-M	100.0%	NA	8.3%	99.2%	100.0%	NA	0.0%	99.8%	100.0%	NA
CHA-S	100.0%	NA	0.0%	100.0%	100.0%	NA	0.0%	100.0%	NA	NA
CMS-S	100.0%	NA	< 0.1%	97.9%	100.0%	NA	69.1%	99.1%	100.0%	NA
COV-L										
COV-M	100.0%	NA	50.0%	100.0%	100.0%	NA	4.3%	100.0%	100.0%	NA
HUM-L										
HUM-M	100.0%	NA	8.2%	98.2%	100.0%	NA	0.0%	99.4%	100.0%	NA
MCC-S	0.0%	100.0%	0.0%	100.0%	1.6%	95.5%	0.0%	99.7%	NA	NA
MOL-L										
MOL-M	100.0%	NA	0.1%	94.8%	100.0%	NA	0.0%	95.5%	100.0%	NA
NBD-M	100.0%	NA	0.0%	99.8%	100.0%	NA	0.0%	100.0%	100.0%	NA
PHC-S	100.0%	NA	0.0%	100.0%	100.0%	NA	0.0%	100.0%	NA	NA
PRS-M	100.0%	NA	0.0%	99.8%	100.0%	NA	0.0%	99.8%	100.0%	NA
SHP-M	100.0%	NA	23.3%	97.0%	100.0%	NA	0.1%	96.2%	100.0%	NA
STW-M	100.0%	NA	100.0%	NA	0.0%	0.0%	0.0%	98.1%	100.0%	NA
SUN-L										
SUN-M	> 99.9%	0.0%	17.8%	99.1%	> 99.9%	0.0%	< 0.1%	99.0%	100.0%	NA
SUN-S	100.0%	NA	28.1%	90.2%	100.0%	NA	0.0%	99.1%	100.0%	NA
URA-L										
URA-M	67.1%	60.2%	0.1%	98.5%	18.0%	73.0%	2.1%	97.6%	17.4%	83.7%
AHCA										
AMG-L										
AMG-M	3.9%	99.5%	3.9%	96.8%	2.0%	99.0%	2.0%	99.2%	1.9%	98.1%
BET-M	13.3%	94.6%	13.3%	99.2%	0.2%	99.9%	0.2%	100.0%	0.0%	91.4%
CHA-S	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	NA	NA
CMS-S	4.3%	98.8%	4.7%	98.5%	2.8%	99.2%	3.1%	98.3%	6.1%	99.2%
COV-L										
COV-M	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%
HUM-L										
HUM-M	11.7%	97.4%	11.7%	98.4%	3.5%	> 99.9%	3.5%	> 99.9%	0.0%	99.0%
MCC-S	1.1%	100.0%	1.1%	92.0%	0.3%	100.0%	0.3%	99.8%	0.0%	96.5%
MOL-L										

	Rendering Provider ID[A, B]		Rendering Provider NPI[A, B]		Billing Provider ID[A, B]		Billing Provider NPI[A, B]		Attending Provider ID[A, B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
MOL-M	44.6%	99.5%	44.9%	99.4%	2.6%	99.9%	2.6%	99.5%	< 0.1%	95.8%
NBD-M	0.6%	99.8%	0.6%	99.9%	0.0%	100.0%	0.0%	100.0%	2.6%	100.0%
PHC-S	NA	NA	NA	NA	0.0%	100.0%	0.0%	100.0%	100.0%	NA
PRS-M	9.2%	98.9%	9.4%	98.8%	0.7%	99.8%	0.7%	98.8%	0.0%	99.8%
SHP-M	23.3%	98.8%	23.6%	99.0%	0.9%	> 99.9%	0.9%	96.7%	0.0%	97.9%
STW-M	6.3%	98.8%	6.4%	97.3%	0.7%	99.9%	0.7%	99.2%	0.0%	97.6%
SUN-L										
SUN-M	6.7%	99.5%	6.8%	98.5%	1.6%	99.6%	1.6%	98.7%	0.0%	98.0%
SUN-S	3.8%	89.8%	3.8%	89.7%	1.4%	99.4%	1.4%	99.0%	0.0%	99.7%
URA-L										
URA-M	37.0%	99.7%	37.0%	99.1%	< 0.1%	> 99.9%	< 0.1%	97.9%	0.0%	98.6%

[A] *Missing* (i.e., percentage missing) and *Valid* (i.e., percentage valid) are based on different denominators; therefore, the percentages will not sum to 100 percent. *Validity* can only be assessed for records where values are present.
[B] *Rendering Provider (ID* and *NPI)* and *Attending Provider (ID)* fields are situational (i.e., not required for every encounter transaction).
"NA" denotes all records had missing values for this data element; therefore, validity could not be assessed.
Gray shading indicates no children's therapy services to assess.

Table E-7—Completeness (Percent Missing) and Accuracy (Percentage Valid) for Key Children's Therapy Category Data Elements by Plan and AHCA (cont.)

	Primary Surgical Code[A, B]		Surgical Code 2[A, B]		Surgical Code 3[A, B]		Revenue Code[A]		NDC[A, B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
Plan										
AMG-L										
AMG-M	> 99.9%	91.7%	100.0%	NA	100.0%	NA	0.0%	100.0%	> 99.9%	71.4%
BET-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
CHA-S	NA	NA	NA	NA	NA	NA	NA	NA	100.0%	NA
CMS-S	> 99.9%	100.0%	> 99.9%	100.0%	> 99.9%	100.0%	0.0%	100.0%	100.0%	NA
COV-L										
COV-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
HUM-L										
HUM-M	100.0%	NA	100.0%	NA	100.0%	NA	< 0.1%	100.0%	100.0%	NA
MCC-S	NA	NA	NA	NA	NA	NA	NA	NA	100.0%	NA
MOL-L										
MOL-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
NBD-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
PHC-S	NA	NA	NA	NA	NA	NA	NA	NA	100.0%	NA
PRS-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	> 99.9%	0.0%
SHP-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
STW-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
SUN-L										
SUN-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
SUN-S	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
URA-L										
URA-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
AHCA										
AMG-L										
AMG-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
BET-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
CHA-S										
CMS-S	> 99.9%	100.0%	> 99.9%	100.0%	> 99.9%	100.0%	0.0%	100.0%	100.0%	NA
COV-L										
COV-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
HUM-L										
HUM-M	> 99.9%	100.0%	> 99.9%	100.0%	100.0%	NA	0.0%	100.0%	100.0%	NA
MCC-S	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
MOL-L										

	Primary Surgical Code[A, B]		Surgical Code 2[A, B]		Surgical Code 3[A, B]		Revenue Code[A]		NDC[A, B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
MOL-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
NBD-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
PHC-S	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
PRS-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
SHP-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
STW-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
SUN-L										
SUN-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
SUN-S	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
URA-L										
URA-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA

[A] *Missing* (i.e., percentage missing) and *Valid* (i.e., percentage valid) are based on different denominators; therefore, the percentages will not sum to 100 percent. *Validity* can only be assessed for records where values are present.
[B] *Primary Surgical Code*, *Surgical Code 2*, *Surgical Code 3*, and *NDC* fields are situational (i.e., not required for every encounter transaction). These fields were not used to evaluate therapy services.
"NA" denotes all records had missing values for this data element; therefore, validity could not be assessed.
Gray shading indicates no children's therapy services to assess.

Long-term Care Encounter Field Reasonableness and Completeness

Table E-8, Table E-9, and Table E-10 show the percentage missing and valid rates for key data fields for encounters associated with long-term care services for data extracted from the plans' and AHCA's encounter systems.

Table E-8—Completeness (Percentage Missing) and Accuracy (Percentage Valid) for Key Long-term Care Category Data Elements by Plan and AHCA

	Primary Diagnosis Code[A]		Diagnosis Code 2[A, B]		Diagnosis Code 3[A, B]		Diagnosis Code 4[A, B]		Diagnosis Code 5 – Diagnosis Code 12[A,B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
Plan										
AMG-L	0.0%	> 99.9%	96.7%	68.0%	97.3%	69.2%	97.9%	71.5%	45.7%	100.0%
AMG-M	0.0%	> 99.9%	67.2%	> 99.9%	79.4%	100.0%	86.9%	> 99.9%	67.4%	100.0%
BET-M	0.0%	99.9%	69.9%	99.4%	79.6%	99.7%	86.2%	99.9%	100.0%	NA
CHA-S	0.0%	99.9%	73.3%	99.9%	79.6%	99.8%	84.3%	> 99.9%	100.0%	NA
CMS-S	< 0.1%	98.7%	78.1%	99.6%	86.6%	99.3%	92.9%	99.9%	75.5%	100.0%
COV-L	< 0.1%	94.9%	80.6%	80.8%	82.8%	75.2%	84.8%	72.7%	100.0%	NA
COV-M	0.0%	100.0%	49.7%	100.0%	67.3%	100.0%	76.9%	100.0%	79.3%	100.0%
HUM-L	< 0.1%	99.9%	87.1%	99.9%	87.9%	99.9%	89.1%	> 99.9%	100.0%	NA
HUM-M	< 0.1%	> 99.9%	60.5%	> 99.9%	74.3%	> 99.9%	83.1%	> 99.9%	70.9%	> 99.9%
MCC-S	0.0%	100.0%	90.3%	100.0%	95.7%	100.0%	97.8%	100.0%	70.0%	100.0%
MOL-L	0.0%	> 99.9%	88.4%	100.0%	89.8%	99.6%	91.4%	100.0%	40.0%	99.3%
MOL-M	0.0%	100.0%	80.0%	> 99.9%	87.0%	100.0%	91.2%	> 99.9%	76.3%	> 99.9%
NBD-M	0.0%	> 99.9%	75.2%	100.0%	86.2%	> 99.9%	91.6%	100.0%	80.5%	100.0%
PHC-S	0.0%	> 99.9%	49.6%	100.0%	63.6%	98.4%	75.8%	99.9%	89.8%	100.0%
PRS-M	0.0%	> 99.9%	70.9%	> 99.9%	82.9%	100.0%	93.1%	100.0%	70.7%	100.0%
SHP-M	< 0.1%	99.3%	65.7%	99.3%	72.2%	99.5%	77.0%	> 99.9%	100.0%	NA
STW-M	0.0%	100.0%	72.7%	100.0%	82.8%	> 99.9%	89.1%	100.0%	65.4%	> 99.9%
SUN-L	0.0%	> 99.9%	97.9%	100.0%	98.6%	100.0%	99.0%	100.0%	100.0%	NA
SUN-M	0.0%	100.0%	79.9%	100.0%	89.1%	100.0%	93.1%	100.0%	100.0%	NA
SUN-S	0.0%	100.0%	93.9%	100.0%	98.4%	100.0%	99.6%	100.0%	100.0%	NA
URA-L	0.0%	> 99.9%	74.3%	99.9%	78.1%	99.9%	81.6%	> 99.9%	48.1%	99.4%
URA-M	0.0%	99.9%	68.5%	99.8%	76.5%	99.9%	82.3%	99.8%	60.0%	99.6%
AHCA										
AMG-L	0.0%	> 99.9%	96.8%	100.0%	97.4%	100.0%	98.0%	100.0%	53.4%	100.0%
AMG-M	0.0%	> 99.9%	72.1%	> 99.9%	81.8%	100.0%	87.4%	100.0%	63.9%	100.0%
BET-M	0.0%	99.8%	78.8%	99.9%	87.0%	99.8%	92.8%	99.8%	64.9%	> 99.9%
CHA-S	0.0%	> 99.9%	78.6%	> 99.9%	83.8%	99.9%	87.6%	> 99.9%	44.5%	99.9%
CMS-S	0.0%	99.2%	82.8%	99.3%	89.7%	99.4%	94.6%	99.8%	73.8%	100.0%
COV-L	0.0%	99.7%	98.3%	100.0%	98.7%	100.0%	98.9%	100.0%	99.6%	100.0%

	Primary Diagnosis Code[A]		Diagnosis Code 2[A, B]		Diagnosis Code 3[A, B]		Diagnosis Code 4[A, B]		Diagnosis Code 5 – Diagnosis Code 12[A,B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
COV-M	0.0%	99.4%	81.0%	100.0%	88.3%	100.0%	92.4%	100.0%	77.8%	99.8%
HUM-L	0.0%	99.8%	96.4%	100.0%	96.6%	100.0%	96.7%	100.0%	100.0%	NA
HUM-M	0.0%	> 99.9%	65.3%	> 99.9%	74.9%	> 99.9%	82.2%	> 99.9%	64.0%	> 99.9%
MCC-S	0.0%	> 99.9%	85.3%	100.0%	91.2%	100.0%	93.9%	100.0%	49.6%	100.0%
MOL-L	0.0%	> 99.9%	82.3%	100.0%	84.3%	99.7%	86.3%	100.0%	38.1%	99.6%
MOL-M	0.0%	> 99.9%	80.4%	> 99.9%	87.4%	100.0%	91.1%	> 99.9%	74.4%	> 99.9%
NBD-M	< 0.1%	> 99.9%	86.9%	100.0%	93.9%	100.0%	96.9%	100.0%	87.8%	99.6%
PHC-S	0.0%	99.8%	60.3%	100.0%	70.4%	100.0%	78.5%	100.0%	56.7%	100.0%
PRS-M	0.0%	> 99.9%	82.9%	> 99.9%	90.0%	100.0%	93.6%	100.0%	67.4%	100.0%
SHP-M	< 0.1%	99.2%	81.5%	99.9%	87.9%	> 99.9%	92.2%	> 99.9%	66.5%	99.9%
STW-M	0.0%	100.0%	77.5%	100.0%	86.9%	100.0%	91.8%	100.0%	68.9%	100.0%
SUN-L	0.0%	> 99.9%	96.6%	100.0%	97.6%	100.0%	98.3%	100.0%	61.2%	100.0%
SUN-M	0.0%	> 99.9%	70.3%	100.0%	82.0%	> 99.9%	87.9%	100.0%	75.4%	100.0%
SUN-S	0.0%	100.0%	93.9%	100.0%	98.3%	100.0%	99.5%	100.0%	85.6%	100.0%
URA-L	0.0%	> 99.9%	58.6%	99.9%	64.3%	99.8%	70.2%	> 99.9%	49.8%	99.9%
URA-M	0.0%	> 99.9%	77.1%	> 99.9%	83.4%	> 99.9%	87.5%	> 99.9%	60.2%	99.9%

[A] *Missing* (i.e., percentage missing) and *Valid* (i.e., percentage valid) are based on different denominators; therefore, the percentages will not sum to 100 percent. *Validity* can only be assessed for records where values are present.
[B] *Diagnosis Code 2* through *Diagnosis Code 12* fields are situational (i.e., not required for every encounter transaction).
"NA" denotes all records had missing values for this data element; therefore, validity could not be assessed.

Table E-9—Completeness (Percentage Missing) and Accuracy (Percentage Valid) for Key Long-term Care Category Data Elements by Plan and AHCA (cont.)

	Rendering Provider ID[A, B]		Rendering Provider NPI[A, B]		Billing Provider ID[A, B]		Billing Provider NPI[A, B]		Attending Provider ID[A, B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
Plan										
AMG-L	100.0%	NA	2.0%	96.6%	100.0%	NA	0.3%	96.7%	100.0%	NA
AMG-M	100.0%	NA	33.6%	98.9%	100.0%	NA	0.1%	97.1%	100.0%	NA
BET-M	100.0%	NA	56.7%	96.5%	100.0%	NA	0.1%	98.6%	100.0%	NA
CHA-S	100.0%	NA	86.2%	95.3%	100.0%	NA	< 0.1%	99.3%	100.0%	NA
CMS-S	100.0%	NA	< 0.1%	98.5%	100.0%	NA	68.8%	99.2%	100.0%	NA
COV-L	100.0%	NA	100.0%	NA	0.0%	92.4%	0.0%	98.0%	100.0%	NA
COV-M	100.0%	NA	1.9%	99.1%	100.0%	NA	0.5%	99.2%	100.0%	NA
HUM-L	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	97.5%	100.0%	NA
HUM-M	100.0%	NA	40.7%	91.5%	100.0%	NA	< 0.1%	88.9%	100.0%	NA
MCC-S	0.2%	97.4%	0.0%	99.6%	0.3%	98.3%	0.0%	99.6%	100.0%	NA
MOL-L	100.0%	NA	0.3%	97.4%	100.0%	NA	0.2%	97.6%	100.0%	NA
MOL-M	100.0%	NA	< 0.1%	97.5%	100.0%	NA	< 0.1%	98.8%	100.0%	NA
NBD-M	100.0%	NA	0.0%	99.5%	100.0%	NA	0.0%	98.9%	100.0%	NA
PHC-S	100.0%	NA	47.7%	97.5%	100.0%	NA	0.0%	99.8%	100.0%	NA
PRS-M	73.1%	99.9%	0.3%	98.8%	76.0%	> 99.9%	1.5%	99.0%	100.0%	NA
SHP-M	100.0%	NA	62.3%	98.1%	100.0%	NA	0.1%	98.8%	100.0%	NA
STW-M	100.0%	NA	100.0%	NA	0.0%	< 0.1%	0.0%	99.1%	100.0%	NA
SUN-L	99.8%	97.1%	95.4%	95.9%	98.6%	11.8%	0.5%	97.1%	100.0%	NA
SUN-M	53.1%	11.7%	6.6%	99.5%	58.2%	11.7%	1.4%	99.0%	100.0%	NA
SUN-S	96.7%	59.1%	4.0%	99.0%	96.7%	59.1%	0.7%	98.8%	100.0%	NA
URA-L	18.5%	79.5%	7.7%	97.2%	17.7%	75.4%	6.1%	98.2%	14.4%	83.7%
URA-M	36.6%	81.4%	19.3%	97.8%	30.0%	72.8%	17.3%	98.1%	33.1%	73.2%
AHCA										
AMG-L	1.4%	99.5%	1.6%	98.3%	0.4%	99.5%	0.6%	98.4%	88.2%	94.3%
AMG-M	4.4%	99.5%	4.5%	99.7%	0.4%	99.6%	0.7%	99.1%	6.8%	96.8%
BET-M	9.9%	93.9%	10.0%	99.7%	7.9%	94.3%	7.9%	98.6%	0.1%	98.3%
CHA-S	2.4%	98.6%	2.4%	99.9%	1.5%	98.8%	1.6%	99.4%	0.3%	98.5%
CMS-S	16.6%	99.4%	17.3%	99.6%	2.4%	99.5%	3.7%	99.5%	3.0%	99.8%
COV-L	14.7%	99.6%	15.4%	96.0%	9.4%	99.5%	9.8%	97.5%	100.0%	NA
COV-M	1.6%	98.4%	1.7%	99.5%	0.9%	98.7%	1.0%	98.8%	0.0%	> 99.9%
HUM-L	13.7%	98.1%	14.6%	93.4%	7.9%	98.0%	8.6%	94.4%	100.0%	NA
HUM-M	41.5%	94.4%	41.6%	91.8%	36.6%	95.8%	36.7%	92.5%	< 0.1%	92.4%
MCC-S	0.4%	99.1%	0.5%	90.2%	0.3%	99.1%	0.3%	90.6%	0.0%	97.6%
MOL-L	3.9%	99.4%	4.5%	98.3%	1.8%	98.3%	2.3%	98.5%	0.1%	82.9%

