Florida Agency for Health Care Administration

SFY 2016–2017 External Quality Review Technical Report

May 2018

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

Glossary of 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
AHRQ ..... Agency for Healthcare Research and Quality
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
CHIP ..... Children's Health Insurance Program
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
CYE ..... Calendar Year Ending
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
ER ..... Emergency Room
F2F ..... *Face-to-Face Encounters*
F.A.C. ..... Florida Administrative Code
FAR ..... Final Audit Report
FFS ..... Fee-for-Service
FFY ..... Federal Fiscal Year
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
FPC ..... *Frequency of Prenatal Care* (formerly *Prenatal Care Frequency [PCF]*)
FQHC ..... Federally Qualified Health Center
F.S. ..... Florida Statutes
HAART ..... *Highly Active Anti-Retroviral Treatment*
HbA1c ..... Hemoglobin A1c
HCBS ..... Home and Community-Based Services
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*
IRR..... Interrater Reliability
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*

PDF ..... Portable Document Format
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
QAPI ..... Quality Assessment and Performance Improvement
QI ..... Quality Improvement
QM ..... Quality Management
RER ..... *Mental Health Readmission Rate*
Roadmap ..... Record of Administration, Date Management, and Processes
RRD ..... *Required Record Documentation*
RY ..... Reporting Year
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*
TA ..... Technical Assistance
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 Persons 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 Code of Federal Regulations (CFR) at 42 CFR §438.364[1-1] requires that states use an external quality review organization (EQRO) to prepare an annual technical report that describes the manner in which data from activities conducted for Medicaid managed care organizations (MCOs), in accordance with the CFR, were aggregated and analyzed. The annual technical report also draws conclusions about the quality of, timeliness of, and access to healthcare services that MCOs provide. The state fiscal year (SFY) 2016–2017 Annual Technical Report of External Quality Review Results, prepared for the Florida Agency for Health Care Administration (AHCA), is presented to comply with 42 CFR §438.364. Health Services Advisory Group, Inc. (HSAG), is the EQRO for AHCA, the State agency responsible for the overall administration of Florida's Medicaid managed care program.

This is the 11th 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(d).

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 MCOs.

HSAG's EQR 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 SFYs 2014–2017, AHCA conducted desk reviews and site visits for all Managed Medical Assistance (MMA) and Long-term Care (LTC) plans for parts of each of the federal standards and all standards for the State contract requirements.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register* Vol. 81, No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27886. 42 CFR Parts 364 Medicaid Program; External Quality Review, Final Rule.

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.
- 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 are 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 of, timeliness of, and access to healthcare services they provide.

The Centers for Medicare & Medicaid Services (CMS) has chosen the domains of quality, access, and timeliness as keys to evaluating 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[1-2]:

> Quality, as it pertains to external quality review, means the degree to which an MCO, prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity (described in §438.310(c)(2)) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics, the provision of services that are consistent with current professional, evidence-based knowledge, and interventions for performance improvement.

[1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register* Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.

Timeliness

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."[1-3] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care).

Access

CMS defines "access" in the final rule at 42 CFR §438.320 as follows[1-4]:

> 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 that each state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner. The State must also ensure the MCO, PIHP, and PAHP provider networks for services covered in the contract meet the standards developed by the State in accordance with the network adequacy standards (§438.68). Any state that contracts with an MCO, PIHP, or PAHP to deliver Medicaid services is required by CFR §438.68 to develop and enforce network adequacy standards.

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 MMA program and the 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

[1-3] National Committee for Quality Assurance. 2013 Standards and Guidelines for the Accreditation of Health Plans.
[1-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register* Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.

(PSNs) that were identified as either Reform or Non-Reform. Reform referred to the Medicaid Reform 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 F for a comprehensive list of plan names, by plan type.

Summary of Findings, Conclusions, and Recommendations

Performance Improvement Projects (PIPs)

During SFY 2016–2017 the MMA plans submitted four PIPs for validation, including the following topics: 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 the following topics: 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 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 2016–2017 had progressed through the Design stage (Activities I–VI), Implementation stage (Activities VII and VIII), and Activity IX of the Outcomes stage, reporting baseline and Remeasurement 1 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.

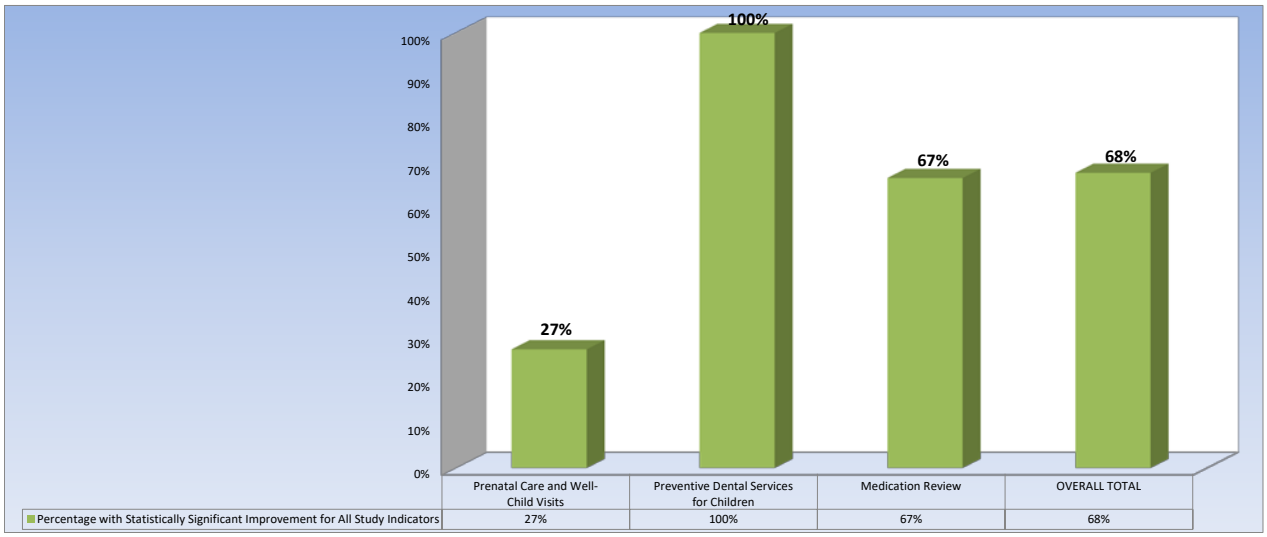
Table 1-1—Current State-mandated PIP Topics

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 Plans	Remeasurement 1 results reported
Preventive Dental Services for Children	MMA Plans	Remeasurement 1 results reported
Medication Review	LTC Plans	Remeasurement 1 results reported

Statistically Significant Improvement

For the SFY 2016–2017 validation cycle, the plans reported Remeasurement 1 study indicator results, and the PIPs were evaluated for achieving real improvement from baseline to Remeasurement 1. The percentages of state-mandated PIPs that demonstrated statistically significant improvement over baseline across all study indicators are presented in Figure 1-1.

Figure 1-1—Percentage of SFY 2016–2017 State-Mandated PIPs That Achieved Statistically Significant Improvement Over Baseline for All Study Indicators, by PIP Topic

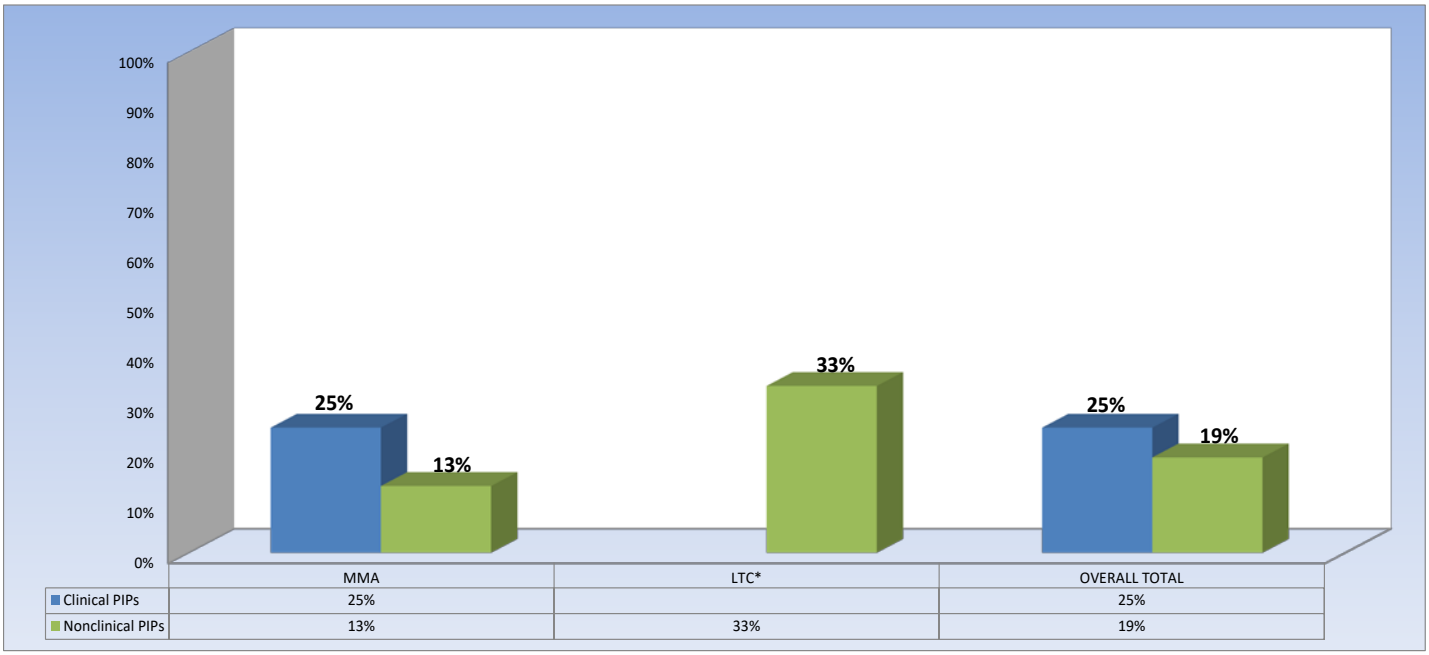


Across the three state-mandated topics, 68 percent of the PIPs demonstrated statistically significant improvement over baseline across all study indicators at Remeasurement 1. The percentage of PIPs demonstrating statistically significant improvement across all study indicators varied by state-mandated topic: 27 percent of the *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIPs, 100 percent of the *Preventive Dental Services for Children* PIPs, and 67 percent of the *Medication Review* PIPs.

Among those PIPs that achieved statistically significant improvement, HSAG identified a pattern for two of the state-mandated topics: *Preventive Dental Services for Children* and *Medication Review*. For plans that demonstrated statistically significant improvement at Remeasurement 1 for these two topics, the plan-specific goal for Remeasurement 1 may not have been met. This pattern suggests that some of the plans may be setting highly ambitious remeasurement goals that go beyond what is required to demonstrate statistically significant improvement. The plans should consider reviewing goals for future remeasurement periods to ensure that the goals are realistic and attainable.

In addition to the state-mandated PIPs represented in Figure 1-1, HSAG evaluated the plan-selected clinical and nonclinical PIPs for achieving real improvement across all study indicators. The percentages of plan-selected clinical and nonclinical PIPs that demonstrated statistically significant improvement over baseline across all study indicators are presented in Figure 1-2.

Figure 1-2—Percentage of SFY 2016–2017 Clinical and Nonclinical PIPs That Achieved Statistically Significant Improvement Over Baseline for All Study Indicators, by PIP Topic and Plan Type



	MMA	LTC*	OVERALL TOTAL
Clinical PIPs	25%		25%
Nonclinical PIPs	13%	33%	19%

* The LTC plans did not submit any plan-selected clinical PIPs for validation; therefore, no data are displayed for LTC clinical PIPs.

Twenty-five percent of the clinical PIPs with comparable Remeasurement 1 results demonstrated statistically significant improvement over baseline across all study indicators at Remeasurement 1. These results are based on the clinical PIPs conducted by the MMA plans because the LTC plans did not submit plan-selected clinical PIPs for validation during SFY 2016–2017. Among all nonclinical PIPs with comparable Remeasurement 1 results, 19 percent of the PIPs demonstrated statistically significant improvement over baseline across all study indicators. A greater percentage of nonclinical PIPs conducted by the LTC plans (33 percent) than conducted by the MMA plans (13 percent) demonstrated statistically significant improvement from baseline to Remeasurement 1 across all indicators. For additional information related to study indicators demonstrating statistically significant improvement, see Section 3—External Quality Review Activities and Results.

Innovative Interventions Associated With Statistically Significant Improvement

As part of the PIP validation process, HSAG identified innovative interventions employed in PIPs that achieved statistically significant improvement across all study indicators. During the SFY 2016–2017 validation cycle, HSAG identified innovative interventions associated with statistically significant improvement for one plan-selected clinical PIP topic, *Annual Diabetic Retinal Eye Exam*, and two state-mandated PIP topics, *Medication Review* and *Preventive Dental Visits for Children*. HSAG identified 11 innovative interventions employed by 12 plans. Examples of the innovative interventions include provider incentive programs, use of community-based liaisons, partnering with the School-Based Sealant Program, and use of mobile dental service units. Additional details about the innovative

interventions identified during the SFY 2016–2017 validation cycle can be found in Section 3—External Quality Review Activities and Results.

Overall PIP Validation Status

HSAG validated PIPs submitted by all 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*. To determine the overall validation status for each PIP, HSAG evaluated the PIP on a set of up to 28 standard evaluation elements that aligned with the three PIP stages—Design, Implementation, and Outcomes—and the 10 steps in CMS' *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012.[1-5] HSAG designated 13 evaluation elements as critical because of their importance in defining a project as valid and reliable. These 13 critical elements all had to receive a *Met* score for the PIP to receive a *Met* overall validation status. The PIP also had to receive a *Met* score for 80 percent or more of all applicable evaluation elements to receive a *Met* overall validation status. The details of HSAG's PIP validation process are provided in Appendix A.

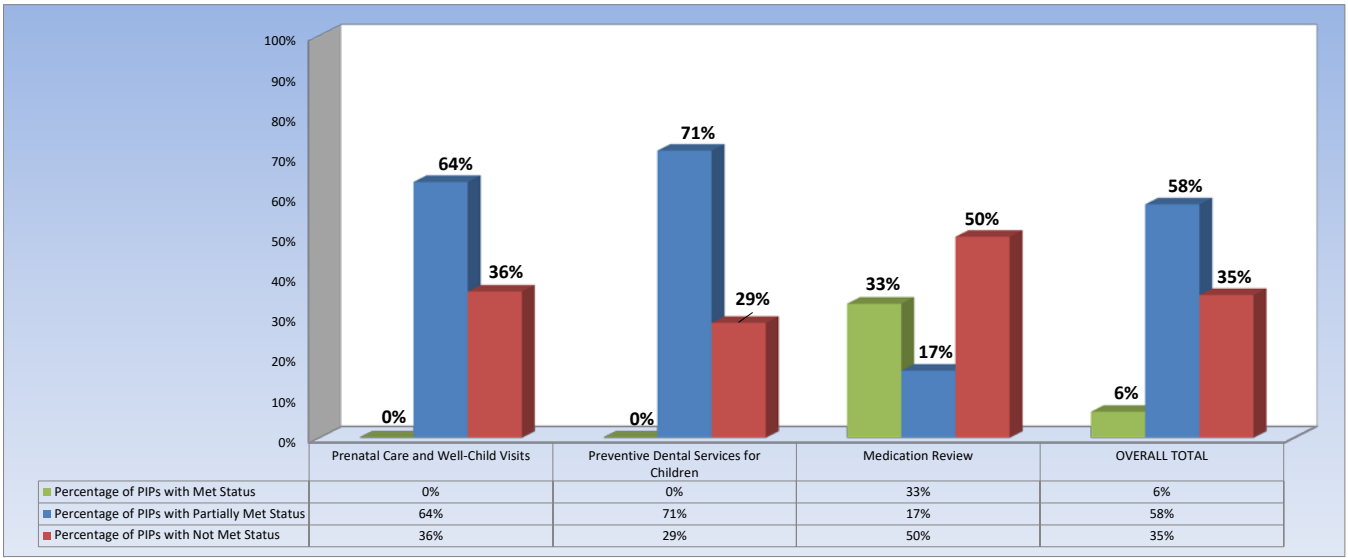
This year's validation was the first year that the PIPs progressed to the Outcomes stage and included study indicator remeasurement results; therefore, it was the first year the PIPs were assessed for real improvement of outcomes. In prior years, the PIPs were evaluated on study design and accuracy of the baseline measurement, having progressed only through the first two of the three PIP stages—Design and Implementation. With progression to the third stage, Outcomes, the PIPs were evaluated on two additional critical evaluation elements that had not been previously evaluated. In Activity VIII (Appropriate Improvement Strategies), the PIPs were evaluated on whether the plans had evaluated each intervention for effectiveness; in Activity IX (Real Improvement Achieved), the PIPs were evaluated on whether there was statistically significant improvement in study indicator rates from baseline to the first remeasurement. If the PIP documentation did not demonstrate sufficient evaluation of each intervention, one of the critical evaluation elements would not receive a *Met* score and the overall validation status would not be *Met*. Likewise, if the PIP did not demonstrate statistically significant improvement across all study indicator rates, from baseline to the first remeasurement, one of the critical evaluation elements would not receive a *Met* score and the overall validation status would not be *Met*. These two critical evaluation elements drove the overall validation status for many PIPs for this year's validation cycle.

Figure 1-3 displays the percentage of state-mandated PIPs receiving a *Met*, *Partially Met*, and *Not Met* overall validation status by plan type and PIP topic for the SFY 2016–2017 validation cycle. Thirty-one of the 76 PIPs validated focused on one of the three state-mandated topics. The green bars represent the percentage of PIPs with an overall validation status of *Met*, the blue bars represent the percentage of

[1-5] 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: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Jan 26, 2018.

PIPs with a *Partially Met* validation status, and the red bars represent the percentage of PIPs with a *Not Met* validation status.

Figure 1-3—Overall Validation Status of State-Mandated PIPs by PIP Topic*



	Prenatal Care and Well-Child Visits	Preventive Dental Services for Children	Medication Review	OVERALL TOTAL
Percentage of PIPs with Met Status	0%	0%	33%	6%
Percentage of PIPs with Partially Met Status	64%	71%	17%	58%
Percentage of PIPs with Not Met Status	36%	29%	50%	35%

*Percentage totals may not equal 100 percent due to rounding.

Across all state-mandated PIPs, 6 percent received an overall *Met* validation status, 58 percent received an overall *Partially Met* validation status, and 35 percent received a *Not Met* validation status. The percentage of PIPs receiving a *Met* validation status was highest for the *Medication Review* PIPs (33 percent). None of the *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIPs or the *Preventive Dental Services for Children* PIPs received a *Met* validation status for the Remeasurement 1 PIP validation. The majority of the *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIPs (64 percent) and the *Preventive Dental Services for Children* PIPs (71 percent) received a *Partially Met* validation status, suggesting that the PIPs addressed some but not all critical evaluation elements included in HSAG's PIP validation methodology.

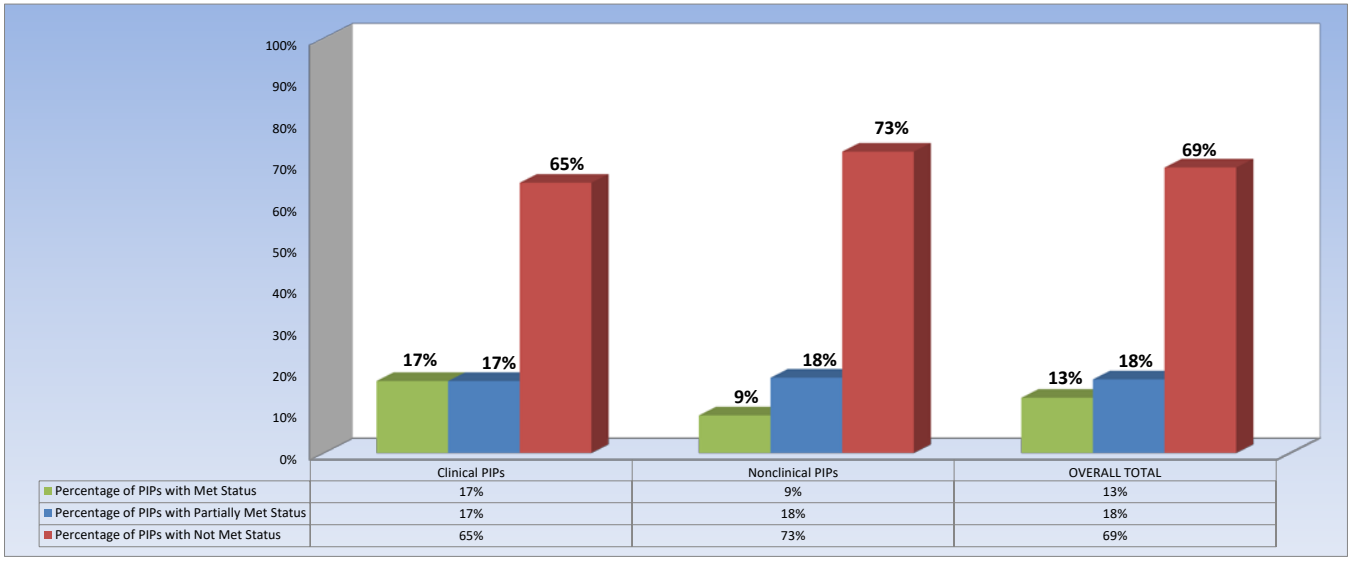
The state-mandated PIPs had progressed through Activity IX of the Outcomes stage for this year's validation; therefore, validation status was based on the study design of the PIP, the data analysis and quality improvement (QI) activities conducted for the Remeasurement 1 period, and whether or not statistically significant improvement was demonstrated by the study indicator results. In general, the PIPs were well-designed; however, opportunities for improvement exist with analysis and interpretation of results, quality improvement activities and interventions, and achieving statistically significant improvement over the baseline. There were three common reasons across the state-mandated PIP topics for plans not receiving a *Met* validation status.

- Plans incorrectly reporting study indicator or statistical testing results
- Lack of processes for evaluating the effectiveness for each intervention
- Not receiving a *Met* score for at least 80 percent of all applicable evaluation elements validated across all PIPs

In addition, for the *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIP, some plans did not achieve statistically significant improvement over the baseline across all study indicators, which resulted in an overall *Partially Met* or *Not Met* validation status. Plans may improve the validation status and the quality of their PIPs by addressing HSAG's feedback in the PIP validation tools and ensuring that all data and statistical testing outcomes are reported accurately; each intervention is evaluated for effectiveness appropriately; and the root cause for not achieving the desired outcomes for the study indicators is investigated and addressed with active, innovative interventions and improvement strategies. Plans can also request technical assistance (TA) from HSAG to address questions related to the PIP methodology and QI tools and processes.

In addition to the 31 state-mandated PIPs represented in Figure 1-4, HSAG validated 23 plan-selected clinical PIPs and 22 plan-selected nonclinical PIPs. Figure 1-4 displays the percentage of clinical and nonclinical PIPs receiving a *Met*, *Partially Met*, and *Not Met* overall validation status for the SFY 2016–2017 validation cycle. The green bars represent the percentage of PIPs with an overall validation status of *Met*, the blue bars represent the percentage of PIPs with a *Partially Met* validation status, and the red bars represent the percentage of PIPs with a *Not Met* validation status.

Figure 1-4—Overall Validation Status of Plan-Selected Clinical and Nonclinical PIPs *



	Clinical PIPs	Nonclinical PIPs	OVERALL TOTAL
Percentage of PIPs with Met Status	17%	9%	13%
Percentage of PIPs with Partially Met Status	17%	18%	18%
Percentage of PIPs with Not Met Status	65%	73%	69%

*Percentage totals may not equal 100 percent due to rounding.

The validation results for the plan-selected PIPs demonstrate that the plans have room for improvement in addressing HSAG's evaluation requirements for receiving a *Met* validation status. Nearly twice as many clinical PIPs (17 percent) than nonclinical PIPs (9 percent) received a *Met* validation status, with 13 percent of the plan-selected PIPs overall receiving a *Met* validation status. Similar percentages of clinical PIPs (17 percent) and nonclinical PIPs (18 percent) received a *Partially Met* validation status. For both clinical and nonclinical PIPs, the most common validation status was *Not Met*, with 65 percent of clinical PIPs, 73 percent of nonclinical PIPs, and 69 percent of plan-selected PIPs overall receiving a

Not Met validation status. The results suggest that most the plan-selected clinical and nonclinical PIPs did not address all of HSAG's PIP validation requirements.

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 QI processes and activities used for the PIPs. While a higher percentage of plan-selected clinical and nonclinical PIPs received a *Met* validation status than two of the state-mandated PIP topics (*Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIPs and the *Preventive Dental Services for Children* PIPs), most of the plan-selected PIPs did not receive a *Met* validation status. The plans should address deficiencies in the Implementation stage, related to data analysis and interpretation and intervention evaluation, to provide a solid foundation for achieving improvement in the study indicator rates at the second remeasurement. The plans have access to HSAG's feedback as well as guidance in the PIP validation tools and the PIP completion instructions, and they have the opportunity to seek TA 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 to improve the structure and implementation of the PIPs as well as to support progress toward improved PIP outcomes in the future. Further detail on opportunities for improvement and expanded recommendations are provided in Section 3—External Quality Review Activities and Results.

Overall recommendations:

- AHCA should continue the PIP check-in process with each plan. This process helps AHCA more closely monitor each plan's PIP progress and identify opportunities for training and TA. AHCA can refer plans to HSAG for more timely TA, as needed, based on the results of the PIP check-in meetings.
- 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 clearly and consistently define and document the criteria used to identify the study population for each PIP.
- The plans should set attainable study indicator goals for each remeasurement period, based on organizational knowledge and study indicator rates from previous measurement periods. Each goal should represent a statistically significant improvement compared to the baseline study indicator rate.
- The plans should correct any errors in the study indicator rate calculations and/or statistical testing results identified by HSAG in the SFY 2016–2017 PIP validation tool. Accurate study indicator rates are necessary for an accurate measurement of progress in improving PIP outcomes during the remeasurement periods.

- The plans should ensure adequate analytical staffing for the PIPs to facilitate methodologically sound design and accurate, appropriate data analysis and interpretation throughout the project.
- The plans should have a process in place for evaluating the performance of each intervention and its impact on the study indicators. Evaluation results should be documented separately for each intervention during each measurement period.
- The plans should use intervention-specific evaluation results to guide next steps of each intervention. The PIP documentation should include the next steps for each intervention, and future intervention plans should be linked to evaluation results.

Performance Measure Validation

HSAG conducted performance measure validation (PMV) activities for the measures calculated and reported by MMA Standard plans, MMA Specialty plans, and LTC plans for reporting year (RY) 2017. All measure indicator data were audited by an NCQA Licensed Organization (LO) in line with the NCQA HEDIS Compliance Audit policies and procedures.[1-6] HSAG's role in the validation of performance measures was to ensure that audit activities conducted by the LO 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 [1-7]). This included validating the audit process to ensure key audit activities were performed, and verifying 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 76 measure indicators, which were grouped into eight domains (Pediatric Care, Women's Care, Living With Illness, Behavioral Health, Access/Availability of Care, Use of Services, and Serious Mental Illness [SMI]; and one MMA Specialty Performance Measure domain: Older Adult Care) (see Table 1-2). For the current measurement year, MMA plans continued to demonstrate strong performance in meeting the NCQA HEDIS Compliance Audit Information Systems (IS) standards. All MMA plans were fully compliant with IS standards 2.0, 3.0, 5.0, and 7.0.[1-8]

For IS Standard 1.0, all but one Standard MMA plan and all Specialty MMA plans were fully compliant. One Standard MMA plan was not compliant because the plan's vendor did not release human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) laboratory (lab) data due to

[1-6] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).
[1-7] 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: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-2.pdf. Accessed on: Jan 18, 2018.
[1-8] NCQA eliminated IS Standard 6 for HEDIS 2017 based on the *Call Answer Timeliness (CAT)* measure being retired.

enrollee confidentiality concerns. As a result, this plan was unable to report the *HIV Viral Load Suppression (VLS)* measure and received a *Biased Rate (BR)* audit designation for this measure.

All but one Standard MMA plan and all Specialty MMA plans were fully complaint with IS Standard 4.0. One MMA plan was partially compliant with this standard because significant errors were identified with the abstraction of records for the *Eye Exam (Retinal) Performed* indicator for the *Comprehensive Diabetes Care (CDC*) measure. A second sample was not completed because two or more errors were identified. Therefore, the auditor required the plan's medical record review vendor to overread the remaining records and submit a corrective action plan (CAP) to ensure there were no further issues.

One MMA Specialty plan (Freedom-S) was required to report an additional measure under the Older Adult Care domain *(Care for Older Adults [COA]),* and one MMA Specialty plan (Magellan-S) was required to report two additional measures under the SMI domain (*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 76 performance measure indicators selected for RY 2017 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, access, and timeliness. Cells shaded gray denote the measures for which AHCA established performance targets for 2017, which were generally established based on the Healthcare Effectiveness Data and Information Set (HEDIS®) [1-9] national Medicaid 75th percentiles. While AHCA has indicated it has set an ambitious target for all plans to achieve and/or surpass the national Medicaid 75th percentile, the more immediate goal is for all plans to have all measure rates above the national Medicaid 50th percentile. See the "Statewide Weighted Average Measure Results" section of Appendix D to view individual measure rates compared to the national Medicaid 50th percentile.