	Rendering Provider ID[A, B]		Rendering Provider NPI[A, B]		Billing Provider ID[A, B]		Billing Provider NPI[A, B]		Attending Provider ID[A, B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
MOL-M	5.7%	98.4%	5.7%	99.1%	1.3%	98.3%	1.4%	99.2%	< 0.1%	54.7%
NBD-M	2.4%	99.6%	2.4%	99.2%	0.7%	99.8%	0.7%	99.3%	4.2%	98.4%
PHC-S	1.0%	99.8%	1.6%	99.7%	0.2%	99.8%	0.2%	99.9%	67.5%	100.0%
PRS-M	1.4%	99.3%	1.4%	99.7%	0.9%	99.0%	0.9%	99.5%	0.0%	99.2%
SHP-M	4.8%	95.9%	4.9%	99.3%	2.9%	96.6%	3.1%	99.1%	0.4%	91.7%
STW-M	9.8%	97.5%	9.9%	99.6%	0.6%	98.2%	0.8%	98.6%	< 0.1%	98.1%
SUN-L	2.5%	98.4%	3.4%	97.2%	1.3%	98.4%	2.2%	97.2%	< 0.1%	92.0%
SUN-M	1.8%	99.5%	2.0%	99.6%	1.3%	99.4%	1.4%	99.2%	0.0%	98.4%
SUN-S	0.2%	99.5%	0.2%	99.3%	0.1%	99.9%	0.1%	99.7%	0.0%	99.7%
URA-L	4.3%	99.5%	4.8%	99.0%	2.3%	98.7%	2.5%	98.9%	0.1%	96.0%
URA-M	2.9%	99.5%	3.1%	99.2%	0.4%	99.3%	0.8%	98.9%	< 0.1%	94.9%

[A] *Missing* (i.e., percentage missing) and *Valid* (i.e., percentage valid) are based on different denominators; therefore, the percentages will not sum to 100 percent. *Validity* can only be assessed for records where values are present.
[B] *Rendering Provider (ID and NPI)* and *Attending Provider (ID)* fields are situational (i.e., not required for every encounter transaction).
"NA" denotes all records had missing values for this data element; therefore, validity could not be assessed.

Table E-10—Completeness (Percentage Missing) and Accuracy (Percentage Valid) for Key Long-term Care Category Data Elements by Plan and AHCA (cont.)

	Primary Surgical Code[A, B]		Surgical Code 2[A, B]		Surgical Code 3[A, B]		Revenue Code[A]		NDC[A, B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
Plan										
AMG-L	> 99.9%	100.0%	100.0%	NA	100.0%	NA	0.0%	100.0%	> 99.9%	100.0%
AMG-M	98.2%	50.2%	> 99.9%	40.0%	100.0%	NA	0.0%	100.0%	99.9%	84.7%
BET-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
CHA-S	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
CMS-S	99.5%	100.0%	99.9%	100.0%	99.9%	100.0%	0.0%	100.0%	99.9%	51.7%
COV-L	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
COV-M	99.7%	100.0%	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
HUM-L	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
HUM-M	100.0%	NA	100.0%	NA	100.0%	NA	< 0.1%	100.0%	> 99.9%	99.0%
MCC-S	100.0%	NA	100.0%	NA	100.0%	NA	100.0%	NA	> 99.9%	100.0%
MOL-L	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
MOL-M	99.9%	100.0%	> 99.9%	100.0%	> 99.9%	100.0%	0.0%	100.0%	> 99.9%	90.7%
NBD-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
PHC-S	100.0%	NA	100.0%	NA	100.0%	NA	71.2%	100.0%	100.0%	NA
PRS-M	99.9%	100.0%	> 99.9%	100.0%	> 99.9%	100.0%	0.0%	100.0%	> 99.9%	73.3%
SHP-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	> 99.9%	96.4%
STW-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	99.9%	68.8%
SUN-L	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
SUN-M	> 99.9%	100.0%	> 99.9%	100.0%	> 99.9%	100.0%	< 0.1%	100.0%	> 99.9%	80.8%
SUN-S	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	> 99.9%	57.1%
URA-L	> 99.9%	37.5%	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
URA-M	99.8%	89.2%	99.9%	67.7%	99.9%	60.5%	0.0%	100.0%	100.0%	NA
AHCA										
AMG-L	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
AMG-M	99.9%	100.0%	99.9%	100.0%	99.9%	100.0%	0.0%	99.9%	100.0%	NA
BET-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	> 99.9%	100.0%
CHA-S	> 99.9%	100.0%	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
CMS-S	99.7%	100.0%	99.9%	100.0%	> 99.9%	100.0%	0.0%	100.0%	99.9%	57.6%
COV-L	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
COV-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	99.9%	100.0%
HUM-L	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
HUM-M	> 99.9%	100.0%	> 99.9%	100.0%	> 99.9%	100.0%	0.0%	> 99.9%	99.8%	96.0%
MCC-S	> 99.9%	100.0%	> 99.9%	100.0%	100.0%	NA	0.0%	100.0%	99.9%	95.7%
MOL-L	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	> 99.9%	100.0%

	Primary Surgical Code[A, B]		Surgical Code 2[A, B]		Surgical Code 3[A, B]		Revenue Code[A]		NDC[A, B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
MOL-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	> 99.9%	83.3%
NBD-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	> 99.9%	100.0%	NA
PHC-S	99.9%	100.0%	100.0%	NA	100.0%	NA	0.0%	100.0%	100.0%	NA
PRS-M	> 99.9%	100.0%	> 99.9%	100.0%	> 99.9%	100.0%	0.0%	> 99.9%	> 99.9%	45.5%
SHP-M	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	> 99.9%	96.4%
STW-M	> 99.9%	100.0%	100.0%	NA	100.0%	NA	0.0%	> 99.9%	99.9%	71.5%
SUN-L	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	> 99.9%	100.0%	NA
SUN-M	> 99.9%	100.0%	> 99.9%	100.0%	> 99.9%	100.0%	0.0%	99.9%	> 99.9%	79.5%
SUN-S	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%	> 99.9%	63.2%
URA-L	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	> 99.9%	100.0%	NA
URA-M	> 99.9%	100.0%	> 99.9%	100.0%	> 99.9%	100.0%	0.0%	99.9%	> 99.9%	98.8%

[A] *Missing* (i.e., percentage missing) and *Valid* (i.e., percentage valid) are based on different denominators; therefore, the percentages will not sum to 100 percent. *Validity* can only be assessed for records where values are present.
[B] *Primary Surgical Code*, *Surgical Code 2*, *Surgical Code 3*, and *NDC* fields are situational (i.e., not required for every encounter transaction).
"NA" denotes all records had missing values for this data element; therefore, validity could not be assessed.

Data Element Completeness

Table E-11, Table E-12, and Table E-13 present the percentage of records with values present in the files submitted by the plans but not in AHCA's files (element omission), and the percentage of records with values present in AHCA's files but not in the files submitted by the plans (element surplus) for dental services, children's therapy services, and long-term care services, respectively. The minimum and maximum plan element omission and surplus rates and the high and low plan performers are also provided.

Table E-11—Element Omission and Surplus: Dental Category

Key Data Elements	Element Omission			Element Surplus		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Dental Encounters						
Line First Date of Service	0.0%	All plans reported 0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%	All plans reported 0.0%
Line Last Date of Service	0.0%	All plans reported 0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%	All plans reported 0.0%
Billing Provider NPI	1.7%	0.0% – 4.7%	Three plans reported 0.0% (CHA-S, CMS-S, and URA-M) BET-M (3.3%) SUN-M (4.6%) HUM-M (4.7%)	13.4%	0.0% – 99.2%	All plans reported 0.0% except CMS-S (97.1%) and URA-M (99.2%)
Rendering Provider NPI	0.4%	0.0% – 2.0%	CHA-S (0.0%) COV-M (0.0%) Two plans reported < 0.1% (BET-M and NBD-M) URA-M (0.8%) PRS-M (1.2%) CMS-S (2.0%)	6.6%	0.0% – 100.0%	Nine plans reported 0.0% (AMG-M, HUM-M, MCC-S, MOL-M, NBD-M, PRS-M, SUN-M, SUN-S, and URA-M) SHP-M (33.6%) BET-M (33.7%) COV-M (100.0%)
Procedure Code	0.0%	All plans reported 0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%	All plans reported 0.0%
Tooth Number	0.4%	0.0% – 75.2%	Eight plans reported 0.0% (CHA-S, CMS-S, COV-M, MOL-M, NBD-M, SHP-M, STW-M, and URA-M) PRS-M (0.2%) MCC-S (75.2%)	10.7%	0.0% – 73.0%	Six plans reported 0.0% (CHA-S, MCC-S, MOL-M, PRS-M, SHP-M, and URA-M,) COV-M (28.6%) STW-M (31.0%) CMS-S (73.0%)
Amount Paid	0.0%	All plans reported 0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%	All plans reported 0.0%
Note: While dental procedure codes were also identified from the institutional and/or professional encounters, the number of records was minimal; therefore, element omission and surplus rates for these encounters were not presented.						

Table E-12—Element Omission and Surplus: Children's Therapy Category by Encounter Type

Key Data Elements	Element Omission			Element Surplus		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Institutional Encounters						
Admission Date	78.4%	0.0% – 100.0%	Two plans reported 0.0% (BET-M and SHP-M) AMG-M (0.3%) Seven plans reported 100.0% (CMS-S, COV-M, MOL-M, PRS-M, SUN-M, SUN-S, and URA-M)	0.0%	All plans reported 0.0%	All plans reported 0.0%
Discharge Date	8.6%	0.0% – 78.3%	Six plans reported 0.0% (AMG-M, BET-M, PRS-M, SHP-M, SUN-M, and SUN-S) URA-M (25.3%) MOL-M (26.4%) COV-M (78.3%)	3.8%	0.0% – 80.5%	Seven plans reported 0.0% (CMS-S, COV-M, MOL-M, PRS-M, SUN-M, SUN-S, and URA-M) HUM-M (21.0%) BET-M (54.7%) NBD-M (80.5%)
Primary Diagnosis Code	0.0%	All plans reported 0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%	All plans reported 0.0%
Procedure Code	0.0%	All plans reported 0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%	All plans reported 0.0%
Revenue Code	0.0%	All plans reported 0.0%	All plans reported 0.0%	< 0.1%	All plans reported 0.0% except HUM-M (<0.1%)	All plans reported 0.0% except HUM-M (<0.1%)
Billing Provider NPI	0.3%	0.0% – 1.3%	Six plans reported 0.0% (BET-M, CMS-S, COV-M, MOL-M, NBD-M, and URA-M) SHP-M (0.6%) STW-M (0.8%) PRS-M (1.3%)	28.0%	0.0% – 96.8%	All plans reported 0.0% except CMS-S (96.8%)
Attending Provider ID	0.0%	All plans reported 0.0%	All plans reported 0.0%	95.2%	21.0% – 100.0%	URA-M (21.0%) CMS-S (94.1%) NBD-M (97.2%) Eight plans reported 100.0% (BET-M, COV-M, HUM-M,

Key Data Elements	Element Omission			Element Surplus		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans	Overall Rate	Plan Range	Top Three and Bottom Three Plans
						PRS-M, SHP-M, STW-M, SUN-M, and SUN-S)
Amount Paid	0.0%	All plans reported 0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%	All plans reported 0.0%
Professional Encounters						
Line First Date of Service	0.0%	All plans reported 0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%	All plans reported 0.0%
Line Last Date of Service	0.0%	All plans reported 0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%	All plans reported 0.0%
Primary Diagnosis Code	0.0%	All plans reported 0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%	All plans reported 0.0%
Procedure Code	0.0%	All plans reported 0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%	All plans reported 0.0%
Billing Provider NPI	0.5%	0.0% – 8.3%	Four plans reported 0.0% (CHA-S, COV-M, MCC-S, and NBD-M) SUN-M (1.2%) AMG-M (3.5%) MOL-M (8.3%)	32.8%	0.0% – 64.6%	Ten plans reported 0.0% (BET-M, CHA-S, COV-M, HUM-M, MCC-S, MOL-M, NBD-M, PRS-M, STW-M, and SUN-S)
Rendering Provider NPI	5.2%	0.0% – 33.9%	Four plans reported 0.0% (CHA-S, COV-M, MCC-S, and STW-M) PRS-M (6.6%) URA-M (24.6%) MOL-M (33.9%)	11.4%	0.0% – 94.4%	Seven plans reported 0.0% (CHA-S, COV-M, MCC-S, MOL-M, NBD-M, PRS-M, and URA-M) SUN-M (14.6%) SUN-S (26.3%) STW-M (94.4%)
Amount Paid	0.0%	All plans reported 0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%	All plans reported 0.0%

Table E-13—Element Omission and Surplus: Long-term Care Category by Encounter Type

Key Data Elements	Element Omission			Element Surplus		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Institutional Encounters						
Admission Date	55.3%	0.0% – 100.0%	Three plans reported 0.0% (BET-M, CHA-S, and SHP-M) SUN-M (99.6%) PRS-M (99.9%) MCC-S (100.0%)	< 0.1%	0.0% – < 0.1%	All plans reported 0.0% except AMG-M, HUM-M, and STW-M (< 0.1%)
Discharge Date	21.5%	0.0% – 97.6%	Eight plans reported 0.0% (AMG-L, BET-M, CHA-S, HUM-L, PHC-S, SHP-M, SUN-M, and SUN-S) MOL-L (94.7%) URA-L (95.2%) COV-L (97.6%)	8.1%	0.0% – 100.0%	11 plans reported 0.0% (AMG-L, CMS-S, COV-L, COV-M, MCC-S, MOL-L, MOL-M, PRS-M, SUN-S, URA-L, and URA-M) SHP-M (98.5%) CHA-S (99.5%) PHC-S (100.0%)
Primary Diagnosis Code	0.0%	All plans reported 0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%	All plans reported 0.0%
Procedure Code	0.0%	All plans reported 0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%	All plans reported 0.0%
Revenue Code	0.0%	All plans reported 0.0%	All plans reported 0.0%	< 0.1%	0.0% – 100.0%	All plans reported < 0.1% except MCC-S reported 100.0%
Billing Provider NPI	0.4%	0.0% – 1.5%	Seven plans reported 0.0% (AMG-L, CMS-S, MCC-S, MOL-L, NBD-M, PHC-S, and SUN-L) STW-M (0.5%) CHA-S (0.7%) HUM-M (1.5%)	2.1%	0.0% – 94.5%	All plans reported <= 0.1% except CMS-S (94.5%)
Attending Provider ID	< 0.1%	0.0% – < 0.1%	All plans reported 0.0% except URA-M (< 0.1%)	78.5%	0.0% – 100.0%	COV-L (0.0%) HUM-L (0.0%) AMG-L (12.0%) Seven plans reported 100.0% (COV-M, MCC-S, MOL-L,

Key Data Elements	Element Omission			Element Surplus		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans	Overall Rate	Plan Range	Top Three and Bottom Three Plans
						PRS-M, STW-M, SUN-M, and SUN-S)
Amount Paid	< 0.1%	0.0% – < 0.1%	All plans reported 0.0% except CMS-S and STW-M (< 0.1%)	< 0.1%	0.0% – 0.1%	All plans reported 0.0% except HUM-M (0.1%)
Payer Responsibility Sequence Code	< 0.1%	0.0% – < 0.1%	All plans reported 0.0% except STW-M (< 0.1%)	9.8%	0.0% – 100.0%	16 plans reported 0.0% (AMG-L, AMG-M, COV-L, COV-M, MCC-S, MOL-L, MOL-M, NBD-M, PHC-S, PRS-M, STW-M, SUN-L, SUN-M, SUN-S, URA-L, and URA-M) Five plans reported 100.0% (BET-M, CHA-S, CMS-S, HUM-L, and SHP-M)
Insurance Group Policy Number	1.1%	0.0% – 100.0%	All plan reported 0.0% except STW-M (5.1%) and PHC-S (100.0%)	12.9%	0.0% – 100.0%	Ten plans reported 0.0% (AMG-L, AMG-M, MCC-S, PHC-S, PRS-M, SUN-L, SUN-M, SUN-S, URA-L, and URA-M) Four plans reported 100.0% (BET-M, CHA-S, CMS-S, and SHP-M)
Claim Filing Indicator Code	< 0.1%	0.0% – < 0.1%	All plans reported 0.0% except STW-M (< 0.1%)	7.5%	0.0% – 100.0%	17 plans reported 0.0% (AMG-L, AMG-M, CMS-S, COV-L, COV-M, MCC-S, MOL-L, MOL-M, NBD-M, PHC-S, PRS-M, STW-M, SUN-L, SUN-M, SUN-S, URA-L, and URA-M) Four plans reported 100.0% (BET-M, CHA-S, HUM-L, and SHP-M)

Key Data Elements	Element Omission			Element Surplus		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Contract Info	84.8%	0.0% – 96.2%	HUM-L (0.0%) SUN-L (0.7%) PRS-M (69.0%) AMG-L (92.9%) URA-L (95.2%) MOL-L (96.2%)	0.1%	0.0% – 4.2%	All plans reported 0.0% except COV-L (0.2%) and HUM-L (4.2%)
Professional Encounters						
Line First Date of Service	0.0%	All plans reported 0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%	All plans reported 0.0%
Line Last Date of Service	0.0%	All plans reported 0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%	All plans reported 0.0%
Primary Diagnosis Code	0.0%	All plans reported 0.0%	All plans reported 0.0%	< 0.1%	0.0% – < 0.1%	All plans reported 0.0% except HUM-M (< 0.1%)
Procedure Code	0.0%	All plans reported 0.0%	All plans reported 0.0%	0.0%	All plans reported 0.0%	All plans reported 0.0%
Billing Provider NPI	1.8%	0.0% – 14.3%	PHC-S (0.0%) Three plan reported 0.1% (CMS-S, MCC-S, and SUN-S) SHP-M (2.4%) BET-M (4.6%) HUM-M (14.3%)	7.0%	0.0% – 66.0%	Seven plans reported 0.0% (COV-L, HUM-L, MCC-S, NBD-M, PHC-S, STW-M, and SUN-S) URA-L (7.5%) URA-M (24.3%) CMS-S (66.0%)
Rendering Provider NPI	2.0%	0.0% – 8.6%	Three plans reported 0.0% (COV-L, HUM-L, and STW-M) AMG-M (3.9%) CMS-S (7.4%) HUM-M (8.6%)	46.3%	0.0% – 97.6%	Three plans reported 0.0% (CMS-S, MCC-S, and NBD-M) SUN-L (94.9%) HUM-L (97.5%) COV-L (97.6%)
Amount Paid	0.0%	All plans reported 0.0%	All plans reported 0.0%	< 0.1%	0.0% – 0.1%	All plans reported 0.0% except HUM-M (0.1%)
Payer Responsibility Sequence Code	0.0%	All plans reported 0.0%	All plans reported 0.0%	19.3%	0.0% – 100.0%	14 plans reported 0.0% (AMG-L, COV-L, COV-M, HUM-M, MCC-S, MOL-L, MOL-M, NBD-M, PHC-S, SUN-L,

Key Data Elements	Element Omission			Element Surplus		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans	Overall Rate	Plan Range	Top Three and Bottom Three Plans
						SUN-M, SUN-S, URA-L, and URA-M) Five plans reported 100.0% (BET-M, CHA-S, CMS-S, HUM-L, and SHP-M)
Insurance Group Policy Number	5.4%	0.0% – 100.0%	14 plans reported 0.0% (AMG-L, AMG-M, BET-M, CHA-S, CMS-S, COV-L, COV-M, HUM-L, MOL-L, MOL-M, NBD-M, PRS-M, SHP-M, and SUN-L) URA-M (26.5%) HUM-M (38.0%) PHC-S (100.0%)	16.4%	0.0% – 100.0%	11 plans reported 0.0% (AMG-L, AMG-M, COV-L, HUM-L, MCC-S, PHC-S, PRS-M, SUN-L, SUN-S, URA-L, and URA-M) Six plans reported 100.0% (BET-M, CHA-S, CMS-S, MOL-L, MOL-M, and SHP-M)
Claim Filing Indicator Code	0.0%	All plans reported 0.0%	All plans reported 0.0%	11.2%	0.0% – 100.0%	15 plans reported 0.0% (AMG-L, CMS-S, COV-L, COV-M, HUM-M, MCC-S, MOL-L, MOL-M, NBD-M, PHC-S, PRS-M, SUN-M, SUN-S, URA-L, and URA-M) Four plans reported 100.0% (BET-M, CHA-S, HUM-L, and SHP-M)
Contract Info	31.9%	0.0% – 81.3%	HUM-L (0.0%) Three plans reported < 0.1% (SUN-L, SUN-M, SUN-S) MOL-L (70.4%) COV-L (72.8%) AMG-L (81.3%)	4.8%	0.0% – 67.5%	All plans reported 0.0% except HUM-L (19.4%), AMG-M (25.9%), and PRS-M (67.5%)

Table E-14, Table E-15, and Table E-16 present the overall agreement rates for each of the evaluated data elements for dental, children's therapy, and long-term care encounters, respectively. The minimum and maximum plan element agreement rates and the high and low plan performers are also provided.

Table E-14—Element Agreement: Dental Category by Encounter Type

Key Data Elements	Element Agreement		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Dental Encounters			
Line First Date of Service	74.7%	0.5% – 100.0%	Nine plans reported 100.0% (AMG-M, BET-M, CHA-S, COV-M, HUM-M, MCC-S, MOL-M, SHP-M, and URA-M) Three plans reported 99.7% (PRS-M, SUN-M, and SUN-S) CMS-S (99.1%) STW-M (0.5%)
Line Last Date of Service	74.6%	0.0% – 100.0%	Seven plans reported 100.0% (BET-M, CHA-S, COV-M, HUM-M, MCC-S, SHP-M, and URA-M) Five plans reported 99.7% (AMG-M, MOL-M, PRS-M, SUN-M, and SUN-S) CMS-S (99.1%) STW-M (0.0%)
Billing Provider NPI	92.0%	73.1% – 100.0%	URA-M (100.0%) SHP-M (98.3%) AMG-M (97.6%) SUN-S (81.1%) SUN-M (73.6%) MCC-S (73.1%)
Rendering Provider NPI	95.4%	91.8% – 100.0%	CHA-S (100.0%) NBD-M (97.7%) STW-M (96.9%) SHP-M (93.7%) MOL-M (92.7%) HUM-M (91.8%)

Key Data Elements	Element Agreement		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Procedure Code	99.8%	80.6% – 100.0%	Seven plans reported 100.0% (BET-M, CHA-S, CMS-S, COV-M, MOL-M, PRS-M, and SHP-M) AMG-M (99.7%) SUN-M (99.5) MCC-S (80.6)
Tooth Number	98.9%	81.0% – 100.0%	Five plans reported 100.0% (BET-M, CHA-S, MOL-M, PRS-M, and SHP-M) AMG-M (99.2%) MCC-S (90.4%) CMS-S (81.0%)
Amount Paid	94.2%	35.7% – 100.0%	Six plans reported 100.0% (BET-M, CHA-S, CMS-S, MOL-M, SHP-M, and STW-M) MCC-S (92.2%) COV-M (43.3%) PRS-M (35.7%)
Note: While dental procedure codes were also identified in the institutional and/or professional encounters, the number of records were minimal; therefore, element agreement rates for these encounters were not presented.			

Table E-15—Element Agreement: Children's Therapy Category by Encounter Type

Key Data Elements	Element Agreement		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Institutional Encounters			
Admission Date	100.0%	Two plans (AMG-M and HUM-M) reported 100.0%. All other plans reported NA.	Two plans (AMG-M and HUM-M) reported 100.0%. All other plans reported NA.
Discharge Date	94.7%	0.0% – 100.0%	Five plans reported 100.0% (AMG-M, HUM-M, MOL-M, NBD-M, and PRS-M) SUN-S (93.1%) SUN-M (92.3%) URA-M (0.0%)
Primary Diagnosis Code	100.0%	All plans reported 100.0%	All plans reported 100.0%
Procedure Code	99.9%	99.1% – 100.0%	All plans reported 100.0% except SUN-M (99.1%) and SUN-S (99.1%)
Revenue Code	88.7%	0.0% – 100.0%	Eight plans reported 100.0% (BET-M, CMS-S, COV-M, MOL-M, NBD-M, SHP-M, STW-M, and URA-M) AMG-M (99.7%) PRS-M (99.6%) SUN-M (0.0%)
Billing Provider NPI	96.2%	0.0% – 100.0%	Five plans reported 100.0 % (COV-M, HUM-M, MOL-M, NBD-M, and SHP-M) STW-M (95.6%) URA-M (93.4%) CMS-S (0.0%)
Attending Provider ID	0.0%	One plan (URA-M) reported 0.0%. All other plans reported NA.	One plan (URA-M) reported 0.0%. All other plans reported NA.
Amount Paid	99.2%	89.9% – 100.0%	Five plans reported 100.0% (BET-M, CMS-S, COV-M, MOL-M, and SHP-M) SUN-M (97.9%) NBD-M (96.8%) URA-M (89.9%)
Professional Encounters			
Line First Date of Service	99.2%	72.7% – 100.0%	Ten plans reported 100.0% (AMG-M, BET-M, CHA-S, CMS-S, COV-M, NBD-M, SHP-

Key Data Elements	Element Agreement		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans
			M, STW-M, SUN-S, and URA-M) MOL-M (99.6%) MCC-S (98.8%) PRS-M (72.7%)
Line Last Date of Service	99.2%	72.6% – 100.0%	12 plans reported 100.0% (AMG-M, BET-M, CHA-S, CMS-S, COV-M, HUM-M, NBD-M, SHP-M, STW-M, SUN-M, SUN-S, and URA-M)
Primary Diagnosis Code	99.6%	97.6% – 100.0%	Six plans reported 100.0% (AMG-M, CHA-S, COV-M, MCC-S, SUN-M, and SUN-S) SHP-M (99.5%) BET-M (98.5%) HUM-M (97.6%)
Procedure Code	> 99.9%	> 99.9% – 100.0%	All plans reported 100.0% except AMG-M (> 99.9%)
Billing Provider NPI	73.0%	1.1% – 100.0%	Two plans reported 100.0% (CHA-S and MCC-S) Two plans reported 99.6% (BET-M and MOL-M) COV-M (94.0%) PRS-M (92.7%) CMS-S (1.1%)
Rendering Provider NPI	95.9%	10.8% – 100.0%	CHA-S (100.0%) Two plans reported 99.7% (BET-M and MOL-M) COV-M (94.0%) MCC-S (92.6%) PRS-M (10.8%)
Amount Paid	87.0%	0.3% – 100.0%	Seven plans reported 100.0% (AMG-M, BET-M, CHA-S, CMS-S, COV-M, MCC-S, and SHP-M) PRS-M (99.2%) SUN-M (98.7%) URA-M (0.3%)

Table E-16—Element Agreement: Long-term Care Category by Encounter Type

Key Data Elements	Element Agreement		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Institutional Encounters			
Admission Date	80.2%	0.2% – 100.0%	Ten plans reported 100.0% (AMG-L, BET-M, CHA-S, CMS-S, HUM-L, MOL-L, MOL-M, NBD-M, SHP-M, and SUN-S) COV-M (21.8%) SUN-L (5.2%) COV-L (0.2%)
Discharge Date	90.8%	0.0% – 100.0%	Five plans reported 100.0% (AMG-L, HUM-M, MCC-S, MOL-L, and MOL-M) COV-L (16.2%) Two plans reported 0.0% (URA-L and URA-M)
Primary Diagnosis Code	96.0%	0.4% – 100.0%	All plans reported >= 99.9% except COV-L (6.8%) and PHC-S (0.4%)
Procedure Code	99.7%	87.5% – 100.0%	All plans reported 100.0% except HUM-M (99.9%), SUN-S (97.6%), SUN-M (96.6%), and MCC-S (87.5%)
Revenue Code	90.2%	0.0% – 100.0%	11 plans reported 100.0% (AMG-L, BET-M, CMS-S, COV-M, HUM-L, MOL-L, MOL-M, NBD-M, SHP-M, SUN-L, and URA-L) COV-L (93.4%) PHC-S (89.9%) SUN-M (0.0%)
Billing Provider NPI	96.6%	0.0% – 100.0%	Three plans reported 100.0% (AMG-L, HUM-L, and PHC-S) AMG-M (89.5%) MCC-S (87.5%) CMS-S (0.0%)
Attending Provider ID	0.0%	All plans reported NA except URA-L and URA-M (0.0%)	All plans reported NA except URA-L and URA-M (0.0%)

Key Data Elements	Element Agreement		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Amount Paid	93.4%	1.2% – 100.0%	Seven plans reported 100.0% (BET-M, CMS-S, COV-M, MCC-S, MOL-L, MOL-M, and SHP-M) URA-L (66.9%) SUN-L (42.8%) PHC-S (1.2%)
Payer Responsibility Sequence Code	88.3%	21.9% – 100.0%	Five plans reported 100.0% (AMG-L, MCC-S, SUN-L, SUN-M, and SUN-S) MOL-M (76.7%) PHC-S (61.1%) MOL-L (21.9%)
Insurance Group Policy Number	56.7%	0.0% – 87.6%	All plans reported NA except STW-M (87.6%), SUN-L (0.0%), SUN-M (0.0%), and SUN-S (0.0%)
Claim Filing Indicator Code	62.2%	0.0% – 100.0%	Five plans reported 100.0% (CMS-S, COV-L, MCC-S, MOL-L, and NBD-M) SUN-M (0.6%) SUN-S (0.3%) Two plans reported 0.0% (AMG-M and SUN-L)
Contract Info	59.6%	0.0% – 100.0%	Ten plans reported 100.0% (AMG-L, AMG-M, BET-M, CHA-S, CMS-S, COV-M, HUM-M, NBD-M, PRS-M, and SHP-M) Six plans reported 0.0% (MCC-S, MOL-L, MOL-M, STW-M, URA-L, and URA-M)
Professional Encounters			
Line First Date of Service	99.9%	98.4% – 100.0%	All plans reported > 99.0% except PRS-M (98.4%)
Line Last Date of Service	99.9%	98.4% – 100.0%	All plans reported > 99.0% with 17 plans reporting 100.0%, except PRS-M (98.4%)
Primary Diagnosis Code	97.7%	5.4% – 100.0%	AMG-L (100.0%) SUN-S (100.0%) CHA-S (99.2%)

Key Data Elements	Element Agreement		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans
			COV-M (86.1%) AMG-M (85.0%) PHC-S (5.4%)
Procedure Code	99.9%	96.0% – 100.0%	All plans reported > 99.0% except NBD-M (96.0%)
Billing Provider NPI	91.5%	4.4% – 100.0%	PHC-S (100.0%) NBD-M (98.7%) CHA-S (98.3%) URA-M (84.5%) PRS-M (78.4%) CMS-S (4.4%)
Rendering Provider NPI	90.9%	51.2% – 99.8%	SUN-S (99.8%) CMS-S (99.3%) SHP-M (99.1%) SUN-L (76.3%) PRS-M (74.8%) AMG-M (51.2%)
Amount Paid	83.7%	3.8% – 100.0%	Four plans reported 100.0% (BET-M, CHA-S, CMS-S, and SHP-M) URA-L (13.3%) PHC-S (4.6%) URA-M (3.8%)
Payer Responsibility Sequence Code	97.2%	79.1% – 100.0%	Four plans reported 100.0% (COV-L, MOL-L, MOL-M, and NBD-M) HUM-M (88.6%) AMG-L (86.8%) PRS-M (79.1%)
Insurance Group Policy Number	20.0%	0.0% – 87.9%	All plans reported NA except STW-M (87.9%), HUM-M (5.3%), and three plans reported 0.0% (SUN-L, SUN-M, SUN-S)

Key Data Elements	Element Agreement		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Claim Filing Indicator Code	56.7%	0.0% – 100.0%	Five plans reported 100.0% (CMS-S, COV-L, MOL-L, MOL-M, and NBD-M) SUN-M (0.1%) Two plans reported 0.0% (AMG-L and AMG-M)
Contract Info	64.6%	0.0% – 100.0%	Six plans reported 100.0% (BET-M, CHA-S, CMS-S, HUM-M, PRS-M, and SHP-M) Six plans reported 0.0% (MCC-S, MOL-L, MOL-M, STW-M, URA-L, and URA-M)

Medical Record, Plan of Care, and Treatment Plan Submission

Table E-17 shows the clinical record procurement status of each of the participating plans, detailing number of records requested, documentation received, and documentation not received for cases meeting eligibility criteria for any of the focused services (i.e., dental, children's therapy or long-term care).

Table E-17—Summary of Records Requested, Received, and Not Received

Plan	Number of Records Requested	Documentation Received		Documentation Not Received	
		Number	Percent	Number	Percent
AMG-L	114	114	100.0%	0	0.0%
AMG-M	114	110	96.5%	4	3.5%
BET-M	114	99	86.8%	15	13.2%
CHA-S	114	82	71.9%	32	28.1%
CMS-S	114	108	94.7%	6	5.3%
COV-L	114	109	95.6%	5	4.4%
COV-M	114	112	98.2%	2	1.8%
HUM-L	114	113	99.1%	1	0.9%
HUM-M	114	82	71.9%	32	28.1%
MCC-S	114	89	78.1%	25	21.9%
MOL-L	114	103	90.4%	11	9.6%
MOL-M	114	105	92.1%	9	7.9%
NBD-M	114	106	93.0%	8	7.0%
PHC-S	114	83	72.8%	31	27.2%
PRS-M	114	110	96.5%	4	3.5%
SHP-M	114	104	91.2%	10	8.8%
STW-M	114	91	79.8%	23	20.2%
SUN-L	114	39	34.2%	75	65.8%
SUN-M	114	27	23.7%	87	76.3%
SUN-S	114	41	36.0%	73	64.0%
URA-L	114	101	88.6%	13	11.4%
URA-M	114	104	91.2%	10	8.8%
All Plans	**2,508**	**2,032**	**81.0%**	**476**	**19.0%**

Table E-18 highlights the medical records submission by each of the participating plans detailing the number of documentation received, medical record received and not received and the number of invalid medical records.