Table 1-2—Reporting Year 2017 MMA Performance Measures and Assignments to the Quality, Access, and Timeliness Domains

Reporting Year 2017 (Calendar Year 2016) Measures	Measure Source	Quality	Access	Timeliness
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	✓		

[1-9] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Reporting Year 2017 (Calendar Year 2016) Measures	Measure Source	Quality	Access	Timeliness
Adolescent Well-Care Visits (AWC)	HEDIS	✓		
Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap/Td) and *Combination 2 (Meningococcal, Tdap, HPV)*[1]	HEDIS	✓		✓
Annual Dental Visit (ADV)—Total	HEDIS	✓	✓	
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—Total (CHL)	HEDIS	✓		
Breast Cancer Screening (BCS)	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		✓	✓
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*[2]	HEDIS	✓		
Annual Monitoring for Patients on Persistent Medications (MPM)—Total	HEDIS	✓		
Plan All-Cause Readmissions (PCR-AD)—18–64 Years of Age—Total and *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	✓		
HIV Viral Load Suppression (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*[3]	Medicaid Adult Core Set	✓		
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	✓	✓	✓
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up and *30-Day Follow-Up*	HEDIS	✓	✓	✓
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	HEDIS	✓	✓	✓

Reporting Year 2017 (Calendar Year 2016) Measures	Measure Source	Quality	Access	Timeliness
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	✓		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	HEDIS	✓		✓
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)^	AHCA-Defined			✓
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*[4]	HEDIS		✓	
MMA Specialty Performance Measures—SMI				
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—Chronic Disease				
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 RY 2017 performance target established by AHCA.

[1] *For this measure, an AHCA performance target was established only for the Immunizations for Adolescents—Combination 1 indicator.*

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

[3] *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.*

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

^ *The CAT measure was retired from HEDIS, so RY 2017 rates were calculated as an AHCA-defined measure.*

A total of 59 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 the measures that had an established performance target in this area, six of 39 (15.4 percent) met or exceeded the performance target. **Additionally, the statewide average met or exceeded the national**

Medicaid 50th percentile for 21 of 39 (53.8 percent) measures that had an established performance target. 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 two of the 12 (16.7 percent) measure indicators with targets established, including *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total.* **Additionally, the statewide weighted average rates met or exceeded the national Medicaid 50th percentile for eight of the 12 (66.7 percent) measure indicators with targets established.** Only one of 12 (8.3 percent) statewide weighted average rates demonstrated a decrease in performance from RY 2016 to RY 2017 (*Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*), **indicating overall positive performance from the prior year** in the Pediatric Care domain for measures with an established performance target.
- For Women's Care, the statewide weighted average rates met or exceeded the AHCA performance target for one of the five (20.0 percent) measure indicators with targets established: *Chlamydia Screening for Women—Total*. **Additionally, the statewide weighted average rates met or exceeded the national Medicaid 50th percentile for four of the five (80.0 percent) measure indicators with targets established. Only one of five (20.0 percent) statewide weighted average rates demonstrated a decrease in performance from RY 2016 to RY 2017 (*Breast Cancer Screening*), indicating overall positive performance from the prior year in the Women's Care domain for measures with an established performance target.**
- For Living With Illness, the statewide weighted average rates met or exceeded the AHCA performance targets for one of the 12 (8.3 percent) measure indicators with targets established: *Annual Monitoring for Patients on Persistent Medications—Total*. **Additionally, the statewide weighted average rates met or exceeded the national Medicaid 50th percentile for five of the 12 (41.7 percent) measure indicators with targets established.** Seven of the 12 (58.3 percent) statewide weighted average rates demonstrated an increase in performance from RY 2016 to RY 2017 (*Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control [>9.0%]*, *HbA1c Control [<8.0%]*, and *Eye Exam [Retinal] Performed*; *Controlling High Blood Pressure*; *Adult BMI Assessment*; and *Annual Monitoring for Patients on Persistent Medications—Total*) indicating varied performance from the prior year in the Living With Illness domain for measures with an established performance target.
- For Behavioral Health, the statewide weighted average rates met or exceeded the AHCA performance targets for one of the 10 (10.0 percent) measure indicators with targets established: *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total*. **Additionally, the statewide weighted average rates met or exceeded the national Medicaid 50th percentile for four of the 10 (40.0 percent) measure indicators with targets established.** Seven of the 10 (70.0 percent) statewide weighted average rates demonstrated an increase in performance from RY 2016 to RY 2017 (*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Initiation of AOD Treatment—Total* and *Engagement of AOD Treatment—Total*; *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*; *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*; *Metabolic Monitoring for Children*

and Adolescents on Antipsychotics—Total; and *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*) indicating varied performance from the prior year in the Behavioral Health domain for measures with an established performance target.

A total of 21 MMA Standard performance measure indicators related to **access** were evaluated as part of the Pediatric Care, Women's Care, Behavioral Health, Access/Availability of Care, and Use of Services domains. Of the measures that had an established performance target, one of 14 (7.1 percent) met or exceeded the performance target. **Additionally, the statewide weighted average met or exceeded the national Medicaid 50th percentile for six of 14 (42.9 percent) measures with an established performance target.** 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 one of the three (33.3 percent) measure indicators with targets established: *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase.* **Additionally, the statewide weighted average rates met or exceeded the national Medicaid 50th percentile for two of three (66.7 percent) indicators with targets established. Only one of three (33.3 percent) statewide weighted average rates demonstrated a decrease in performance from RY 2016 to RY 2017 (*Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*), indicating overall positive performance from the prior year in the Pediatric Care domain for measures with an established performance target.**
- For Women's Care, the statewide weighted average rates did not meet the AHCA performance targets for any of the three measure indicators with targets established. **Additionally, the statewide weighted average rates met or exceeded the national Medicaid 50th percentile for all three measure indicators with targets established.** All three statewide weighted averages for these measures (*Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*; and *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits*) increased from the prior year.
- For Behavioral Health, the statewide weighted average rates did not meet the AHCA performance targets for either of the two measure indicators with targets established. Additionally, the statewide weighted average rates did not meet or exceed the national Medicaid 50th percentile for either of the two measure indicators with targets established. The two statewide weighted averages for these measures (*Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*) increased from the prior year.
- For Access/Availability of Care, the statewide weighted average rates did not meet the AHCA performance targets for any of the five measure indicators with targets established. **The statewide weighted average rates met or exceeded the national Medicaid 50th percentile for one of the five (20.0 percent) measure indicators with targets established.** Of note, all five statewide weighted averages for these measures (*Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*, *25 Months–6 Years*, *7–11 Years*, and *12–19 Years*; and *Adults' Access to Preventive/Ambulatory Health Services—Total*) decreased from the prior year.
- For Use of Services, the statewide weighted average rate did not exceed the national Medicaid 50th percentile or the AHCA performance target for the one measure indicator with a target established, *Ambulatory Care (AMB)—ED Visits per 1,000 Member Months (MM).*

A total of 21 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. Of the measures that had an established performance target in this area, one of 15 (6.7 percent) met or exceeded the performance target. **Additionally, the statewide weighted average met or exceeded the national Medicaid 50th percentile for nine of 15 (60.0 percent) measures with an established performance target.** 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 one of the six (16.7 percent) measure indicators with targets established: *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase.* **Additionally, the statewide weighted average rates met or exceeded the national Medicaid 50th percentile for four of the six (66.7 percent) measure indicators with targets established. Only one of six (16.7 percent) statewide weighted average rates decreased from RY 2016 to RY 2017 (*Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*), indicating overall positive performance from the prior year in the Pediatric Care domain for measures with an established performance target.**
- For Women's Care, the statewide weighted average rates did not meet the AHCA performance targets for any of the three measure indicators with targets established. **However, the statewide weighted average rates met or exceeded the national Medicaid 50th percentile for all three measure indicators with targets established.** Additionally, all three statewide weighted averages for these measures (*Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*; and *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits*) demonstrated an increase in performance from the prior year.
- For Behavioral Health, the statewide weighted average rates did not meet the AHCA performance targets for any of the five measure indicators with targets established. **However, the statewide weighted average rates met or exceeded the national Medicaid 50th percentile for one of the five (20.0 percent) measure indicators with targets established. All four of the statewide weighted average rates with rates reported for RY 2016 and RY 2017 demonstrated an increase in performance from the prior year (*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Initiation of AOD Treatment—Total* and *Engagement of AOD Treatment—Total*; and *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*) indicating positive performance from the prior year in the Behavioral Health domain for measures with an established performance target.**
- For Access/Availability of Care, *Call Answer Timeliness* was the only measure related to **timeliness** that had an AHCA performance target established. The statewide weighted average rate did not meet this target, **but it did meet or exceed the national Medicaid 50th percentile for this measure.** In addition, the statewide weighted average for this measure increased from the prior year.

In addition to the Standard MMA performance measures, some Specialty MMA plans were also required to report other performance measures specific to the enrollee population that they served. Six Specialty MMA plans operated during RY 2017. The HIV/AIDS Specialty plans (Clear Health-S and Positive-S), Children's Medical Services Network plan (Children's Medical Services-S), and the Child Welfare Specialty plan (Sunshine-S) reported no measures beyond the Standard MMA performance

measures, while the SMI Specialty plan (Magellan-S) reported the SMI measure rates and the Chronic Disease Specialty plan (Freedom-S) reported the Older Adult Care measure rates.

The SMI measure rates reported by the Specialty MMA plan were both related to **quality** and **timeliness** and had AHCA performance targets established. One of the two (50.0 percent) reported rates for the SMI performance measures met or exceeded the AHCA performance targets: *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*. **Additionally, both rates reported for the SMI performance measures met or exceeded the national Medicaid 50th percentile**. The Older Adult Care measure rates reported by the Chronic Disease Specialty plan did not have established performance targets.

Opportunities for improvement in almost all domains of care exist, as only a few statewide weighted averages reached their associated performance targets for RY 2017; **however, the majority of measures increased in performance from the prior year.**

LTC Plans

For RY 2017, the LTC plans were required to report one HEDIS-based and five AHCA-defined measures. The LTC plans were compliant with all NCQA HEDIS Compliance Audit IS standards. HSAG had no concerns with the data systems and processes used by the LTC plans for measure calculations based on the information present in the final audit reports (FARs). The LTC plans continued to have adequate validation processes in place to ensure data completeness and accuracy.

Table 1-3 below presents the 12 performance measure indicators selected for RY 2017 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, access, and timeliness. The cell shaded gray denotes the measure for which AHCA established a performance target for RY 2017, which was generally established based on the HEDIS national Medicaid 75th percentile.

Table 1-3—Reporting Year 2017 LTC Performance Measures and Assignments to the Quality, Access, and Timeliness Domains

Reporting Year 2017 (Calendar Year 2016) Measures	Measure Source	Quality	Access	Timeliness
Care for Adults (CFA)—Advance Care Planning—Total, Medication Review—Total, and *Functional Status Assessment—Total*	HEDIS & AHCA-Defined	✓		
Call Answer Timeliness (CAT)	AHCA-Defined			✓
Required Record Documentation (RRD)—701B Assessment, Plan of Care—Enrollee Participation, Plan of Care—Primary Care Physician Notification, Freedom of Choice Form, and *Plan of Care/Long Term Care Service Authorization*	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 RY 2017 performance target established by AHCA.
** The CAT measure was retired from HEDIS, so RY 2017 rates were calculated as an AHCA-defined measure.*

The LTC plans reported 12 performance measure indicator rates, which were all related to **quality** and **timeliness**. An AHCA performance target was established for one of these measure indicators, *Call Answer Timeliness*. The statewide weighted average rate for this measure did not meet the AHCA performance target established and represents an opportunity for improvement. Of note, all statewide measures that were trended from RY 2016 to RY 2017 in this report demonstrated an increase in performance except for the *Face-to-Face Encounters* measure. AHCA has recently discovered that two plans had calculated the *Face-to-Face Encounters* measures incorrectly, leading to lower rates being reported. Due to the timing of this update, the revised data for those plans were not able to be included in the performance measure validation activities.

Review of Compliance

In SFY 2016–2017, AHCA's Medicaid Quality and Plan Management Operations Bureaus and its HIPAA Compliance Office conducted desk reviews and plan site visits for all MMA and LTC plans. These reviews included most of the federal standards and all standards for the State contract requirements.

To conduct the compliance reviews, AHCA follows a process that ensures consistency with the intent of CMS' protocol, by monitoring plans to ensure they comply with the Access, Measurement and Improvement, and Structure and Operations standards. AHCA accomplishes this through various methods of review including weekly reviews of enrollee and provider complaints, analysis of required reports submitted by plans, secret shopper calls, visits related to marketing, and verification of the plans' provider networks.

AHCA provided Table 1-4 which describes the methods of review that AHCA uses to monitor each of the standards.

Table 1-4—Standards and Monitoring Activities

Standards	Monitoring Activities	Bureau Responsible for Monitoring the Standards
Access Standards: • Availability of Services • Adequacy of Capacity and Services • Coordination and Continuity of Care • Coverage and Authorization of Services	• Addressing contractually required Access standards by (1) reviewing plan Provider Network Verification (PNV) data files; Quest ratio, time, and distance reports; portable document format (PDF) and online directory analysis; complaints received by the complaint hub; Medicaid Fair Hearing requests; plans' annual Timely Access/PCP Wait Times reports; plans' Annual Network Development Plans (ANDPs); and (2) conducting secret shopper exercises. • Monitoring specific recipient-centered priority areas including private duty nursing, targeted	Bureau of Plan Management Operations (PMO) Quality Bureau

Standards	Monitoring Activities	Bureau Responsible for Monitoring the Standards
	monitoring of Statewide Inpatient Psychiatric Program (SIPP) care coordination; targeted monitoring of therapy services; targeted monitoring of prenatal, newborn, and postpartum care; targeted monitoring of potentially preventable hospital and emergency department (ED) visits; targeted monitoring of follow-up after inpatient and ED mental health or substance abuse treatment; and targeted review of unnecessary ancillary services during hospitalization or ED visits. • Monthly, quarterly, and annual review of Report Guide data. • Annual review of Disease Management Summary Reports, Medical Case Record Review Strategy Summary Reports, and Vaccines for Children Summary Reports. • Clinical review of health policy changes, outreach and education documents, and clinical initiatives documents.	
Measurement and Improvement Standards: • Practice Guidelines • Quality Assessment and Performance Improvement • Health Information Systems	• Addressing contractually required Measurement and Improvement standards by reviewing plans' PIPs, performance measures, provider and enrollee survey results, and quality improvement plans. • Addressing contractually required Measurement and Improvement standards related to Health Information Systems by reviewing plans' self-reported system issues; complaints submitted via the complaint hub and Medicaid Fair Hearing requests; and weekly encounter reports.	Quality Bureau PMO
Structure and Operations Standards: • Provider Selection • Credentialing/Recredentialing • Enrollee Information • Enrollee Rights and Protections • Confidentiality • Enrollment and Disenrollment	• Addressing contractually required Structure and Operations standards regarding Provider Selection by reviewing Quest ratio reports to identify and track specific provider types for network adequacy against the plan PDF and online directory analyses; reviewing complaints received through the complaint hub; and validating terminated and excluded provider information against the plans' PNV files to	PMO

Standards	Monitoring Activities	Bureau Responsible for Monitoring the Standards
• Grievance Systems • Sub-contractual Relationships and Delegation	ensure that excluded providers are not included in the plans' networks. • Addressing contractually required Structure and Operations standards regarding subcontractors by reviewing plan subcontracts and subcontract monitoring schedules against the Subcontract Delegation checklist, which includes the applicable CFR language; and reviewing complaints submitted to the complaint hub and Medicaid Fair Hearing requests related to plan subcontractors. • Addressing Grievance Systems requirements by reviewing complaints submitted through the complaint hub and Medicaid Fair Hearing requests; reviewing plans monthly regarding Enrollee Complaints, Grievances, and Appeals and the Denial, Reduction, Termination, or Suspension of Services Reports; and reviewing and approving plans' Notice of Action and other grievance and appeal letters to enrollees. • Addressing information requirement standards by reviewing the enrollee handbook for compliance with contractual requirements and reviewing and approving written enrollee materials.	PMO PMO PMO and Quality Bureau

If plans are out of compliance with their contract, AHCA may impose corrective actions plans (CAPs), monetary liquidated damages, and/or monetary/nonmonetary sanctions. Compliance actions and associated liquidated damages and sanctions are posted publicly on AHCA's website.[1-10]

When a plan does not meet or only partially meets a standard, AHCA issues a compliance action that may or may not require a CAP. When the plan corrects the noncompliance, AHCA designates the standard as *Met*. As mentioned, AHCA also issues liquidated damages and/or monetary/nonmonetary sanctions. In its report, *Florida Medicaid SMMC [Statewide Medicaid Managed Care] Compliance Actions Q1–Q4 FY16/17*, AHCA defines a "liquidated damage" as follows[1-11]:

> In some cases, the Agency will impose liquidated damages in writing against the Managed Care Plan for a breach of contract. The liquidated damages are not intended to

[1-10] Agency for Health Care Administration. *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY16/17*. Available at: https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Q1-Q4_FY1617_Compliance_Actions.pdf. Accessed on: Feb 5, 2018.
[1-11] Ibid.

> be in the nature of a penalty, but are intended to be reasonable estimates of the Agency's projected financial loss and damage resulting from the Managed Care Plan's nonperformance, including financial loss as a result of project delays.

AHCA defines a "sanction" as follows[1-12]:

> In the event the Agency identifies a violation of or other noncompliance with the contract by a managed care plan, the Agency may sanction the Managed Care Plan. Sanctions can be monetary or nonmonetary, including, but not limited to enrollment freezes or temporary management of the managed care plan.

AHCA has a detailed process for establishing whether a contract requirement is noncompliant with the contract/federal requirements. For example, a CAP may result from a compliance action referral by an AHCA monitoring unit. This referral is reviewed by the PMO, including the contract manager. The contract manager meets with the referring unit to discuss the request for the compliance action and then reviews the request with the PMO administrator, who decides whether a compliance action (liquidated damages or a sanction) will be imposed. The contract manager informs the referring unit of the compliance decision, and the unit issues a letter to the plan informing the plan of the decision. If liquidated damages or sanctions are not imposed, the plan is required to complete a CAP. The plan has an opportunity to appeal the compliance action to the Medicaid director. Please see Table 1-5 for an aggregate of liquidated damages and sanctions per standard category issued by AHCA.

AHCA emphasizes the issuance of liquidated damages for performance measures that do not meet the established thresholds. AHCA has a detailed methodology for determining how the measure threshold is calculated. If a plan does not meet the performance measurement threshold, AHCA will issue a letter that outlines the area of noncompliance and inform the plan about the amount of liquidated damages or sanctions as well as how the plan can dispute the decision.

AHCA uses a comprehensive Strategic Onsite Monitoring tool that includes plan-focused questions to determine how a plan is implementing the contract and/or federal requirements in relation to the grievance and appeals system and subcontractor oversight as well as provider networks.

The Targeted Monitoring Project is another example of the kind of comprehensive monitoring that AHCA employs to ensure plans follow the regulations. AHCA has written a desk review guide that serves as a framework to effectively identify, review, analyze, and evaluate issues effecting the provision of services for Medicaid enrollees. The monitoring process is composed of the following phases:

- Information collection
- Project design
- Intra-agency coordination and collaboration
- Data collection

[1-12] Ibid.

- Plan communication
- Sample selection
- Monitoring instruments development
- Analysis
- Management reporting
- Feedback to plan
- Potential actions

The Quality Performance Review and Clinical Monitoring Unit, composed of a multidisciplinary team of clinical staff such as registered nurse consultants and specialists, medical healthcare program analysts, and social workers, provides oversight for the Targeted Monitoring Project process. The monitoring techniques used by this unit have evolved into a more robust process that focuses on identified issues so that corrective action may be employed to prevent or remedy the nonconformance observed. During SFY 2016–2017, AHCA reviewed 11 standards and contract requirements in three standard categories—Access, Measurement and Improvement, and Structure and Operations. The standards are listed below according to category:

A. Access Standards:
   - I. Availability of Services
   - II. Adequacy of Capacity and Services
   - III. Coordination and Continuity of Care
   - IV. Coverage and Authorization of Services

B. Measurement and Improvement Standards:
   - V. Quality Assessment and Performance Improvement
   - VI. Health Information Systems

C. Structure and Operations Standards:
   - VII. Provider Selection and Credentialing/Recredentialing
   - VIII. Enrollee Information
   - IX. Confidentiality
   - X. Grievance Systems
   - XI. Sub-contractual Relationships and Delegation

As a result of these reviews, using the results AHCA provided to HSAG from the various periodic monitoring activities and reviews of compliance, HSAG organized, analyzed, and aggregated the compliance activity results for each plan and presents them in Section 3 under the subheading "Review of Compliance With Access, Structure, and Operations Standards." In addition, HSAG aggregated the results of all liquidated damages, sanctions, and compliance actions and analyzed the results below.

Findings

HSAG aggregated all liquidated damages and sanctions that AHCA assigned to each plan for each issue type and included these in Table 1-5.

Table 1-5—SMMC Final Actions by Issue Type Q1–Q4 FY16/17[+*]

Plan Name	Marketing	Enrollee Services and Grievances	Medicaid Fair Hearing	Covered Services	Provider Network	Quality and Utilization Management	Administration and Management	Finance	Reporting	Total Number of Actions	Total Liquidated Damages Dollar Amount[+]	Total Sanction Dollar Amount[+]
Positive	0	0	0	0	0	1	1	3	0	**5**	**$40,200**	**$2,500**
American Eldercare***	0	1	0	0	0	1	0	0	0	**2**	**$3,100**	**$0**
Amerigroup	0	1	3	6	0	2	3	1	0	**16**	**$536,400**	**$10,000**
Better Health	0	2	1	1	0	1	3	1	0	**9**	**$537,600**	**$0**
Community Care Plan	0	0	0	0	0	1	2	0	0	**3**	**$288,300**	**$0**
Clear Health	0	2	0	1	0	1	5	0	0	**9**	**$750,000**	**$0**
Children's Medical Service	0	0	0	0	0	0	0	0	0	**0**	**$0**	**$0**
Aetna Better Health	0	1	0	5	0	1	2	0	0	**9**	**$286,900**	**$0**
Humana	0	3	0	3	3	1	3	1	1	**15**	**$880,500**	**$2,500**
Magellan	1	0	0	1	1	1	1	0	0	**5**	**$2,558,450**	**$0**
Molina	2	0	1	4	1	2	4	0	0	**14**	**$999,600**	**$7,500**
Prestige	0	1	2	1	3	1	6	0	0	**14**	**$2,085,500**	**$0**
Simply	0	2	0	0	0	1	3	1	0	**7**	**$392,200**	**$0**
Staywell	1	3	1	3	0	1	2	0	1	**12**	**$2,747,600**	**$7,500**
Sunshine	0	3	0	3	1	2	3	0	0	**12**	**$3,810,900**	**$0**
United	1	5	2	7	0	2	0	0	2	**19**	**$1,333,500**	**$0**
TOTAL	**5**	**24**	**10**	**35**	**9**	**19**	**38**	**7**	**4**	**151**	**$17,250,750**	**$30,000**

[+]**Source:** *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY16/17*. Available at: https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Q1-Q4_FY1617_Compliance_Actions.pdf.

* Although included elsewhere in this report, Freedom is not included in Table 1-5 as it was not included in the *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY16/17* report.

**American Eldercare, Inc. (American Eldercare) is not included elsewhere in this technical report because it was acquired by Humana; however, it was included in the *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY16/17* report.

AHCA issued a total of $17,250,750 in liquidated damages to all plans except Children's Medical Services and Freedom. Sunshine incurred the highest liquidated damages at $3,810,900; however, caution must be taken when interpreting this amount because Sunshine has three lines of business. Staywell and Magellan incurred $2,747,600 and $2,558,450 in liquidated damages, respectively; both plans have only one line of business. Disregarding American Eldercare's results, Positive incurred the lowest liquidated damages at $40,200.

AHCA issued monetary sanctions for five plans (Positive, Amerigroup, Humana, Molina, and Staywell) totaling $30,000. Amerigroup incurred the highest sanction amount at $10,000, and both Positive and Humana incurred sanctions of $2,500 each.

AHCA issued a total of 151 final actions for 16 plans, including American Eldercare. The issue types that received the highest number of final actions were Administration and Management, and Covered Services, with 38 and 35 actions, respectively. The issue types with the least number of final actions were Reporting and Marketing, with four and five actions, respectively. The plans with the highest number of final actions were United and Amerigroup, with 19 and 16 final actions, respectively. Disregarding American Eldercare, the plans with the lowest number of final actions were Community Care Plan, with three final actions; Positive, with five final actions; and Magellan, with five final actions. Children's Medical Services did not receive any final actions.

In Table 1-6, HSAG aggregated all the compliance actions that resulted from each method of review for each standard. Information was compiled from individual plan spreadsheets that AHCA provided to HSAG.

Table 1-6—Number of Compliance Actions by Standard and Method of Review

Method of Review	Standards											
	Availability of Services	Adequacy of Capacity and Services	Coordination and Continuity of Care	Coverage and Authorization of Services	Quality Assessment and Performance Improvement	Health Information Systems	Provider Selection and Credentialing/Recredentialing	Enrollee Information	Confidentiality	Grievance Systems	Sub-contractual Relationships and Delegation	Total
Online Provider Directory Analysis	26	23	0	0	0	0	10	0	0	0	0	**59**
Access Complaints	5	8	12	0	0	0	0	0	0	0	0	**24**

Method of Review	Standards											
	Availability of Services	Adequacy of Capacity and Services	Coordination and Continuity of Care	Coverage and Authorization of Services	Quality Assessment and Performance Improvement	Health Information Systems	Provider Selection and Credentialing/Recredentialing	Enrollee Information	Confidentiality	Grievance Systems	Sub-contractual Relationships and Delegation	Total
Critical Incident Reporting	15	0	0	0	0	0	0	0	0	0	0	**15**
Unable to Locate/ Refused Services Report	2	0	0	0	0	0	0	0	0	0	0	**2**
Corrective Action Plan Follow-up	8	8	0	0	0	0	0	0	0	0	0	**16**
Medicaid Complaint Hub	0	0	0	23	0	0	0	0	0	1	0	**24**
Denial, Reduction, Termination or Suspension of Services Report	0	0	0	0	0	0	0	0	0	12	0	**12**
Enrollee Complaints Grievances and Appeals Report	0	0	0	0	0	0	0	0	0	13	0	**13**
Medicaid Fair Hearings	1	1	0	7	0	0	0	0	0	11	0	**20**
Performance Measure Quality Standards	0	0	0	0	14	0	0	0	0	0	0	**14**
On Base Encounter Reports	0	0	0	0	0	45	0	0	0	0	0	**45**
PNV Data Files	13	13	0	0	0	0	15	0	0	0	0	**41**

Method of Review	Standards											
	Availability of Services	Adequacy of Capacity and Services	Coordination and Continuity of Care	Coverage and Authorization of Services	Quality Assessment and Performance Improvement	Health Information Systems	Provider Selection and Credentialing/Recredentialing	Enrollee Information	Confidentiality	Grievance Systems	Sub-contractual Relationships and Delegation	Total
Notice of Adverse Benefit Determination Template	0	0	0	0	0	0	0	2	0	3	0	**5**
Enrollee Roster and Facility Residence Report	0	0	1	0	0	0	0	0	0	0	0	**1**
LTC Quarterly Submissions	0	0	0	1	0	0	0	0	0	0	0	**1**
1915c Performance Measures	0	0	0	2	0	0	0	0	0	0	0	**2**
Quest Ratio, Time and Distance Report	3	4	0	0	0	0	0	0	0	0	0	**7**
Participant Direction Option Report	1	0	0	0	0	0	0	0	0	0	0	**1**
Provider Directory Reviews	0	0	0	0	0	0	0	1	0	0	0	**1**
Managed Care Plan Self-reports	0	0	0	0	0	1	0	0	0	0	0	**1**
Missed Services Report	1	0	0	0	0	0	0	0	0	0	0	**1**
Printed Provider Directory Analysis	0	0	0	0	0	0	1	0	0	0	0	**1**

Method of Review	Standards											
	Availability of Services	Adequacy of Capacity and Services	Coordination and Continuity of Care	Coverage and Authorization of Services	Quality Assessment and Performance Improvement	Health Information Systems	Provider Selection and Credentialing/Recredentialing	Enrollee Information	Confidentiality	Grievance Systems	Sub-contractual Relationships and Delegation	Total
Network Adequacy Ad Hoc Reviews	1	0	0	0	0	0	0	0	0	0	0	**1**
Disclosure Form—OIG	0	0	0	0	0	0	0	0	2	0	0	**2**
Totals	**76**	**57**	**13**	**33**	**14**	**46**	**26**	**3**	**2**	**40**	**0**	**309**

Note: In June 2017, Florida Medicaid had 3,197,981 MMA enrollees and 96,785 LTC enrollees.

AHCA assessed compliance actions based on all 24 methods of review. The Availability of Services and Adequacy of Capacity and Services standards demonstrated the most compliance actions, with 76 and 57 actions, respectively. For these two standards, the methods of review that demonstrated the most compliance actions were Online Provider Directory Analysis (59), Access Complaints (24), the Provider Network Verification (PNV) Data Files (41), and Critical Incident Reporting (15), all of which occurred within the Availability of Services standard). The Sub-contractual Relationships and Delegation standard did not have any compliance actions. The Health Information Systems standard had 46 compliance actions, with 45 of those actions related to On Base Encounter Reports.