Table E-18—Medical Record Submission

Plan	Documentation Received	Medical Record Received		Medical Record Not Received		Medical Record Not Valid	
		Number	Percent	Number	Percent	Number	Percent
AMG-L	114	93	81.6%	11	9.6%	10	8.8%
AMG-M	110	83	75.5%	25	22.7%	2	1.8%
BET-M	99	97	98.0%	0	0.0%	2	2.0%
CHA-S	82	82	100.0%	0	0.0%	0	0.0%
CMS-S	108	94	87.0%	8	7.4%	6	5.6%
COV-L	109	94	86.2%	0	0.0%	15	13.8%
COV-M	112	105	93.8%	4	3.6%	3	2.7%
HUM-L	113	85	75.2%	11	9.7%	17	15.0%
HUM-M	82	81	98.8%	0	0.0%	1	1.2%
MCC-S	89	82	92.1%	3	3.4%	4	4.5%
MOL-L	103	102	99.0%	0	0.0%	1	1.0%
MOL-M	105	103	98.1%	0	0.0%	2	1.9%
NBD-M	106	102	96.2%	1	0.9%	3	2.8%
PHC-S	83	42	50.6%	36	43.4%	5	6.0%
PRS-M	110	108	98.2%	0	0.0%	2	1.8%
SHP-M	104	99	95.2%	0	0.0%	5	4.8%
STW-M	91	90	98.9%	0	0.0%	1	1.1%
SUN-L	39	33	84.6%	4	10.3%	2	5.1%
SUN-M	27	27	100.0%	0	0.0%	0	0.0%
SUN-S	41	39	95.1%	0	0.0%	2	4.9%
URA-L	101	88	87.1%	3	3.0%	10	9.9%
URA-M	104	85	81.7%	18	17.3%	1	1.0%
All Plans	**2,032**	**1,814**	**89.3%**	**124**	**6.1%**	**94**	**4.6%**

Table E-19 highlights the plan of care/treatment plan submissions by each of the participating plans detailing the number of documentation received, plans of care/treatment plans received and not received, and the number of invalid plans of care/treatment plans.

Table E-19—Plan of Care/Treatment Plan Submission

Plan	Documentation Received[1]	Plan of Care/Treatment Plan Received		Plan of Care/Treatment Plan Not Received		Plan of Care/Treatment Plan Not Valid	
		Number	Percent	Number	Percent	Number	Percent
AMG-L	114	37	32.5%	0	0.0%	77	67.5%
AMG-M	77	30	39.0%	1	1.3%	46	59.7%
BET-M	61	53	86.9%	0	0.0%	8	13.1%
CHA-S	67	57	85.1%	0	0.0%	10	14.9%
CMS-S	72	46	63.9%	5	6.9%	21	29.2%
COV-L	109	17	15.6%	78	71.6%	14	12.8%
COV-M	77	47	61.0%	0	0.0%	30	39.0%
HUM-L	113	89	78.8%	0	0.0%	24	21.2%
HUM-M	44	33	75.0%	5	11.4%	6	13.6%
MCC-S	47	37	78.7%	6	12.8%	4	8.5%
MOL-L	103	10	9.7%	70	68.0%	23	22.3%
MOL-M	69	46	66.7%	4	5.8%	19	27.5%
NBD-M	69	58	84.1%	2	2.9%	9	13.0%
PHC-S	83	67	80.7%	12	14.5%	4	4.8%
PRS-M	72	49	68.1%	0	0.0%	23	31.9%
SHP-M	66	49	74.2%	6	9.1%	11	16.7%
STW-M	53	47	88.7%	0	0.0%	6	11.3%
SUN-L	39	15	38.5%	18	46.2%	6	15.4%
SUN-M	12	9	75.0%	0	0.0%	3	25.0%
SUN-S	21	13	61.9%	1	4.8%	7	33.3%
URA-L	101	2	2.0%	7	6.9%	92	91.1%
URA-M	77	48	62.3%	1	1.3%	28	36.4%
All Plans	**1,546**	**859**	**55.6%**	**216**	**14.0%**	**471**	**30.5%**

[1] Documentation received only includes the children's therapy and long-term care categories, since plans of care/treatment plans were not applicable for the dental services category.

Encounter Data Completeness

Table E-20 presents the percentage of dates of service identified in the encounter data that were not found in the enrollees' medical records, by focused service category (i.e., dental, children's therapy, long-term care, and overall service category). Analysis was conducted at the date of service level.

Table E-20—Medical Record Omission for Date of Service, by Plan and Service Category

Plan	Dental		Children's Therapy		Long-term Care		Overall
	Date of Service Identified in Encounter Data	Rate	Date of Service Identified in Encounter Data	Rate	Date of Service Identified in Encounter Data	Rate	Rate
AMG-L					57	0.0%	0.0%
AMG-M	19	0.0%	19	0.0%	19	0.0%	0.0%
BET-M	19	0.0%	22	0.0%	20	0.0%	0.0%
CHA-S	8	0.0%			57	8.8%	7.7%
CMS-S	20	5.0%	21	0.0%	23	0.0%	1.6%
COV-L					57	17.5%	17.5%
COV-M	19	0.0%	20	0.0%	25	4.0%	1.6%
HUM-L					66	3.0%	3.0%
HUM-M	19	5.3%	15	0.0%	23	0.0%	1.8%
MCC-S	25	4.0%	13	0.0%	23	0.0%	1.6%
MOL-L					57	0.0%	0.0%
MOL-M	19	5.3%	19	0.0%	27	0.0%	1.5%
NBD-M	19	0.0%	21	0.0%	27	0.0%	0.0%
PHC-S					42	0.0%	0.0%
PRS-M	20	0.0%	21	0.0%	24	0.0%	0.0%
SHP-M	20	10.0%	20	0.0%	28	0.0%	2.9%
STW-M	19	0.0%	21	0.0%	25	4.0%	1.5%
SUN-L					30	3.3%	3.3%
SUN-M	15	0.0%	8	0.0%	4	0.0%	0.0%
SUN-S	18	0.0%	13	0.0%	7	0.0%	0.0%
URA-L					57	10.5%	10.5%
URA-M	19	0.0%	21	4.8%	24	4.2%	3.1%
All Plans	**278**	**2.2%**	**254**	**0.4%**	**722**	**3.7%**	**2.7%**

Note: Gray shading indicates that the plan has no enrollees meeting the eligibility criteria for the selected category.

Table E-21 presents the percentage of diagnosis codes identified in the encounter data that were not found in the enrollees' medical records, by focused service category (i.e., children's therapy, long-term care, and overall service category). Diagnosis codes were not evaluated for dental services since this field is not collected for this type of service.

Table E-21—Medical Record Omission for Diagnosis Code, by Plan and Service Category

Plan	Children's Therapy		Long-term Care		Overall
	Number of Diagnoses Identified in Encounter Data	Rate	Number of Diagnoses Identified in Encounter Data	Rate	Rate
AMG-L			77	15.6%	15.6%
AMG-M	29	6.9%	39	23.1%	16.2%
BET-M	28	0.0%	54	9.3%	6.1%
CHA-S			284	36.6%	36.6%
CMS-S	38	0.0%	40	12.5%	6.4%
COV-L			60	33.3%	33.3%
COV-M	43	4.7%	59	18.6%	12.7%
HUM-L			69	7.2%	7.2%
HUM-M	22	13.6%	68	22.1%	20.0%
MCC-S	39	38.5%	55	7.3%	20.2%
MOL-L			111	39.6%	39.6%
MOL-M	23	4.3%	56	8.9%	7.6%
NBD-M	25	0.0%	48	10.4%	6.8%
PHC-S			126	19.8%	19.8%
PRS-M	33	12.1%	62	12.9%	12.6%
SHP-M	34	14.7%	87	25.3%	22.3%
STW-M	37	0.0%	61	9.8%	6.1%
SUN-L			30	3.3%	3.3%
SUN-M	9	0.0%	7	0.0%	0.0%
SUN-S	14	7.1%	7	14.3%	9.5%
URA-L			99	46.5%	46.5%
URA-M	35	17.1%	53	26.4%	22.7%
All Plans	**409**	**9.5%**	**1,552**	**23.6%**	**20.7%**

Note: Gray shading indicates that the plan has no enrollees meeting the eligibility criteria for the selected category.

Table E-22 presents the percentage of diagnoses (i.e., primary and secondary diagnoses) from enrollees' medical records that were not found in the encounter data, by focused service category (i.e., children's therapy, long-term care, and overall service category). Diagnosis codes were not evaluated for dental services since this field is not collected for this type of service.

Table E-22—Encounter Data Omission for Diagnosis Code, by Plan and Service Category

Plan	Children's Therapy		Long-term Care		Overall
	Number of Diagnosis Codes Identified in the Medical Records	Rate	Number of Diagnosis Codes Identified in the Medical Records	Rate	Rate
AMG-L			127	48.8%	48.8%
AMG-M	30	10.0%	33	9.1%	9.5%
BET-M	30	6.7%	59	16.9%	13.5%
CHA-S			200	10.0%	10.0%
CMS-S	57	33.3%	47	25.5%	29.8%
COV-L			71	43.7%	43.7%
COV-M	43	4.7%	66	27.3%	18.3%
HUM-L			125	48.8%	48.8%
HUM-M	21	9.5%	65	18.5%	16.3%
MCC-S	26	7.7%	61	16.4%	13.8%
MOL-L			104	35.6%	35.6%
MOL-M	31	29.0%	61	16.4%	20.7%
NBD-M	28	10.7%	50	14.0%	12.8%
PHC-S			132	23.5%	23.5%
PRS-M	37	21.6%	55	1.8%	9.8%
SHP-M	39	25.6%	72	9.7%	15.3%
STW-M	40	7.5%	61	9.8%	8.9%
SUN-L			58	50.0%	50.0%
SUN-M	9	0.0%	8	12.5%	5.9%
SUN-S	16	18.8%	9	33.3%	24.0%
URA-L			96	44.8%	44.8%
URA-M	34	14.7%	62	37.1%	29.2%
All Plans	**441**	**16.1%**	**1,622**	**26.9%**	**24.6%**

Note: Gray shading indicates that the plan has no enrollees meeting the eligibility criteria for the selected category.

Table E-23 presents the percentage of procedure codes identified in the encounter data that were not found in the enrollees' medical records, by focused service category (i.e., dental, children's therapy, long-term care, and overall service category).

Table E-23—Medical Record Omission for Procedure Code, by Plan and Service Category

Plan	Dental		Children's Therapy		Long-term Care		Overall
	Number of Procedure Codes Identified in Encounter Data	Rate	Number of Procedure Codes Identified in Encounter Data	Rate	Number of Procedure Codes Identified in Encounter Data	Rate	Rate
AMG-L					100	3.0%	3.0%
AMG-M	81	9.9%	21	0.0%	95	23.2%	15.2%
BET-M	116	2.6%	24	4.2%	103	4.9%	3.7%
CHA-S	38	0.0%			456	30.0%	27.7%
CMS-S	76	9.2%	21	0.0%	59	3.4%	5.8%
COV-L					91	31.9%	31.9%
COV-M	103	4.9%	27	0.0%	123	37.4%	20.2%
HUM-L					113	22.1%	22.1%
HUM-M	86	7.0%	15	0.0%	143	26.6%	18.0%
MCC-S	128	3.1%	16	0.0%	70	2.9%	2.8%
MOL-L					104	37.5%	37.5%
MOL-M	110	18.2%	20	0.0%	118	16.9%	16.1%
NBD-M	95	3.2%	22	0.0%	90	6.7%	4.3%
PHC-S					107	20.6%	20.6%
PRS-M	100	1.0%	21	0.0%	89	23.6%	10.5%
SHP-M	125	16.8%	25	0.0%	158	19.0%	16.6%
STW-M	89	2.2%	31	0.0%	108	26.9%	13.6%
SUN-L					43	2.3%	2.3%
SUN-M	94	26.6%	8	0.0%	6	16.7%	24.1%
SUN-S	106	9.4%	13	0.0%	9	0.0%	7.8%
URA-L					92	32.6%	32.6%
URA-M	120	8.3%	22	9.1%	97	28.9%	16.7%
All Plans	**1,467**	**8.5%**	**286**	**1.0%**	**2,374**	**22.6%**	**16.1%**

Note: Gray shading indicates that the plan had no enrollees meeting the eligibility criteria for the selected category.

Table E-24 presents the percentage of procedure codes from enrollees' medical records that were not found in the encounter data, by focused service categories (i.e., dental, children's therapy, long-term care, and overall service category).

Table E-24—Encounter Data Omission for Procedure Code, by Plan and Service Category

Plan	Dental		Children's Therapy		Long-term Care		Overall
	Number of Procedure Codes Identified in the Medical Record	Rate	Number of Procedure Codes Identified in the Medical Record	Rate	Number of Procedure Codes Identified in the Medical Record	Rate	Rate
AMG-L					87	1.1%	1.1%
AMG-M	79	7.6%	21	0.0%	73	2.7%	4.6%
BET-M	120	5.8%	20	5.0%	104	8.7%	7.0%
CHA-S	38	0.0%			341	7.0%	6.3%
CMS-S	85	18.8%	21	0.0%	57	0.0%	9.8%
COV-L					67	7.5%	7.5%
COV-M	105	6.7%	27	0.0%	79	3.8%	4.7%
HUM-L					54	1.9%	1.9%
HUM-M	83	3.6%	13	0.0%	105	3.8%	3.5%
MCC-S	139	10.8%	17	5.9%	74	8.1%	9.6%
MOL-L					68	5.9%	5.9%
MOL-M	100	10.0%	20	0.0%	105	6.7%	7.6%
NBD-M	97	5.2%	22	0.0%	92	8.7%	6.2%
PHC-S					100	15.0%	15.0%
PRS-M	107	7.5%	20	0.0%	81	18.5%	11.1%
SHP-M	127	18.1%	26	3.8%	131	4.6%	10.6%
STW-M	89	2.2%	31	0.0%	80	6.3%	3.5%
SUN-L					34	5.9%	5.9%
SUN-M	70	1.4%	8	0.0%	3	0.0%	1.2%
SUN-S	98	2.0%	13	0.0%	7	0.0%	1.7%
URA-L					66	6.1%	6.1%
URA-M	112	1.8%	20	0.0%	79	12.7%	5.7%
All Plans	**1,449**	**7.4%**	**279**	**1.1%**	**1,887**	**6.9%**	**6.7%**

Note: Gray shading indicates that the plan had no enrollees meeting the eligibility criteria for the selected category.

Table E-25 presents the percentage of procedure code modifiers identified in the encounter data that were not found in the enrollees' medical records, by focused service category (i.e., children's therapy, long-term care, and overall service category). Procedure code modifier was not evaluated for dental services since this field is not collected for this type of service.

Table E-25—Medical Record Omission for Procedure Code Modifier, by Plan and Service Category

Plan	Children's Therapy		Long-term Care		Overall
	Number of Modifiers Identified in Encounter Data	Rate	Number of Modifiers Identified in Encounter Data	Rate	Rate
AMG-L			54	1.9%	1.9%
AMG-M	8	0.0%	19	26.3%	18.5%
BET-M	2	0.0%	25	28.0%	25.9%
CHA-S			61	32.8%	32.8%
CMS-S	7	0.0%	17	17.6%	12.5%
COV-L			8	75.0%	75.0%
COV-M	27	0.0%	27	22.2%	11.1%
HUM-L			0	NA	NA
HUM-M	5	0.0%	27	14.8%	12.5%
MCC-S	15	6.7%	17	0.0%	3.1%
MOL-L			64	68.8%	68.8%
MOL-M	11	9.1%	20	20.0%	16.1%
NBD-M	4	0.0%	30	20.0%	17.6%
PHC-S			29	48.3%	48.3%
PRS-M	11	0.0%	25	24.0%	16.7%
SHP-M	13	0.0%	26	3.8%	2.6%
STW-M	11	0.0%	25	48.0%	33.3%
SUN-L			1	0.0%	0.0%
SUN-M	0	NA	5	40.0%	40.0%
SUN-S	0	NA	8	37.5%	37.5%
URA-L			111	42.3%	42.3%
URA-M	19	21.1%	33	39.4%	32.7%
All Plans	**133**	**4.5%**	**632**	**32.3%**	**27.5%**

Note: Gray shading indicates that the plan has no enrollees meeting the eligibility criteria for the selected category.
"NA" indicates no records were present; therefore, no rates were able to be reported.

Table E-26 presents the percentage of procedure code modifiers from enrollees' medical records that were not found in the encounter data, by focused service category (i.e., children's therapy, long-term care, and overall service category). Procedure code modifier was not evaluated for dental services since this field is not collected for this type of service.

Table E-26—Encounter Data Omission for Procedure Code Modifier, by Plan and Service Category

Plan	Children's Therapy		Long-term Care		Overall
	Number of Procedure Code Modifiers Identified in the Medical Record	Rate	Number of Procedure Code Modifiers Identified in the Medical Record	Rate	Rate
AMG-L			53	0.0%	0.0%
AMG-M	14	42.9%	14	0.0%	21.4%
BET-M	8	75.0%	21	14.3%	31.0%
CHA-S			47	12.8%	12.8%
CMS-S	9	22.2%	15	6.7%	12.5%
COV-L			12	83.3%	83.3%
COV-M	28	3.6%	22	4.5%	4.0%
HUM-L			10	100.0%	100.0%
HUM-M	9	44.4%	26	11.5%	20.0%
MCC-S	15	6.7%	18	5.6%	6.1%
MOL-L			20	0.0%	0.0%
MOL-M	17	41.2%	20	20.0%	29.7%
NBD-M	8	50.0%	26	7.7%	17.6%
PHC-S			19	21.1%	21.1%
PRS-M	14	21.4%	21	9.5%	14.3%
SHP-M	14	7.1%	27	7.4%	7.3%
STW-M	13	15.4%	14	7.1%	11.1%
SUN-L			1	0.0%	0.0%
SUN-M	5	100.0%	3	0.0%	62.5%
SUN-S	7	100.0%	5	0.0%	58.3%
URA-L			68	5.9%	5.9%
URA-M	23	34.8%	29	31.0%	32.7%
All Plans	**184**	**31.0%**	**491**	**12.8%**	**17.8%**

Note: Gray shading indicates that the plan has no enrollees meeting the eligibility criteria for the selected category.
"NA" indicates no records were present; therefore, no rates were able to be reported.

Encounter Data Accuracy

Table E-27 presents the percentage of diagnosis codes associated with validated dates of service from the encounter data that were correctly coded based on enrollees' medical records, by focused service category (i.e., children's therapy, long-term care, and overall service category). Diagnosis code was not evaluated for dental services since this field is not collected for this type of service.

Table E-27—Accuracy Results for Diagnosis Code, by Plan and Service Category

Plan	Children's Therapy		Long-term Care		Overall
	Number of Diagnosis Codes Present in Both Sources	Rate	Number of Diagnosis Codes Present in Both Sources	Rate	Rate
AMG-L			65	64.6%	64.6%
AMG-M	27	92.6%	30	83.3%	87.7%
BET-M	28	96.4%	49	93.9%	94.8%
CHA-S			180	93.3%	93.3%
CMS-S	38	92.1%	35	94.3%	93.2%
COV-L			40	75.0%	75.0%
COV-M	41	82.9%	48	89.6%	86.5%
HUM-L			64	54.7%	54.7%
HUM-M	19	100.0%	53	96.2%	97.2%
MCC-S	24	95.8%	51	78.4%	84.0%
MOL-L			67	68.7%	68.7%
MOL-M	22	90.9%	51	88.2%	89.0%
NBD-M	25	100.0%	43	97.7%	98.5%
PHC-S			101	91.1%	91.1%
PRS-M	29	89.7%	54	94.4%	92.8%
SHP-M	29	93.1%	65	95.4%	94.7%
STW-M	37	91.9%	55	96.4%	94.6%
SUN-L			29	62.1%	62.1%
SUN-M	9	100.0%	7	100.0%	100.0%
SUN-S	13	100.0%	6	83.3%	94.7%
URA-L			53	96.2%	96.2%
URA-M	29	86.2%	39	89.7%	88.2%
All Plans	**370**	**92.4%**	**1,185**	**86.1%**	**87.6%**

Note: Gray shading indicates that the plan has no enrollees meeting the eligibility criteria for the selected category.

Table E-28 presents the percentage of procedure codes associated with validated dates of service from the encounter data that were correctly coded based on enrollees' medical records, by focused service category (i.e., dental, children's therapy, long-term care, and overall service category).

Table E-28—Accuracy Results for Procedure Code, by Plan and Service Category

Plan	Dental		Children's Therapy		Long-term Care		Overall
	Number of Procedure Codes Present in Both Sources	Rate	Number of Procedure Codes Present in Both Sources	Rate	Number of Procedure Codes Present in Both Sources	Rate	Rate
AMG-L					97	100.0%	100.0%
AMG-M	73	98.6%	21	100.0%	73	95.9%	97.6%
BET-M	113	87.6%	23	100.0%	98	92.9%	91.0%
CHA-S	38	94.7%			319	96.2%	96.1%
CMS-S	69	95.7%	21	100.0%	57	100.0%	98.0%
COV-L					62	93.5%	93.5%
COV-M	98	94.9%	27	100.0%	77	93.5%	95.0%
HUM-L					88	98.9%	98.9%
HUM-M	80	87.5%	15	100.0%	105	98.1%	94.0%
MCC-S	124	97.6%	16	100.0%	68	95.6%	97.1%
MOL-L					65	98.5%	98.5%
MOL-M	90	92.2%	20	100.0%	98	96.9%	95.2%
NBD-M	92	95.7%	22	100.0%	84	92.9%	94.9%
PHC-S					85	89.4%	89.4%
PRS-M	99	96.0%	21	95.2%	68	95.6%	95.7%
SHP-M	104	91.3%	25	100.0%	128	96.1%	94.6%
STW-M	87	97.7%	31	100.0%	79	93.7%	96.4%
SUN-L					42	100.0%	100.0%
SUN-M	69	100.0%	8	100.0%	5	100.0%	100.0%
SUN-S	96	96.9%	13	100.0%	9	100.0%	97.5%
URA-L					62	98.4%	98.4%
URA-M	110	96.4%	20	100.0%	69	92.8%	95.5%
All Plans	**1,342**	**94.7%**	**283**	**99.6%**	**1,838**	**95.9%**	**95.8%**

Note: Gray shading indicates that the plan has no enrollees meeting the eligibility criteria for the selected category.

Table E-29 presents the percentage of procedure code modifiers associated with validated dates of service from AHCA's encounter data that were correctly coded based on enrollees' medical records, by focused service category (i.e., dental, children's therapy, long-term care, and overall service category). Procedure code modifier was not evaluated for dental services since this field is not collected for this type of service.

Table E-29—Accuracy Results for Procedure Code Modifier, by Plan and Service Category

Plan	Children's Therapy		Long-term Care		Overall
	Number of Procedure Code Modifiers Present in Both Sources	Rate	Number of Procedure Code Modifiers Present in Both Sources	Rate	Rate
AMG-L			53	100.0%	100.0%
AMG-M	8	100.0%	14	92.9%	95.5%
BET-M	2	100.0%	18	100.0%	100.0%
CHA-S			41	97.6%	97.6%
CMS-S	7	100.0%	14	100.0%	100.0%
COV-L			2	100.0%	100.0%
COV-M	27	100.0%	21	100.0%	100.0%
HUM-L			0	NA	NA
HUM-M	5	100.0%	23	100.0%	100.0%
MCC-S	14	100.0%	17	100.0%	100.0%
MOL-L			20	100.0%	100.0%
MOL-M	10	90.0%	16	93.8%	92.3%
NBD-M	4	100.0%	24	100.0%	100.0%
PHC-S			15	100.0%	100.0%
PRS-M	11	100.0%	19	100.0%	100.0%
SHP-M	13	100.0%	25	100.0%	100.0%
STW-M	11	100.0%	13	100.0%	100.0%
SUN-L			1	100.0%	100.0%
SUN-M	0	NA	3	100.0%	100.0%
SUN-S	0	NA	5	100.0%	100.0%
URA-L			64	100.0%	100.0%
URA-M	15	100.0%	20	100.0%	100.0%
All Plans	**127**	**99.2%**	**428**	**99.3%**	**99.3%**

Note: Gray shading indicates that the plan has no enrollees meeting the eligibility criteria for the selected category.
"NA" indicates no records were present; therefore, rates were not able to be presented.

Table E-30 presents the percentage of dates of service present in both AHCA's encounter data and in the medical records with exactly the same values for all key data elements (*Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*). The denominator is the total number of dates of service that matched in both data sources. The numerator is the total number of dates of service with exactly the same values for all key data elements. Higher all-element accuracy rates indicate that the values populated in AHCA's encounter data are more complete and accurate for all key data elements when compared to medical records.

Table E-30—All Element Accuracy by Plan and Service Category

Plan	Dental		Children's Therapy		Long-term Care		Overall
	Number of Dates of Service Present in Both Sources	Rate	Number of Dates of Service Present in Both Sources	Rate	Number of Dates of Service Present in Both Sources	Rate	Rate
AMG-L					57	31.6%	31.6%
AMG-M	19	73.7%	19	47.4%	19	21.1%	47.4%
BET-M	19	42.1%	22	77.3%	20	35.0%	52.5%
CHA-S	8	75.0%			52	17.3%	25.0%
CMS-S	19	47.4%	21	28.6%	23	52.2%	42.9%
COV-L					47	42.6%	42.6%
COV-M	19	47.4%	20	55.0%	24	20.8%	39.7%
HUM-L					64	23.4%	23.4%
HUM-M	18	61.1%	15	53.3%	23	26.1%	44.6%
MCC-S	24	54.2%	13	53.8%	23	17.4%	40.0%
MOL-L					57	19.3%	19.3%
MOL-M	18	44.4%	19	31.6%	27	25.9%	32.8%
NBD-M	19	68.4%	21	71.4%	27	40.7%	58.2%
PHC-S					42	14.3%	14.3%
PRS-M	20	65.0%	21	52.4%	24	29.2%	47.7%
SHP-M	18	38.9%	20	50.0%	28	21.4%	34.8%
STW-M	19	78.9%	21	76.2%	24	20.8%	56.3%
SUN-L					29	51.7%	51.7%
SUN-M	15	46.7%	8	37.5%	4	25.0%	40.7%
SUN-S	18	61.1%	13	30.8%	7	42.9%	47.4%
URA-L					51	43.1%	43.1%
URA-M	19	36.8%	20	30.0%	23	13.0%	25.8%
All Plans	**272**	**55.5%**	**253**	**51.0%**	**695**	**28.3%**	**39.1%**

Note: Gray shading indicates that the plan has no enrollees meeting the eligibility criteria for the selected category.

Plan of Care and/or Treatment Plan Review

Review of Treatment Plan Documentation for Children's Therapy Category

Table E-31 and Table E-32 present findings from the review of treatment plan documentation for the children's therapy services category.

Table E-31—Review of Treatment Plan Documentation: Children's Therapy Category

Plan	Date of Service Identified in Encounter Data	Valid Treatment Plan Document Was Submitted	Treatment Plan Document Was Signed	Selected Date of Service Was Within the Effective Dates of Treatment Plan Document
AMG-L				
AMG-M	19	9	8	8
BET-M	22	20	20	16
CHA-S				
CMS-S	21	20	20	20
COV-L				
COV-M	20	16	16	16
HUM-L				
HUM-M	15	3	2	2
MCC-S	13	10	10	10
MOL-L				
MOL-M	19	14	14	14
NBD-M	21	13	13	13
PHC-S				
PRS-M	21	17	15	14
SHP-M	20	18	18	18
STW-M	21	20	20	20
SUN-L				
SUN-M	8	4	4	4
SUN-S	13	7	7	7
URA-L				
URA-M	21	17	16	16
All Plans	**254**	**188**	**183**	**178**

Note: Gray shading indicates that the plan has no enrollees meeting the eligibility criteria for the selected category.

Table E-32—Treatment Plan Documentation Compared to Medical Record Information: Children's Therapy Category

Plan	Date of Service Identified in Encounter Data	Servicing Provider Was Documented	Documented Servicing Provider Supports Provider Information in the Medical Record	Documented Procedures Support Procedures Identified in the Medical Record	Documented Number of Units Support the Units Identified in the Medical Record
AMG-L					
AMG-M	19	8	8	8	6
BET-M	22	16	12	12	11
CHA-S					
CMS-S	21	20	19	18	18
COV-L					
COV-M	20	16	15	16	13
HUM-L					
HUM-M	15	2	1	1	1
MCC-S	13	10	10	10	7
MOL-L					
MOL-M	19	14	13	13	13
NBD-M	21	13	12	12	11
PHC-S					
PRS-M	21	14	8	8	8
SHP-M	20	18	18	18	18
STW-M	21	18	18	20	17
SUN-L					
SUN-M	8	4	4	4	3
SUN-S	13	7	7	7	5
URA-L					
URA-M	21	15	13	16	8
All Plans	**254**	**175**	**158**	**163**	**139**

Note: Gray shading indicates that the plan has no enrollees meeting the eligibility criteria for the selected category.

Review of Plan of Care / Treatment Plan Documentation for Long-term Care Category

Table E-33 and Table E-34 present findings from the review of treatment plan documentation for the long-term care services category.

Table E-33—Review of Plan of Care Documentation: Long-term Care Category

Plan	Date of Service Identified in Encounter Data	Adjusted Number of Expected Plan of Care Documents[1]	Valid Plan of Care Document Was Submitted	Plan of Care Document Was Signed	Selected Date of Service Was Within the Effective Dates of the Plan of Care Document
AMG-L	57	57	26	26	26
AMG-M	19	8	4	3	3
BET-M	20	5	4	4	3
CHA-S	57	23	6	6	6
CMS-S	23	18	17	17	17
COV-L	57	57	16	15	15
COV-M	25	1	0	0	0
HUM-L	66	66	62	60	57
HUM-M	23	8	3	3	2
MCC-S	23	17	9	9	9
MOL-L	57	57	13	8	8
MOL-M	27	8	6	4	4
NBD-M	27	12	11	11	11
PHC-S	42	16	5	5	5
PRS-M	24	11	4	4	4
SHP-M	28	8	6	6	5
STW-M	25	10	9	9	9
SUN-L	30	30	16	13	13
SUN-M	4	2	2	2	2
SUN-S	7	6	4	4	4
URA-L	57	57	8	8	8
URA-M	24	13	10	10	10
All Plans	**722**	**490**	**241**	**227**	**221**

[1] Long-term care service was identified based on E & M service codes. As such, plan of care documentation may not be available.

Table E-34—Plan of Care Documentation Compared to Medical Record Information: Long-term Care Category

Plan	Adjusted Number of Expected Plan of Care Documents[1]	Servicing Provider Was Documented	Documented Servicing Provider Supports Provider Information in the Medical Record	Documented Procedures Support Procedures Identified in the Medical Record	Documented Number of Units Support the Units Identified in the Medical Record
AMG-L	57	25	19	24	22
AMG-M	8	3	3	3	3
BET-M	5	3	3	2	2
CHA-S	23	6	6	6	6
CMS-S	18	17	17	17	17
COV-L	57	14	13	12	8
COV-M	1	0	0	0	0
HUM-L	66	56	51	45	44
HUM-M	8	2	0	0	0
MCC-S	17	9	7	9	7
MOL-L	57	6	5	6	6
MOL-M	8	4	4	4	3
NBD-M	12	11	8	8	7
PHC-S	16	5	5	5	5
PRS-M	11	4	4	4	4
SHP-M	8	5	5	5	5
STW-M	10	9	9	9	9
SUN-L	30	13	12	12	12
SUN-M	2	2	2	2	2
SUN-S	6	4	4	4	4
URA-L	57	8	7	5	5
URA-M	13	10	10	10	10
All Plans	**490**	**216**	**194**	**192**	**181**

[1] Long-term care service was identified based on E & M service codes. As such, plan of care documentation may not be available.

Appendix F. Hospital Network Adequacy Results—Phase 1

Table F-1—Amerigroup Network Adequacy for Hospital Providers by Region and County

		BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
County	Enrollment[1]	No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Region 5															
Pasco	24,772	394	1:62	31	1:799	0	NR	0	NR	2	MET	3	MET	0	NOT MET
Pinellas	48,865	2,059	1:23	41	1:1191	126	1:387	24	1:2036	4	MET	7	MET	0	NOT MET
Region 6															
Hardee	733	25	1:29	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Highlands	1,794	306	1:5	6	1:299	17	1:105	0	NR	3	MET	3	MET	0	NOT MET
Hillsborough	75,989	2,733	1:27	77	1:986	59	1:1287	0	NR	6	MET	7	MET	0	NOT MET
Manatee	10,588	409	1:25	7	1:1512	0	NR	0	NR	2	MET	2	MET	0	NOT MET
Polk	39,916	1,555	1:25	20	1:1995	94	1:424	8	1:4989	4	MET	5	MET	1	NOT MET
Region 7															
Brevard	12,708	1,273	1:9	20	1:635	24	1:529	0	NR	4	MET	6	MET	0	NOT MET
Orange	46,966	1,896	1:24	36	1:1304	59	1:796	0	NR	4	MET	5	MET	0	NOT MET
Osceola	13,520	84	1:160	10	1:1352	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Seminole	10,554	126	1:83	0	NR	62	1:170	8	1:1319	1	NOT MET	1	NOT MET	1	NOT MET
Region 11															
Miami-Dade	57,593	3,640	1:15	137	1:420	520	1:110	64	1:899	6	MET	11	MET	1	NOT MET
Monroe	256	0	NR	8	1:32	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
TOTAL	344,254	14,500	1:23	393	1:875	961	1:358	104	1:3310	36	9 of 13	52	9 of 13	3	0 of 13

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-2—Better Health Network Adequacy for Hospital Providers by Region and County

		BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
County	Enrollment[1]	No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Region 6															
Hardee	288	25	1:11	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Highlands	789	306	1:2	6	1:131	17	1:46	0	NR	3	MET	3	MET	0	NOT MET
Hillsborough	12,359	3,247	1:3	77	1:160	81	1:152	0	NR	7	MET	11	MET	1	NOT MET
Manatee	1,332	764	1:1	7	1:190	0	NR	0	NR	3	MET	3	MET	0	NOT MET
Polk	5,639	1,555	1:3	20	1:281	94	1:59	8	1:704	4	MET	5	MET	1	NOT MET
Region 10															
Broward	74,940	4,536	1:16	189	1:396	336	1:223	18	1:4163	11	MET	14	MET	0	NOT MET
TOTAL	95,347	10,433	1:9	299	1:318	528	1:180	26	1:3667	28	5 of 6	37	5 of 6	2	0 of 6

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-3—Clear Health Network Adequacy for Hospital Providers by Region and County