The compliance actions with the highest incident numbers were the Online Provider Directory Analysis (59), Access Complaints (24), Medicaid Complaints Hub (24), On Base Encounter Reports (45), and PNV Data Files (41). Except for Medicaid Complaints Hub, these actions are related to network adequacy; however, it is possible that Hub-related complaints concern network adequacy as well. Several of the methods of review had very few compliance actions, primarily those associated with reports.

Strengths

AHCA has developed a comprehensive system for examining all contract requirements, as well as most of the federal standards. Using multiple methods of review, AHCA is able to assess liquidated damages and sanctions when necessary when a plan is out of compliance with standards. AHCA assessed a total of $17,250,750 in liquidated damages that specifically were levied when a plan caused AHCA a projected financial loss and damage resulting from the nonperformance, including financial loss because of project delays. AHCA assessed $30,000 in monetary sanctions for those plans that were noncompliant with the contract.

AHCA has developed numerous tools to assist staff in the review process. For example, AHCA has developed a comprehensive desk review booklet for the Targeted Monitoring Project that includes the following questions for each phase of the workflow:

1. Who collects the data?
2. How is [are] the data collected?
3. When is [are] the data collected?
4. What is the justification for the review?

The booklet includes a workflow diagram that displays the procedure on a single page. In addition, the Compliance Action Process map provides a workflow diagram depicting the process for identifying and imposing contract noncompliance, dispute and appeal processes for the plans, the issuance of sanctions and liquidated damages letters, and how CAPs are determined and issued to the plans.

AHCA did not issue any liquidated damages or sanctions to either Children's Medical Services or Freedom. AHCA issued very few liquidated damages related to Marketing and Reporting issue types, which implies that the plans were compliant with those policies and procedures. In addition, nearly 60 percent of the plans received no sanctions.

As shown in Table 1-6, plans demonstrated strong performance for the following standards: Enrollee Information (no compliance actions), Confidentiality (two compliance actions), and Sub-contractual Relationships and Delegation (three compliance actions). The plans were in compliance with many of the reports that AHCA requires as well, including the Enrollee Roster and Facility Residence Report, LTC Quarterly Submission, Participant Direction Option Report, Provider Directory Reviews, Managed Care Plan Self-reports, Missed Services Report, Printed Provider Directory Analysis, and Network Adequacy Ad Hoc Reviews. Each of these methods of review was assessed only one compliance action.

Opportunities for Improvement—AHCA

HSAG found that AHCA has in effect a monitoring system that meets federal requirements for State monitoring as stated in §438.66; however, the oversight activities that are consistent with federal requirements for State monitoring in §438.66 do not encompass the requirements in §438.358(b)(1)(iii) 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 in the Quality Assessment and Performance Improvement (QAPI) requirements described in §438.330.

For this annual technical report, as part of the compliance documentation submitted to HSAG, AHCA included a summary of each plan's compliance with contract standards as assessed through 24 methods of review. AHCA uses various methods of review to continuously monitor plans' compliance and to assess the quality of services delivered in the State through the managed care system. In addition, AHCA issues liquidated damages and sanctions to plans that either cause AHCA financial loss and damage in the case of liquidated damages or are out of compliance with the State contract.

While AHCA had numerous detailed procedures to determine contract compliance, AHCA did not have an overarching review tool that contained all the federal standards or a consistent mechanism to determine compliance with standards. For example, the individual spreadsheets that AHCA supplied to HSAG for this technical report had almost every method of review designated as *Met*. There was no way to determine whether the method of review had been either *Not Met* or *Partially Met* before it was ultimately assigned a *Met* designation.

Opportunities for Improvement—Plans

For the SFY 2015–2016 Technical Report, HSAG highlighted the following vulnerable areas from AHCA's 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

Judging by the number of compliance actions in Table 1-6, the plans have made progress toward compliance with the Enrollee Information standard; however, maintenance of the online provider network directory remains a significant problem. Based on the information in Table 1-6, the plans should focus on standards with the most compliance actions, including Availability of Services (76), Adequacy of Capacity and Services (57), Health Information Systems (46), and Coverage and Authorization of Services (33).

In addition, from Table 1-5, the plans need to address areas where they received final actions in the Administration and Management (38), Covered Services (35), Enrollee Services and Grievances (24), and Quality and Utilization Management (19) categories.

Recommendations

HSAG established that in accordance with 42 CFR §438.66, State Monitoring Requirements, AHCA conducted various compliance and monitoring activities, including on-site visits, desk reviews, reviews of documents prepared and issued by the plans, and interviews with the plans throughout SFY 2016–2017 which constituted a comprehensive system that encompassed all contract requirements for the plans and most of the federal standards. AHCA has made considerable progress in describing and monitoring the methods of review as well as assessing liquidated damages and sanctions. HSAG recommends that, in accordance with 42 CFR §438.358(b)(1)(iii), AHCA enhance its systematic reviews by conducting a comprehensive compliance review every three years to determine each plan's adherence to all federal standards in subparts D and E.

AHCA should establish an agency-wide methodology and overarching tool when conducting monitoring and review activities, as well as a consistent scoring methodology to establish uniformity. AHCA should also include a written summary that documents the plans' noncompliance with contract requirements and/or federal standards.

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. Specifically, the plans should focus efforts on maintaining the online provider network directory; addressing all complaints, especially those related to access; On Base Encounter reports; and PNV data files. Plans should concentrate improvement efforts in all standards and contract requirements, especially those related to these areas: Availability of Services, Adequacy of Capacity, Continuity and Coordination of Care, Health Information Systems, Enrollee Services and Grievances, Covered Services, Quality and Utilization Management, and Administration and Management.

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 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 2016–2017, AHCA contracted with HSAG to conduct an EDV study. The goal of the study was to examine the extent to which dental encounters submitted to AHCA by its contracted SMMC plans, including MMA and Specialty plans (collectively referred to as "plans" in this section) are complete and accurate.

The SFY 2016–2017 study focused its review on all dental encounters with the code on dental procedures and nomenclature (CDT) for children under the age of 21. To assess the quality of the dental encounters submitted to AHCA by the plans, the study included two evaluation components:

- Administrative and comparative data analysis of encounter data
- Clinical record review

Encounter Data File Review Findings and Conclusions

Prior to conducting the comparative analysis and clinical record review for the EDV study, HSAG conducted a preliminary review of the encounter data submitted by AHCA and the plans. This investigation evaluated general encounter counts and trends in order to provide a high-level summary of the differences and variation in the quality of encounter data managed by AHCA and the individual plans. During this process, two significant observations were discovered:

- There were plans for which the plan assignment (based on the *Plan Provider ID* field) associated with the encounter data received from AHCA did not match the corresponding enrollees' plan enrollment. AHCA noted that the *Plan Provider ID* field is a plan-submitted field and indicated that while there was an edit in place when data were received from the plans, the edit was infrequently applied. Consequently, this type of discrepancy was not detected or reported consistently with the incoming data.

- For a few of the plans, the number of records submitted for the study was lower than the number of records received from AHCA. This difference appeared to have been due to apparent "duplicate" records, even though the unique internal control numbers (ICNs) were different. AHCA noted that the encounter ICNs were assigned according to an algorithm based on the type of transaction and how they were received (e.g., original encounter submission, adjustment of paid/accepted encounter, encounter resubmission, denied encounter). Although AHCA was able to use the *Latest Paid Claim* indicator to determine the final status for an adjustment of paid/accepted encounters, AHCA noted that it was not able to determine the final status for resubmissions of denied encounters. As such, these types of submissions appear as duplicate submissions with different ICNs. To remove the apparent duplicates, AHCA is aware that it would need to run additional de-duplication logic on the encounter submissions based on additional combinations of fields. However, since the goal of the EDV study is to determine the accuracy and completeness of AHCA's encounter data when compared to the data from the plans' claims systems, any manipulation of data received from either source was not recommended for the purpose of the study.

A review of the encounter data volume highlighted variation in the overall and month-to-month submission of encounters by source (i.e., AHCA's and plans' submitted encounters). While AHCA's encounter data showed consistently greater encounter data volume than the volume submitted by the plans, month-to-month volume trends were relatively consistent between both data sources.

Key data elements such as *Billing* and *Rendering Provider NPI* and *Dental Procedure Code* fields were consistently complete (i.e., non-missing) and accurate (i.e., valid values) for both data sources (AHCA's and plans'). However, the *Provider ID* fields (*Billing* and *Rendering*) were consistently missing from most of the plans, and when the values were present, some plans submitted values that were not valid Medicaid ID values. It is also important to note that while the provider Medicaid IDs were requested from AHCA and the plans for the EDV study, these fields were not required to be submitted to AHCA for providers who qualify for an NPI.

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). Dental services as reported within the dental encounter type exhibited the most complete data as shown by the lowest overall record omission and record surplus rates—i.e., 9.3 percent and 16.6 percent, respectively. The overall record omission rates (9.3 percent [dental], 28.1 percent [institutional], and 13.2 percent [professional]) were much lower across the three encounter types when compared to the overall record surplus rates (16.6 percent [dental], 55.0 percent

[institutional], and 56.4 percent [professional]). The high surplus rates across all encounter types were primarily due to the duplicate records submitted by AHCA. As noted earlier, AHCA was unable to determine the final status of an encounter depending on the type of transaction and how it was received.

Encounter Data Element Completeness

The level of completeness for key dental services data elements was high (i.e., low overall omission and surplus rates), with a high level of completeness for nearly all of the data elements (i.e., *Line First Date of Service*; *Line Last Date of Service*; *Procedure Code*; *Tooth Number*; *Tooth Surface 3, 4, 5,* and *6*; and *Amount Paid*). Provider-related data elements were most frequently associated with incomplete data, specifically, the provider ID data elements (i.e., *Billing Provider ID* and *Rendering Provider ID*), exhibiting surplus rates of 68.6 percent and 89.4 percent, respectively. Although not critical for processing claims received from the plans, incomplete and inaccurate provider data affect both Medicaid oversight and reporting.

Encounter Data Element Agreement

High levels of agreement were noted for key dental data elements showing at least 90 percent agreement, such as *Rendering Provider NPI; Procedure Code; Units; Tooth Number; Tooth Surface 1, 2,* and *3;* and *Amount Paid*. This finding suggests that encounter data elements compared between AHCA's and the plans' submitted data have the same values when populated.

Clinical Record Review Findings and Conclusions

Medical Record Submission

A total of 2,125 sample cases (i.e., 120 sample and 30 oversample cases per plan, except for Clear Health Alliance) were requested to be procured by the participating plans. Clear Health Alliance had only 25 cases that met the eligibility criteria to be included in the study. While all plans completed and submitted all tracking sheets associated with the requested cases, overall, nearly 4 percent included no dental records (i.e., 83 of the 2,125 requested cases). Dental records were not submitted for various reasons including provider refusal, provider unable to locate the record, lack of documentation, and "other" reasons. Among the non-submissions listed as "other" reasons, most of the cases were from one plan (UnitedHealthcare of Florida, Inc.) noting that provider offices did not return the requested documents.

Encounter Data Completeness

Overall, AHCA's encounter data were highly supported by the clinical documentation in enrollees' dental records, with only 10 out of 1,705 cases reviewed not having documentation to support dental treatments for the sampled date of service. While the medical record omission rate for date of service was low, nearly 5.4 percent of dental procedure codes identified in AHCA's encounter data were not present in the enrollees' dental records. This finding may suggest incomplete and inaccurate provider documentation in enrollees' dental records for services that were performed. Additionally, how providers submitted data to the plans and ultimately how information was captured within the plans' systems may have also contributed to the discrepancy. The encounter data omission rate of 9.1 percent

was nearly double compared to the medical record omission rate. This finding suggests that not all services documented in enrollees' dental records were submitted to or processed and stored by AHCA.

Encounter Data Element Accuracy

The assessment of the procedure codes associated with validated dates of service from the encounter data that were correctly coded on the enrollees' medical records showed a high overall accuracy rate of 93.9 percent.

Although the individual procedure code accuracy rate was high, the overall percentage of dates of service having procedure codes documented accurately (i.e., not omitted or coded correctly) was only 54.3 percent. This finding suggests that submission of encounter data elements is frequently incomplete, leading to overall inaccuracy in the representation of clinical record information contained in the State's encounter data.

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 are related to AHCA's ability to process the encounter data based on the criteria specified for the study (i.e., preparation of the data), high rates of omission, surplus, and errors, coupled with variation between plans suggest systemic issues with the transmission of data between the plans and Florida's Medicaid Management Information System (FMMIS). To ensure the quality of encounter data submissions from contracted plans, the following recommendations have been identified to address potential opportunities for improvement.

- AHCA should continue to work with the plans and monitor the submission of the *Plan Provider ID* field to ensure the accuracy of the submitted field. Additionally, while AHCA noted that edits are in place, the implementation of these edits should be consistently applied and reported. Accurate attribution of the enrollees' encounters to their assigned plans is critical to ensuring complete and accurate federal and State encounter-based reporting of plan and program performance.
- AHCA should work with the FMMIS data vendor to develop a standardized process to track and identify the final adjudication record of an encounter. AHCA and its data vendor should develop an algorithm that is in alignment with the assignment of the ICNs according to the type of encounter transaction and how the encounter was received. AHCA should also consider enhancing current submission requirements to ensure adjusted encounters are submitted appropriately to better identify the final status records in AHCA's encounter data. By having a standardized process, AHCA can ensure the consistency of data extraction as well as production of analytic data files for use in other units that potentially impact the State's encounter-based reporting.
- While plans are required to submit the provider NPI, the provider Medicaid ID should only be submitted by non-healthcare providers who cannot obtain an NPI. AHCA should work with the plans in ensuring accurate processing of provider information within the plans' systems. Plans may have provider data stored in separate data systems (e.g., a credentialing database versus a billing database) because of subcontracting and delegation arrangements for oversight of provider

information. If plans used different data systems for provider credentialing, provider billing, and claims processing, formal policies and procedures may not exist regarding the reconciliation of provider information across data systems. The use of multiple data systems increases the likelihood of discrepancies in provider data between sources.

- AHCA should consider requiring the plans to audit provider encounter submissions for completeness and accuracy. AHCA may want to require the plans to develop periodic provider education related to dental record documentation and coding practices. These activities should include a review of both State and national coding standards, especially for new providers contracted with the plans. In addition, AHCA should consider requiring the plans to perform periodic reviews of submitted claims to verify appropriate coding and completeness to ensure encounter data quality.

Overall Assessment of Progress in Meeting Agency Goals and Priorities

During previous years, HSAG made recommendations in the annual reports for each of the activities that were conducted. Table 1-7 is a summary of the follow-up actions per activity that AHCA completed in response to HSAG's recommendations during SFY 2015–2016.

Table 1-7—HSAG Recommendations With AHCA Actions

HSAG Recommendation	AHCA Action
Performance Improvement Projects	
AHCA should continue to offer and facilitate training and support opportunities to enhance the plans' capacity to implement robust 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's PIP Check-in Teams held quarterly meetings with each of the plans throughout the year. AHCA staff asked plans to describe which QI processes and tools they were using and encouraged plans to reach out to HSAG's PIP team and to AHCA for additional TA as needed. HSAG's PIP team provided TA throughout the year to enhance the plans' capacity to implement robust QI processes and strategies for their PIPs.
Validation of Performance Measures	
For MMA plan measures with AHCA-established performance targets, HSAG recommends that improvement efforts be focused on measures with HEDIS 2015 rates falling below AHCA's performance targets by at least 10 percentage points. These measures include: <u>Pediatric Care:</u> • *Well-Child Visits in the First 15 Months—Six or More Visits* • *Lead Screening in Children*	AHCA reviews the plans' performance measure results each year, comparing them to the previous year's National Medicaid Means and Percentiles. These comparisons are used to establish report card ratings and to identify measures for which the plan is subject to liquidated damages. These activities are aimed at improving plan performance on all the HEDIS measures. AHCA has an annual review of plan performance measure results and identifies priority areas in need of improvement. AHCA has prioritized three

HSAG Recommendation	AHCA Action
• *Annual Dental Visit—Total* • *Immunization for Adolescents—Combination 1* <u>Women's Care:</u> • *Prenatal Care Frequency (>81% of Expected Visits)* <u>Living With Illness:</u> • *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* <u>Access to Care:</u> • Adults' Access to Preventive/Ambulatory Health Services—Total <u>Mental Health:</u> • *Follow-Up After Hospitalization for Mental Illness—7-Day and 30-Day Follow-Up*	of the areas (though not the exact measures) HSAG identified for PIPs by the MMA plans: Preventive Dental Services, Well-Child Visits in the First 15 Months, and Timeliness of Prenatal Care. During the year, AHCA sent letters to the plans regarding liquidated damages for performance measures.
For MMA Plan measures without an AHCA-established performance target, HSAG recommends that improvement efforts be focused on the following measures with low 2015 statewide performance: • *Preventive Dental Services* • *Dental Treatment Services* • *Sealants* • *HIV-Related Medical Visits ≥2 Visits (182 Days Apart)* • *Transportation Timeliness* • *Mental Health Readmission Rate*	AHCA required MMA plans to conduct PIPs to improve their *Preventive Dental Services* rates. AHCA has established performance targets for *Preventive Dental Services* and *Dental Treatment Services* in the MMA contract, and plans are subject to liquidated damages if they do not achieve those targets. In addition, AHCA sent letters to the plans regarding liquidated damages for performance measures. AHCA has prioritized three of the areas (though not the exact measures) HSAG identified for PIPs by the MMA plans: Preventive Dental Services, Well-Child Visits in the First 15 Months, and Timeliness of Prenatal Care. An annual review of plan performance measure results and identification of priority areas in need of improvement is part of AHCA's regular activities. Improving plan performance regarding *Preventive Dental Services* and *Dental Treatment Services* is emphasized through PIPs and potential liquidated damages if plans do not reach targets set in the contract. The Agency continues to track plan performance on all performance measures over time.
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*	AHCA shared HSAG's feedback with the federal CMS Medicaid and CHIP [Children's Health Insurance Program] Quality Technical Assistance

HSAG Recommendation	AHCA Action
measure for the MMA plans. During the review, HSAG noted that most 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 did not seem to clearly define the criteria that should be used to identify the eligible population for this measure (only the denominator), so it was unclear if the eligible population and denominator values should be equivalent. Further, in the rate reporting template, it appeared acceptable for plans to report denominator values that were 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.	team on March 15, 2017, and the team provided the following response on March 16, 2017: Thank you for providing this feedback on the *SEAL* measure technical specifications. The eligible population and denominator hold the same three criteria: age, continuous enrollment, and risk level. Therefore, most plans who reported equivalent values for the eligible population and denominator were correct in their interpretation. We are in the process of updating the technical specification for FFY [federal fiscal year] 2017 reporting and will share your feedback with the measure steward.
HSAG identified an opportunity to improve the clarification of specifications for the *Timeliness of Services* measure for the LTC plans. During the review, HSAG noted that most 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 they should be excluded from the eligible population and denominator). HSAG	AHCA revised the technical specifications for the *Timeliness of Services* measure to clarify that exclusions should be applied prior to identifying the eligible population. The revised specifications were posted online in January 2017.

HSAG Recommendation	AHCA Action
recommends that AHCA provides clear guidance for the identification of the eligible population in the reporting requirements to unify reporting requirements across all participating plans for the next reporting period.	
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 TA for the SMMC plans to assist the plans in understanding and meeting requirements in these areas.	AHCA staff conducted on-site reviews of the plans from June–November 2016 that focused on these areas: Provider Network, Grievance and Complaint Systems, Subcontractor Delegation Oversight, and Long-term Care. AHCA staff continue to monitor plans' contractual compliance through regular monitoring. Contract managers meet weekly with management to discuss issues as they come up and are identified. Remediation occurs through compliance actions.
AHCA should ensure that its ongoing compliance monitoring is designed to cover all 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 compiled a list of the monitoring areas and responsible units, which is updated regularly. AHCA staff conducted on-site reviews of the plans during June–November 2016.
Validation of Encounter Data	
AHCA should continue to work with FMMIS and Decision Support System (DSS) teams to review quality control procedures to ensure 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 staff members work continuously with the FMMIS vendor to improve the collection of encounter data from the plans.

HSAG Recommendation	AHCA Action
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 the FMMIS 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, TA calls/meetings can be scheduled to make sure all parties understand any new submission requirements. Additionally, AHCA should work with its FMMIS and DSS data vendors to develop internal data processing routines to establish standardized programming logic to ensure plan encounter data are accurately processed.	AHCA staff members work continuously with the FMMIS vendor to improve the collection of encounter data from the plans.

HSAG Recommendation	AHCA Action
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 into contracts regarding the submission of supporting documentation. Moreover, HSAG recommends including language that allows AHCA to hold 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. Including this information ensures the availability to information critical to oversight activities.	AHCA has added liquidated damages to the contract in cases where the plans have not properly submitted requested data, including case or medical records, to AHCA or HSAG.
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.	AHCA staff members are continually working with the plans to improve their encounter data submissions.

2. Introduction

Background

The Code of Federal Regulations (CFR) at 42 CFR §438. 364[2-1] requires that states use an EQRO to prepare an annual technical report that describes the manner in which data from activities conducted for Medicaid MCOs, in accordance with the CFR, were aggregated and analyzed. The annual technical report also draws conclusions about the quality of, timeliness of, and access to healthcare services that MCOs provide.

History and 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 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 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 Research and 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.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register* Vol. 81, No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27886. 42 CFR Parts 364 Medicaid Program; External Quality Review, Final Rule.

- The SMMC program was successfully implemented by August 1, 2014. This change moved most enrollees to a managed care delivery system and reduced the number of enrollees in different healthcare delivery systems within Florida Medicaid. SMMC was designed to ensure improved coordination and quality of medical, behavioral health, dental, and long-term care for all enrollees. Since the initial SMMC program was implemented and as of September 2017, the plans have consolidated to 16 MMA plans that include 11 MMA Standard plans, six MMA Specialty plans, and six LTC plans.
- AHCA pursued a reprocurement of the SMMC plan contracts in July 2017. AHCA intends to award the SMMC contracts to nationally accredited managed care plans that offer comprehensive, quality-driven provider networks; streamlined processes that enhance the enrollee and provider experience; and expanded benefits targeted to improve outcomes for enrollees, to increase quality scores. AHCA's goal is to produce high rates of enrollee satisfaction to deliver an efficient, high-quality, innovative, cost-effective, and integrated healthcare delivery model.

The demographics of the Florida Medicaid population (excluding the fee-for-service [FFS] population) as of August 2017 were as follows[2-2]:

- Approximately 3 million were enrolled in an MMA Standard plan.
- Approximately 162,000 were enrolled in an MMA Specialty plan.
- Approximately 97,000 were enrolled in an LTC plan.

The State's Comprehensive Quality Strategy

Part of AHCA's mission is to promote better healthcare for all Floridians. AHCA's Comprehensive Quality Strategy (CQS) 2017 documents priorities and goals that guide the design for delivery of Medicaid services in Florida via AHCA, its contracted plans, and their service providers. This strategy also forms an integrated framework to guide improvement of the various elements of service delivery. AHCA's primary focus is to improve health quality while streamlining processes and providing transparency and accountability for all functions. The CQS outlines AHCA's priorities and goals for the Florida Medicaid program, includes methods and metrics for assessing program performance, describes performance improvement activities and results, and highlights achievements and opportunities for SFY 2016–17.

CMS listed the following priorities for all consumers in its 2016 CMS Quality Strategy[2-3]:

1. Make care safer by reducing harm caused in the delivery of care.
2. Strengthen person and family engagement as partners in their care.

[2-2] 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: Sept 13, 2017.
[2-3] Centers for Medicare & Medicaid Services. CMS Quality Strategy Goals. Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/CMS-Quality-Strategy-Goal-Card.pdf. Accessed on: Jan 24, 2018.

3. Promote effective communication and coordination of care.
4. Promote effective prevention and treatment of chronic disease.
5. Work with communities to promote best practices of healthy living.
6. Make care affordable.

Accordingly, AHCA has outlined five priorities for Florida Medicaid for SFY 2016–17. Related to each priority are specific, measurable goals to guide the program's priority quality initiatives. These efforts are designed to measurably improve the health outcomes of enrollees in the most efficient, innovative, and cost-effective ways possible. AHCA strives to provide high-quality care to all enrollees, regardless of their race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location. AHCA considers health disparities in the development and implementation of all quality improvement and initiatives.

The five priorities and the accompanying goals are listed as follows[2-4]:

1. Priority: Improved health outcomes
   Goal: Focus on priority populations with needed, improved services

2. Priority: Simplified and streamlined service delivery to promote efficient, timely, appropriate use of health services
   Goal: Reduce unnecessary ED visits, unplanned pregnancies, C-sections, hospital readmissions, inappropriate use of medications, etc., through prevention, planning, and service accessibility

3. Priority: Support for person and family-centered care
   Goal: Improve health literacy to engage recipients, families, [and] consumers in healthcare planning and service delivery

4. Priority: Greater transparency and accountability to promote cost effectiveness and efficient administration
   Goal: Promote a quality-focused, data-informed and continuous learning Agency

5. Priority: Improved care coordination via performance monitoring and communication
   Goal: Promote clear communication among providers, plans, patients, families; promote care that is accessible, coordinated, co-located, [and] optimal

As mentioned earlier, AHCA operates under a Section 1115 Research and Demonstration Waiver. That waiver authority allowed the Medicaid program to transition to the SMMC program in SFY 2013–14. There are two components to SMMC: The LTC program and the MMA program.

[2-4] Agency for Health Care Administration. Florida Medicaid Comprehensive Quality Strategy Summary. Available at: http://b.ahca.myflorida.com/medicaid/Policy_and_Quality/Quality/docs/Draft_Full_Amended_012317.pdf. Accessed on: Jan 24, 2018.

For the LTC program, AHCA consolidated five home and community-based services (HCBS) programs into a single LTC/HCBS program. AHCA created rate incentives to "encourage the increased utilization of home and community-based services and a commensurate reduction of institutional placement.[2-5]" (F.S. 409.983(5)). To facilitate successful transitions from a nursing facility to HCBS, LTC plans developed and implemented individualized, person-centered care plans for every LTC enrollee, and case managers counseled enrollees about their options for transitioning to the community. To encourage integration between LTC services and medical services in comprehensive plans, AHCA's auto-assignment algorithm was designed to refer to the enrollee's existing plan (MMA or LTC) and prioritize assignment to the new plan. To support this goal, the plan contracts specified that the coordination of mixed services (services provided by both MMA and LTC) be integrated and coordinated by one LTC case manager.

For the MMA program, in February 2014 AHCA executed contracts with 17 plans. AHCA also executed a contract with an MMA Specialty plan serving enrollees who were dually eligible for both Medicare and Medicaid and who had certain chronic conditions. In April 2014, AHCA executed an additional contract with an MMA Specialty plan serving children with chronic conditions. By November 2016, after several mergers, 16 MMA plans remained in the SMMC program. Ten of these plans provide only MMA services, while six of the plans are comprehensive LTC plans that provide both MMA and LTC services. One of the comprehensive LTC plans includes a Specialty plan for children in the child welfare system. In addition to the Specialty plans for children in the child welfare system and for dual eligibles, there are also two MMA specialty plans for recipients with HIV/AIDS, and one MMA specialty plan for recipients with Serious Mental Illness (SMI). Please refer to Appendix F for a comprehensive list of plan names, by plan type.

The shift from multiple delivery systems to SMMC included a greater emphasis on quality improvement and quality measurement for enrollees. Prior to SMMC, there were silos for quality improvement activities for the various delivery systems, with the focus on administrative processes. The SMMC program, through improved coordination of each enrollee's services, allows for an integrated, comprehensive quality strategy.

To meet CMS requirements and State priorities and goals, AHCA contracted with HSAG to conduct EQR mandatory and optional activities for SFY 2016–2017. The assessment of these activities and recommendations that follow, as discussed in Section 3 of this report, form an integral component of AHCA's CQS. These recommendations are used to continually improve quality of care to Medicaid enrollees in Florida.

[2-5] Florida Legislature. The 2017 Florida Statutes. Available at: http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0409/Sections/0409.983.html. Accessed on: Jan 24, 2018.

Purpose of the Report

The purpose of the SFY 2016–2017 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 of, 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–F. Except for 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. Appendix B and C, D, and E include plan-specific PIP, performance measure, and EDV results, respectively. Appendix F includes a comprehensive list of plan names, by plan type.

Validation of Performance Improvement Projects

AHCA facilitated a variety of activities throughout SFY 2016–2017 independently, and collaboratively with HSAG, to support the plans as they conducted their PIPs. These activities included one-on-one PIP check-ins between AHCA staff and each plan, PIP-related educational presentations delivered during quarterly meetings with the plans, and on-demand TA sessions with HSAG. The different activities provided support and assistance to the plans in various venues and formats to strengthen the improvement processes and strategies used in the PIPs.

AHCA initiated two new PIP processes in spring 2016: an interim PIP review and a PIP check-in process with the plans. For the interim PIP review, AHCA instructed the plans to address all *Partially Met* and *Not Met* PIP validation scores, incorporating HSAG's validation feedback, and 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 TA when needed. For the PIP check-in process, QI teams from AHCA worked together with each plan in one-on-one meetings to evaluate and enhance the plan's PIPs. The check-in process served to strengthen the collaborative relationships between AHCA and the plans, promoting open communication, problem solving, and sharing of evidence-based practices. By closely reviewing PIP progress with the plans, AHCA could identify needs for additional support and facilitate utilization of TA resources. AHCA assisted the plans in developing QI capacity in identifying and prioritizing barriers, rapid-cycle improvement methods, and the use of PDSA cycles for intervention evaluation. The PIP check-in process has increased communication and collaboration among the plans.