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Region 1															
Escambia	159	1,301	1:0	0	NR	121	1:1	26	1:6	3	MET	3	MET	0	NOT MET
Okaloosa	36	354	1:0	0	NR	48	1:0	0	NR	2	MET	3	MET	0	NOT MET
Santa Rosa	11	178	1:0	0	NR	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
Walton	10	108	1:0	0	NR	0	NR	0	NR	2	MET	2	MET	0	NOT MET
Region 2															
Bay	47	511	1:0	0	NR	0	NR	0	NR	2	MET	2	MET	0	NOT MET
Calhoun	2	25	1:0	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Franklin	0	25	1:0	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Gadsden	28	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Gulf	3	19	1:0	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Holmes	4	20	1:0	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Jackson	24	100	1:0	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Jefferson	6	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Leon	150	809	1:0	0	NR	69	1:2	15	1:10	2	MET	2	MET	0	NOT MET
Liberty	3	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Madison	7	25	1:0	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Taylor	5	48	1:0	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Wakulla	3	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Washington	8	25	1:0	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Region 3															
Alachua	135	1,213	1:0	0	NR	30	1:4	0	NR	2	MET	2	MET	0	NOT MET
Bradford	5	49	1:0	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Citrus	22	310	1:0	0	NR	0	NR	0	NR	2	MET	2	MET	0	NOT MET
Columbia	29	166	1:0	0	NR	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
Dixie	11	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Gilchrist	2	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Hamilton	10	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Hernando	56	496	1:0	0	NR	0	NR	0	NR	2	MET	3	MET	0	NOT MET
Lafayette	2	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Lake	56	717	1:0	0	NR	0	NR	0	NR	3	MET	3	MET	0	NOT MET
Levy	14	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Marion	109	731	1:0	0	NR	0	NR	0	NR	1	NOT MET	3	MET	0	NOT MET
Putnam	33	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Sumter	14	277	1:0	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Suwannee	19	25	1:0	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Union	7	25	1:0	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Region 5															
Pasco	237	1,003	1:0	0	NR	46	1:5	0	NR	5	MET	6	MET	0	NOT MET
Pinellas	635	3,105	1:0	0	NR	126	1:5	24	1:26	6	MET	11	MET	0	NOT MET
Region 6															
Hardee	3	25	1:0	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Highlands	37	306	1:0	0	NR	17	1:2	0	NR	3	MET	3	MET	0	NOT MET

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Hillsborough	599	3,247	1:0	0	NR	81	1:7	0	NR	7	MET	11	MET	1	NOT MET
Manatee	95	764	1:0	0	NR	0	NR	0	NR	3	MET	3	MET	0	NOT MET
Polk	173	1,555	1:0	0	NR	94	1:1	8	1:21	4	MET	5	MET	1	NOT MET
Region 7															
Brevard	290	1,483	1:0	0	NR	24	1:12	0	NR	5	MET	7	MET	0	NOT MET
Orange	676	3,228	1:0	0	NR	59	1:11	0	NR	8	MET	9	MET	0	NOT MET
Osceola	112	808	1:0	0	NR	25	1:4	0	NR	4	MET	5	MET	0	NOT MET
Seminole	87	732	1:0	0	NR	62	1:1	8	1:10	3	MET	3	MET	1	NOT MET
Region 8															
Charlotte	32	620	1:0	0	NR	52	1:0	0	NR	1	NOT MET	3	MET	0	NOT MET
Collier	43	569	1:0	0	NR	23	1:1	0	NR	2	MET	3	MET	0	NOT MET
De Soto	12	49	1:0	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Glades	5	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Hendry	45	25	1:1	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Lee	202	1,391	1:0	0	NR	15	1:13	0	NR	4	MET	5	MET	0	NOT MET
Sarasota	97	1,217	1:0	0	NR	65	1:1	37	1:2	1	NOT MET	4	MET	0	NOT MET
Region 9															
Indian River	130	407	1:0	0	NR	34	1:3	12	1:10	1	NOT MET	2	MET	0	NOT MET
Martin	58	239	1:0	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Okeechobee	26	100	1:0	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Palm Beach	654	3,389	1:0	0	NR	180	1:3	27	1:24	11	MET	13	MET	1	NOT MET
St. Lucie	467	504	1:0	0	NR	46	1:10	0	NR	2	MET	2	MET	0	NOT MET

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Region 10															
Broward	959	4,536	1:0	0	NR	336	1:2	18	1:53	11	MET	14	MET	0	NOT MET
Region 11															
Miami-Dade	2,447	5,100	1:0	0	NR	616	1:3	64	1:38	9	MET	15	MET	1	NOT MET
Monroe	83	128	1:0	0	NR	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
TOTAL	9,234	42,087	1:0	0	NR	2,169	1:4	239	1:38	120	25 of 60	172	32 of 60	5	0 of 60

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Note: Ratios of 1:0 indicate more than one bed per enrollee.

Table F-4—Coventry Network Adequacy for Hospital Providers by Region and County

		BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
County	Enrollment[1]	No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Region 11															
Monroe	51,617	6,039	1:8	137	1:376	660	1:78	64	1:806	11	MET	17	MET	0	NOT MET
Miami-Dade	220	128	1:1	8	1:27	0	NR	0	NR	1	NOT MET	2	MET	1	NOT MET
TOTAL	51,837	6,167	1:8	145	1:357	660	1:78	64	1:809	12	1 of 2	19	2 of 2	1	0 of 2

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-5—Humana Network Adequacy for Hospital Providers by Region and County

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Region 1															
Escambia	30,060	1,301	1:23	0	NR	121	1:248	26	1:1156	3	MET	3	MET	0	NOT MET
Okaloosa	9,814	354	1:27	2	1:4907	48	1:204	0	NR	2	MET	3	MET	0	NOT MET
Santa Rosa	10,840	255	1:42	33	1:328	0	NR	0	NR	1	NOT MET	3	MET	0	NOT MET
Walton	3,878	108	1:35	0	NR	0	NR	0	NR	2	MET	2	MET	0	NOT MET
Region 6															
Hardee	375	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Highlands	1,453	126	1:11	6	1:242	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Hillsborough	23,396	2,573	1:9	77	1:303	81	1:288	0	NR	4	MET	7	MET	1	NOT MET
Manatee	2,582	764	1:3	7	1:368	0	NR	0	NR	3	MET	3	MET	0	NOT MET
Polk	9,260	1,555	1:5	20	1:463	94	1:98	8	1:1157	4	MET	5	MET	1	NOT MET
Region 9															
Indian River	6,011	407	1:14	0	NR	34	1:176	12	1:500	1	NOT MET	2	MET	0	NOT MET
Martin	3,851	239	1:16	12	1:320	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Okeechobee	1,613	100	1:16	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Palm Beach	50,743	2,772	1:18	378	1:134	119	1:426	0	NR	9	MET	10	MET	1	NOT MET
St. Lucie	12,837	504	1:25	58	1:221	46	1:279	0	NR	2	MET	2	MET	0	NOT MET
Region 10															
Broward	69,137	4,536	1:15	189	1:365	384	1:180	34	1:2033	11	MET	15	MET	1	NOT MET
Region 11															
Miami-Dade	93,147	5,696	1:16	137	1:679	720	1:129	64	1:1455	9	MET	17	MET	1	NOT MET
Monroe	373	128	1:2	8	1:46	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
TOTAL	329,370	21,418	1:15	927	1:355	1,647	1:199	144	1:2287	54	10 of 17	77	13 of 17	5	0 of 17

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-6—Magellan Network Adequacy for Hospital Providers by Region and County

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Region 2															
Bay	564	511	1:1	0	NR	72	1:7	14	1:40	2	MET	2	MET	0	NOT MET
Calhoun	72	25	1:2	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Franklin	50	25	1:2	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Gadsden	173	4	1:43	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Gulf	38	19	1:2	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Holmes	68	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Jackson	210	125	1:1	0	NR	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
Jefferson	60	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Leon	642	809	1:0	0	NR	69	1:9	15	1:42	2	MET	2	MET	0	NOT MET
Liberty	42	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Madison	52	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Taylor	82	48	1:1	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Wakulla	84	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Washington	90	25	1:3	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Region 4															
Baker	109	25	1:4	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Clay	443	330	1:1	0	NR	24	1:18	0	NR	1	NOT MET	2	MET	0	NOT MET
Duval	3,606	2,681	1:1	0	NR	296	1:12	14	1:257	7	MET	7	MET	1	NOT MET
Flagler	220	99	1:2	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Nassau	204	62	1:3	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
St. Johns	256	307	1:0	0	NR	21	1:12	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Volusia	1,746	1,272	1:1	0	NR	60	1:29	30	1:58	4	MET	7	MET	1	NOT MET
Region 5															
Pasco	1,405	883	1:1	0	NR	93	1:15	25	1:56	5	MET	5	MET	0	NOT MET
Pinellas	2,540	3,173	1:0	0	NR	319	1:7	24	1:105	6	MET	12	MET	1	NOT MET
Region 6															
Hardee	53	25	1:2	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Highlands	229	306	1:0	0	NR	17	1:13	0	NR	3	MET	3	MET	0	NOT MET
Hillsborough	3,626	3,247	1:1	0	NR	121	1:29	20	1:181	7	MET	11	MET	1	NOT MET
Manatee	887	764	1:1	0	NR	18	1:49	0	NR	3	MET	3	MET	1	NOT MET
Polk	2,150	1,555	1:1	0	NR	94	1:22	8	1:268	4	MET	5	MET	1	NOT MET
Region 7															
Brevard	1,685	1,483	1:1	0	NR	76	1:22	0	NR	5	MET	7	MET	0	NOT MET
Orange	3,846	3,228	1:1	0	NR	153	1:25	64	1:60	8	MET	9	MET	1	NOT MET
Osceola	1,177	808	1:1	0	NR	25	1:47	0	NR	4	MET	5	MET	0	NOT MET
Seminole	902	732	1:1	0	NR	62	1:14	8	1:112	3	MET	3	MET	1	NOT MET
Region 9															
Indian River	344	407	1:0	0	NR	34	1:10	12	1:28	1	NOT MET	2	MET	0	NOT MET
Martin	192	339	1:0	0	NR	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
Okeechobee	199	100	1:1	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Palm Beach	2,363	3,389	1:0	0	NR	180	1:13	27	1:87	11	MET	13	MET	1	NOT MET
St. Lucie	935	588	1:1	0	NR	106	1:8	0	NR	3	MET	4	MET	1	NOT MET

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Region 10															
Broward	3,531	4,224	1:0	0	NR	476	1:7	34	1:103	11	MET	16	MET	1	NOT MET
Region 11															
Miami-Dade	6,927	5,449	1:1	0	NR	794	1:8	62	1:111	9	MET	16	MET	1	NOT MET
Monroe	107	103	1:1	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
TOTAL	41,909	37,170	1:1	0	NR	3,110	1:13	357	1:117	106	18 of 40	151	22 of 40	12	0 of 40

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Note: Ratios of 1:0 indicate more than one bed per enrollee.

Table F-7—Molina Network Adequacy for Hospital Providers by Region and County

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Region 1															
Escambia	21,245	802	1:26	0	NR	121	1:175	26	1:817	2	MET	2	MET	0	NOT MET
Okaloosa	12,309	110	1:111	2	1:6154	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Santa Rosa	6,535	255	1:25	33	1:198	0	NR	0	NR	1	NOT MET	3	MET	0	NOT MET
Walton	3,873	50	1:77	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Region 4															
Baker	2,033	25	1:81	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Clay	4,071	330	1:12	0	NR	24	1:169	0	NR	1	NOT MET	2	MET	0	NOT MET
Duval	49,227	2,133	1:23	85	1:579	80	1:615	14	1:3516	6	MET	6	MET	0	NOT MET
Flagler	1,045	99	1:10	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Nassau	3,110	62	1:50	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
St. Johns	1,254	307	1:4	27	1:46	21	1:59	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Volusia	3,391	803	1:4	19	1:178	60	1:56	0	NR	3	MET	4	MET	1	NOT MET
Region 6															
Hardee	705	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Highlands	1,693	273	1:6	6	1:282	0	NR	0	NR	2	MET	2	MET	0	NOT MET
Hillsborough	5,725	1,846	1:3	77	1:74	45	1:127	0	NR	4	MET	7	MET	1	NOT MET
Manatee	3,975	409	1:9	7	1:567	0	NR	0	NR	2	MET	2	MET	0	NOT MET
Polk	4,143	1,483	1:2	20	1:207	94	1:44	8	1:517	3	MET	4	MET	1	NOT MET
Region 7															
Brevard	2,425	1,483	1:1	20	1:121	24	1:101	0	NR	5	MET	7	MET	0	NOT MET
Orange	6,307	829	1:7	36	1:175	38	1:165	64	1:98	3	MET	4	MET	1	NOT MET

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Osceola	3,593	562	1:6	10	1:359	25	1:143	0	NR	3	MET	3	MET	0	NOT MET
Seminole	1,853	334	1:5	0	NR	62	1:29	8	1:231	2	MET	2	MET	1	NOT MET
Region 8															
Charlotte	1,009	0	NR	13	1:77	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Collier	23,964	368	1:65	16	1:1497	23	1:1041	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
De Soto	1,288	49	1:26	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Glades	61	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Hendry	1,215	25	1:48	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Lee	9,060	627	1:14	68	1:133	15	1:604	0	NR	2	MET	2	MET	0	NOT MET
Sarasota	4,062	666	1:6	0	NR	49	1:82	37	1:109	1	NOT MET	1	NOT MET	0	NOT MET
Region 9															
Indian River	2,670	286	1:9	0	NR	34	1:78	12	1:222	1	NOT MET	1	NOT MET	0	NOT MET
Martin	2,112	339	1:6	12	1:176	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
Okeechobee	894	100	1:8	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Palm Beach	58,514	3,122	1:18	378	1:154	180	1:325	27	1:2167	11	MET	13	MET	1	NOT MET
St. Lucie	4,732	504	1:9	58	1:81	46	1:102	0	NR	2	MET	2	MET	0	NOT MET
Region 11															
Miami-Dade	47,742	3,985	1:11	137	1:348	512	1:93	0	NR	7	MET	13	MET	0	NOT MET
Monroe	449	128	1:3	8	1:56	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
TOTAL	296,284	22,394	1:13	1,032	1:287	1,453	1:203	196	1:1511	69	15 of 34	94	19 of 34	6	0 of 34

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-8—Positive Network Adequacy for Hospital Providers by Region and County

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Region 10															
Broward	769	2,626	1:0	0	NR	258	1:2	26	1:29	5	MET	8	MET	1	NOT MET
Region 11															
Miami-Dade	1,023	3,334	1:0	0	NR	512	1:1	62	1:16	5	MET	8	MET	1	NOT MET
Monroe	32	128	1:0	0	NR	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
TOTAL	1,824	6,088	1:0	0	NR	770	1:2	88	1:20	11	2 of 3	18	3 of 3	2	0 of 3

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Note: Ratios of 1:0 indicate more than one bed per enrollee.

Table F-9—Prestige Network Adequacy for Hospital Providers by Region and County

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Region 2															
Bay	12,975	323	1:40	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Calhoun	1,174	25	1:46	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Franklin	936	25	1:37	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Gadsden	4,371	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Gulf	1,157	19	1:60	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Holmes	1,714	20	1:85	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Jackson	4,821	125	1:38	0	NR	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
Jefferson	822	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Leon	14,680	242	1:60	14	1:1048	24	1:611	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Liberty	541	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Madison	1,116	25	1:44	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Taylor	1,560	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Wakulla	1,514	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Washington	2,349	25	1:93	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Region 3															
Alachua	14,532	400	1:36	25	1:581	20	1:726	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Bradford	1,420	49	1:28	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Citrus	2,016	310	1:6	0	NR	0	NR	0	NR	2	MET	2	MET	0	NOT MET
Columbia	5,973	67	1:89	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Dixie	1,244	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Gilchrist	1,244	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Hamilton	1,161	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Hernando	2,628	496	1:5	0	NR	10	1:262	0	NR	2	MET	3	MET	0	NOT MET
Lafayette	456	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Lake	5,734	409	1:14	30	1:191	0	NR	0	NR	2	MET	2	MET	0	NOT MET
Levy	2,874	40	1:71	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Marion	14,565	216	1:67	23	1:633	15	1:971	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Putnam	3,940	0	NR	8	1:492	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Sumter	1,436	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Suwannee	3,193	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Union	968	25	1:38	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Region 5															
Pasco	8,211	120	1:68	31	1:264	46	1:178	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Pinellas	14,261	1,287	1:11	41	1:347	76	1:187	14	1:1018	3	MET	3	MET	0	NOT MET
Region 6															
Hardee	821	25	1:32	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Highlands	1,818	180	1:10	6	1:303	17	1:106	0	NR	2	MET	2	MET	0	NOT MET
Hillsborough	16,111	1,394	1:11	77	1:209	0	NR	0	NR	3	MET	3	MET	0	NOT MET
Manatee	3,230	0	NR	7	1:461	18	1:179	0	NR	0	NOT MET	0	NOT MET	1	NOT MET
Polk	5,338	0	NR	20	1:266	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Region 7															
Brevard	7,740	269	1:28	20	1:387	52	1:148	0	NR	1	NOT MET	2	MET	0	NOT MET
Orange	17,723	1,570	1:11	36	1:492	0	NR	0	NR	4	MET	5	MET	0	NOT MET

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Osceola	5,377	160	1:33	10	1:537	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
Seminole	3,838	334	1:11	0	NR	62	1:61	8	1:479	2	MET	2	MET	1	NOT MET
Region 8															
Charlotte	4,533	403	1:11	13	1:348	52	1:87	0	NR	1	NOT MET	2	MET	0	NOT MET
Collier	6,248	617	1:10	16	1:390	23	1:271	0	NR	2	MET	2	MET	0	NOT MET
De Soto	1,588	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Glades	367	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Hendry	5,084	25	1:203	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Lee	28,682	291	1:98	68	1:421	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Sarasota	8,382	1,078	1:7	0	NR	49	1:171	37	1:226	1	NOT MET	3	MET	0	NOT MET
Region 9															
Indian River	5,185	407	1:12	0	NR	34	1:152	12	1:432	1	NOT MET	2	MET	0	NOT MET
Martin	2,922	339	1:8	12	1:243	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
Okeechobee	4,260	100	1:42	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Palm Beach	24,692	1,752	1:14	378	1:65	75	1:329	0	NR	8	MET	8	MET	0	NOT MET
St. Lucie	9,250	381	1:24	58	1:159	24	1:385	0	NR	2	MET	2	MET	0	NOT MET
Region 11															
Miami-Dade	14,647	2,823	1:5	137	1:106	341	1:42	38	1:385	4	MET	9	MET	0	NOT MET
Monroe	250	128	1:1	8	1:31	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
TOTAL	313,672	16,524	1:18	1,038	1:302	938	1:334	109	1:2877	51	12 of 55	79	20 of 55	2	0 of 55

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-10—SFCCN Network Adequacy for Hospital Providers by Region and County

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Region 10															
Broward	42,691	3,386	1:12	189	1:225	312	1:136	18	1:2371	7	MET	10	MET	0	NOT MET
TOTAL	42,691	3,386	1:12	189	1:225	312	1:136	18	1:2371	7	1 of 1	10	1 of 1	0	0 of 1

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-11—Simply Network Adequacy for Hospital Providers by Region and County

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Region 11															
Miami-Dade	81,031	5,100	1:15	137	1:591	616	1:131	64	1:1266	9	MET	15	MET	1	NOT MET
Monroe	273	128	1:2	8	1:34	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
TOTAL	81,304	5,228	1:15	145	1:560	616	1:131	64	1:1270	10	1 of 2	17	2 of 2	1	0 of 2

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-12—Staywell Network Adequacy for Hospital Providers by Region and County

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Region 2															
Bay	14,531	511	1:28	0	NR	0	NR	0	NR	2	MET	2	MET	0	NOT MET
Calhoun	1,390	25	1:55	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Franklin	897	25	1:35	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Gadsden	5,339	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Gulf	797	19	1:41	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Holmes	1,935	20	1:96	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Jackson	3,629	125	1:29	0	NR	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
Jefferson	1,278	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Leon	16,774	809	1:20	14	1:1198	69	1:243	15	1:1118	2	MET	2	MET	0	NOT MET
Liberty	675	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Madison	2,693	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Taylor	2,381	48	1:49	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Wakulla	2,013	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Washington	2,069	25	1:82	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Region 3															
Alachua	7,577	1,213	1:6	25	1:303	76	1:99	15	1:505	2	MET	2	MET	1	NOT MET
Bradford	813	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Citrus	10,384	310	1:33	0	NR	0	NR	0	NR	2	MET	2	MET	0	NOT MET
Columbia	3,038	67	1:45	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Dixie	1,043	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Gilchrist	696	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Hamilton	842	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Hernando	15,967	496	1:32	0	NR	61	1:261	0	NR	2	MET	3	MET	1	NOT MET
Lafayette	390	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Lake	14,034	577	1:24	30	1:467	0	NR	0	NR	2	MET	2	MET	0	NOT MET
Levy	2,042	40	1:51	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Marion	22,206	609	1:36	23	1:965	54	1:411	0	NR	1	NOT MET	2	MET	1	NOT MET
Putnam	6,736	0	NR	8	1:842	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Sumter	4,292	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Suwannee	2,477	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Union	366	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Region 4															
Baker	647	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Clay	3,672	330	1:11	0	NR	24	1:153	0	NR	1	NOT MET	2	MET	0	NOT MET
Duval	26,709	2,681	1:9	85	1:314	216	1:123	14	1:1907	7	MET	7	MET	0	NOT MET
Flagler	2,808	99	1:28	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Nassau	1,258	62	1:20	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
St. Johns	6,581	307	1:21	27	1:243	21	1:313	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Volusia	22,836	727	1:31	19	1:1201	6	1:3806	0	NR	3	MET	5	MET	1	NOT MET
Region 5															
Pasco	20,820	1,003	1:20	31	1:671	0	NR	0	NR	5	MET	6	MET	0	NOT MET
Pinellas	28,547	3,173	1:8	41	1:696	319	1:89	24	1:1189	6	MET	12	MET	1	NOT MET
Region 6															
Hardee	2,761	25	1:110	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Highlands	7,454	306	1:24	6	1:1242	17	1:438	0	NR	3	MET	3	MET	0	NOT MET
Hillsborough	57,513	3,141	1:18	77	1:746	81	1:710	0	NR	5	MET	9	MET	1	NOT MET
Manatee	19,447	764	1:25	7	1:2778	0	NR	0	NR	3	MET	3	MET	0	NOT MET
Polk	38,624	679	1:56	20	1:1931	30	1:1287	0	NR	3	MET	3	MET	0	NOT MET
Region 7															
Brevard	25,549	329	1:77	20	1:1277	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
Orange	79,490	2,069	1:38	36	1:2208	200	1:397	87	1:913	3	MET	4	MET	1	NOT MET
Osceola	31,456	443	1:71	10	1:3145	25	1:1258	0	NR	2	MET	3	MET	0	NOT MET
Seminole	14,214	208	1:68	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Region 8															
Charlotte	9,436	620	1:15	13	1:725	52	1:181	0	NR	1	NOT MET	3	MET	0	NOT MET
Collier	4,474	432	1:10	16	1:279	5	1:894	0	NR	1	NOT MET	2	MET	0	NOT MET
De Soto	2,920	49	1:59	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Glades	254	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Hendry	3,301	25	1:132	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Lee	52,512	764	1:68	68	1:772	0	NR	0	NR	2	MET	3	MET	0	NOT MET
Sarasota	17,834	1,217	1:14	0	NR	65	1:274	37	1:482	1	NOT MET	4	MET	0	NOT MET
Region 11															
Miami-Dade	60,596	3,617	1:16	137	1:442	404	1:149	20	1:3029	7	MET	13	MET	0	NOT MET
Monroe	3,003	128	1:23	8	1:375	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
TOTAL	694,020	28,117	1:24	721	1:962	1,725	1:402	212	1:3273	75	18 of 57	118	26 of 57	7	0 of 57

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-13—Sunshine Network Adequacy for Hospital Providers by Region and County

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Region 3															
Alachua	5,308	1,213	1:4	25	1:212	30	1:176	0	NR	2	MET	2	MET	0	NOT MET
Bradford	1,232	49	1:25	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Citrus	2,104	310	1:6	0	NR	0	NR	0	NR	2	MET	2	MET	0	NOT MET
Columbia	2,154	166	1:12	0	NR	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
Dixie	524	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Gilchrist	508	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Hamilton	625	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Hernando	3,390	496	1:6	0	NR	0	NR	0	NR	2	MET	3	MET	0	NOT MET
Lafayette	199	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Lake	8,710	717	1:12	30	1:290	0	NR	0	NR	3	MET	3	MET	0	NOT MET
Levy	983	40	1:24	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Marion	6,462	421	1:15	23	1:280	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Putnam	2,566	99	1:25	8	1:320	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Sumter	1,162	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Suwannee	1,691	25	1:67	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Union	480	25	1:19	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Region 4															
Baker	784	25	1:31	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Clay	8,387	266	1:31	0	NR	24	1:349	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Duval	53,279	2,001	1:26	85	1:626	84	1:634	0	NR	5	MET	5	MET	0	NOT MET

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Flagler	3,304	99	1:33	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Nassau	1,417	62	1:22	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
St. Johns	2,594	307	1:8	27	1:96	21	1:123	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Volusia	11,984	433	1:27	19	1:630	6	1:1997	0	NR	1	NOT MET	3	MET	1	NOT MET
Region 5															
Pasco	11,392	1,049	1:10	31	1:367	47	1:242	25	1:455	5	MET	6	MET	0	NOT MET
Pinellas	16,121	2,886	1:5	41	1:393	197	1:81	24	1:671	6	MET	11	MET	0	NOT MET
Region 6															
Hardee	716	25	1:28	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Highlands	1,402	126	1:11	6	1:233	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Hillsborough	28,663	1,977	1:14	77	1:372	81	1:353	0	NR	3	MET	7	MET	1	NOT MET
Manatee	2,426	764	1:3	7	1:346	0	NR	0	NR	3	MET	3	MET	0	NOT MET
Polk	11,521	1,555	1:7	20	1:576	94	1:122	8	1:1440	4	MET	5	MET	1	NOT MET
Region 7															
Brevard	3,480	1,364	1:2	20	1:174	24	1:145	0	NR	5	MET	6	MET	0	NOT MET
Orange	35,000	261	1:134	36	1:972	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
Osceola	10,074	443	1:22	10	1:1007	25	1:402	0	NR	2	MET	3	MET	0	NOT MET
Seminole	7,023	208	1:33	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Region 8															
Charlotte	2,491	620	1:4	13	1:191	52	1:47	0	NR	1	NOT MET	3	MET	0	NOT MET
Collier	3,182	569	1:5	16	1:198	23	1:138	0	NR	2	MET	3	MET	0	NOT MET
De Soto	648	49	1:13	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Glades	161	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Hendry	1,648	25	1:65	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Lee	7,794	735	1:10	68	1:114	0	NR	0	NR	2	MET	3	MET	0	NOT MET
Sarasota	5,039	1,217	1:4	0	NR	65	1:77	0	NR	1	NOT MET	4	MET	1	NOT MET
Region 9															
Indian River	3,791	407	1:9	0	NR	34	1:111	12	1:315	1	NOT MET	2	MET	0	NOT MET
Martin	5,006	239	1:20	12	1:417	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Okeechobee	1,612	100	1:16	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Palm Beach	37,688	2,320	1:16	378	1:99	92	1:409	27	1:1395	9	MET	10	MET	0	NOT MET
St. Lucie	19,939	504	1:39	58	1:343	46	1:433	0	NR	2	MET	2	MET	0	NOT MET
Region 10															
Broward	63,921	2,927	1:21	189	1:338	173	1:369	0	NR	7	MET	11	MET	0	NOT MET
Region 11															
Miami-Dade	25,974	3,077	1:8	137	1:189	315	1:82	20	1:1298	6	MET	12	MET	0	NOT MET
Monroe	656	128	1:5	8	1:82	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
TOTAL	427,215	30,329	1:14	1,344	1:317	1,433	1:298	116	1:3682	87	18 of 49	133	25 of 49	4	0 of 49

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-14—United Network Adequacy for Hospital Providers by Region and County

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Region 3															
Alachua	4,041	1,213	1:3	25	1:161	76	1:53	15	1:269	2	MET	2	MET	1	NOT MET
Bradford	1,076	49	1:21	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Citrus	4,605	310	1:14	0	NR	0	NR	0	NR	2	MET	2	MET	0	NOT MET
Columbia	2,005	166	1:12	0	NR	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
Dixie	369	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Gilchrist	357	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Hamilton	352	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Hernando	5,632	496	1:11	0	NR	0	NR	0	NR	2	MET	3	MET	0	NOT MET
Lafayette	146	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Lake	16,618	717	1:23	30	1:553	41	1:405	0	NR	3	MET	4	MET	1	NOT MET
Levy	1,094	40	1:27	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Marion	13,525	731	1:18	23	1:588	69	1:196	0	NR	1	NOT MET	3	MET	1	NOT MET
Putnam	3,765	99	1:38	8	1:470	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Sumter	1,220	277	1:4	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Suwannee	1,333	25	1:53	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Union	420	25	1:16	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Region 4															
Baker	1,160	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Clay	7,196	330	1:21	0	NR	24	1:299	0	NR	1	NOT MET	2	MET	0	NOT MET
Duval	25,330	2,681	1:9	85	1:298	296	1:85	14	1:1809	7	MET	7	MET	1	NOT MET

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Flagler	5,500	99	1:55	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Nassau	2,610	62	1:42	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
St. Johns	4,246	307	1:13	27	1:157	21	1:202	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Volusia	35,842	1,272	1:28	19	1:1886	60	1:597	0	NR	4	MET	7	MET	1	NOT MET
Region 7															
Brevard	14,914	1,483	1:10	20	1:745	24	1:621	0	NR	5	MET	7	MET	0	NOT MET
Orange	20,650	3,138	1:6	36	1:573	256	1:80	87	1:237	8	MET	8	MET	1	NOT MET
Osceola	7,116	732	1:9	10	1:711	25	1:284	0	NR	3	MET	4	MET	0	NOT MET
Seminole	7,398	732	1:10	0	NR	62	1:119	8	1:924	3	MET	3	MET	1	NOT MET
Region 11															
Miami-Dade	87,448	6,133	1:14	137	1:638	774	1:112	82	1:1066	10	MET	18	MET	1	NOT MET
Monroe	893	153	1:5	8	1:111	0	NR	0	NR	1	NOT MET	3	MET	0	NOT MET
TOTAL	276,861	21,270	1:13	428	1:646	1,728	1:160	206	1:1343	57	11 of 29	84	15 of 29	8	0 of 29

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-15—Network Adequacy for Hospital Providers by Plan

		BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS						
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds					Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child								
County	Enrollment[1]	No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Counties Served by Plan	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Amerigroup	344,254	14,500	1:23	393	1:875	961	1:358	104	1:3310	13	36	9 of 13	52	9 of 13	3	0 of 13
Better Health	95,347	10,433	1:9	299	1:318	528	1:180	26	1:3667	6	28	5 of 6	37	5 of 6	2	0 of 6
Clear Health	9,234	42,087	1:0	0	NR	2,169	1:4	239	1:38	60	120	25 of 60	172	32 of 60	5	0 of 60
Coventry	51,837	6,167	1:8	145	1:357	660	1:78	64	1:809	2	12	1 of 2	19	2 of 2	1	0 of 2
Humana	329,370	21,418	1:15	927	1:355	1,647	1:199	144	1:2287	17	54	10 of 17	77	13 of 17	5	0 of 17
Magellan	41,909	37,170	1:1	0	NR	3,110	1:13	357	1:117	40	106	18 of 40	151	22 of 40	12	0 of 40
Molina	296,284	22,394	1:13	1,032	1:287	1,453	1:203	196	1:1511	34	69	15 of 34	94	19 of 34	6	0 of 34
Positive	1,824	6,088	1:0	0	NR	770	1:2	88	1:20	3	11	2 of 3	18	3 of 3	2	0 of 3
Prestige	313,672	16,524	1:18	1,038	1:302	938	1:334	109	1:2877	55	51	12 of 55	79	20 of 55	2	0 of 55
SFCCN	42,691	3,386	1:12	189	1:225	312	1:136	18	1:2371	1	7	1 of 1	10	1 of 1	0	0 of 1
Simply	81,304	5,228	1:15	145	1:560	616	1:131	64	1:1270	2	10	1 of 2	17	2 of 2	1	0 of 2
Staywell	694,020	28,117	1:24	721	1:962	1725	1:402	212	1:3273	57	75	18 of 57	118	26 of 57	7	0 of 57
Sunshine	427,215	30,329	1:14	1,344	1:317	1,433	1:298	116	1:3682	49	87	18 of 49	133	25 of 49	4	0 of 49
United	276,861	21,270	1:13	428	1:646	1,728	1:160	206	1:1343	29	57	11 of 29	84	15 of 29	8	0 of 29
TOTAL	3,005,822	265,111	1:11	6,661	1:451	18,050	1:166	1,943	1:1547	368	723	146 of 368	1,061	194 of 368	58	0 of 309

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Note: Ratios of 1:0 indicate more than one bed per enrollee.

Table F-16—Region 1 Network Adequacy for Hospital Providers by County

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Escambia	52,289	1,301	1:40	0	NR	121	1:432	26	1:2011	3	MET	3	MET	0	NOT MET
Okaloosa	22,409	354	1:63	2	1:11,204	48	1:466	0	NR	2	MET	3	MET	0	NOT MET
Santa Rosa	17,621	255	1:69	33	1:533	0	NR	0	NR	1	NOT MET	3	MET	0	NOT MET
Walton	7,816	108	1:72	0	NR	0	NR	0	NR	2	MET	2	MET	0	NOT MET
TOTAL	100,135	2,081	1:48	35	1:2861	169	1:592	26	1:3851	8	3 of 4	11	4 of 4	0	0 of 4

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-17—Region 2 Network Adequacy for Hospital Providers by County

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Bay	29,199	511	1:57	0	NR	72	1:405	14	1:2085	2	MET	2	MET	0	NOT MET
Calhoun	2,704	25	1:108	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Franklin	1,945	25	1:77	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Gadsden	10,290	4	1:2572	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Gulf	2,093	19	1:110	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Holmes	3,786	20	1:189	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Jackson	8,925	125	1:71	0	NR	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
Jefferson	2,228	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Leon	33,697	809	1:41	14	1:2406	69	1:488	15	1:2246	2	MET	2	MET	0	NOT MET
Liberty	1,310	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Madison	3,952	25	1:158	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Taylor	4,121	48	1:85	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Wakulla	3,763	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Washington	4,648	25	1:185	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
TOTAL	112,661	1,636	1:68	14	1:8047	141	1:799	29	1:3884	7	2 of 14	14	3 of 14	0	0 of 14

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-18—Region 3 Network Adequacy for Hospital Providers by County

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Alachua	32,399	1,213	1:26	25	1:1295	76	1:426	15	1:2159	2	MET	2	MET	1	NOT MET
Bradford	4,631	49	1:94	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Citrus	19,554	310	1:63	0	NR	0	NR	0	NR	2	MET	2	MET	0	NOT MET
Columbia	13,425	166	1:80	0	NR	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
Dixie	3,242	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Gilchrist	2,869	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Hamilton	3,039	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Hernando	28,324	610	1:46	0	NR	71	1:398	0	NR	2	MET	3	MET	1	NOT MET
Lafayette	1,203	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Lake	45,948	717	1:64	30	1:1531	41	1:1120	0	NR	3	MET	4	MET	1	NOT MET
Levy	7,170	40	1:179	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Marion	58,552	919	1:63	23	1:2545	84	1:697	0	NR	1	NOT MET	3	MET	1	NOT MET
Putnam	17,275	99	1:174	8	1:2159	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Sumter	8,253	277	1:29	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Suwannee	8,837	25	1:353	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Union	2,267	25	1:90	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
TOTAL	256,988	4,450	1:57	86	1:2988	272	1:944	15	1:17132	13	4 of 16	22	6 of 16	4	0 of 16