In addition to the interim PIP reviews and PIP check-in meetings, AHCA and HSAG arranged PIP-related presentations and discussions for each quarterly meeting that occurred during the period between the SFY 2015–2016 PIP validation and the SFY 2016–2017 PIP validation. The quarterly meetings occurred in August 2015, November 2015, February 2016, and May 2016.

Finally, as part of the SFY 2016–2017 PIP validation process, HSAG provided PIP-related TA to the plans. The modes of TA varied and included webinars, on-site presentations, on-site guided group discussions, one-on-one in-person TA sessions, one-on-one TA teleconferences, and email consultation. Topics for TA also varied and included (but were not limited to) statistical testing and interpretation, methods of causal/barrier analysis, barrier prioritization, development of appropriate and innovative interventions, and use of PDSA cycles and other QI science tools.

MMA Plans

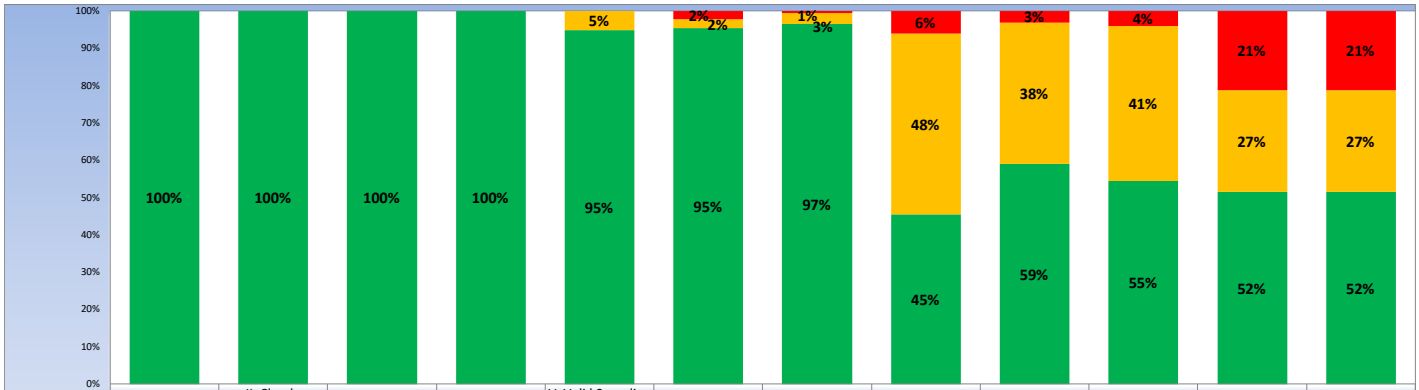
HSAG validated two state-mandated MMA PIPs for the SFY 2016–2017 validation year. The *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIP was submitted by 11 MMA plans. The *Preventive Dental Services for Children* PIP was submitted by 14 MMA plans. The plans progressed through Activity IX of the Outcomes stage and reported Remeasurement 1 study indicator results for the state-mandated PIPs in SFY 2016–2017, and HSAG validated PIP Activities I–IX accordingly. HSAG will validate Activity X (Sustained Improvement) during the next validation cycle for those PIPs that demonstrated statistically significant improvement at the first remeasurement during this year's validation cycle.

Results—PIP Validation Status

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

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 11 MMA 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	IX. Real Improvement Achieved	Outcomes Total
Not Met	0%	0%	0%	0%	0%	2%	1%	6%	3%	4%	21%	21%
Partially Met	0%	0%	0%	0%	5%	2%	3%	48%	38%	41%	27%	27%
Met	100%	100%	100%	100%	95%	95%	97%	45%	59%	55%	52%	52%

The MMA plans generally performed well 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, receiving a *Met* score for 97 percent of the evaluation elements across Activities I through VI. The MMA plans had some opportunities for improvement in Activity V (Valid Sampling Techniques) and Activity VI (Accurate, Complete Data Collection), the only activities in the Design stage that did not receive a *Met* score for 100 percent of applicable evaluation elements. The greatest challenge in Activity V involved inaccurate

documentation of the sample size used for the PIP, and the greatest challenges in Activity VI were related to gaps in the documentation of the data collection process and neglecting to provide the data collection tool used for manual data collection. Despite minor challenges related to documentation of sampling and data collection methods, the MMA plans generally 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.

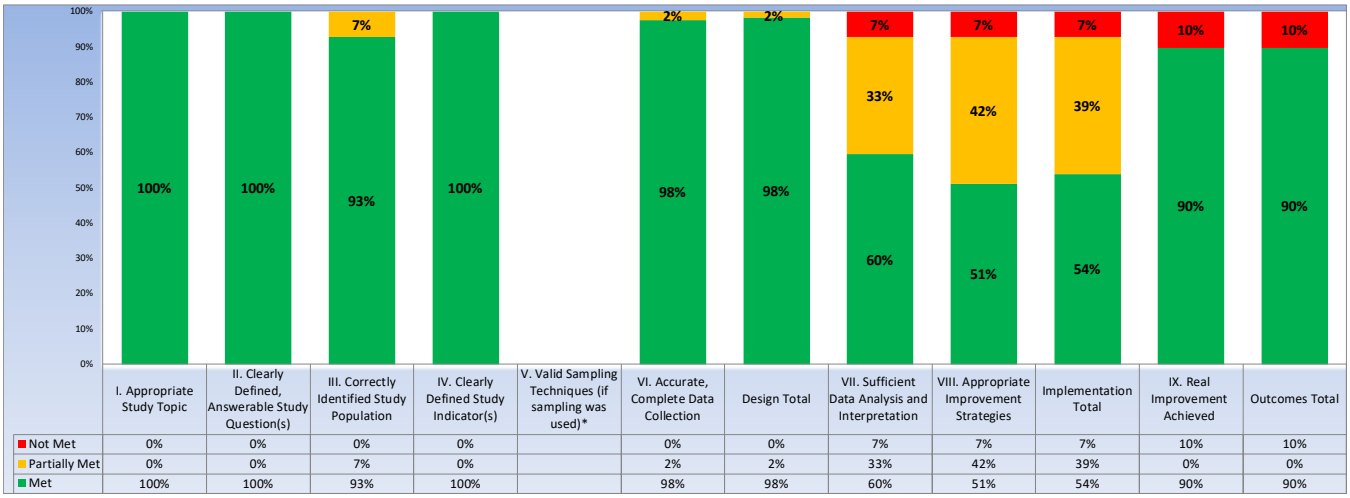
In the Implementation stage of the PIPs, 55 percent of evaluation elements received a *Met* score, suggesting substantial opportunities for improvement in this stage. The MMA plans performed better in Activity VIII (Appropriate Improvement Strategies), with 59 percent of evaluation elements being scored *Met*, compared to Activity VII (Sufficient Data Analysis and Interpretation), where only 45 percent of elements were scored *Met*. In Activity VII, the MMA plans were equally challenged by the activity's evaluation elements: reporting and interpreting study indicator results accurately, and clearly documenting whether factors were identified that affected the validity of the results. In Activity VIII, the most common challenges were related to not evaluating the effectiveness of each intervention and not using intervention-specific evaluation results to guide the next steps of the improvement strategies. The MMA plans should address any errors in Activities VII and VIII to ensure that accurate data analysis and effective QI strategies are being used to achieve desired outcomes.

Based on the first remeasurement results of the *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIPs, the MMA plans had room for improvement in Activity IX (Real Improvement Achieved) of the Outcomes stage. Slightly more than half (52 percent) of the evaluation elements in the Outcomes stage received a *Met* score. Across the plans' PIPs, only 27 percent received a *Met* score for demonstrating statistically significant improvement in the study indicator rates at the first remeasurement. Because achieving desired PIP outcomes relies on the use of methodologically sound and comprehensive QI strategies in the Implementation stage of the PIP, the plans should address challenges encountered in the Implementation stage in order to improve performance in the Outcomes stage.

Validation Status of the *Preventive Dental Services for Children* PIPs

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 14 PIPs submitted by MMA plans 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	IX. Real Improvement Achieved	Outcomes Total
Not Met	0%	0%	0%	0%		0%	0%	7%	7%	7%	10%	10%
Partially Met	0%	0%	7%	0%		2%	2%	33%	42%	39%	0%	0%
Met	100%	100%	93%	100%		98%	98%	60%	51%	54%	90%	90%

* 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 98 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. The MMA plans had the greatest opportunities for improvement in Activity III (Correctly Identified Study Population), where 93 percent of the evaluation elements received a *Met* score. The plans also had minimal opportunities for improvement in Activity VI (Accurate, Complete Data Collection), where 98 percent of the evaluation elements received a *Met* score. The MMA plans may address deficiencies in Activities III and VI by reviewing HSAG's feedback in the PIP validation tools and the state-defined specifications for the PIP. The plans should ensure that the PIP documentation clearly and accurately defines the eligible population and the data collection process for the PIP, and aligns with the state-defined specifications.

The percentage of elements receiving a *Met* score for the Implementation stage was 54 percent, suggesting the MMA plans had room for improvement in this stage. The MMA plans performed better in Activity VII (Sufficient Data Analysis and Interpretation) than in Activity VIII (Appropriate Improvement Strategies). In Activity VII, 60 percent of the evaluation elements were scored *Met* compared to Activity VIII, where only 51 percent received a *Met* score. In Activity VII, the plans struggled most with clear and accurate documentation of the study indicator results and reporting whether factors were identified that affected the validity of the results. In Activity VIII, the most

common challenges were related to not evaluating the effectiveness of each intervention and not using intervention-specific evaluation results to guide the next steps of the improvement strategies. 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. Additionally, the plans should ensure that each PIP intervention is evaluated for effectiveness and that evaluation results and next steps are clearly documented for each intervention. TA from HSAG is available to the plans, on request, for PIP implementation questions requiring further guidance.

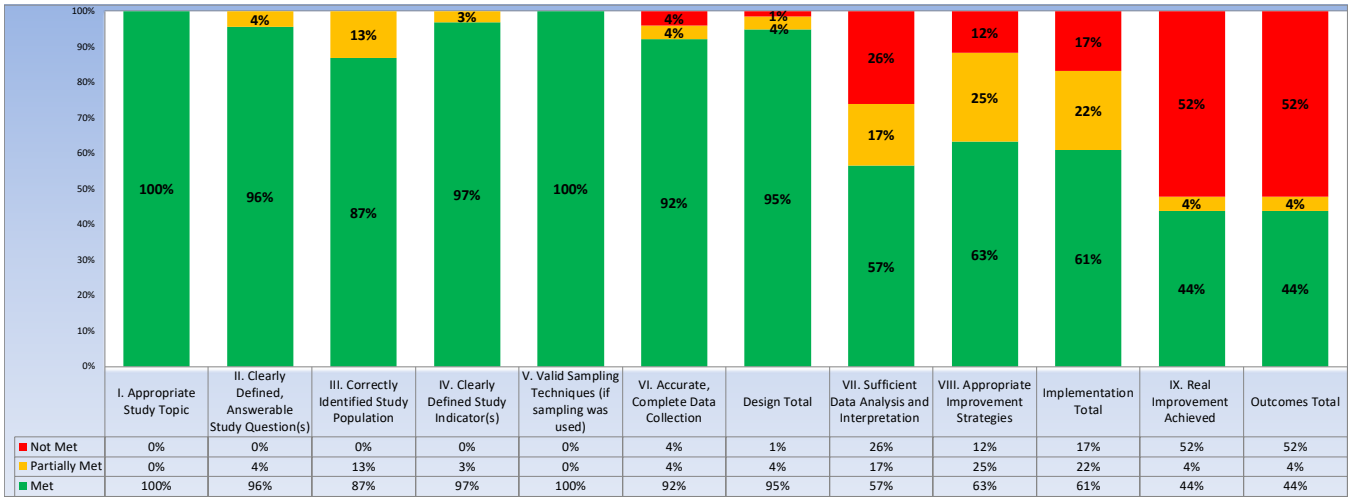
Based on the first remeasurement results of the *Preventive Dental Services for Children* PIPs, the MMA plans performed well in Activity IX (Real Improvement Achieved) of the Outcomes stage. Most of the evaluation elements (90 percent) in the Outcomes stage received a *Met* score. Additionally, 100 percent of the PIPs received a *Met* score in the Activity IX evaluation element for demonstrating statistically significant improvement over baseline at the first remeasurement. While all *Preventive Dental Services for Children* PIPs demonstrated statistically significant improvement at Remeasurement 1, only 69 percent of the PIPs received a *Met* score for study indicator results that achieved the plan-specified Remeasurement 1 goal. This pattern of validation scores suggests that some of the MMA plans set particularly ambitious Remeasurement 1 goals that were not achieved despite demonstrating a statistically significant improvement over the baseline rate. The plans may want to review the goals for the next remeasurement period to ensure they are realistic and attainable.

The validation results in the Outcomes stage of the *Preventive Dental Services for Children* PIP are considerably better than those in the Implementation stage. Because of the MMA plans' strong performance in the Outcomes stage, it is possible that the issues identified in Activity VIII (Appropriate Improvement Strategies) of the Implementation stage were due to a lack of *documentation* of sound QI strategies, rather than the absence of these strategies in the PIPs. Because the PIP validation process is based on a desk audit of documentation submitted by the plans, the plans must adequately document the PIP process, including improvement strategies and evaluation processes, in order to improve validation scores in the Implementation stage.

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 23 clinical PIPs. Percentage totals may not equal 100 due to rounding.

Figure 3-3—MMA Clinical PIP Validation Scores by Activity and PIP Stage



	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)	VI. Accurate, Complete Data Collection	Design Total	VII. Sufficient Data Analysis and Interpretation	VIII. Appropriate Improvement Strategies	Implementation Total	IX. Real Improvement Achieved	Outcomes Total
Not Met	0%	0%	0%	0%	0%	4%	1%	26%	12%	17%	52%	52%
Partially Met	0%	4%	13%	3%	0%	4%	4%	17%	25%	22%	4%	4%
Met	100%	96%	87%	97%	100%	92%	95%	57%	63%	61%	44%	44%

The MMA plans demonstrated strong performance in the Design stage of the clinical PIPs, receiving a *Met* score for 95 percent of applicable evaluation elements across the six activities. The most common challenge for the MMA plans in the Design stage involved Activity III (Correctly Identified Study Population), where 87 percent of the evaluation elements received a *Met* score. For the remaining activities in the Design stage, the percentage of *Met* scores ranged from 92 percent in Activity VI (Accurate, Complete Data Collection) to 100 percent in both Activities I (Appropriate Study Topic) and V (Valid Sampling Techniques). The MMA standard plans can strengthen the study design of their clinical PIPs by reviewing and addressing HSAG's feedback in the PIP validation tool and seeking additional TA for further clarification, as needed.

Similar to their performance on the state-mandated PIPs, the MMA plans had room for improvement in the Implementation stage of the clinical PIPs. Across the two activities in this stage, 61 percent of applicable evaluation elements received a *Met* score. The MMA plans performed better in Activity VIII (Appropriate Improvement Strategies), receiving a *Met* score for 63 percent of evaluation elements, compared to 57 percent in Activity VII (Sufficient Data Analysis and Interpretation). In Activity VII, the greatest challenge for the plans involved documenting whether factors were identified that affected the validity of the study indicator results. In Activity VIII, as demonstrated in the state-mandated PIPs, the MMA plans had the most room for improvement in evaluating the effectiveness of each intervention and using intervention-specific evaluation results to guide the next steps of the improvement strategies. As with all PIPs, the MMA plans should ensure that each PIP intervention is evaluated for effectiveness and that evaluation results and next steps are clearly documented for each intervention. Plans may contact HSAG for TA in developing methodologically sound intervention evaluation plans.

Based on the first remeasurement results of the clinical PIPs, the MMA plans had room for improvement in Activity IX (Real Improvement Achieved) of the Outcomes stage. Less than half (44 percent) of the evaluation elements in the Outcomes stage received a *Met* score. Across the clinical PIPs, only 25 percent received a *Met* score for demonstrating statistically significant improvement in the study indicator rates at the first remeasurement. To improve performance in the Outcomes stage, the plans should address challenges encountered in the Implementation stage, ensuring that sound QI strategies are employed. Desired PIP outcomes can be achieved by using methodologically sound and comprehensive QI strategies in the Implementation stage of the PIP.

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 16 nonclinical PIPs. Percentage totals may not equal 100 due to rounding.

Figure 3-4—MMA Nonclinical PIP Validation Scores by Activity and PIP Stage

	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)	VI. Accurate, Complete Data Collection	Design Total	VII. Sufficient Data Analysis and Interpretation	VIII. Appropriate Improvement Strategies	Implementation Total	IX. Real Improvement Achieved	Outcomes Total
Not Met	0%	0%	0%	0%	0%	2%	1%	13%	9%	10%	53%	53%
Partially Met	0%	6%	6%	0%	0%	0%	1%	25%	38%	33%	4%	4%
Met	100%	94%	94%	100%	100%	98%	98%	63%	54%	57%	42%	42%

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 98 percent of the evaluation elements received a *Met* score. The percentage of evaluation elements receiving a *Met* score by activity ranged from 94 percent in Activities II (Clearly Defined, Answerable Study Question[s]) and III (Correctly Identified Study Population) to 100 percent in Activities I (Appropriate Study Topic), IV (Clearly Defined Study Indicator[s]), and V (Valid Sampling Techniques). The plans can review and address HSAG's feedback in the PIP validation tool to improve validation scores in the Design stage of the PIPs.

The MMA standard plans had greater room for improvement in the Implementation stage, where 57 percent of applicable evaluation elements across the two activities received a *Met* score. The plans performed better in Activity VII (Sufficient Data Analysis and Interpretation), where 63 percent of evaluation elements were scored *Met* compared to Activity VIII (Appropriate Improvement Strategies), where 54 percent of evaluation elements were scored *Met*. The most common areas in need of improvement in Activity VII included the narrative interpretation of study indicator results and identification of factors affecting the validity of the

results. In Activity VIII, the MMA plans' greatest challenges continued to be conducting intervention-specific evaluations and using evaluation results to guide next steps for interventions. Additional challenges in Activity VIII included conducting interventions that were timely and logically linked to the barriers identified for the PIP. The plans should seek additional assistance, as needed, to address gaps in their data analysis and QI capacity, identified by any evaluation elements that did not receive a *Met* score.

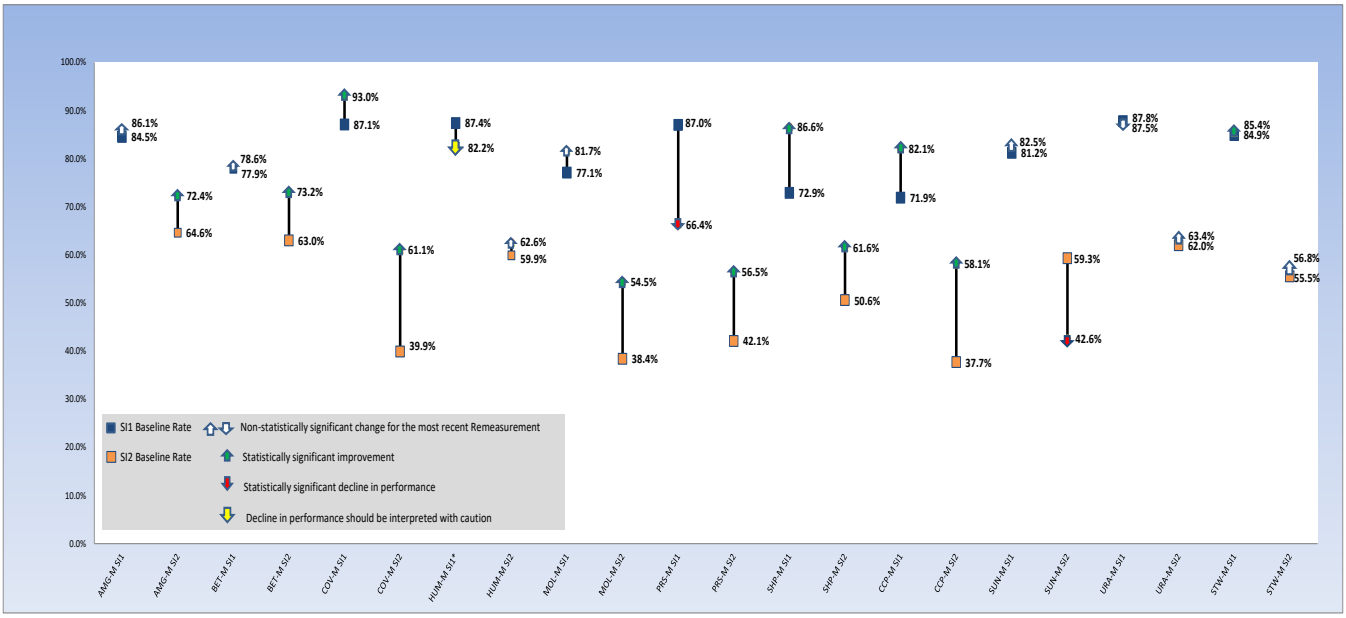
The first remeasurement results of the nonclinical PIPs demonstrated that the MMA plans had room for improvement in Activity IX (Real Improvement Achieved) of the Outcomes stage. Similar to their performance on the clinical PIPs, the MMA plans received a *Met* score for less than half (42 percent) of the evaluation elements in the Outcomes stage. Across the nonclinical PIPs, only 13 percent received a *Met* score for demonstrating statistically significant improvement in the study indicator rates at the first remeasurement. To improve performance in the Outcomes stage, the plans should address deficiencies identified in the Implementation stage. To achieve desired PIP outcomes, the plans should ensure accurate data calculation and interpretation, deploy timely interventions that are linked to identified barriers, evaluate each intervention for effectiveness, and use evaluation results to drive next steps for improvement strategies.

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* PIPs

Figure 3-5 displays the baseline measurement period and Remeasurement 1 period rates reported by the MMA 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—the rate of pregnant enrollees who received a timely prenatal care visit and Study Indicator 2—the rate of child enrollees 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. Remeasurement 1 rates for both study indicators are designated by arrow symbols. A white arrow designates an improvement or decline that was not statistically significant. A green arrow designates a statistically significant improvement, and a red arrow designates a statistically significant decline in performance. A yellow arrow designates a Remeasurement 1 rate that was not comparable to the baseline rate due to a change in data collection methodology. 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 F.

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 SFY 2016–2017



Eleven MMA plans reported Remeasurement 1 results for the two study indicators in the *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIP. Across the 11 PIPs, each plan reported higher baseline and Remeasurement 1 rates for SI1 (timely prenatal visits—in dark blue) than it reported for SI2 (well-child visits—in orange), suggesting that, in general, 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. For each study indicator, the amount of improvement or decline from baseline to Remeasurement 1 varied by plan.

For SI1 (timely prenatal visits—in dark blue), the Remeasurement 1 rates ranged from a minimum of 66.4 percent, reported by Prestige, to a maximum of 93.0 percent, reported by Coventry. Four plans reported a statistically significant improvement from baseline to Remeasurement 1 in SI1 (timely prenatal visits): Coventry, Simply, CCP, and Staywell. The largest increase in the SI1 rate (13.7 percentage points) was reported by Simply. Among the seven plans that did not report a statistically significant improvement in the SI1 rate from baseline to Remeasurement 1, two plans (Humana and Prestige) reported a statistically significant decline, and the remaining five plans reported either an improvement or a decline in the rate that was not statistically significant.

It should be noted that Humana, one of the plans that reported a statistically significant decline in the SI1 (timely prenatal visits) rate, changed the study indicator methodology from hybrid data collection for the baseline measurement period, to administrative data collection for the Remeasurement 1 period. Because administrative data collection was not approved as part of the state-defined specifications for the *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIP, and because shifting from hybrid to administrative data collection results in study indicator rates that are not comparable, Humana's study indicator results should be interpreted with

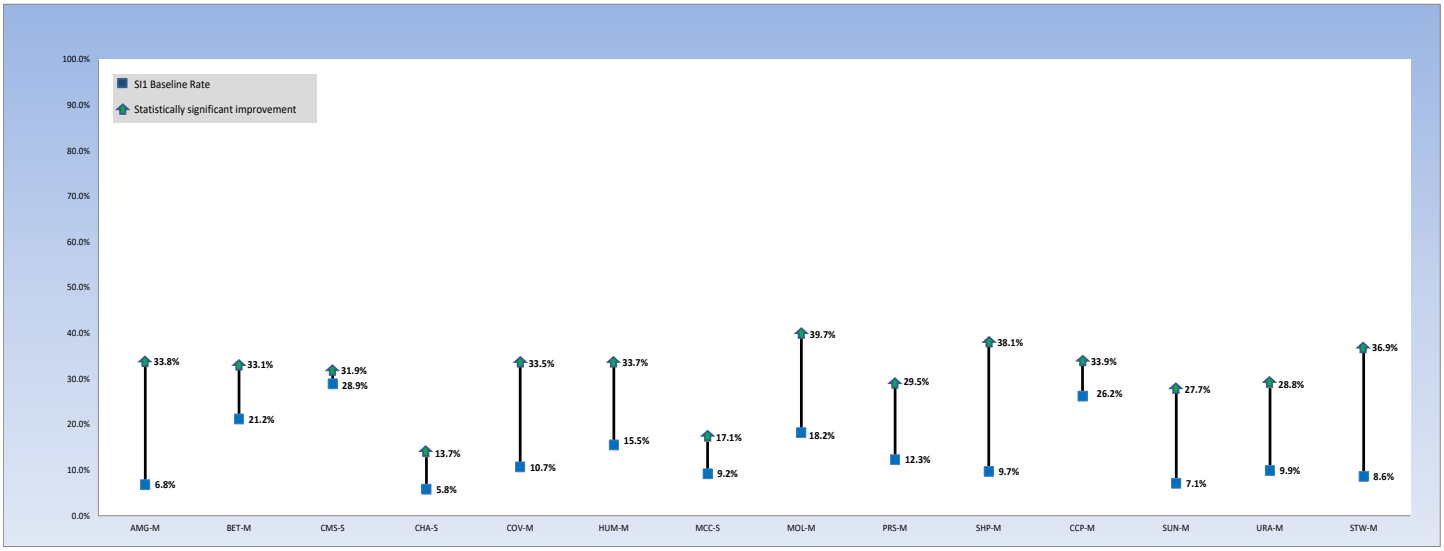
caution. HSAG used a yellow arrow to designate Humana's SI1 results in Figure 3-5. In the PIP validation tool for Humana's *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIP, HSAG recommended that the plan correct the Remeasurement 1 SI1 rate using a hybrid data collection methodology so that the study indicator results are comparable between measurement periods and align with the state-defined PIP specifications.

For SI2 (well-child visits—in orange), the Remeasurement 1 rates ranged from a minimum of 42.6 percent, reported by Sunshine, to a maximum of 73.2 percent, reported by Better Health. Seven plans reported a statistically significant improvement from baseline to Remeasurement 1 in SI2 (well-child visits): Amerigroup, Better Health, Coventry, Molina, Prestige, Simply, and CCP. The largest increase in the SI2 rate (21.2 percentage points) was reported by Coventry. Among the four plans that did not report a statistically significant improvement in the SI2 rate from baseline to Remeasurement 1, one plan, Sunshine, reported a statistically significant decline in the SI2 rate, and three plans reported an improvement in the rate that was not statistically significant.

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

Figure 3-6 displays the baseline measurement period rates and Remeasurement 1 period rates reported by the MMA plans for the state-mandated *Preventive Dental Services for Children* PIP. The PIP had one study indicator, which measured the rate of child enrollees, 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 Remeasurement 1 rates for the study indicator are designated by arrow symbols. A green arrow designates a statistically significant improvement in performance. 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 F.

Figure 3-6—State-Mandated *Preventive Dental Services for Children* Study Indicator Results for SFY 2016–2017



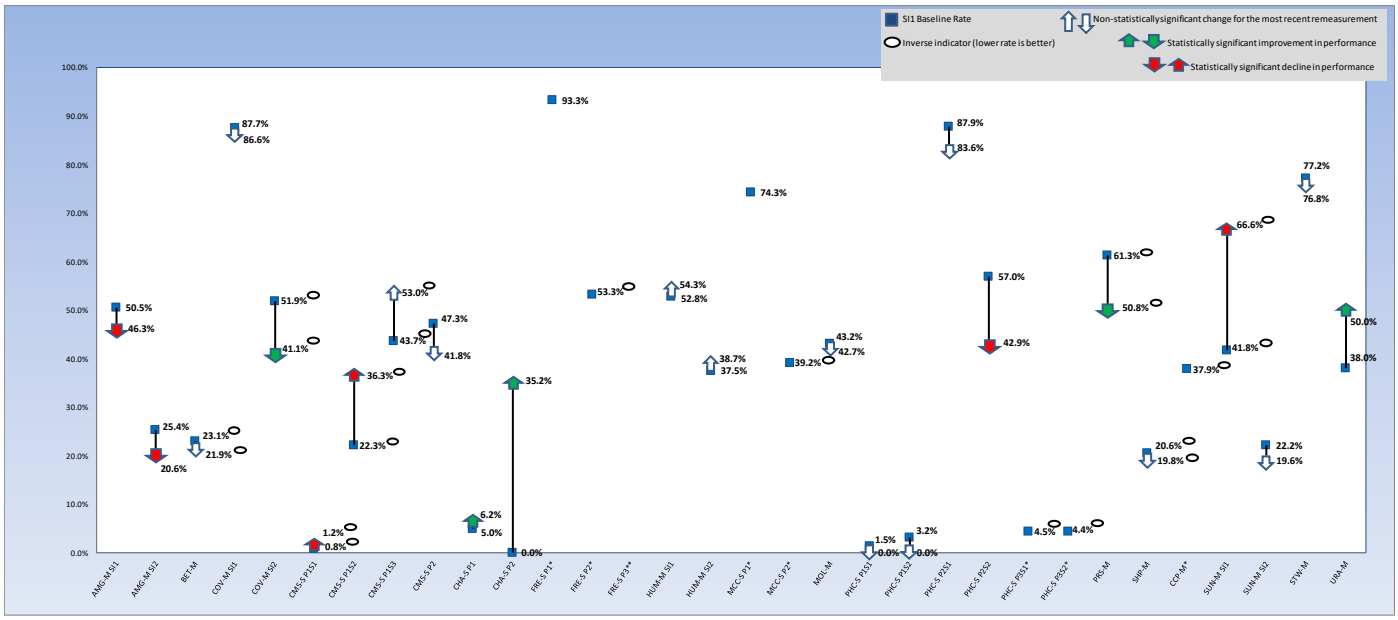
Fourteen MMA plans reported Remeasurement 1 results for the PIP's study indicator. Each of the MMA plans reported a statistically significant improvement in the study indicator rate from baseline to Remeasurement 1. The Remeasurement 1 rates ranged from a minimum of 13.7 percent, reported by Clear Health-S, to a maximum of 39.7 percent, reported by Molina. Simply reported the largest increase, with an improvement of 28.4 percentage points from baseline to the first remeasurement. With all Remeasurement 1 rates remaining below 40.0 percent, there are still opportunities for improvement in the preventive dental visit rates among all plans.

Clinical PIP Study Indicator Results

The MMA plans submitted baseline and Remeasurement 1 study indicator results for additional clinical PIPs beyond those submitted for the state-mandated PIP topics described above. The MMA plans selected the specific clinical topics to be addressed in the PIPs; therefore, the specific PIP topics and study indicators varied by plan. HSAG validated 23 clinical PIPs submitted by the MMA plans.

Figure 3-7 displays the baseline and Remeasurement 1 study indicator results for the clinical PIPs submitted by the MMA plans. The blue boxes on the chart represent the baseline study indicator rate reported for each study indicator. Remeasurement 1 rates are designated by arrow symbols. A white arrow designates an improvement or decline that was not statistically significant. A green arrow designates a statistically significant improvement, and a red arrow designates a statistically significant decline in performance. An additional symbol, an oval next to the rate, is used to signify that the indicator was an inverse indicator, where lower rates indicate better performance. For those PIPs with multiple study indicators, a study indicator identifier follows the plan name (i.e., SI1 for Study Indicator 1 and SI2 for Study Indicator 2). The X axis is labeled with the plan name abbreviation and, if applicable, the PIP number (P1 or P2) and/or study indicator (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 F.

Figure 3-7—Clinical PIP Study Indicator Results for SFY 2016–2017 for MMA Plans



* The plan did not progress to reporting Remeasurement 1 results for the current validation cycle.
**The plan did not progress to reporting baseline or Remeasurement 1 results for the current validation cycle.

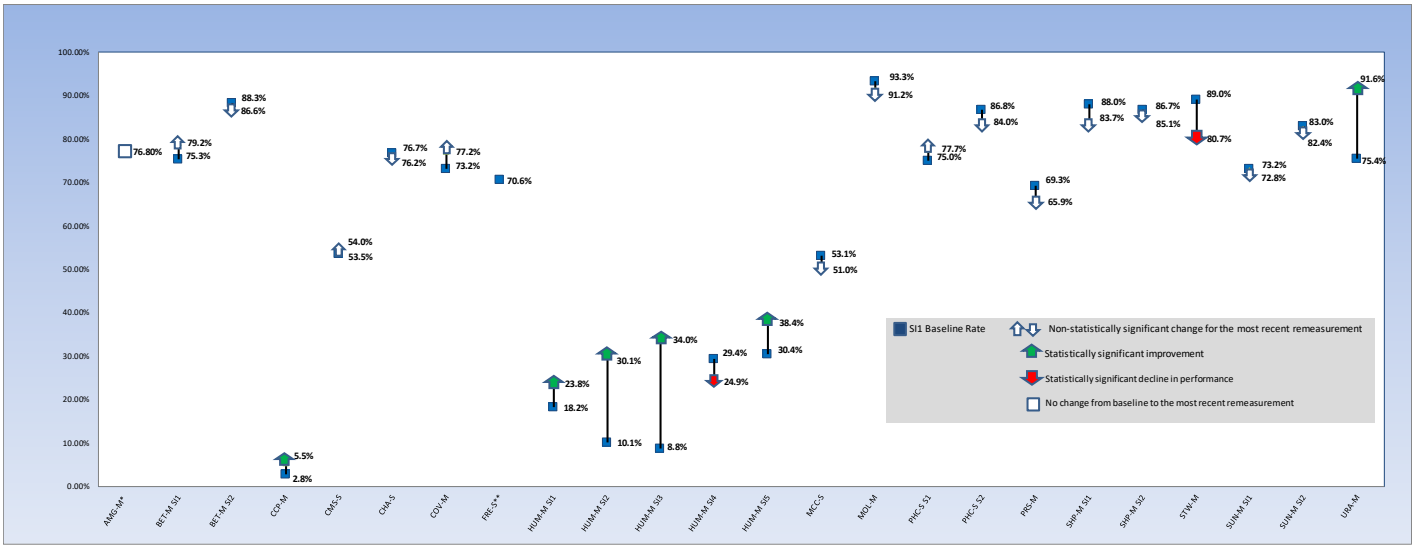
The 23 clinical PIPs had a total of 32 study indicators. The MMA plans reported Remeasurement 1 results for 24 of the 32 study indicators. For seven of the 32 study indicators, the MMA plans reported baseline results only; and for one study indicator, neither baseline nor Remeasurement 1 results were reported. Of the 24 study indicators with Remeasurement 1 results, five indicators demonstrated statistically significant improvement from baseline to Remeasurement 1. Three MMA plans, Coventry, Prestige, and United, reported a statistically significant improvement in one study indicator for each of their clinical PIPs; and one plan, Clear Health-S, reported statistically significant improvement in two study indicators. Thirteen of the study indicators with Remeasurement 1 results demonstrated an improvement or decline in performance that was not statistically significant. The remaining six study indicators with Remeasurement 1 results demonstrated a statistically significant decline in performance: Amerigroup (two indicators), Children's Medical Services-S (two indicators), Positive-S (one indicator), and Sunshine (one indicator).

The wide range of Remeasurement 1 study indicator rates among the clinical PIPs suggested that there was considerable variation, by plan and PIP topic, in the opportunities for improvement across these PIPs. Among the 16 standard study indicators (where a higher rate indicates better performance) with Remeasurement 1 results, the Remeasurement 1 rates ranged from a minimum of 0.0 percent, reported by Positive-S for two study indicators, to a maximum of 86.6 percent, reported by Coventry. Among the eight inverse study indicators (where a lower rate indicates better performance) with Remeasurement 1 results, the rates ranged from a minimum of 1.2 percent, reported by Children's Medical Services-S, to a maximum of 66.6 percent, reported by Sunshine.

Nonclinical PIP Study Indicator Results—MMA Plans

Figure 3-8 displays the baseline and Remeasurement 1 study indicator results for the nonclinical PIPs submitted by the MMA plans. The blue boxes on the chart represent the baseline study indicator rate reported for each study indicator. Remeasurement 1 rates are designated by arrow symbols. A white arrow designates an improvement or decline that was not statistically significant. A green arrow designates a statistically significant improvement, and a red arrow designates a statistically significant decline in performance. A white box designates that there was no change in the study indicator rate from baseline to Remeasurement 1. 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 F.

Figure 3-8—Nonclinical PIP Study Indicator Results for SFY 2016–2017 for MMA Plans



* The study indicator rate remained the same for the baseline and Remeasurement 1 periods.
**The plan did not progress to reporting Remeasurement 1 results for the current validation cycle.

The 16 nonclinical PIPs had a total of 24 study indicators. Fifteen MMA plans reported Remeasurement 1 results for 23 of the nonclinical PIP study indicators. One plan, Freedom-S, reported only baseline study indicator results for the one study indicator in its nonclinical PIP. Of the 23 study indicators with Remeasurement 1 results, six indicators demonstrated statistically significant improvement from baseline to Remeasurement 1. The plans that reported statistically significant improvement in one or more nonclinical study indicators were CCP (one indicator), Humana (four indicators), and United (one indicator). Fifteen of the 23 study indicators with Remeasurement 1 results demonstrated an improvement or decline that was not statistically significant, or no change in the rate. The remaining two study indicators with Remeasurement 1 results demonstrated a statistically significant decline in performance. The MMA plans that reported statistically significant declines from baseline to Remeasurement 1 were Humana and Staywell.

The Remeasurement 1 study indicator rates among the nonclinical PIPs suggested that there was considerable variation, by plan and PIP topic, in the opportunities for improvement in the nonclinical PIPs. Among the 23 nonclinical PIP study indicators with Remeasurement 1 results, the Remeasurement 1 rates ranged from a minimum of 5.5 percent, reported by CCP, to a maximum of 91.6 percent, reported by United.

Results—Notable Improvements and Interventions

The strongest evidence for notable improvement is statistically significant improvement for all study indicators and sustaining the improvement achieved. During the SFY 2016–2017 validation cycle, the MMA plans progressed to reporting Remeasurement 1 study indicator results for most PIPs. For those PIPs with comparable Remeasurement 1 study indicator results, HSAG evaluated the results and identified PIPs that had demonstrated statistically significant improvement over baseline at Remeasurement 1 for all study indicators. HSAG will assess sustained improvement for those PIPs that achieved statistically significant improvement at Remeasurement 1 when the plans progress to reporting Remeasurement 2 results for the next validation cycle.

The percentage of PIPs submitted by MMA plans that achieved statistically significant improvement over baseline for all study indicators at Remeasurement 1 varied by PIP topic. For the state-mandated PIP topics, three (27 percent) of the 11 *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIPs and 100 percent of the 14 *Preventive Dental Services for Children* PIPs achieved statistically significant improvement across all study indicators. Among the plan-selected topics, four (25 percent) of the 16 clinical PIPs and 2 (13 percent) of the 15 nonclinical PIPs achieved statistically significant improvement across all study indicators at Remeasurement 1.

Regardless of the PIP topic, success in achieving statistically significant improvement in study indicator outcomes is strongly influenced by the QI strategies used in the PIP to drive improvement. As part of the PIP validation process, HSAG identified innovative interventions employed by the MMA plans in PIPs that achieved statistically significant improvement across all study indicators.

Table 3-1 summarizes the innovative interventions associated with statistically significant improvement that HSAG identified during the SFY 2016–2017 validation cycle.

Table 3-1—Innovative Interventions Associated With Statistically Significant Improvement Above Baseline Across All Study Indicators

PIP Topic	Notable Intervention	Plan
Annual Diabetic Retinal Eye Exam	South Florida Vision targeted enrollee eye exam program: a financial incentive program for optometrist vendors to partner with primary care provider (PCP) offices to complete eye exams via a portable scan machine.	United
Preventive Dental Services for Children	Identifying dental providers to serve as dental homes for enrollees.	Humana Sunshine
	Collaboration with federally qualified health centers (FQHCs) and school-based clinics to schedule preventive dental appointments during Dental Clinic Days for enrollees due for services.	Amerigroup

PIP Topic	Notable Intervention	Plan
	Hosting dental fairs at various locations to provide more convenient access to preventive dental services.	Coventry
	Partnering with the School-Based Sealant Program to provide preventive dental services for enrollees.	Prestige Staywell Sunshine
	PCP training on preventive dental services, application of fluoride in the PCP's office, information about the dental network, and a reminder card to give to enrollees prompting them to make a dental appointment.	CCP
	Provider incentive program for preventive dental services.	Better Health Clear Health-S Simply Staywell
	Recorded educational message, developed in collaboration with the transportation vendor, heard by all inbound callers. The message reminded enrollees of the importance of preventive dental visits and provided information on available transportation assistance.	United
	Recruitment of dental providers to partner with nearby PCPs to schedule days in the office for providing preventive dental care.	United
	Use of mobile dental service units to provide preventive services.	Prestige Staywell

HSAG identified innovative interventions associated with statistically significant improvement in study indicator outcomes for one MMA plan-selected clinical PIP topic, *Annual Diabetic Retinal Eye Exam*, and one MMA state-mandated PIP topic, *Preventive Dental Visits for Children*. For the *Annual Diabetic Retinal Eye Exam* PIP, United used an innovative incentive program that targeted optometrist vendors to partner with PCP offices to complete eye exams using a portable retinal scanner. HSAG identified nine innovative interventions deployed by 11 MMA plans for the state-mandated *Preventive Dental Services for Children* PIP. The innovative interventions identified during the SFY 2016–2017 validation cycle suggest that the plans were particularly focused on finding creative solutions to improving the rate of preventive dental visit rates for the state-mandated PIP. The plans were supported by AHCA's state-wide focus on this topic and the various training opportunities and resources that AHCA provided to the plans to support improvement efforts in this area. The widespread use of innovative interventions for the *Preventive Dental Services for Children* PIP was associated with statistically significant improvement over baseline in the preventive dental visit rate among all 14 MMA plans that reported Remeasurement 1 study indicator results for this PIP.

MCO Comparison

Based on the PIP validation scores (Figure 3-1 through Figure 3-4), the MMA plans performed similarly in the Design stage of the state-mandated *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* and *Preventive Dental Services for Children* PIPs and the plan-selected clinical and nonclinical PIPs. The MMA plans performed well in the Design stage,

with the percentages of *Met* scores for all evaluation elements ranging from 95 percent to 98 percent for the four types of PIPs. The performance was also similar across the Implementation stage, with the percentages of *Met* scores ranging from 54 percent to 61 percent, suggesting greater opportunities for improvement in this stage across the four types of PIPs. In the Outcomes stage, the MMA plans performed particularly well in the *Preventive Dental Services for Children* PIPs, where 90 percent of the evaluation elements received a *Met* score, but they were less successful in the other three types of PIPs, where the percentage of *Met* scores ranged from 42 percent to 52 percent.

With respect to the Remeasurement 1 study indicator outcomes for the state-mandated *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIPs (Figure 3-5), the MMA plans varied in their performance on improving outcomes during the SFY 2016–2017 validation cycle. Among the 11 MMA plans that reported Remeasurement 1 results for the PIP, only three plans, Coventry, Simply, and CCP, achieved statistically significant improvement over baseline for both study indicators. Three other MMA plans, Humana, Sunshine, and United, did not achieve statistically significant improvement over baseline for either study indicator. The remaining five plans achieved statistically significant improvement for only one of the two study indicators.

For the state-mandated *Preventive Dental Services for Children* PIPs, all 14 MMA plans demonstrated strength in improving study indicator outcomes (Figure 3-6). All 14 plans demonstrated statistically significant improvement over baseline at Remeasurement 1. Molina reported the highest Remeasurement 1 study indicator rate, and Clear Health-S reported the lowest Remeasurement 1 rate. Simply reported the largest percentage point increase from baseline to Remeasurement 1. With a maximum Remeasurement 1 rate of 39.7 percent, the MMA plans continue to have room for improvement in the *Preventive Dental Services for Children* study indicator outcomes.

The Remeasurement 1 study indicator outcomes for the plan-selected clinical PIPs (Figure 3-7) suggested variation in the MMA plans' performance demonstrating improvement in various clinical topics. The variation in demonstrated improvement should be interpreted within the context of the specific clinical PIP topics and study indicators that each MMA plan selected (see Appendix C), as some topics may present greater challenges for improvement than others. Three MMA plans, Clear Health-S, Prestige, and United, demonstrated strength in the clinical PIPs by achieving statistically significant improvement over baseline across all study indicators at Remeasurement 1. One plan, Amerigroup, demonstrated statistically significant declines from baseline across all study indicators at Remeasurement 1.

The Remeasurement 1 study indicator outcomes for the plan-selected nonclinical PIPs (Figure 3-8) suggested variation in the MMA plans' performance demonstrating improvement in various nonclinical topics. Like the clinical PIPs, the variation in demonstrated improvement should be interpreted within the context of the specific nonclinical PIP topics and study indicators that each MMA plan selected (see Appendix C), as some topics may present greater challenges for improvement than others. Two MMA plans, CCP and United, achieved statistically significant improvement over baseline across all study indicators at Remeasurement 1. One plan, Staywell, demonstrated a statistically significant decline from baseline across all study indicators at Remeasurement 1.

Conclusions and Recommendations

During the SFY 2016–2017 validation cycle, HSAG validated the first remeasurement period of the MMA plans' PIPs though the Design, Implementation, and Outcomes stages (Activities I through IX). The MMA plans submitted four types of PIPs for validation: the state-mandated *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* and *Preventive Dental Services for Children* PIPs, and the plan-selected clinical and nonclinical PIPs. The overall validation status and validation scores for each PIP varied by plan and topic.

HSAG determined that opportunities for improvement existed in the three PIP stages for the MMA plans. The validation scores in the Design stage suggested that, overall, the plans designed methodologically sound projects. While there were minimal opportunities to improve in the Design stage, a few PIPs had challenges in this stage related to alignment with state-mandated specifications, documentation of study population and study indicators, and documentation of data collection methodology. The plans had greater opportunities for improvement in the Implementation and Outcome stages of the PIPs.

In the Implementation stage, the PIPs continued to have errors in data analysis and interpretation of study indicator results. Some MMA plans did not conduct sufficient causal/barrier analyses for their PIPs. In some cases, the plans' interventions did not appear to be clearly linked to identified barriers. Additionally, many PIPs did not describe appropriate intervention evaluation processes to assess and refine the interventions throughout each measurement period.

In the Outcomes stage, the MMA plans had progressed to reporting study indicator results from the first remeasurement; therefore, the PIPs were evaluated on whether statistically significant improvement over baseline was achieved for all study indicators. The plans' success in the Outcomes stage varied by PIP topic. The MMA plans achieved statistically significant improvement over baseline at Remeasurement 1 for all *Preventive Dental Services for Children* PIPs compared to only 27 percent of the state-mandated *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIPs. In the plan-selected clinical and nonclinical PIPs, some plans were able to achieve statistically significant improvement over baseline for all study indicators, and other plans were not. 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.

AHCA facilitated a variety of activities throughout the year to support the plans as they conducted their PIPs. These activities included one-on-one PIP check-ins between AHCA staff and each plan, PIP-related educational presentations delivered during quarterly meetings with the plans, and on-demand TA sessions with HSAG. The different activities provided support and assistance to the plans in various venues and formats to strengthen the improvement processes and strategies used in the PIPs. HSAG recommends that AHCA continue to offer a variety of opportunities and venues for the plans to receive TA on QI processes and strategies to improve PIP performance and outcomes. Additionally, AHCA should continue to explore and identify innovative interventions and share intervention examples with

the plans. Sharing potentially promising strategies with the plans may help facilitate improvement in individual PIPs and in statewide efforts.

To improve the design of the PIPs going forward, the MMA plans should ensure clear and accurate documentation of the PIP study population, including inclusion and exclusion criteria, and following applicable state-defined specifications. The MMA plans should also set attainable study indicator goals for each remeasurement period, based on organizational knowledge and study indicator rates from previous measurement periods. Each study indicator goal should represent a statistically significant improvement compared to the baseline study indicator rate. When using sampling, the MMA plans should employ methodologically sound sampling techniques and ensure clear documentation of the sampling methods used. Finally, the MMA plans should thoroughly describe the administrative and/or manual data collection methods used for each PIP, including manual data collection tools when used.

To improve the implementation of the PIPs, the MMA plans should focus on accuracy and completeness of study indicator results analyses and interpretation, as well as using appropriate, sound quality improvement processes and strategies. The MMA plans should correct any errors in the study indicator rate calculations and/or statistical testing results identified during the SFY 2016–2017 PIP validation. Accurate study indicator rates are necessary for an accurate measurement of progress in improving PIP outcomes during the remeasurement periods. The plans should ensure adequate analytical staffing for the PIPs to facilitate methodologically sound design and accurate, appropriate data analysis and interpretation throughout the project. The MMA plans should use sound QI science tools and processes to analyze barriers to improvement and prioritize identified barriers at least annually. The plans should leverage resources to deploy interventions addressing the highest-priority barriers to improvement. For each intervention, the MMA plans should have a process in place for evaluating the performance of each intervention and its impact on the study indicators. Evaluation results should be documented separately for each intervention during each measurement period. The evaluation process should be ongoing and cyclical to allow for iterative learning and continual refinement of improvement strategies. The MMA plans should use intervention-specific evaluation results to guide next steps of each intervention. The PIP documentation should include the next steps for each intervention, and future intervention plans should be linked to evaluation results.

To achieve desired improvement in PIP outcomes, the MMA plans should revisit the casual/barrier analysis for each PIP at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions. For those PIPs that have not yet demonstrated significant improvement in the study indicator results, the MMA plans should identify and document new or revised barriers that have prevented improvement in PIP outcomes and should develop new or revised interventions to better address high-priority barriers associated with lack of improvement. The MMA plans should utilize opportunities for TA through AHCA and HSAG to address challenging barriers and develop innovative improvement strategies.

LTC Plans

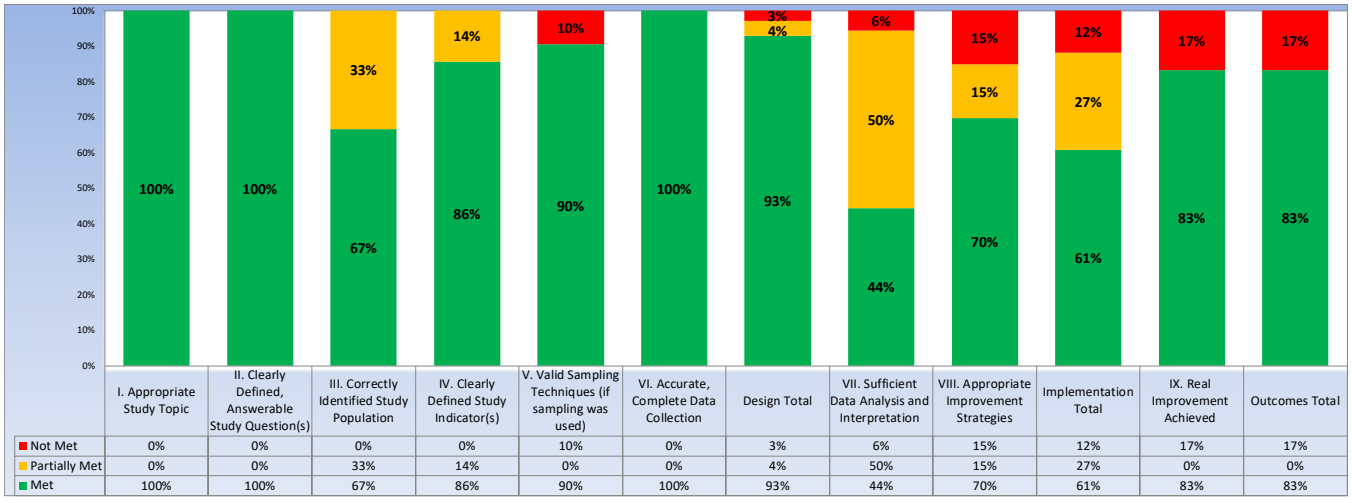
Results—PIP Validation Status

Validation Status of the *Medication Review* PIPs

HSAG validated one state-mandated LTC PIP topic for the SFY 2016–2017 validation year. The *Medication Review* PIP was submitted by six LTC plans. The plans progressed through Activity IX of the Outcomes stage and reported Remeasurement 1 study indicator results for the state-mandated PIPs in SFY 2016–2017, and HSAG validated PIP Activities I–IX accordingly. HSAG will validate Activity X (Sustained Improvement) during the next validation cycle for those PIPs that demonstrated statistically significant improvement at the first remeasurement during this year's validation cycle.

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 six PIPs submitted by the LTC plans for this topic. Percentage totals may not equal 100 due to rounding.

Figure 3-9—State-Mandated PIP Validation Scores by Activity and PIP 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	IX. Real Improvement Achieved	Outcomes Total
Not Met	0%	0%	0%	0%	10%	0%	3%	6%	15%	12%	17%	17%
Partially Met	0%	0%	33%	14%	0%	0%	4%	50%	15%	27%	0%	0%
Met	100%	100%	67%	86%	90%	100%	93%	44%	70%	61%	83%	83%

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 93 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[s]), and VI (Accurate, Complete Data Collection). The LTC plans struggled most in Activity III (Correctly Identified Study Population), where 67 percent of evaluation elements received a *Met* score. There was also some room for improvement in Activity IV (Clearly Defined Study Indicator[s]) and Activity V (Valid Sampling Techniques), where the percentages of evaluation elements that received a *Met* score were 86 percent and 90 percent, respectively. The LTC plans may improve scores in the Design stage of

the PIP by reviewing the state-defined specifications for the *Medication Review* PIP, addressing HSAG's feedback in the PIP validation tool, and requesting additional TA, as needed.

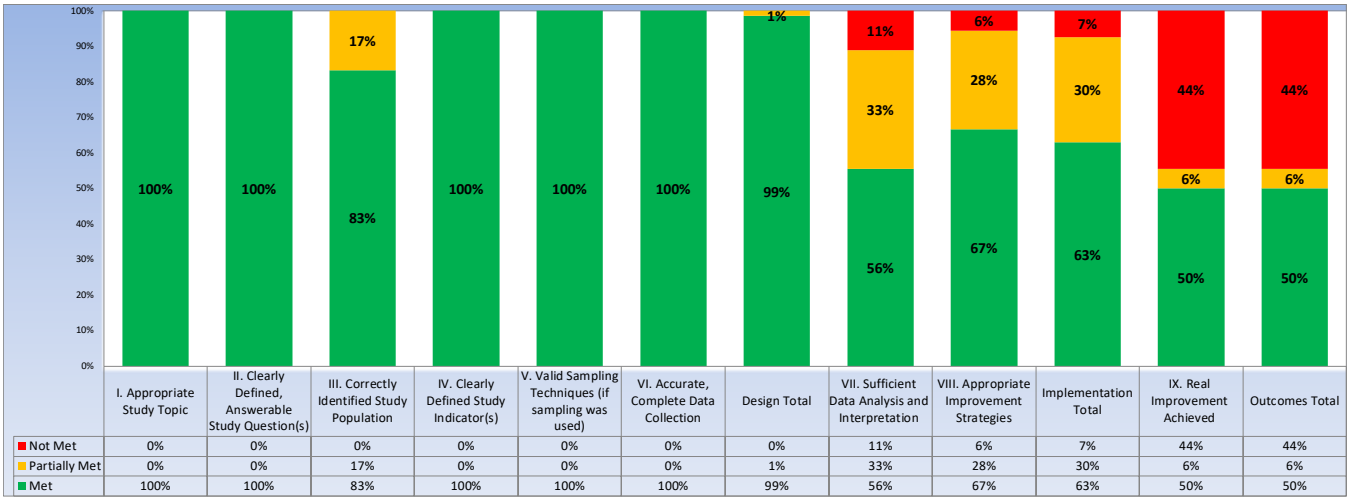
The LTC plans had room for improvement in the Implementation stage of the *Medication Review* PIP, where only 61 percent of the evaluation elements received a *Met* score. The LTC plans performed better in Activity VIII (Appropriate Improvement Strategies), receiving a *Met* score for 70 percent of the elements, compared with Activity VII (Sufficient Data Analysis and Interpretation), where they received a *Met* score for only 44 percent of the elements. The LTC plans' most common challenge in Activity VII involved providing an accurate and complete narrative description and interpretation of the PIP study indicator results. In Activity VIII, similar to the MMA plans' performance on the other state-mandated PIPs, the LTC plans' most common challenges were related to not evaluating the effectiveness of each intervention and not using intervention-specific evaluation results to guide the next steps of the improvement strategies.

Two of the six *Medication Review* PIPs progressed to the point of being assessed for real improvement in Activity IX of the Outcomes stage. Based on the first remeasurement results for the two *Medication Review* PIPs that were assessed, the LTC plans demonstrated strong performance in Activity IX. The plans received a *Met* score for 83 percent of all applicable evaluation elements in Activity IX. Additionally, similar to the MMA plans' performance on the *Preventive Dental Services for Children* PIPs, 100 percent of the PIPs received a *Met* score in the Activity IX evaluation element for demonstrating statistically significant improvement over baseline at the first remeasurement. While all *Medication Review* PIPs demonstrated statistically significant improvement at Remeasurement 1, only 50 percent of the PIPs received a *Met* score for study indicator results that achieved the plan-specified Remeasurement 1 goal. This pattern of validation scores suggests that some of the LTC plans set highly ambitious Remeasurement 1 goals that were not achieved despite demonstrating a statistically significant improvement over the baseline rate. To improve scores for this evaluation element, the plans may choose to review the goal set for the next remeasurement period and consider whether the goal is realistic and attainable.

Validation Status of 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 six nonclinical PIPs. Percentage totals may not equal 100 due to rounding.

Figure 3-10—LTC Nonclinical PIP Validation Scores by Activity and PIP Stage



	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)	VI. Accurate, Complete Data Collection	Design Total	VII. Sufficient Data Analysis and Interpretation	VIII. Appropriate Improvement Strategies	Implementation Total	IX. Real Improvement Achieved	Outcomes Total
Not Met	0%	0%	0%	0%	0%	0%	0%	11%	6%	7%	44%	44%
Partially Met	0%	0%	17%	0%	0%	0%	1%	33%	28%	30%	6%	6%
Met	100%	100%	83%	100%	100%	100%	99%	56%	67%	63%	50%	50%

The LTC plans designed methodologically sound nonclinical PIPs and received a *Met* score for 99 percent of the applicable evaluation elements across the six activities in the Design stage. Activity III (Correctly Identified Study Population) was the only activity in the Design stage for which less than 100 percent of the evaluation elements were scored *Met*. One of the six nonclinical PIPs submitted by the LTC plans received a *Partially Met* score for the evaluation element in Activity III, resulting in 83 percent of the evaluation elements in Activity III across the six PIPs receiving a *Met* score. All other evaluation elements in the Design stage received a *Met* score across the six PIPs, demonstrating strong performance by the LTC plans in this stage.