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-19—Region 4 Network Adequacy for Hospital Providers by County

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Baker	4,796	25	1:191	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Clay	24,104	330	1:73	0	NR	24	1:1004	0	NR	1	NOT MET	2	MET	0	NOT MET
Duval	160,419	3,142	1:51	60	1:2673	296	1:541	14	1:11458	7	MET	8	MET	1	NOT MET
Flagler	13,079	99	1:132	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Nassau	8,720	62	1:140	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
St. Johns	15,152	307	1:49	27	1:561	21	1:721	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Volusia	77,099	1,272	1:60	19	1:4057	60	1:1284	30	1:2569	4	MET	7	MET	1	NOT MET
TOTAL	303,369	5,237	1:57	106	1:2861	401	1:756	44	1:6894	14	2 of 7	21	3 of 7	2	0 of 7

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-20—Region 5 Network Adequacy for Hospital Providers by County

		BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
County	Enrollment[1]	No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Pasco	68,170	1,049	1:64	31	1:2199	93	1:733	25	1:2726	5	MET	6	MET	0	NOT MET
Pinellas	113,340	3,295	1:34	41	1:2764	341	1:332	24	1:4722	6	MET	12	MET	1	NOT MET
TOTAL	181,510	4,344	1:41	72	1:2520	434	1:418	49	1:3704	11	2 of 2	18	2 of 2	1	0 of 2

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-21—Region 6 Network Adequacy for Hospital Providers by County

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Hardee	6,520	25	1:260	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Highlands	16,925	306	1:55	6	1:2820	17	1:995	0	NR	3	MET	3	MET	0	NOT MET
Hillsborough	228,316	4,383	1:52	77	1:2965	180	1:1268	20	1:11415	7	MET	11	MET	1	NOT MET
Manatee	45,146	764	1:59	7	1:6449	36	1:1254	0	NR	3	MET	3	MET	1	NOT MET
Polk	118, 769	1,555	1:76	20	1:5938	94	1:1263	8	1:14846	4	MET	5	MET	1	NOT MET
TOTAL	415,676	7,033	1:59	110	1:3778	327	1:1271	28	1:14845	17	4 of 5	23	4 of 5	3	0 of 5

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-22—Region 7 Network Adequacy for Hospital Providers by County

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Brevard	70,807	1,483	1:47	20	1:3540	128	1:553	0	NR	5	MET	7	MET	0	NOT MET
Orange	213,856	3,263	1:65	36	1:5940	294	1:727	151	1:1416	8	MET	9	MET	1	NOT MET
Osceola	73,608	808	1:91	10	1:7360	25	1:2944	0	NR	4	MET	5	MET	0	NOT MET
Seminole	46,599	732	1:63	0	NR	62	1:751	8	1:5824	3	MET	3	MET	1	NOT MET
TOTAL	404,870	6,286	1:64	66	1:6134	509	1:795	159	1:2546	20	4 of 4	24	4 of 4	2	0 of 4

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-23—Region 8 Network Adequacy for Hospital Providers by County

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Charlotte	17,641	620	1:28	13	1:1357	52	1:339	0	NR	1	NOT MET	3	MET	0	NOT MET
Collier	38,872	900	1:43	16	1:2429	28	1:1388	0	NR	3	MET	4	MET	0	NOT MET
De Soto	6,524	49	1:133	0	NR	0	NR	0	NR	1	NOT MET	1	NOT MET	0	NOT MET
Glades	858	0	NR	0	NR	0	NR	0	NR	0	NOT MET	0	NOT MET	0	NOT MET
Hendry	11,465	25	1:458	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Lee	99,760	1,391	1:71	68	1:1467	93	1:1072	0	NR	4	MET	5	MET	1	NOT MET
Sarasota	35,859	1,883	1:19	0	NR	114	1:314	37	1:969	1	NOT MET	4	MET	1	NOT MET
TOTAL	210,979	4,868	1:43	97	1:2175	287	1:735	37	1:5702	10	2 of 7	18	4 of 7	2	0 of 7

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-24—Region 9 Network Adequacy for Hospital Providers by County

		BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
County	Enrollment[1]	No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Indian River	18,416	693	1:26	0	NR	68	1:270	24	1:767	1	NOT MET	2	MET	0	NOT MET
Martin	14,398	339	1:42	12	1:1199	0	NR	0	NR	1	NOT MET	2	MET	0	NOT MET
Okeechobee	8,757	100	1:87	0	NR	0	NR	0	NR	0	NOT MET	1	NOT MET	0	NOT MET
Palm Beach	177,731	3,469	1:51	301	1:590	224	1:793	27	1:6582	12	MET	14	MET	1	NOT MET
St. Lucie	49,348	588	1:83	58	1:850	106	1:465	0	NR	3	MET	4	MET	1	NOT MET
TOTAL	268,650	5,189	1:51	371	1:724	398	1:675	51	1:5267	17	2 of 5	23	4 of 5	2	0 of 5

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-25—Region 10 Network Adequacy for Hospital Providers by County

		BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
County	Enrollment[1]	No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Broward	262,364	5,136	1:51	189	1:1388	528	1:496	34	1:7716	12	MET	18	MET	1	NOT MET
TOTAL	262,364	5,136	1:51	189	1:1388	528	1:496	34	1:7716	12	1 of 1	18	1 of 1	1	0 of 1

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-26—Region 11 Network Adequacy for Hospital Providers by County

County	Enrollment[1]	BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS					
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds				Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child							
		No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)	No. of Facilities	Compliance (2:County)
Miami-Dade	535,946	8,067	1:66	117	1:4580	952	1:562	100	1:5359	13	MET	22	MET	1	NOT MET
Monroe	6,638	153	1:43	8	1:829	0	NR	0	NR	1	NOT MET	3	MET	0	NOT MET
TOTAL	542,584	8,220	1:66	125	1:4340	952	1:569	100	1:5425	14	1 of 2	25	2 of 2	1	0 of 2

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Table F-27—Network Adequacy for Hospital Providers by Region

		BED-TO-ENROLLEE RATIOS								COUNTY FACILITY STANDARDS						
		Acute Care Hospital Beds		Inpatient Substance Abuse Detox Unit Beds		Fully Accredited Psychiatric Community Hospital/Crisis Stabilization Unit/Freestanding Psychiatric Specialty Hospital Beds					Hospital or Facility With Birth/Delivery Services Beds		24/7 Emergency Service Facilities		Licensed Community Substance Abuse Treatment Centers	
						Adult		Child								
County	Enrollment[1]	No. of Beds	Ratio (1:275)	No. of Beds	Ratio (1:4000)	No. of Beds	Ratio (1:2000)	No. of Beds	Ratio (1:2000)	No. of Counties in Region	No. of Facilities	Number of Counties That Meet Standard (2:County)	No. of Facilities	Number of Counties That Meet Standard (2:County)	No. of Facilities	Number of Counties That Meet Standard (2:County)
Region 1	98,812	2,018	1:49	35	1:2861	169	1:592	26	1:3851	4	3	3 of 4	4	4 of 4	0	0 of 4
Region 2	108,741	1,636	1:68	14	1:8047	141	1:799	29	1:3884	14	2	2 of 14	3	3 of 14	0	0 of 14
Region 3	251,569	4,450	1:57	86	1:2988	272	1:944	15	1:17132	16	4	4 of 16	6	6 of 16	0	0 of 16
Region 4	303,369	5,237	1:57	106	1:2861	401	1:756	44	1:6894	7	2	2 of 7	3	3 of 7	0	0 of 7
Region 5	181,510	4,344	1:41	72	1:2520	434	1:418	49	1:3704	2	2	2 of 2	2	2 of 2	0	0 of 2
Region 6	415,676	7,033	1:59	110	1:3778	327	1:1271	28	1:14845	5	4	4 of 5	4	4 of 5	0	0 of 5
Region 7	404,870	6,286	1:64	66	1:6134	509	1:795	159	1:2546	4	4	4 of 4	4	4 of 4	0	0 of 4
Region 8	210,949	4,868	1:43	97	1:2175	287	1:735	37	1:5702	7	2	2 of 7	4	4 of 7	0	0 of 7
Region 9	268,650	5,189	1:51	371	1:724	398	1:675	51	1:5267	5	2	2 of 5	4	4 of 5	0	0 of 5
Region 10	262,364	5,136	1:51	189	1:1388	528	1:496	34	1:7716	1	1	1 of 1	1	1 of 1	0	0 of 1
Region 11	542,584	8,220	1:66	125	1:4340	952	1:569	100	1:5425	2	1	1 of 2	2	2 of 2	0	0 of 2
TOTAL	3,059,786	54,417	1:56	1,271	1:2407	4,418	1:692	572	1:5349	67	27	27 of 67	37	37 of 67	0	0 of 67

[1] Children's Medical Services was not included because the county-level enrollment data were not available.

Note: NR = Not Reported; designation for bed-to-enrollee ratios that could not be reported due to the absence of beds in a particular county.

Appendix G. Hospital Network Adequacy Results—Phase 2

Table G-1—Region 01–Time/Distance for Acute Hospitals by Region and County

County and Designation	Distance (in Miles)			Drive Time (in Minutes)		
	HSD Standard	AHCA Standard	Difference	HSD Standard	AHCA Standard	Difference
Rural						
Walton	60	20	40	80	30	50
Average Difference			**40**			**50**
Urban						
Escambia	30	20	10	45	30	15
Okaloosa	30	20	10	45	30	15
Santa Rosa	30	20	10	45	30	15
Average Difference			**10**			**15**

Table G-2—Region 02–Time/Distance for Acute Hospitals by Region and County

County and Designation	Distance (in Miles)			Drive Time (in Minutes)		
	HSD Standard	AHCA Standard	Difference	HSD Standard	AHCA Standard	Difference
Rural						
Calhoun	60	20	40	75	30	45
Franklin	60	20	40	75	30	45
Gadsden	60	20	40	80	30	50
Gulf	60	20	40	75	30	45
Holmes	60	20	40	75	30	45
Jackson	60	20	40	80	30	50
Jefferson	60	20	40	75	30	45
Liberty	100	20	80	110	30	80
Madison	60	20	40	75	30	45
Taylor	60	20	40	75	30	45
Wakulla	60	20	40	80	30	50
Washington	60	20	40	75	30	45
Average Difference			**43**			**49**
Urban						
Bay	30	20	10	45	30	15
Leon	30	20	10	45	30	15
Average Difference			**10**			**15**

Table G-3—Region 03–Time/Distance for Acute Hospitals by Region and County

County and Designation	Distance (in Miles)			Drive Time (in Minutes)		
	HSD Standard	AHCA Standard	Difference	HSD Standard	AHCA Standard	Difference
Rural						
Bradford	60	20	40	80	30	50
Columbia	60	20	40	80	30	50
Dixie	60	20	40	75	30	45
Gilchrist	60	20	40	75	30	45
Hamilton	60	20	40	75	30	45
Lafayette	60	20	40	75	30	45
Levy	60	20	40	75	30	45
Putnam	60	20	40	80	30	50
Suwannee	60	20	40	80	30	50
Union	60	20	40	80	30	50
Average Difference			**40**			**48**
Urban						
Alachua	30	20	10	45	30	15
Citrus	30	20	10	45	30	15
Hernando	30	20	10	45	30	15
Lake	30	20	10	45	30	15
Marion	30	20	10	45	30	15
Sumter	30	20	10	45	30	15
Average Difference			**10**			**15**

Table G-4—Region 04–Time/Distance for Acute Hospitals by Region and County

County and Designation	Distance (in Miles)			Drive Time (in Minutes)		
	HSD Standard	AHCA Standard	Difference	HSD Standard	AHCA Standard	Difference
Rural						
Baker	60	20	40	75	30	45
Average Difference			**40**			**45**
Urban						
Clay	30	20	10	45	30	15
Duval	30	20	10	45	30	15
Flagler	30	20	10	45	30	15
Nassau	30	20	10	45	30	15
St. Johns	30	20	10	45	30	15
Volusia	30	20	10	45	30	15
Average Difference			**10**			**15**

Table G-5—Region 05–Time/Distance for Acute Hospitals by Region and County

County and Designation	Distance (in Miles)			Drive Time (in Minutes)		
	HSD Standard	AHCA Standard	Difference	HSD Standard	AHCA Standard	Difference
Urban						
Pasco	30	20	10	45	30	15
Pinellas	**10**	**20**	**-10**	**20**	**30**	**-10**
Average Difference			**0**			**3**

Table G-6—Region 06–Time/Distance for Acute Hospitals by Region and County

County and Designation	Distance (in Miles)			Drive Time (in Minutes)		
	HSD Standard	AHCA Standard	Difference	HSD Standard	AHCA Standard	Difference
Rural						
Hardee	60	20	40	75	30	45
Highlands	60	20	40	80	30	50
Average Difference			**40**			**48**
Urban						
Hillsborough	**10**	**20**	**-10**	**20**	**30**	**-10**
Manatee	30	20	10	45	30	15
Polk	30	20	10	45	30	15
Average Difference			**3**			**7**

Table G-7—Region 07–Time/Distance for Acute Hospitals by Region and County

County and Designation	Distance (in Miles)			Drive Time (in Minutes)		
	HSD Standard	AHCA Standard	Difference	HSD Standard	AHCA Standard	Difference
Urban						
Brevard	30	20	10	45	30	15
Orange	**10**	**20**	**-10**	**20**	**30**	**-10**
Osceola	30	20	10	45	30	15
Seminole	30	20	10	45	30	15
Average Difference			**5**			**9**

Table G-8—Region 08–Time/Distance for Acute Hospitals by Region and County

County and Designation	Distance (in Miles)			Drive Time (in Minutes)		
	HSD Standard	AHCA Standard	Difference	HSD Standard	AHCA Standard	Difference
Rural						
DeSoto	60	20	40	80	30	50
Glades	60	20	40	75	30	45
Hendry	60	20	40	75	30	45
Average Difference			**40**			**47**
Urban						
Charlotte	30	20	10	45	30	15
Collier	30	20	10	45	30	15
Lee	30	20	10	45	30	15
Sarasota	30	20	10	45	30	15
Average Difference			**10**			**15**

Table G-9—Region 09–Time/Distance for Acute Hospitals by Region and County

County and Designation	Distance (in Miles)			Drive Time (in Minutes)		
	HSD Standard	AHCA Standard	Difference	HSD Standard	AHCA Standard	Difference
Rural						
Okeechobee	60	20	40	80	30	50
Average Difference			**40**			**50**
Urban						
Indian River	30	20	10	45	30	15
Martin	30	20	10	45	30	15
Palm Beach	30	20	10	45	30	15
St. Lucie	30	20	10	45	30	15
Average Difference			**10**			**15**

Table G-10—Region 10–Time/Distance for Acute Hospitals by Region and County

County and Designation	Distance (in Miles)			Drive Time (in Minutes)		
	HSD Standard	AHCA Standard	Difference	HSD Standard	AHCA Standard	Difference
Urban						
Broward	**10**	**20**	**-10**	**20**	**30**	**-10**
Average Difference			**-10**			**-10**

Table G-11—Region 11–Time/Distance for Acute Hospitals by Region and County

County and Designation	Distance (in Miles)			Drive Time (in Minutes)		
	HSD Standard	AHCA Standard	Difference	HSD Standard	AHCA Standard	Difference
Rural						
Monroe	60	20	40	80	30	50
Average Difference			**40**			**50**
Urban						
Miami-Dade	**10**	**20**	**-10**	**20**	**30**	**-10**
Average Difference			**-10**			**-10**

Appendix H. Plan Names/Abbreviations

Table H-1—SFY 2015–2016 Plan-Approved Naming Convention

Full Plan Name	4-Letter Code	Shortened Name
MMA Plans		
Amerigroup Community Care	AMG-M	Amerigroup
Better Health	BET-M	Better Health
Coventry Health Care of Florida, Inc.	COV-M	Coventry
Humana Medical Plan, Inc.	HUM-M	Humana
Integral Quality Care*	IHP-M	Integral
Molina Healthcare of Florida, Inc.	MOL-M	Molina
Preferred Medical Plan, Inc.†	PRE-M	Preferred
Prestige Health Choice	PRS-M	Prestige
South Florida Community Care Network‡	NBD-M	SFCCN
Simply Healthcare Plans, Inc.	SHP-M	Simply
Sunshine State Health Plan, Inc.	SUN-M	Sunshine
UnitedHealthcare of Florida, Inc.	URA-M	United
Wellcare d/b/a Staywell Health Plan of Florida, Inc.	STW-M	Staywell
Specialty Plans		
AHF MCO of Florida, Inc. dba Positive Healthcare, Inc.	PHC-S	Positive-S
Children's Medical Services Network	CMS-S	Children's Medical Services-S
Clear Health Alliance	CHA-S	Clear Health-S
Freedom Health, Inc.	FRE-S	Freedom-S
Magellan Complete Care	MCC-S	Magellan-S
Sunshine State Health Plan, Inc.	SUN-S	Sunshine-S
Long-term Care Plans		
American Eldercare, Inc.§	AEC-L	American Eldercare-LTC
Amerigroup Community Care	AMG-L	Amerigroup-LTC
Coventry Health Care of Florida, Inc.	COV-L	Coventry-LTC
Humana Medical Plan, Inc.	HUM-L	Humana-LTC
Molina Healthcare of Florida, Inc.	MOL-L	Molina-LTC
Sunshine State Health Plan, Inc.	SUN-L	Sunshine-LTC
UnitedHealthcare of Florida, Inc.	URA-L	United-LTC

* Integral was purchased by Molina on November 1, 2015.
† Preferred was purchased by Molina on August 1, 2015.
‡ SFCCN changed its name to South Florida Community Care Network, DBA Community Care Plan (CCP) in SFY 2017. For the purposes of this report, CCP is used as the reference in the PMV reporting as it is based on SFY 2017 data.
§ American Eldercare-LTC was purchased by Humana on July 1, 2015.