The LTC plans had greater room for improvement in the Implementation stage of the nonclinical PIPs, receiving a *Met* score for 63 percent of the evaluation elements across the two activities in this stage. The LTC plans performed better in Activity VIII (Appropriate Improvement Strategies), where 67 percent of evaluation elements received a *Met* score, compared to Activity VII (Sufficient Data Analysis and Interpretation), where 56 percent of the evaluation elements received a *Met* score. Opportunities for improvement in Activity VII were most commonly related to inaccurate documentation and interpretation of study indicator results and not documenting whether any factors were identified that affected the validity of the results. In Activity VIII, the most common challenges were related to not evaluating each intervention for effectiveness and not using intervention-specific evaluation results to guide next steps for improvement strategies. To improve performance in the Implementation stage of the PIPs, the LTC plans should review and address HSAG's feedback related to data analysis and interpretation, as well as feedback on evaluating intervention effectiveness. For further clarification and support, the plans should contact HSAG to request additional TA in these areas.

The first remeasurement results of the nonclinical PIPs demonstrated that the LTC plans had room for improvement in Activity IX (Real Improvement Achieved) of the Outcomes stage. The LTC plans received a *Met* score for 50 percent of the evaluation elements in the Outcomes stage. Across the nonclinical PIPs, 33 percent received a *Met* score for demonstrating statistically significant improvement in the study indicator rates at the first remeasurement. Because improved outcomes result from methodologically sound QI processes and strategies, the plans should address deficiencies identified in the Implementation stage to improve validation scores in the Outcomes stage. To achieve the desired PIP outcomes, the plans should ensure accurate data calculation and interpretation, evaluate each intervention for effectiveness, and use evaluation results to drive next steps of improvement strategies.

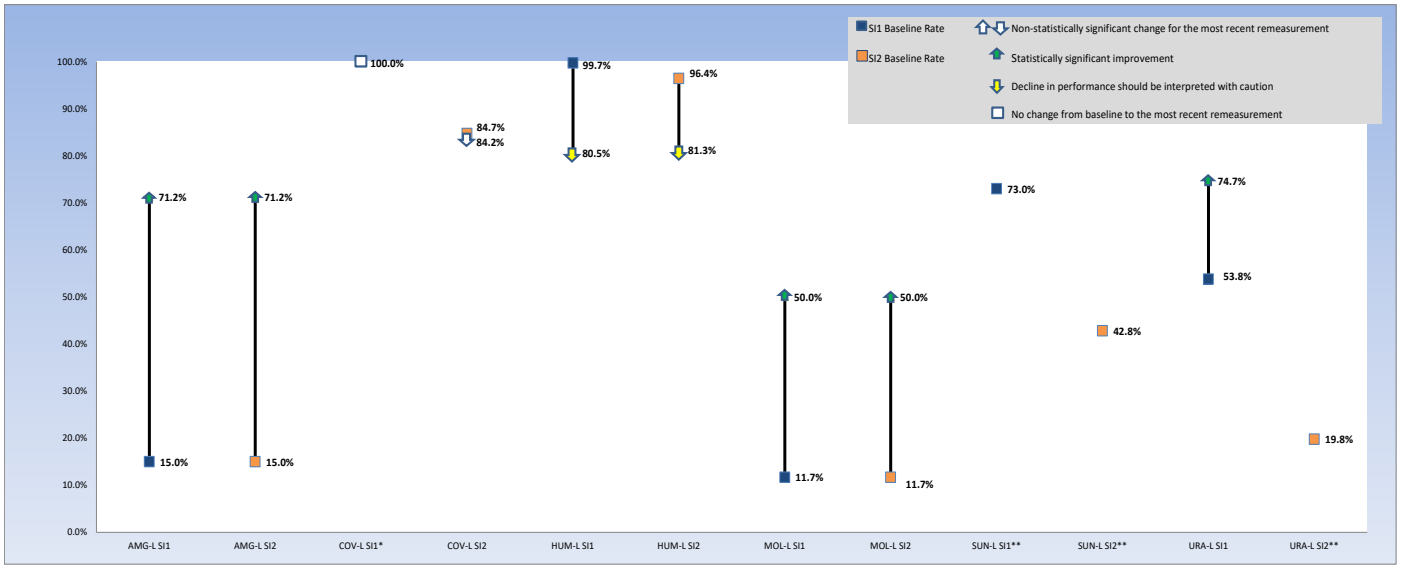
Results—Study Indicator Results

Study Indicator Results for the *Medication Review* PIPs

Figure 3-11 displays the baseline measurement period and Remeasurement 1 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)—the rate of members who had evidence of a medication list in the medical record and Study Indicator 2—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 Remeasurement 1 rates for both study indicators are designated by arrow symbols. A white arrow designates an improvement or decline that was not statistically significant. A green arrow designates a statistically significant improvement in performance. A white box designates no change in the study indicator rate from baseline to Remeasurement 1. 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 F.

It should be noted that the state-defined specifications for both *Medication Review* PIP study indicators were changed following the baseline measurement period, to exclude dual Medicare/Medicaid enrollees from the eligible population. The State instructed the LTC plans to recalculate the baseline study indicator rates using the revised specifications so that a valid comparison could be made between the baseline and Remeasurement 1 study indicator rates. One plan, Humana-LTC, was unable to recalculate the baseline study indicator rates for this year's PIP validation because the plan used a hybrid data collection methodology and it was not feasible for the plan to conduct additional medical record reviews for the revised eligible population prior to submitting the PIP for validation. Because Humana-LTC reported Remeasurement 1 study indicator rates following the revised specifications but was unable to recalculate the baseline rates, the plan's baseline and Remeasurement 1 study indicator rates were not based on the same eligible population, and valid comparisons between the two measurement periods could not be made. To reflect this issue in Figure 3-11, a yellow arrow designates a Remeasurement 1 rate that was not comparable to the baseline rate due to a change in data collection methodology.

Figure 3-11—State-Mandated *Medication Review* Study Indicator Results for SFY 2016–2017



* The study indicator rate remained at 100.0 percent for the baseline and Remeasurement 1 periods.
**The plan did not progress to reporting Remeasurement 1 results for the current validation cycle.

Four LTC plans reported Remeasurement 1 results for both study indicators. One plan, United-LTC, reported Remeasurement 1 results for SI1 (documented medication list) but only baseline results for SI2 (evidence of a medication review). One other plan, Sunshine-LTC, reported only baseline results for both study indicators. For each study indicator, the amount of improvement or decline from baseline to Remeasurement 1 varied by plan.

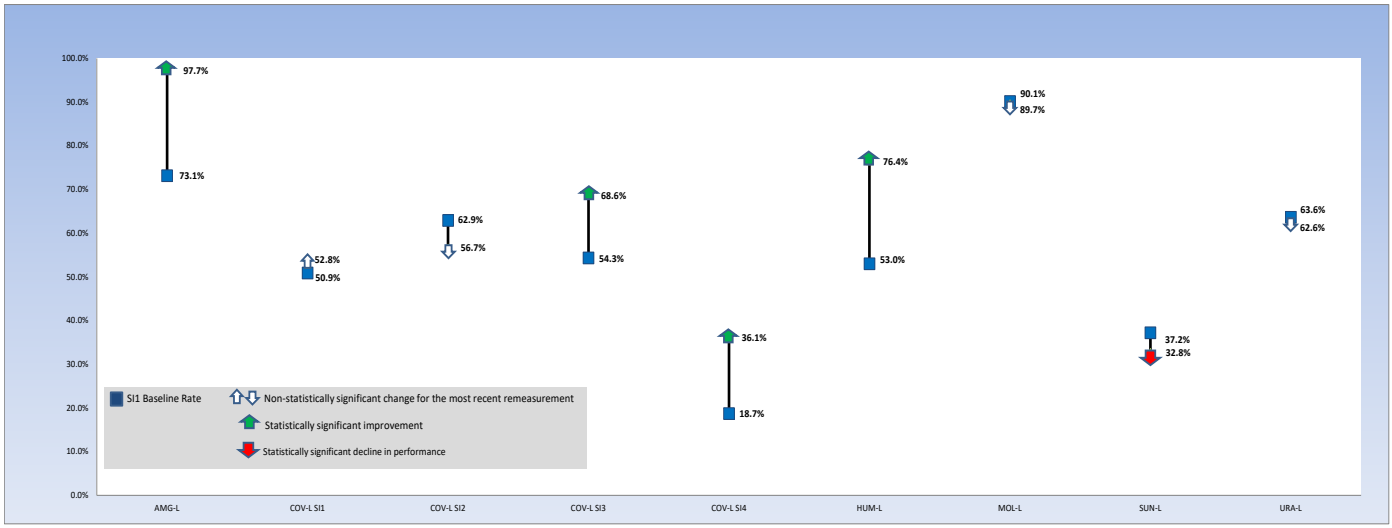
For SI1 (documented medication list), the Remeasurement 1 rates ranged from a minimum of 50.0 percent, reported by Molina-LTC, to a maximum of 100.0 percent, reported by Coventry-LTC. One plan, Sunshine-LTC, did not progress to reporting Remeasurement 1 results for SI1. Three plans, Amerigroup-LTC, Molina-LTC, and United-LTC, reported a statistically significant improvement from baseline to Remeasurement 1 in the SI1 (documented medication list) rate. Because Coventry-LTC reported a rate of 100 percent at both baseline and Remeasurement 1, there was no room for improvement in the study indicator rate, and it was impossible to demonstrate statistically significant improvement. One plan, Humana-LTC, reported a statistically significant decline in the SI1 rate from baseline to Remeasurement 1; however, these results should be interpreted with caution, as described in the paragraph preceding Figure 3-11.

For SI2 (evidence of a medication review), the Remeasurement 1 rates ranged from a minimum of 50.0 percent, reported by Molina-LTC, to a maximum of 84.2 percent, reported by Coventry-LTC. Two plans, Sunshine-LTC and United-LTC, did not progress to reporting Remeasurement 1 results for SI2. Two other plans, Amerigroup-LTC and Molina-LTC, reported statistically significant improvement from baseline to Remeasurement 1 in the SI2 (evidence of a medication review) rate. One plan, Coventry-LTC, reported a decline in the SI2 rate that was not statistically significant. One plan, Humana-LTC, reported a statistically significant decline in the SI2 rate from baseline to Remeasurement 1; however, these results should be interpreted with caution, as described in the paragraph preceding Figure 3-11.

Nonclinical PIP Study Indicator Results

Figure 3-12 displays the baseline and Remeasurement 1 study indicator results for the nonclinical PIPs submitted by the LTC plans. The blue boxes on the chart represent the baseline study indicator rate reported for each study indicator. Remeasurement 1 rates are designated by arrow symbols. A white arrow designates an improvement or decline that was not statistically significant. A green arrow designates a statistically significant improvement, and a red arrow designates a statistically significant decline in performance. For those PIPs with multiple study indicators, a study indicator identifier follows the plan name (i.e., SI1 for Study Indicator 1 and SI2 for Study Indicator 2). 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 LTC standard plan and associated plan name abbreviation are presented in Appendix F.

Figure 3-12—Nonclinical PIP Study Indicator Results for SFY 2016–2017 for LTC Plans



Six LTC plans reported Remeasurement 1 results for a total of nine nonclinical PIP study indicators. The Remeasurement 1 study indicator rates for the nonclinical PIPs ranged from a minimum of 32.8 percent, reported by Sunshine-LTC, to a maximum of 97.7 percent, reported by Amerigroup-LTC. Four of the nine study indicators demonstrated statistically significant improvement at Remeasurement 1: Amerigroup-LTC (one indicator), Coventry-LTC (two indicators), and Humana-LTC (one indicator). Another four of the nine study indicators demonstrated improvements or declines in performance that were not statistically significant. A statistically significant decline in performance from baseline to Remeasurement 1 was reported by Sunshine-LTC for the remaining study indicator.

Results—Notable Improvements and Interventions

The strongest evidence for notable improvement is statistically significant improvement for all study indicators and sustaining the improvement achieved. During the SFY 2016–2017 validation cycle, the LTC plans progressed to reporting Remeasurement 1 study indicator results for most PIPs. For those PIPs with comparable Remeasurement 1 study indicator results, HSAG evaluated the results and identified PIPs that had demonstrated statistically significant improvement over baseline at Remeasurement 1 for all study indicators. HSAG will assess sustained improvement for those PIPs that achieved statistically significant improvement at Remeasurement 1 when the plans progress to reporting Remeasurement 2 results for the next validation cycle.

The percentage of PIPs submitted by LTC plans that achieved statistically significant improvement over baseline for all study indicators at Remeasurement 1 varied by PIP topic. For the state-mandated PIP topic, two (67 percent) of three *Medication Review* PIPs with comparable baseline and Remeasurement 1 results achieved statistically significant improvement across all study indicators. For the LTC plan-selected nonclinical topics, two (33 percent) of the six nonclinical PIPs achieved statistically significant improvement over baseline across all study indicators at Remeasurement 1.

Success in achieving statistically significant improvement in study indicator outcomes is strongly influenced by the QI strategies used in the PIP to drive improvement. As part of the PIP validation process, HSAG identified one innovative intervention employed by an LTC plan in a PIP that achieved statistically significant improvement across all study indicators. The innovative intervention identified by HSAG was deployed by Molina-LTC for the state-mandated *Medication Review* PIP. For this intervention, the plan involved "community connectors" to assist LTC case managers in locating enrollees eligible to receive medication review services.

MCO Comparison

Based on the PIP validation scores (Figure 3-9 and Figure 3-10), the LTC plans demonstrated similar performance on the state-mandated *Medication Review* PIPs and the plan-selected nonclinical PIPs. For both types of PIPs, the LTC plans' strongest performance was in the Design stage, where 93 percent of all evaluation elements across the *Medication Review* PIPs and 99 percent of all evaluation elements across the nonclinical PIPs received a *Met* score. The LTC plans' performance in the Implementation stages of the two types of PIPs was not as strong; only 61 percent of evaluation elements across the Implementation stage for the *Medication Review* PIPs and 63 percent of evaluation elements in this stage for the nonclinical PIPs received a *Met* score. In the Outcomes stage, the LTC plans received better validation scores on the *Medication Review PIPs*, where 83 percent of the evaluation elements received a *Met* score compared to 50 percent of evaluation elements across the nonclinical PIPs. It should be noted, however, that only three of the six LTC plans reported comparable Remeasurement 1 results and progressed to being evaluated in the Outcomes stage for the *Medication Review* PIPs during the SFY 2016–2017 validation cycle while all LTC plans progressed to being evaluated for the Outcomes stage for the nonclinical PIPs.

Based on the Remeasurement 1 study indicator outcomes for the *Medication Review* PIPs (Figure 3-11), the LTC plans varied in their performance on improving outcomes during the SFY 2016–2017

validation cycle. As noted previously, only three of the six LTC plans reported comparable Remeasurement 1 results for both study indicators and progressed to being evaluated in the Outcomes stage during this validation cycle. The three LTC plans that progressed to being evaluated for outcomes were Amerigroup-LTC, Coventry-LTC, and Molina-LTC. Two of the three plans, Amerigroup-LTC and Molina-LTC, had success in achieving statistically significant improvement across all study indicators at Remeasurement 1. Amerigroup-LTC reported the largest improvement, with an increase of 56.2 percentage points from baseline to Remeasurement 1 for both study indicators. Coventry-LTC maintained 100.0 percent for one of the *Medication Review* study indicators but reported a decline in the other study indicator at Remeasurement 1. The remaining LTC plans were unable to report comparable Remeasurement 1 study indicator results for both study indicators for the SFY 2016–2017 validation cycle.

The Remeasurement 1 study indicator outcomes for the nonclinical PIPs (Figure 3-12) suggested variation in the LTC plans' performance demonstrating improvement in the nonclinical topics. The variation in demonstrated improvement should be interpreted within the context of the specific nonclinical PIP topics and study indicators that each LTC plan selected (see Appendix C), as some topics may present greater challenges for improvement than others. While all LTC plans reported comparable Remeasurement 1 results for the SFY 2016–2017 validation cycle, only two plans, Amerigroup-LTC and Humana-LTC, succeeded in demonstrating statistically significant improvement over baseline across all study indicators at Remeasurement 1. Coventry-LTC reported statistically significant improvement for two of the four study indicators included in the plan's nonclinical PIP, but the remaining two study indicators did not demonstrate statistically significant changes from baseline to Remeasurement 1. Two LTC plans, Molina-LTC and United-LTC, reported rate declines that were not statistically significant, while one plan, Sunshine-LTC, reported a statistically significant decline in the study indicator rate from baseline to Remeasurement 1.

Conclusions and Recommendations

During the SFY 2016–2017 validation cycle, HSAG validated the first remeasurement period of the LTC plans' PIPs though the Design, Implementation, and Outcomes stages (Activities I through IX). The LTC plans submitted two types of PIPs for validation: the state-mandated *Medication Review* PIP and a plan-selected, nonclinical PIP. The overall validation status and validation scores for each PIP varied by plan and topic.

HSAG determined that opportunities for improvement existed in the three PIP stages for the LTC plans. The validation scores in the Design stage suggested that, overall, the plans designed methodologically sound projects. While there were minimal opportunities to improve in the Design stage, a few PIPs had challenges in this stage related to documenting the study question and defining the study population and study indicators. The plans had greater opportunities for improvement in the Implementation and Outcome stages of the PIPs.

In the Implementation stage, the LTC plans' PIPs had errors in interpretation of data analysis results. Additionally, many PIPs did not include sufficient intervention evaluation processes to assess and refine the interventions throughout each measurement period. In the Outcomes stage, the PIPs had progressed

to reporting study indicator results from the first remeasurement; therefore, the PIPs were evaluated on whether statistically significant improvement over baseline was achieved for all study indicators.

The LTC plans had mixed performance in the Outcomes stage of the PIPs. Some plans were able to demonstrate statistically significant improvement over baseline across all study indicators at Remeasurement 1, but others were not. Additionally, some plans that demonstrated statistically significant improvement in study indicator outcomes reported that the plan-specific goals were not met. In these cases, the plans may not have been setting realistic or attainable goals for the PIPs. 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.

AHCA facilitated a variety of activities throughout the year to support the plans as they conducted their PIPs. These activities included one-on-one PIP check-ins between AHCA staff and each plan, PIP-related educational presentations delivered during quarterly meetings with the plans, and on-demand TA sessions with HSAG. The different activities provided support and assistance to the plans in various venues and formats to strengthen the improvement processes and strategies used in the PIPs. HSAG recommends that AHCA continue to offer a variety of opportunities and venues for the plans to receive TA on QI processes and strategies to improve PIP performance and outcomes. Additionally, AHCA should continue to explore and identify innovative interventions and share intervention examples with the plans. Sharing potentially promising strategies with the plans may help facilitate improvement in individual PIPs and in statewide efforts.

To improve the design of the PIPs going forward, the LTC plans should ensure clear and accurate documentation of the PIP study question, study population, and study indicators, following state-defined specifications if applicable. For the PIP study population, the LTC plans should clearly and consistently define and document inclusion and exclusion criteria. For the study indicators, the plans should accurately report the indicator definition, including numerator, denominator, and measurement period dates, and align the documentation with relevant measurement specifications. The LTC plans should also set attainable study indicator goals for each remeasurement period, based on organizational knowledge and study indicator rates from previous measurement periods. Each study indicator goal should represent a statistically significant improvement compared to the baseline study indicator rate.

To improve the implementation of the PIPs, the LTC plans should focus on accuracy and completeness of study indicator results analyses and interpretation, as well as using appropriate, sound quality improvement processes and strategies. The LTC plans should correct any errors in the study indicator rate calculations and/or statistical testing results identified by HSAG in the SFY 2016–2017 PIP validation tool. Accurate study indicator rates are necessary for a true measurement of progress in improving PIP outcomes during the remeasurement periods. The plans should ensure adequate analytical staffing for the PIPs to facilitate methodologically sound design and accurate, appropriate data analysis and interpretation throughout the project. For each intervention, the LTC plans should have a process in place for evaluating the performance of each intervention and its impact on the study indicators. Evaluation results should be documented separately for each intervention during each measurement period. The evaluation process for each intervention should address each step in the PDSA cycle—Plan,

Do, Study, and Act. The evaluation process should be ongoing and cyclical to allow for iterative learning and continual refinement of improvement strategies. The LTC plans should use intervention-specific evaluation results to guide next steps of each intervention. The PIP documentation should include the next steps for each intervention, and future intervention plans should be linked to evaluation results.

To optimize the improvement achieved in PIP outcomes, the LTC plans should revisit the casual/barrier analysis for each PIP at least annually to ensure that the barriers identified continue to be barriers, and to determine if any new barriers exist that require the development of interventions. For those PIPs that have not yet demonstrated significant improvement in the study indicator results, the LTC plans should identify and document new or revised barriers that have prevented improvement in PIP outcomes and should develop new or revised interventions to better address high-priority barriers associated with lack of improvement. The LTC plans should utilize opportunities for TA through AHCA and HSAG to address challenging barriers and develop innovative improvement strategies.

Validation of Performance Measures

The BBA requires states to ensure that 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 with either 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 2016 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 validated the audits conducted for the MMA Standard and Specialty plans and LTC plans during SFY 2016–2017. This section of the report includes the PMV 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 2017–2018 *Performance Measure Validation Findings Report.*

MMA Plans

AHCA required that each MMA plan undergo an NCQA HEDIS Compliance Audit of the performance measures selected for reporting. These audits were performed by NCQA-Licensed Organizations (LOs) in 2017, on data collected during CY 2016.

Table 3-2 presents the 76 performance measure indicators selected for reporting year (RY) 2017 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, Serious Mental Illness [SMI] or MMA Specialty Performance Measures—Older Adult Care). Cells shaded gray denote measures for which AHCA established performance targets for 2017. These performance targets were generally established based on the HEDIS national Medicaid 75th percentiles. While AHCA has indicated it has set an ambitious target for all plans to achieve and/or surpass the national Medicaid 75th percentile, the more immediate goal is for all plans to have all measure rates above the national Medicaid 50th percentile. See the "Statewide Weighted Average Measure Results" section in Appendix D to view individual measure rates compared to the national Medicaid 50th percentile.

Results by Domain

Table 3-2—Reporting Year 2017 MMA Performance Measures

Reporting Year 2017 (Calendar Year 2016) Measures	Measure Source
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) and *Combination 2 (Meningococcal, Tdap, HPV)*[1]	HEDIS
Annual Dental Visit (ADV)—Total	HEDIS
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—Total (CHL)	HEDIS
Breast Cancer Screening (BCS)	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
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*[2]	HEDIS
Annual Monitoring for Patients on Persistent Medications (MPM)—Total	HEDIS
Plan All-Cause Readmissions (PCR-AD)—18–64 Years of Age—Total and *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
HIV Viral Load Suppression (VLS)—18–64 Years and *65+Yyears*	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*[3]	Medicaid Adult Core Set

Reporting Year 2017 (Calendar Year 2016) Measures	Measure Source
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
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up and *30-Day Follow-Up*	HEDIS
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	HEDIS
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
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	HEDIS
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)[^]	AHCA-Defined
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*[4]	HEDIS
MMA Specialty Performance Measures—SMI	
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—Chronic Disease	
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 RY 2017 performance target established by AHCA.

[1] *For this measure, an AHCA performance target was established only for the Immunizations for Adolescents—Combination 1 indicator.*

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

[3] *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.*

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

[^] *The CAT measure was retired from HEDIS, so RY 2017 rates were calculated as an AHCA-defined measure.*

For this section of the report, performance measure results and plan comparisons are discussed according to 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 RY 2016 to RY 2017.

Additionally, the plan comparison 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®[3-1] national Medicaid HMO percentiles for HEDIS 2016, which are expressed in percentiles of national performance for different measures. For comparative purposes, the plans' rates were categorized using the following star ratings:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

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

Results—Pediatric Care

Table 3-3 displays the statewide weighted averages calculated by HSAG for RY 2016 and RY 2017 for all measures in the Pediatric Care domain. As shown with measures shaded in gray in the table, AHCA established performance targets for 12 of the 14 measure indicators in this domain. Cells shaded in green indicate performance rates that met or exceeded AHCA's RY 2017 performance targets. AHCA holds MMA plans accountable for meeting the national Medicaid 50th percentile. To review the Pediatric Care measure rates compared to the national Medicaid 50th percentile, please see Table D-38 in Appendix D.

Table 3-3—Florida Medicaid Performance Measure Result Summary Table, Pediatric Care[1]

Measure	Reporting Year 2016	Reporting Year 2017
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	2.35%	1.97%
Six or More Well-Child Visits	58.26%	63.50%
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	75.43%	75.66%
Childhood Immunization Status		
Combination 2	77.48%	78.21%
Combination 3	72.41%	74.22%

[3-1] Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Measure	Reporting Year 2016	Reporting Year 2017
Lead Screening in Children		
Lead Screening in Children	60.50%	65.85%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	49.94%	48.55%
Continuation and Maintenance Phase	62.70%	65.09%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	62.45%	78.40%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	52.85%	52.91%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap)	67.32%	70.62%
Combination 2 (Meningococcal, Tdap, HPV)	—	19.43%
Annual Dental Visit		
Total	46.67%	48.55%
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	25.22%†	30.41%

** Indicates that lower rates are better for this measure.*
— Indicates the measure was not presented in the previous year's HEDIS aggregate report; therefore, only the 2017 rate is 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.
[1] While 14 rates are presented in this table, plans reported up to 25 rates in this domain, which are presented in Appendix D.

Indicates that AHCA established a performance target for the measure for RY 2017.

Indicates that the performance measure rate for RY 2017 met or exceeded the performance target.

Statewide rates for *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* met or exceeded the performance targets for RY 2017. Conversely, statewide rates for *Lead Screening in Children*, *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*, and *Annual Dental Visit—Total* fell below AHCA's performance targets by at least 10 percentage points, indicating opportunities for improvement. Additionally, the statewide weighted average rates met or exceeded the national Medicaid 50th percentile for eight of the 12 (66.7 percent) measure indicators with targets established.

From RY 2016 to RY 2017, the statewide measure rate within this domain that demonstrated the largest rate increase was *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, with an increase of approximately 16 percentage points. Of note, only one measure rate (*Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*) indicated a decrease in performance from RY 2016 to RY 2017.

MCO Comparison—Pediatric Care

The greatest range of Standard MMA plan results for RY 2017 was observed for *Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk*, at 54.82 percentage points, from 54.82 percent (Staywell) to 0.00 percent (Molina and Prestige). For the Specialty MMA plan results, *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* demonstrated the greatest range of plan results, at 71.03 percentage points, from 71.03 percent (Sunshine-S) to 0.00 percent (Magellan-S). For *Lead Screening in Children* and *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*, no plans reached the corresponding AHCA performance target. It should be noted that the Specialty MMA plans serve those with specialty conditions, so caution should be exercised when comparing their results to each other and to the Standard MMA plans.

Sunshine-S had the highest percentage of reported rates that met or exceeded the national Medicaid 90th percentile on Pediatric Care measures, with approximately 23 percent of its rates (five of 22 rates) ranking at or above the 90th percentile. Amerigroup had the second-highest percentage of reported rates above the national Medicaid 90th percentile in this domain (about 14 percent [three of 22 rates]). The remaining plans reported fewer than 10 percent of their rates at or above the national Medicaid 90th percentile, with five plans (Better Health, Clear Health-S, Community Care Plan, Humana, Magellan-S, and Simply) reporting no measure rates above the national Medicaid 90th percentile in the Pediatric Care domain. Note that two of these six plans serve those with specialty conditions, so their populations and the measures reported may differ from other MMA plans.

Results—Women's Care

Table 3-4 displays the statewide weighted averages calculated by HSAG for RY 2016 and RY 2017 for all measures in the Women's Care domain. As shown by measures shaded in gray in the table, AHCA established performance targets for all six of the measure indicators in this domain. Cells shaded in green indicate performance rates that met or exceeded AHCA's RY 2017 performance targets. AHCA holds MMA plans accountable for meeting the national Medicaid 50th percentile. To review the Women's Care measure rates compared to the national Medicaid 50th percentile, please see Table D-39 in Appendix D.

Table 3-4—Florida Medicaid Performance Measure Result Summary Table, Women's Care[1]

Measure	Reporting Year 2016	Reporting Year 2017
Cervical Cancer Screening		
Cervical Cancer Screening	51.27%	56.08%
Chlamydia Screening in Women		
Total	61.80%	62.55%
Breast Cancer Screening		
Breast Cancer Screening	61.16%	54.83%

Measure	Reporting Year 2016	Reporting Year 2017
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	82.91%	84.26%
Postpartum Care	58.62%	63.55%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	66.52%	66.59%

[1] *While six rates are presented in this table, plans reported up to eight rates in this domain, which are presented in Appendix D.*

Indicates that AHCA established a performance target for the measure for RY 2017.

Indicates that the performance measure rate for RY 2017 met or exceeded the performance target.

At the statewide level, only one of the measure rates (*Chlamydia Screening in Women—Total*) in the Women's Care domain met AHCA's RY 2017 performance target. The statewide rate for *Breast Cancer Screening* fell below AHCA's 2017 performance target by more than 10 percentage points, indicating opportunities for improvement for this measure. In addition, the *Breast Cancer Screening* statewide rate was the only measure indicator to decrease from RY 2016 to RY 2017 in this domain. Additionally, the statewide weighted average rates met or exceeded the national Medicaid 50th percentile for five of the six (83.3 percent) measure indicators with targets established.

MCO Comparison—Women's Care

The greatest range of Standard MMA plan results for RY 2017 was observed for *Breast Cancer Screening*, at 33.13 percentage points, from 68.76 percent (Aetna Better Health) to 35.63 percent (Sunshine). For the Specialty MMA plan results, *Chlamydia Screening in Women—Total* demonstrated the greatest range of plan results, at 34.79 percentage points, from 76.71 percent (Clear Health-S) to 41.92 percent (Children's Medical Services-S). At least two plans reached the corresponding AHCA performance target for each measure in this domain. It should be noted that the Specialty MMA plans serve those with specialty conditions, so caution should be exercised when comparing their results to each other and to the Standard MMA plans.

Sunshine-S had the highest percentage of reported rates for the Specialty MMA plans that were above the national Medicaid 90th percentile in the Women's Care domain, with 40 percent of the plan's rates (two of five rates) ranking at or above the 90th percentile. The Standard MMA plan with the highest percentage of reported rates (25 percent [two of eight rates]) ranking at or above the national Medicaid 90th percentile was Aetna Better Health. Conversely, Children's Medical Services-S demonstrated the highest percentage of reported rates falling below the national Medicaid 25th percentile for the MMA plans (100 percent of its rates [five of five rates]). It should be noted that the Specialty MMA plans serve those with specialty conditions, so caution should be exercised when comparing their results to the Standard MMA plans and to each other as their populations and the measures reported may differ from other MMA plans.

Results—Living With Illness

Table 3-5 displays the statewide weighted averages calculated by HSAG for RY 2016 and RY 2017 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 2017. Cells shaded in green indicate performance rates that met or exceeded AHCA's RY 2017 performance targets. AHCA holds MMA plans accountable for meeting the national Medicaid 50th percentile. To review Living With Illness measure rates compared to the national Medicaid 50th percentile, please see Table D-40 in Appendix D.

Table 3-5—Florida Medicaid Performance Measure Result Summary Table, Living With Illness[1]

Measure	Reporting Year 2016	Reporting Year 2017
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	81.04%	81.95%
*HbA1c Poor Control (>9.0%)**	47.81%	45.41%
HbA1c Control (<8.0%)	43.61%	44.09%
Eye Exam (Retinal) Performed	51.06%	55.87%
Medical Attention for Nephropathy	91.65%	90.91%
Controlling High Blood Pressure		
Controlling High Blood Pressure	50.33%	54.85%
Adult BMI Assessment		
Adult BMI Assessment	86.68%	87.21%
Medication Management for People With Asthma		
Medication Compliance 50%—Total	53.57%	54.00%
Medication Compliance 75%—Total	29.90%	28.82%
Annual Monitoring for Patients on Persistent Medications		
Total	91.01%	91.75%
Plan All-Cause Readmissions*		
Total 18–64 Years of Age—Total	22.82%	24.01%
Total 65+ Years of Age—Total	10.52%	13.45%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	27.88%	47.21%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	65.09%	86.70%
HIV Viral Load Suppression[2]		
18–64 Years	13.08%	13.03%
65+ Years	8.97%	6.27%
Medical Assistance With Smoking and Tobacco Use Cessation[3]		
Advising Smokers and Tobacco Users to Quit—18–64 Years of Age	74.18%	46.79%

Measure	Reporting Year 2016	Reporting Year 2017
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	61.15%	19.65%
Advising Smokers and Tobacco Users to Quit—Total	71.49%	41.23%
Discussing Cessation Medications—18–64 Years of Age	46.45%	31.54%
Discussing Cessation Medications—65+ Years of Age	41.30%	12.41%
Discussing Cessation Medications—Total	45.39%	27.64%
Discussing Cessation Strategies—18–64 Years of Age	41.74%	29.20%
Discussing Cessation Strategies—65+ Years of Age	33.94%	11.52%
Discussing Cessation Strategies—Total	40.13%	25.59%

** Indicates that lower rates are better for this measure.*
[1]While 25 rates are presented in this table, plans reported up to 39 rates in this domain, which are presented in Appendix D.
[2]Due to issues associated with the plans obtaining complete HIV/AIDS lab data for this measure, low rates may be associated with a lack of complete data rather than cases of non-suppression of HIV viral load. Therefore, caution should be exercised when interpreting results.
[3]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 AHCA established a performance target for the measure for RY 2017.

Indicates that the performance measure rate for RY 2017 met or exceeded the performance target.

Only one of 12 RY 2017 statewide rates in the Living With Illness domain with a performance target met or exceeded the target (*Annual Monitoring for Patients on Persistent Medications—Total*). Of note, the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* and *Adult BMI Assessment* rates were within 5 percentage points of their respective targets. Three of the 12 indicators with performance targets had statewide rates that fell 20 percentage points or more below the performance target, including *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total*, *Discussing Cessation Medications—Total*, and *Discussing Cessation Strategies—Total*. Additionally, the statewide weighted average rates met or exceeded the national Medicaid 50th percentile for five of the 12 (41.7 percent) measure indicators with targets established. From RY 2016 to RY 2017, the statewide measure rate that increased the most was *Highly Active Anti-Retroviral Treatment*, with an increase of 21.61 percentage points, indicating improved performance from the prior year in this area. Conversely, the statewide rate for *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—65+ Years of Age* decreased the most from RY 2016 to RY 2017 (i.e., 41.50 percentage points), indicating opportunities for improvement.

MCO Comparison—Living With Illness

The greatest range of Standard MMA plan results for RY 2017 for the Living With Illness domain was observed for *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total*, at 63.66 percentage points, from 77.14 percent (Sunshine) to 13.48 percent (Simply). For the Specialty MMA plan results, *Adult BMI Assessment* demonstrated the greatest

range of plan results, at 73.84 percentage points, from 92.70 percent (Positive-S) to 18.86 percent (Children's Medical Services-S). For *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total* and *Discussing Cessation Strategies—Total*, no plans reached the corresponding AHCA performance target. It should be noted that the Specialty MMA plans serve those with specialty conditions, so caution should be exercised when comparing their results to each other and to the Standard MMA plans as their populations and the measures reported may different from other MMA plans.

In this domain, Freedom-S demonstrated the best performance, with 100 percent of its four reported rates ranking at or above the national Medicaid 90th percentile. Of the Standard MMA plans, Simply reported the highest percentage of measures (25 percent) at or above the 90th percentile (six of 24 rates) Conversely, Sunshine demonstrated the worst performance on measures in this domain, with approximately 46 percent of its rates (11 of 24 rates) falling below the national Medicaid 25th percentile. For the Specialty MMA plans, Children's Medical Services-S demonstrated the highest percentage of reported rates (approximately 41 percent [seven of 17 rates]) falling below the national Medicaid 25th percentile.

Results—Behavioral Health

Table 3-6 displays the statewide weighted averages calculated by HSAG for RY 2016 and RY 2017 for all measures in the Behavioral Health domain. As denoted by the gray shaded cells, AHCA established a 2017 performance target for 10 of the 15 reported measure indicators. Cells shaded in green indicate performance rates that met or exceeded AHCA's RY 2017 performance targets. AHCA holds MMA plans accountable for meeting the national Medicaid 50th percentile. To review the Behavioral Health measure rates compared to the national Medicaid 50th percentile, please see Table D-41 in Appendix D.

Table 3-6—Florida Medicaid Performance Measure Result Summary Table, Behavioral Health[1]

Measure	Reporting Year 2016	Reporting Year 2017
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—Total	39.99%	40.11%
Engagement of AOD Treatment—Total	6.39%	7.05%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	35.71%	43.01%
30-Day Follow-Up	53.77%	56.24%†
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up	—	33.05%
30-Day Follow-Up	—	51.14%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence		
7-Day Follow-Up—Total	—	9.69%
30-Day Follow-Up—Total	—	12.30%
Antidepressant Medication Management		

Measure	Reporting Year 2016	Reporting Year 2017
Effective Acute Phase Treatment	51.85%	51.38%
Effective Continuation Phase Treatment	36.81%	35.72%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	59.04%	63.31%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
Total	37.77%	38.06%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*[2]		
Total	1.77%	1.64%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	26.62%	33.52%
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	—	80.62%

** Indicates that lower rates are better for this measure.*
† Molina had issues with reporting the correct denominator for FHM due to limitations with the custom rate template (would only allow one eligible population to be entered for all components). This has been corrected in the custom rate template for July 1, 2018 reporting.
[1] While 15 rates are presented in this table, plans reported up to 28 rates in this domain, which are presented in Appendix D.
[2] Due to changes in the HEDIS 2017 technical specifications for this measure, exercise caution when trending rates between 2017 and prior years and when comparing HEDIS 2017 rates for this measure to performance targets derived using data reported for HEDIS 2016.
— Indicates the measure was not presented in the previous year's HEDIS aggregate report; therefore, only the 2017 rate is presented in this report.

Indicates that AHCA established a performance target for the measure for RY 2017.

Indicates that the performance measure rate for RY 2017 met or exceeded the performance target.

For the Behavioral Health domain, the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total* rate was the only statewide rate that met the 2017 performance target, indicating overall opportunities for improvement related to behavioral health statewide. Of note, despite increases from RY 2016, statewide rates for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* measure indicators still fell below AHCA's performance targets by more than 10 and 15 percentage points, respectively. Additionally, the statewide weighted average rates met or exceeded the national Medicaid 50th percentile for four of the 10 (40.0 percent) measure indicators with targets established.

MCO Comparison—Behavioral Health

The greatest range of Standard MMA plan results for RY 2017 for the Behavioral Health domain was observed for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* at 36.47 percentage points, from 55.24 percent (United) to 18.77 percent (Prestige). For the Specialty MMA plan results,

Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up demonstrated the greatest range of plan results at 61.15 percentage points, from 79.21 percent (Sunshine-S) to 18.06 percent (Positive-S). At least one plan performed above AHCA's performance target for each measure in this domain except for *Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—Total*. It should be noted that the Specialty MMA plans serve those with specialty conditions, so caution should be exercised when comparing their results to each other and to the Standard MMA plans.

In this domain of care, Sunshine-S reported approximately 43 percent of its rates (six of 14 rates) at or above the national Medicaid 90th percentile. Of the Standard MMA plans, Simply had approximately 27 percent of its rates (four of 15 rates) meet or exceed the 90th percentile. Conversely, Better Health had reported the highest percentage of rates below the national Medicaid 25th percentile compared to the other plans (approximately 65 percent [11 of 17 rates]), followed by Positive-S (approximately 56 percent [five of nine rates]).

Results—Access/Availability of Care

Table 3-7 displays the statewide weighted averages calculated by HSAG for RY 2016 and RY 2017 for all measures in the Access/Availability of Care domain. As denoted by the gray shaded cells, six of the eight measure indicators reported for RY 2017 had a performance target established by AHCA. AHCA holds MMA plans accountable for meeting the national Medicaid 50th percentile. To review the Access/Availability of Care measure rates compared to the national Medicaid 50th percentile, please see Table D-42 in Appendix D.

Table 3-7—Florida Medicaid Performance Measure Result Summary Table, Access/Availability of Care[1]

Measure	Reporting Year 2016	Reporting Year 2017
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	94.81%	94.37%
25 Months–6 Years	88.74%	87.82%
7–11 Years	89.28%	88.75%
12–19 Years	86.28%	85.16%
Adults' Access to Preventive/Ambulatory Health Services		
Total	74.93%	74.11%
Call Answer Timeliness		
Call Answer Timeliness	83.63%	87.70%
Transportation Availability		
Transportation Availability	98.75%	99.74%
Transportation Timeliness		
Transportation Timeliness	79.32%	86.04%

[1] *While eight rates are presented in this table, plans reported up to 11 rates in this domain, which are presented in Appendix D.*

Indicates that AHCA established a performance target for the measure for RY 2017.

No statewide rates met AHCA's RY 2017 performance targets. The statewide rate for *Adults' Access to Preventive/Ambulatory Health Services—Total* fell below AHCA's performance targets by more than 10 percentage points, indicating the greatest opportunity for improvement related to the performance targets. Additionally, the statewide weighted average rates met or exceeded the national Medicaid 50th percentile for two of the six (33.3 percent) measure indicators with targets established.

MCO Comparison—Access/Availability of Care

The greatest range of Standard MMA plan results for RY 2017 for the Access/Availability of Care domain was observed for *Adults' Access to Preventive/Ambulatory Health Services—Total* at 25.55 percentage points, from 83.40 percent (Simply) to 57.85 percent (Community Care Plan). For the Specialty MMA plan results, *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* demonstrated the greatest range of plan results at 29.85 percentage points, from 94.14 percent (Children's Medical Services-S) to 64.29 percent (Magellan-S). At least one plan performed above AHCA's performance target for each measure in this domain. It should be noted that the Specialty MMA plans serve those with specialty conditions, so caution should be exercised when comparing their results to each other and to the Standard MMA plans.

In this domain, Freedom-S had the highest percentage (100 percent [three of three rates]) of reported rates ranking at or above the national Medicaid 90th percentile. Of the Standard MMA plans, Humana, Prestige, and Simply reported approximately 11 percent of their rates (one of nine rates) at or above the 90th percentile, which was the highest percentage for the Standard MMA plans. Conversely, Sunshine had the highest percentage (approximately 78 percent [seven of nine rates]) of reported rates fall below the national Medicaid 25th percentile for the Standard MMA plans. For the Specialty MMA plans, Magellan-S demonstrated the most opportunity for improvement in this domain, with approximately 63 percent (five of eight rates) falling below the 25th percentile.

Results—Use of Services

Table 3-8 displays the statewide weighted averages for RY 2016 and RY 2017 for the *Ambulatory Care—Outpatient Visits per 1,000 Member Months (MM*) and *ED Visits per 1,000 MM* measure indicators. 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. As denoted by the gray shaded cells, AHCA established a 2017 performance target for one of the two reported measure indicators. Cells shaded in green indicate performance rates that met or exceeded AHCA's RY 2017 performance targets. AHCA holds MMA plans accountable for meeting the national Medicaid 50th percentile. To review the Use of Services measure rates compared to the national Medicaid 50th percentile, please see Table D-42 in Appendix D.

Table 3-8—Statewide Ambulatory Care Weighted Averages[1]

Measure	Reporting Year 2016	Reporting Year 2017
AMB—Outpatient Visits per 1,000 MM	304.82	320.89
*AMB—ED Visits per 1,000 MM**	69.06	71.22

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

[1] Please refer to Appendix D for the plan-specific rates for these two rates.

Indicates that AHCA established a performance target for the measure for RY 2017.

Indicates that the performance measure rate for RY 2017 met or exceeded the performance target.

Slight variation in statewide performance occurred for both measures from RY 2016 to RY 2017. The RY 2017 statewide performance for *Ambulatory Care—ED Visits per 1,000 MM* did not exceed the 2017 target, as lower rates indicate better performance for this measure. Additionally, the statewide weighted average rate did not exceed the national Medicaid 50th percentile for this measure indicator (the only indicator with a target established).

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 indicator, plan rates ranged from 227.77 per 1,000 MM (Magellan-S) to 581.66 per 1,000 MM (Freedom-S). For the *Ambulatory Care—ED Visits per 1,000 MM* measure indicator, plan rates ranged from 202.98 per 1,000 MM (Positive-S) to 54.83 per 1,000 MM (Simply).

For the *Ambulatory Care—ED Visits per 1,000 MM* measure, none of the rates for 17 reporting plans exceeded the 2017 performance target, indicating opportunities for improvement in this area. Although these visits were not adjusted to account for differences in the MMA plans' enrollee demographic and/or clinical characteristics, a lower value suggests more appropriate utilization.

Results—Performance Measures for MMA Specialty Plans

In addition to the Standard MMA performance measures, some Specialty MMA plans were required to report other performance measures specific to the enrollee population that they served. Six Specialty MMA plans operated during RY 2017. The HIV/AIDS Specialty plans (Clear Health-S and Positive-S), Children's Medical Services Network plan (Children's Medical Services-S), and Child Welfare Specialty plan (Sunshine-S) reported no measures beyond the Standard MMA performance measures.

In contrast, the SMI and Chronic Disease Specialty plans (Magellan-S and Freedom-S, respectively) reported additional measures.

Table 3-9 displays the weighted averages for RY 2016 and RY 2017 for the SMI measures reported by Magellan-S. Cells shaded gray indicate the measure indicators with a 2017 performance target established by AHCA. Cells shaded green indicate performance rates that met or exceeded AHCA's RY 2017 performance targets. AHCA holds MMA plans accountable for meeting the national Medicaid 50th

percentile. To review the MMA Specialty plans measure rates compared to the national Medicaid 50th percentile, please see Table D-44 in Appendix D.

Table 3-9—Florida Medicaid MMA Weighted Averages for MMA Specialty Performance Measures SMI Measures

Measure	Reporting Year 2016	Reporting Year 2017
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	66.25%	70.21%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	88.33%

NA (i.e., Small Denominator) indicates that the organizations followed the specifications, but the denominator was too small (<30) to report valid rates.

Indicates that AHCA established a performance target for the measure for RY 2017.

Indicates that the performance measure rate for RY 2017 met or exceeded the performance target.

One Specialty MMA plan, Magellan-S, serving SMI enrollees, was required to report two additional measures (*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 with cardiovascular disease and schizophrenia who received cardiovascular monitoring were reported at 70.21 and 88.33, respectively. The measure rate for *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* exceeded AHCA's RY 2017 performance target. Additionally, both performance measure rates exceeded the national Medicaid 50th percentile.

Table 3-10 displays the weighted averages for RY 2016 and RY 2017 for the Older Adult Care measure indicators reported by Freedom-S.

Table 3-10—Florida Medicaid MMA Weighted Averages for Specialty MMA Performance Older Adult Care Measures

Measure	Reporting Year 2016	Reporting Year 2017
Care for Older Adults		
Advance Care Planning—66+ Years	70.59%	85.19%
Medication Review—66+ Years	88.24%	94.44%
Functional Status Assessment—66+ Years	85.29%	90.74%
Pain Assessment—66+ Years	85.29%	96.30%

Indicates that AHCA established a performance target for the measure for RY 2017.

Indicates that the performance measure rate for RY 2017 met or exceeded the performance target.

One Specialty MMA plan, Freedom-S, providing care for Medicare-Medicaid dual-eligible enrollees with chronic diseases, was required to report four additional measure indicators (*Care for Older Adults—Advance Care Planning—66+ Years*, *Medication Review—66+ Years*, *Functional Status Assessment—66+ Years*, and *Pain Assessment—66+ Years*). Approximately 85 percent of enrollees 66 years and older received advance care planning. In addition, the other indicators for this measure (*Medication Review—66+ Years*, *Functional Status Assessment—66+ Years*, and *Pain Assessment—66+ Years*) all demonstrated a rate greater than 90 percent and positive improvement from RY 2016 to RY 2017.

Conclusions and Recommendations

During SFY 2016–2017, all plans were required to undergo an NCQA HEDIS Compliance Audit for those performance measures they were contracted to report to AHCA. Based on the FARs and supporting documents submitted to HSAG for validation, all Standard and Specialty MMA plans were fully compliant with the following NCQA HEDIS Compliance Audit Standards: IS 2.0 (Enrollment Data), IS 3.0 (Practitioner Data), IS 5.0 (Supplemental Data), and IS 7.0 (Data Integration).

All Specialty MMA plans and all but one Standard MMA plan were fully compliant with IS 1.0 (Medical Services Data). The one Standard MMA plan that was not compliant with IS 1.0 was not compliant with lab services and data processing because the plan's lab vendor did not release HIV/AIDS lab data due to enrollee confidentiality concerns. As a result, the plan was unable to report the *HIV Viral Load Suppression* measure and received a *BR* audit designation for this measure.

Further, all Standard MMA plans but one were fully compliant with IS 4.0 (Medical Record Review Processes). One plan was partially compliant with this standard because significant errors were identified in the abstraction of records for the *Eye Exam (Retinal) Performed* indicator for the *CDC* measure. A second sample was not completed because two or more errors were identified. Therefore, the auditor required the medical record review vendor for the plan to conduct an over-read for all remaining records and submit a CAP to ensure there were no further issues.

Under the Pediatric Care domain, the statewide weighted averages for MMA plans exceeded the performance target for two out of 12 (16.7 percent) measures: *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*. Additionally, rates for the following measures were all within 5 percentage points of their respective targets: *Well-Child Visits in the First 15 Months of Life—No Well Child Visits* and *Six or More Well-Child Visits*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Childhood Immunization Status—Combination 2* and *Combination 3*; *Follow-Up Care for Children Prescribed ADHD Medication–Initiation Phase*; and *Adolescent Well-Care Visits*. Focusing improvements in these areas may help measure rates exceed future performance targets.

For Women's Care, the statewide weighted averages for MMA plans exceeded the performance target for one of six (16.7 percent) measures: *Chlamydia Screening in Women—Total*. Of note, three indicators were all within 5 percentage points of their respective targets: *Prenatal and Postpartum Care—*

Timeliness of Prenatal Care and *Postpartum Care*; and *Frequency of Ongoing Prenatal Care.* Focusing improvements in these areas may help measure rates exceed future performance targets.

Based on statewide weighted averages, MMA plans exceeded the AHCA performance target for one of 12 (8.3 percent) measures in the Living With Illness domain: *Annual Monitoring for Patients on Persistent Medications—Total*. The *Comprehensive Diabetes Care—Medical Attention for Nephropathy* and *Adult BMI Assessment* rates were within 5 percentage points of their respective targets. Focusing improvements in these areas may help measure rates exceed future performance targets.

For the Behavioral Health domain, the MMA plan statewide weighted averages exceeded the AHCA performance target for one of 10 (10.0 percent) measures: *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total*. The *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Initiation of AOD Treatment—Total*, *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*, *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*, and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* rates were within 5 percentage points of their respective targets. Focusing improvements in these areas may help measure rates exceed future performance targets.

In the domain of Access/Availability of Care, MMA plan statewide weighted averages fell below the AHCA performance targets for each of the six measures in this domain where performance targets were provided. Nonetheless, four 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*; and *Call Answer Timeliness*. Focusing improvements in these areas may help measure rates exceed future performance targets.

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. Except for the *Ambulatory Care—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 assess MMA plan performance for these measures based on comparisons to other performance targets or national benchmarks.

With regard to the Specialty MMA SMI performance measure results, Magellan-S's rate for the *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* measure exceeded the AHCA performance target. In contrast, the plan's *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure rate was less than 5 percentage points below AHCA's performance target.

For the Specialty MMA Older Adult Care performance results, Freedom-S's rates for all four *Care for Older Adults* indicators improved from RY 2016 to RY 2017, with all four measure rates increasing by more than 5 percentage points. Of note, the measure rates for *Care for Older Adults—Advance Care Planning—66+ Years* (85.19 percent) and *Pain Assessment—66+ Years* (96.30 percent) both increased by more than 10 percentage points from RY 2016 to 2017.

Overall, 42 statewide MMA rates fell below AHCA's performance targets and eight 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 RY 2017 rates falling below AHCA's performance targets by at least 10 percentage points, as listed below.
  - **Pediatric Care—***Lead Screening in Children, Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap),* and *Annual Dental Visit—Total*
  - **Women's Care—***Breast Cancer Screening*
  - **Living With Illness—***Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total, Discussing Cessation Medications—Total,* and *Discussing Cessation Strategies—Total*
  - **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*
- In addition to the measures listed above, HSAG recommends that improvement efforts be focused on measures with notable performance declines (more than 10 percentage points) from RY 2016 to 2017, as listed in below:
  - **Living With Illness—** *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—18–64 Years of Age, 65+ Years of Age,* and *Total*; *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications—18–64 Years of Age, 65+ Years of Age,* and *Total*; *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies—18–64 Years of Age, 65+ Years of Age*, and *Total*
- 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 children and thereby target improvement activities that could increase compliance on numerous indicators of care such as *Immunizations for Adolescents*.

LTC Plans

Six LTC plans were contracted with AHCA for providing long-term care services to Medicaid enrollees. The LTC plans were required to report select performance measures for SFY 2016–2017 including 12 performance measure indicators using CY 2016 data (see Table 3-11). The LTC plans underwent a PMV audit to ensure that the rates calculated and reported for these measures were valid and accurate. AHCA intended that an NCQA HEDIS Compliance Audit be conducted for all LTC plans to the extent possible. All audits were conducted by LOs.

Table 3-11—Reporting Year 2017 LTC Performance Measures

Reporting Year 2017 (Calendar Year 2016) 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)	AHCA-Defined
Required Record Documentation (RRD)—701B Assessment, Plan of Care—Enrollee Participation, Plan of Care—Primary Care Physician Notification, Freedom of Choice Form, and *Plan of Care/Long Term Care Service Authorization*	AHCA-Defined
Face-to-Face Encounters (F2F)	AHCA-Defined
Case Manager Training (CMT)	AHCA-Defined
Timeliness of Services (TOS)	AHCA-Defined

Results

Table 3-12 displays the LTC program weighted averages for RY 2016 and RY 2017 for the LTC measures. The *Call Answer Timeliness* measure is shaded gray to indicate that this is the only measure with a 2017 performance target established by AHCA. The 2017 performance target was not met this year; therefore, no cells are shaded green.

Table 3-12—Florida Medicaid LTC Program Weighted Averages

Measure	Reporting Year 2016	Reporting Year 2017
LTC		
Care for Adults		
Advance Care Planning—18–60 Years	35.41%	84.14%
Advance Care Planning—61–65 Years	39.02%	83.41%
Advance Care Planning—66+ Years	43.04%	84.00%
Advance Care Planning—Total	41.91%	83.99%
Medication Review—18–60 Years[1]	—	55.87%
Medication Review—61–65 Years[1]	—	48.50%
Medication Review—66+ Years[1]	—	19.26%
Medication Review—Total[1]	—	31.85%

Measure	Reporting Year 2016	Reporting Year 2017
Functional Status Assessment—18–60 Years	84.11%	91.90%
Functional Status Assessment—61–65 Years	81.87%	92.80%
Functional Status Assessment—66+ Years	84.77%	92.42%
Functional Status Assessment—Total	84.53%	92.38%
Call Answer Timeliness		
Call Answer Timeliness	77.25%	87.87%
Required Record Documentation		
701B Assessment	79.92%	89.71%^
Care Plan—Enrollee Participation	70.41%	73.71%
Care Plan—Primary Care Physician Notification	53.52%	56.51%
Freedom of Choice Form	68.94%	84.39%
Plan of Care/LTC Service Authorizations[*,2]*	—	0.63%^
Face-to-Face Encounters		
Face-to-Face Encounters	90.23%	76.41%
Case Manager Training		
Case Manager Training	94.38%†	97.01%
Timeliness of Services		
Timeliness of Services	51.11%†	71.43%

** Indicates that lower rates are better for this measure.*
— Indicates the rate is not being presented.
† Due to issues associated with the plan-level eligible population values for this measure, the 2016 average rate was weighted by select plans' denominators rather than by the eligible populations; therefore, caution should be exercised when trending the average rate for RY 2016 to 2017.
^ Molina had issues with reporting the correct eligible population for RRD—701B Assessment and RRD—LTC Service Authorizations due to limitations with the custom rate template (would only allow one eligible population to be entered for all components). This has been corrected in the custom rate template for July 1, 2018 reporting.
[1]The population used in the calculation of the rate for Aetna Better Health-LTC only included new enrollees, resulting in a substantial decrease in the eligible population. Therefore, the RY 2016 aggregate rate for this measure indicator is not displayed.
[2] Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2016 rate is not presented in this report.
Indicates that AHCA established a performance target for the measure for RY 2017.

From RY 2016 to RY 2017, the statewide weighted measure rate with the largest increase was *Care for Adults—Advance Care Planning—18–60 Years*, with an increase of approximately 49 percentage points, followed by *Care for Adults—Advance Care Planning—61–65 Years*, with an increase of approximately 44 percentage points. Conversely, *Face-to-Face Encounters* demonstrated the greatest performance decline from RY 2016 to 2017, with a decrease of approximately 14 percentage points. Of note, despite increasing by more than 10 percentage points, the *Call Answer Timeliness* measure rate still did not meet or exceed the 2017 performance target.

MCO Comparison

At the plan level, there was variation in performance across all measures for the LTC plans. Six of the 12 (50.0 percent) measures reported by the LTC plans had a difference of 25 percentage points or more between plans: *Care for Adults—Advance Care Planning—Total* and *Medication Review—Total*; *Call Answer Timeliness*; *Required Record Documentation—701B Assessment*, *Plan of Care—Enrollee Participation*, *Plan of Care—Primary Care Physician Notification*, and *Freedom of Choice Form*; *Face-to-Face Encounters*; and *Timeliness of Service*. It should be noted that due to issues with the calculation of Aetna Better Health-LTC's measure rate for the *Care for Adults—Medication Review—Total*, caution should be exercised when comparing this rate to other LTC plans for this measure indicator. Rates for three of six (50.0 percent) plans (Aetna Better Health-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 21 measure indicators. For the current year, HSAG identified that all the LTC plan audits were conducted following NCQA HEDIS Compliance Audit policies and procedures.

In terms of performance measure results, for LTC plans, only *Call Answer Timeliness* was assigned a performance target by AHCA. The 2017 rate for *Call Answer Timeliness* fell below AHCA's performance targets by less than 5 percentage points. Therefore, HSAG offers the following recommendations:

- Focus improvement efforts on measures with notable performance declines from RY 2016 to RY 2017 (i.e., a decrease of 10 or more percentage points) 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*
  - *Required Record Documentation*
  - *Face-to-Face Encounters*
- 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. LTC plans with less than 100 percent performance should investigate the root cause of the noncompliance and assure proper and timely training on the mandate to report abuse, neglect, and exploitation 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.
- For RY 2017, the *Face-to-Face Encounters* measure was the only statewide weighted average that demonstrated a decline of more than 10 percentage points, indicating an opportunity to investigate and address the decline in performance, and increase the number of face-to-face encounters with case/care managers for enrollees.

- Focus improvement efforts on the *Call Answer Timeliness* measure as it represents the sole opportunity for improvement relative to an AHCA-defined performance target. Of note, the LTC plan statewide weighted average for the *Call Answer Timeliness* measure increased by 10.62 percentage points from RY 2016 to RY 2017.
- Some of the AHCA-defined measures rely on data that are collected outside the usual data systems included in the NCQA HEDIS Compliance Audit policies and procedures, such as the case management system. In the past, HSAG found that the FARs failed to provide adequate detail regarding the validation of data systems outside those typically included in the NCQA HEDIS Compliance Audit. Therefore, HSAG recommends that the FARs include a brief description of those data systems used for calculating AHCA-defined measures.

Review of Compliance With Access, Structure, and Operations Standards

Section 1932(c) of the Social Security Act requires State Medicaid agencies to 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.

Title 42, CFR §438.358,[3-2] requires that states use an EQRO to prepare an annual technical report that describes the way data from activities conducted are aggregated and analyzed in accordance with the CFR. The annual technical report also draws conclusions about the quality of, timeliness of, and access to healthcare services that managed care organizations provide.

AHCA is Florida's single State agency designated to administer and supervise the administration of the Medicaid program under Title XIX of the Social Security Act. In 2011, the Florida statutes granted the authority to AHCA to implement the SMMC program. AHCA was responsible for an estimated budget of $25.2 billion to serve a projected population of 4.27 million enrollees during SFY 2016–2017.

To fulfill the requirements as set forth under 42 CFR §438.358, in SFY 2014–2015, AHCA conducted readiness reviews of each of its SMMC plans prior to implementation of each phase of Florida's SMMC program.

In SFY 2015–2016, AHCA conducted various types of compliance activities. For example, AHCA focused on those areas that were problematic for the plans as indicated by the readiness reviews and other monitoring activities. These included Administration and Management, Enrollee Materials, Grievance System, Prescribed Drug Services, 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.

In SFY 2015–2016, 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. 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. In addition, AHCA used various data sources and review methods, such as periodic and ad hoc reports, complaints, and the PNV system to compile information for the compliance reviews.

In SFY 2016–2017, AHCA's Medicaid Quality and Plan Management Operations Bureaus and the HIPAA Compliance Office conducted desk reviews and site visits for all MMA and LTC plans for most of the federal standards and all standards.

[3-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

The following 11 standards were reviewed for each plan to determine plan compliance with federal standards and the SMMC contract requirements:

Access Standards

I. Availability of Services
II. Adequacy of Capacity and Services
III. Coordination and Continuity of Care
IV. Coverage and Authorization of Services

Measurement and Improvement Standards

V. Quality Assessment and Performance Improvement
VI. Health Information Systems

Structure and Operations Standards

VII. Provider Selection and Credentialing/Recredentialing
VIII. Enrollee Information
IX. Confidentiality
X. Grievance Systems
XI. Sub-contractual Relationships and Delegation

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 §438).
- Increase AHCA's knowledge of the plans' operations and other contract implementation areas.
- Provide TA 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

To conduct the compliance reviews, AHCA follows a process that ensures consistency with the intent of CMS' protocol. AHCA monitors plans to ensure they comply with access, measurement, and structure and operations standards through various methods of review, including weekly reviews of enrollee and provider complaints, analysis of required reports submitted by plans, secret shopper calls, visits related to marketing, and verification of the plans' provider networks. If plans are out of compliance with their contract, AHCA may impose CAPs, monetary liquidated damages, and monetary/nonmonetary sanctions, which are posted publicly on AHCA's website.[3-3]

[3-3] Agency for Health Care Administration. *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY16/17*. Available at: https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Q1-Q4_FY1617_Compliance_Actions.pdf. Accessed on: Feb 5, 2018.

Bureaus and offices within AHCA's Division of Medicaid use "methods of review" to collect data and monitor plan operations to ensure compliance with federally required standards and contract requirements. To determine whether a plan meets the established thresholds for an identified group of standards and requirements, each bureau/office uses a set of methods of review and submits a compliance action referral to the contract manager, if necessary. For some methods of review, a plan receives a score of *Met*, *Partially Met*, or *Not Met*. Some standards are designated as *Not Scored* (*N/S*) or *Not Applicable* (*N/A*). When the plan corrects the noncompliance, AHCA designates the standard as *Met*. Not all methods of review have a scoring system; however, AHCA has mechanisms to determine whether a plan is in compliance. When a plan does not meet a standard, AHCA will issue a compliance action. If AHCA determines that a compliance action will be imposed, a letter is issued to the plan informing the plan of the decision.

Methods of Review by Bureau/Office

Bureau of Plan Management Operations (PMO)

The PMO addresses contractually required Access standards by reviewing plan Provider Network Verification (PNV) data files; Quest Ratio, Time, and Distance reports; PDF and online directory analyses; complaints received by the Medicaid Complaint Hub; Medicaid fair hearings requests; plans' annual Timely Access/PCP Wait Times reports; plans' Annual Network Development plans; and secret shopper exercises.

The PMO addresses contractually required Measurement and Improvement standards related to health information systems by reviewing plans' self-reported system issues, complaints submitted via the Medicaid Complaint Hub, Medicaid fair hearing requirements, and weekly encounter reports.

The PMO addresses contractually required Structure and Operations standards regarding provider selection by reviewing Quest Ratio reports to identify and track specific provider types for network adequacy against plan PDF and online directory analyses, reviewing complaints received through the Medicaid Complaint Hub, and validating terminated and excluded provider information against the plans' PNV files to ensure that excluded providers are not included in the plans' networks. The PMO reviews plan subcontracts and subcontract monitoring schedules against the subcontract delegation checklist, which includes the applicable CFR language.

The PMO works in conjunction with the Bureau of Medicaid Quality to address Grievance System requirements by:

- Reviewing complaints submitted through the Medicaid Complaint Hub, Medicaid fair hearing requests, and plans' monthly reports regarding:
  - Enrollee complaints, grievances, and appeals.
  - Denial, reduction, termination, or suspension of services.
- Reviewing and approving plans' Notice of Action and other grievance and appeal letters to enrollees.

Bureau of Medicaid Quality

The Bureau of Medicaid Quality (Medicaid Quality) monitors specific enrollee-centered priority areas including private duty nursing and targeted monitoring of Statewide Inpatient Psychiatric Program (SIPP) care coordination; therapy services; and prenatal, newborn, and postpartum care; potentially preventable hospital and emergency room (ER) visits; and unnecessary ancillary services during hospitalization or ER visits. Medicaid Quality conducts monthly, quarterly, and annual reviews of the Report Guide disease management summary reports; medical case record review strategy summary reports; vaccines for children summary reports; and a clinical review of health policy changes and outreach, education, and clinical initiatives documents.

Medicaid Quality addresses contractually required Measure and Improvement standards by reviewing plans' PIPs, performance measure results, provider and enrollee survey results, and quality improvement plans.

HIPAA Compliance Office

The HIPAA Compliance Office receives and reviews reports and notifications identified in the Business Associate Agreement (BAA). These reports are reviewed for timeliness, completeness, and accuracy. If a deficiency is identified, a corrected form may be requested or a compliance action request may be sent to the contract manager for any final action. If no deficiencies are present, the contract manager would be notified.

The HIPAA Compliance Office receives the notifications to the Department of Health and Human Services identified in the standard contract as well as in Item 10d of the BAA from the contract managers for an annual review. These notifications are compared to the reports submitted under the BAA throughout the year for discrepancies, including identification of any breaches not reported to AHCA. If a deficiency is identified, a compliance action request would be sent to the contract manager for any final action.

The HIPAA Compliance Office receives complaints submitted by any party related to these BAAs as well as any additional self-reported issues. A review of these complaints and reports is conducted and reviewed for any appropriate recommendations to the contract managers based on the requirements of the contracts and/or the BAA**.**

Review of Compliance Actions

PMO contract managers review the compliance actions issued throughout the year, as well as complaints received and other types of escalations. As mentioned, most methods of review did not result in an escalation for a compliance action of any kind, so they were noted as *Met*. AHCA considers a standard *Met* if results from most of the methods of review comply with the standard. Each contract manager is responsible for reviewing notices of noncompliance. In addition, once a plan has completed any necessary corrective action, the standard is designated as *Met*.

Corrective Actions

AHCA's analysis of the documents and other data gathered from desk and on-site reviews result in a determination of compliance. In some cases, plans can either be in compliance (*Met*), or they receive a *Partially Met* or *Not Met* designation. If a standard is *Not Met*, the plan may receive a compliance action which requires a CAP and/or other actions such as sanctions or liquidated damages, which are communicated to the plan in a formal letter. The letter describes how the plan failed to provide services to enrollees.

All plans are given an opportunity to dispute the imposition of a penalty by submitting a written dispute directly to the Medicaid director or designee. The dispute must be received by AHCA within 21 days after the plan receives notice that a penalty was imposed.

Plan-Specific Results

For the methods of review that AHCA conducted for each plan as described in the following tables, AHCA designated each standard as *Met*, *Partially Met*, *Not Met*, *N/A*, or *N/S.* Although most standards are scored as *Met*, if a standard received a compliance action, the *Met* designation signifies that the plan submitted a CAP which AHCA accepted or that AHCA has determined that the plan has corrected the issues and is in compliance. Totals in the Compliance Actions column were compiled from AHCA's plan- specific worksheets.

Using the verified results that AHCA obtained from conducting the compliance reviews, HSAG organized and aggregated the performance data for each plan. Based on its analysis, HSAG identified strengths and opportunities for improvement for each plan.

For SFY 2016–2017, AHCA conducted multiple methods of review for 11 standards for each plan. Plan-specific results are presented below.

Aetna Better Health

Findings

Table 3-13 below presents Aetna Better Health's overall compliance results for the 11 standards reviewed by AHCA.

Table 3-13—Aetna Better Health Levels of Compliance

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
I	Availability of Services	24	24	0	0	0	4
II	Adequacy of Capacity and Services	16	16	0	0	0	1
III	Coordination and Continuity of Care	16	16	0	0	0	2
IV	Coverage and Authorization of Services	12	12	0	0	0	3
V	Quality Assessment and Performance Improvement	5	4	1	0	0	1 (Liquidated Damages)
VI	Health Information Systems	5	5	0	0	0	2
VII	Provider Selection and Credentialing/ Recredentialing	8	8	0	0	0	1
VIII	Enrollee Information	9	9	0	0	0	1
IX	Confidentiality	1	1	0	0	0	0
X	Grievance Systems	11	11	0	0	0	2
XI	Sub-contractual Relationships and Delegation	8	8	0	0	0	0

Note: In June 2017, Aetna Better Health had 58,092 MMA enrollees and 4,990 LTC enrollees.

Table 3-13 shows that Aetna Better Health received *Met* scores for all methods of review, except for a *Partially Met* score for the Quality Assessment and Performance Improvement standard; Aetna Better Health was assessed liquidated damages for failure to meet certain performance measure quality standards in calendar year ending (CYE) 2015. Aetna Better Health received no compliance actions for the following standards: Confidentiality, and Sub-contractual Relationships and Delegation.

Aetna Better Health received compliance actions for the following standards based on the noted methods of review:

- Availability of Services—Online Provider Directory Analysis (1), Critical Incident Reporting (3)
- Adequacy of Capacity and Services—Online Provider Directory Analysis (1)
- Coordination and Continuity of Care—Access Complaints (1), Enrollee Roster and Facility Residence Report (1)
- Coverage and Authorization of Services—LTC Quarterly Submissions (1), 1915c Performance Measures (2)
- Quality Assessment and Performance Improvement—Performance Measure Quality Standards (1)
- Health Information Systems—On Base Encounter Reports (2)
- Provider Selection and Credentialing/Recredentialing—Online Provider Directory Analysis (1)
- Enrollee Information—Provider Directory Reviews (1)
- Grievance Systems—Denial, Reduction, Termination or Suspension of Services Report (2)

In addition, according to the *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY16/17 Report*, Aetna Better Health incurred liquidated damages totaling $286,900 in the Covered Services, Quality and Utilization Management, Administration and Management, and Enrollee Services and Grievances areas. Aetna received no monetary sanctions.

Strengths

Aetna Better Health demonstrated strong performance for the Confidentiality and Sub-contractual Relationships and Delegation standards, scoring *Met* for all methods of review, with no compliance actions. Aetna Better Health had only one compliance action for each of these standards: Adequacy of Capacity and Services, Provider Selection and Credentialing/Recredentialing, and Enrollee Information.

Opportunities for Improvement

Aetna Better Health has opportunities for improvement in the Availability of Services, Adequacy of Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Quality Assessment and Performance Improvement, Health Information Systems, Provider Selection and Credentialing/Recredentialing, Enrollee Information, and Grievance Systems standards. The Quality Assessment and Performance Improvement standard received a *Partially Met* score, with liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. The methods of review that identified areas needing improvement are Online Provider Directory Analysis (3), Critical Incident Reporting (3), Access Complaints (1), Enrollee Roster and Facility Residence Report (1), LTC Quarterly Submissions (1), 1915c Performance Measures (2), On Base Encounter Reports (2), Provider Directory Reviews (1), and the Denial, Reduction, Termination or Suspension of Services Report (2).

Aetna Better Health received liquidated damages for the Enrollee Services and Grievances, Covered Services, Quality and Utilization Management, and Administration and Management areas.

Amerigroup

Findings

Table 3-14 below presents Amerigroup's overall compliance results for the 11 standards reviewed by AHCA. Totals in the Compliance Actions column were compiled from AHCA's plan-specific worksheets.

Table 3-14—Amerigroup Levels of Compliance

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
I	Availability of Services	24	24	0	0	0	4
II	Adequacy of Capacity and Services	16	16	0	0	0	3
III	Coordination and Continuity of Care	17	17	0	0	0	2
IV	Coverage and Authorization of Services	12	12	0	0	0	2
V	Quality Assessment and Performance Improvement	5	4	1	0	0	1 (Liquidated Damages)
VI	Health Information Systems	5	5	0	0	0	4
VII	Provider Selection and Credentialing/ Recredentialing	8	8	0	0	0	3
VIII	Enrollee Information	9	9	0	0	0	0
IX	Confidentiality	1	1	0	0	0	0
X	Grievance Systems	11	11	0	0	0	2
XI	Sub-contractual Relationships and Delegation	8	8	0	0	0	0

Note: In June 2017, Amerigroup had 334,854 MMA enrollees and 4,908 LTC enrollees.

Table 3-14 shows that Amerigroup received *Met* scores for all methods of review, except for a *Partially Met* score for the Quality Assessment and Performance Improvement standard; Amerigroup was assessed liquidated damages for failure to meet certain performance measure quality standards in CYE

2015. Amerigroup received no compliance actions for the following standards: Enrollee Information, Confidentiality, and Sub-contractual Relationships and Delegation.

Amerigroup received compliance actions for the following standards based on the noted methods of review:

- Availability of Services—Online Provider Directory Analysis (1), Access Complaints (2), and Critical Incident Reporting (1)
- Adequacy of Capacity and Services—Online Provider Directory Analysis (1), Access Complaints (2)
- Coordination and Continuity of Care—Access Complaints (2)
- Coverage and Authorization of Services—Medicaid Complaint Hub (2)
- Quality Assessment and Performance Improvement—Performance Measure Quality Standards (1)
- Health Information Systems—On Base Encounter Reports (4)
- Provider Selection and Credentialing/Recredentialing—PNV Data Files (2), Online Provider Directory Analysis (1)
- Grievance Systems—Medicaid Fair Hearings (2)

In addition, according to the *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY16/17 Report*, Amerigroup received liquidated damages totaling $536,400 in the Enrollee Services and Grievances, Medicaid Fair Hearing, Covered Services, Quality and Utilization Management, Administration and Management, and Finance areas. Amerigroup incurred $10,000 in monetary sanctions.

Strengths

Amerigroup demonstrated strong performance for the Enrollee Information, Confidentiality, and Sub-contractual Relationships and Delegation standards, scoring *Met* for all methods of review, with no compliance actions.

Opportunities for Improvement

Amerigroup has opportunities for improvement in the Availability of Services, Adequacy of Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Quality Assessment and Performance Improvement, Health Information Systems, Provider Selection and Credentialing/Recredentialing, and Grievance Systems standards. The Quality Assessment and Performance Improvement standard received a *Partially Met* score with liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. The methods of review that identified areas needing improvement are the Online Provider Directory Analysis (3) Access Complaints (6), Critical Incident Reporting (1), Medicaid Complaint Hub (2), On Base Encounter Reports (4), PNV Data Files (2), Online Provider Directory Analysis (1), and Medicaid Fair Hearings (2).

Amerigroup incurred liquidated damages totaling $536,400 in the Enrollee Services and Grievances, Medicaid Fair Hearings, Covered Services, Quality and Utilization Management, Administration and Management, and Finance areas. Amerigroup incurred $10,000 in monetary sanctions.

Better Health

Findings

Table 3-15 below presents Better Health's overall compliance results for the 11 standards reviewed by AHCA. Totals in the Compliance Actions column were compiled from AHCA's plan-specific worksheets.

Table 3-15—Better Health Levels of Compliance

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
I	Availability of Services	24	18	0	0	6 (N/A)	0
II	Adequacy of Capacity and Services	16	16	0	0	0	0
III	Coordination and Continuity of Care	16	15	0	0	1 (N/A)	0
IV	Coverage and Authorization of Services	12	8	0	0	4 (N/A)	2
V	Quality Assessment and Performance Improvement	5	4	1	0	0	1 (Liquidated Damages)
VI	Health Information Systems	5	5	0	0	0	4
VII	Provider Selection and Credentialing/ Recredentialing	8	8	0	0	0	0
VIII	Enrollee Information	9	9	0	0	0	1
IX	Confidentiality	1	1	0	0	0	0
X	Grievance Systems	11	10	0	0	1 (N/A)	2
XI	Sub-contractual Relationships and Delegation	8	8	0	0	0	0

Note: In June 2017, Better Health had 101,157 MMA enrollees.

Table 3-15 shows that Better Health received *Met* scores for all methods of review, except for a *Partially Met* score for the Quality Assessment and Performance Improvement standard; Better Health was assessed liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. The plan received an *N/A* for 12 of the methods of review. Better Health received no compliance actions for the following standards: Availability of Services, Adequacy of Capacity and Services, Coordination and Continuity of Care, Provider Selection and Credentialing/Recredentialing, Confidentiality, and Sub-contractual Relationships and Delegation.

Better Health received compliance actions for the following standards based on the noted methods of review:

- Coverage and Authorization of Services—Medicaid Complaint Hub (2)
- Quality Assessment and Performance Improvement—Performance Measure Quality Standards (1)
- Health Information Systems—On Base Encounter Reports (4)
- Enrollee Information—Notice of Adverse Benefit Determination Template (1)
- Grievance Systems—Medicaid Fair Hearings (1), Notice of Adverse Benefit Determination Template (1)

In addition, according to the *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY16/17 Report*, Better Health incurred liquidated damages totaling $537,600 in the Enrollee Services and Grievances, Medicaid Fair Hearings, Covered Services, Quality and Utilization Management, Administration and Management, and Finance areas. Better Health received no monetary sanctions.

Strengths

Better Health demonstrated strong performance for the Availability of Services, Adequacy of Capacity and Services, Coordination and Continuity of Care, Provider Selection and Credentialing/Recredentialing, Confidentiality, and Sub-contractual Relationships and Delegation standards, scoring *Met* for all methods of review, with no compliance actions. Better Health had only one compliance action for these standards: Quality Assessment and Performance Improvement, and Enrollee Information.

Opportunities for Improvement

Better Health has opportunities for improvement in the Coverage and Authorization of Services, Quality Assessment and Performance Improvement, Enrollee Information, Health Information Systems, and Grievance Systems standards. The Quality Assessment and Performance Improvement standard received a *Partially Met* score with liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. The methods of review that identified areas needing improvement are the Medicaid Complaint Hub (2), On Base Encounter Reports (4), Notice of Adverse Benefit Determination Template (2), and Medicaid Fair Hearings (1).

Better Health received liquidated damages for the Enrollee Services and Grievances, Medicaid Fair Hearings, Covered Services, Quality and Utilization Management, Administration and Management, and Finance areas.

Children's Medical Services

Findings

Table 3-16 below presents Children's Medical Services' overall compliance results for the 11 standards reviewed by AHCA. Totals in the Compliance Actions column were compiled from AHCA's plan-specific worksheets.

Table 3-16—Children's Medical Services Levels of Compliance

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
I	Availability of Services	24	18	0	0	6	0
II	Adequacy of Capacity and Services	16	16	0	0	0	0
III	Coordination and Continuity of Care	16	16	0	0	1	0
IV	Coverage and Authorization of Services	12	8	0	0	4	0
V	Quality Assessment and Performance Improvement	5	5	0	0	0	0
VI	Health Information Systems	5	5	0	0	0	0
VII	Provider Selection and Credentialing/ Recredentialing	8	8	0	0	0	0
VIII	Enrollee Information	9	9	0	0	0	0
IX	Confidentiality	1	1	0	0	0	0
X	Grievance Systems	11	10	0	0	1	0
XI	Sub-contractual Relationships and Delegation	8	8	0	0	0	0

Note: In June 2017, Children's Medical Services had 50,724 MMA enrollees.

Table 3-16 shows that Children's Medical Services received *Met* scores for all methods of review. In addition, Children's Medical Services received no compliance actions for any of the standards.

According to the *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY16/17 Report*, Children's Medical Services received no liquidated damages or monetary sanctions.

Strengths

Children's Medical Services demonstrated strong performance in all standards, scoring *Met* for all methods of review, with no compliance actions, liquidated damages, or monetary sanctions.

Opportunities for Improvement

Children's Medical Services has opportunities for improvement in all standards in that the plan needs to consolidate gains made in the year to maintain its success.

Clear Health

Findings

Table 3-17 below presents Clear Health's overall compliance results for the 11 standards reviewed by AHCA. Totals in the Compliance Actions column were compiled from AHCA's plan-specific worksheets.

Table 3-17—Clear Health Levels of Compliance

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
I	Availability of Services	24	18	0	0	6	2
II	Adequacy of Capacity and Services	16	16	0	0	0	2
III	Coordination and Continuity of Care	13	12	0	0	1	1
IV	Coverage and Authorization of Services	12	8	0	0	4	2
V	Quality Assessment and Performance Improvement	5	4	1	0	0	1 (Liquidated Damages)
VI	Health Information Systems	5	5	0	0	0	6

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
VII	Provider Selection and Credentialing/ Recredentialing	8	8	0	0	0	0
VIII	Enrollee Information	9	9	0	0	0	1
IX	Confidentiality	1	1	0	0	0	0
X	Grievance Systems	11	10	0	0	1	1
XI	Sub-contractual Relationships and Delegation	8	8	0	0	0	0

Note: In June 2017, Clear Health had 9,450 MMA enrollees.

Table 3-17 shows that Clear Health received *Met* scores for all methods of review, except for a *Partially Met* score for the Quality Assessment and Performance Improvement standard; Clear Health was assessed liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. Clear Health received no compliance actions for the following standards: Provider Selection and Credentialing/Recredentialing, Confidentiality, and Sub-contractual Relationships and Delegation.

Clear Health received compliance actions for the following standards based on the noted methods of review:

- Availability of Services—Online Provider Directory Analysis (2)
- Adequacy of Capacity and Services—Online Provider Directory Analysis (2)
- Coordination and Continuity of Care—Access Complaints (1)
- Coverage and Authorization of Services—Medicaid Complaint Hub (2)
- Quality Assessment and Performance Improvement—Performance Measure Quality Standards (1)
- Health Information Systems—On Base Encounter Reports (6)
- Enrollee Information—Notice of Adverse Benefit Determination Template (1)
- Grievance Systems—Notice of Adverse Benefit Determination Template (1)

In addition, according to the *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY16/17 Report*, Clear Health incurred liquidated damages totaling $750,000 in the Enrollee Services and Grievances, Covered Services, Quality and Utilization Management, and Administration and Management areas. Clear Health incurred no monetary sanctions.

Strengths

Clear Health demonstrated strong performance for the Provider Selection and Credentialing/Recredentialing, Confidentiality, and Sub-contractual Relationships and Delegation

standards, scoring *Met* for all methods of review with no compliance actions. For the Quality Assessment and Performance Improvement standard, Clear Health had only one compliance action that involved liquidated damages for failure to meet performance measure quality standards. Clear Health received only one compliance action for each of these standards: Coordination and Continuity of Care, Enrollee Information, and Grievance Systems.

Opportunities for Improvement

Clear Health has opportunities for improvement in the Availability of Services, Adequacy of Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Quality Assessment and Performance Improvement, Health Information Systems, Enrollee Information, and Grievance Systems standards. The Quality Assessment and Performance Improvement standard received a *Partially Met* score with liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. The methods of review that identified areas needing improvement are the Online Provider Directory Analysis (4), Access Complaints (1), Medicaid Complaint Hub (2), On Base Encounter Reports (6), and the Notice of Adverse Benefit Determination Template (2).

Community Care Plan

Findings

Table 3-18 below presents Community Care Plan's overall compliance results for the 11 standards reviewed by AHCA. Totals in the Compliance Actions column were compiled from AHCA's plan-specific worksheets.

Table 3-18—Community Care Plan Levels of Compliance

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
I	Availability of Services	24	18	0	0	6	1
II	Adequacy of Capacity and Services	16	16	0	0	0	1
III	Coordination and Continuity of Care	15	14	0	0	1	0
IV	Coverage and Authorization of Services	12	8	0	0	4	0
V	Quality Assessment and Performance Improvement	5	4	1	0	0	1 (Liquidated Damages)

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
VI	Health Information Systems	5	5	0	0	0	5
VII	Provider Selection and Credentialing/ Recredentialing	8	8	0	0	0	1
VIII	Enrollee Information	9	9	0	0	0	0
IX	Confidentiality	1	1	0	0	0	0
X	Grievance Systems	11	11	0	0	0	1
XI	Sub-contractual Relationships and Delegation	8	8	0	0	0	0

Note: In June 2017, Community Care Plan had 45,274 MMA enrollees.

Table 3-18 shows that Community Care Plan received *Met* scores for all methods of review, except for a *Partially Met* score for the Quality Assessment and Performance Improvement standard; Community Care Plan was assessed liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. Community Care Plan received no compliance actions for the following standards: Coordination and Continuity of Care, Coverage and Authorization of Services, Enrollee Information, Confidentiality, and Sub-contractual Relationships and Delegation.

Community Care Plan received compliance actions for the following standards based on the noted methods of review:

- Availability of Services—PNV Data Files (1)
- Adequacy of Capacity and Services—PNV Data Files (1)
- Quality Assessment and Performance Improvement—Performance Measure Quality Standards (1)
- Health Information Systems—On Base Encounter Reports (5)
- Provider Selection and Credentialing/Recredentialing—PNV Data Files (1)
- Grievance Systems—Enrollee Complaints Grievances and Appeals Report (1)

In addition, according to the *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY16/17 Report*, Community Care Plan incurred liquidated damages totaling $288,300 in the Quality and Utilization Management, and Administration and Management areas. Community Care Plan received no monetary sanctions.

Strengths

Community Care Plan demonstrated strong performance for the Coordination and Continuity of Care, Coverage and Authorization of Services, Enrollee Information, Confidentiality, and Sub-contractual

Relationships and Delegation standards, scoring *Met* for all methods of review, with no compliance actions. For the Quality Assessment and Performance Improvement standard, Community Care Plan had only one compliance action that involved liquidated damages for failure to meet performance measures quality standards. Community Care Plan received only one compliance action for each of these standards: Availability of Services, Adequacy of Capacity and Services, Provider Selection and Credentialing/Recredentialing, and Grievance Systems standards.

Opportunities for Improvement

Community Care Plan has opportunities for improvement in the Availability of Services, Adequacy of Capacity and Services, Quality Assessment and Performance Improvement, Health Information Systems, Provider Selection and Credentialing/Recredentialing, and Grievance Systems standards. The Quality Assessment and Performance Improvement standard received a *Partially Met* score with liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. The methods of review that identified areas needing improvement are PNV Data Files (3), On Base Encounter Reports (5), and the Enrollee Complaints Grievances and Appeals Report (1).

Community Care Plan incurred liquidated damages in the Quality and Utility Management and Administration and Management areas.

Freedom

Findings

Table 3-19 below presents Freedom's overall compliance results for the 11 standards reviewed by AHCA. Totals in the Compliance Actions column were compiled from AHCA's plan-specific worksheets.

Table 3-19—Freedom Levels of Compliance

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
I	Availability of Services	24	18	0	0	6	0
II	Adequacy of Capacity and Services	16	16	0	0	0	0
III	Coordination and Continuity of Care	10	9	0	0	1	0
IV	Coverage and Authorization of Services	12	1	0	0	1	0

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
V	Quality Assessment and Performance Improvement	5	5	0	0	0	0
VI	Health Information Systems	5	5	0	0	0	0
VII	Provider Selection and Credentialing/ Recredentialing	8	8	0	0	0	0
VIII	Enrollee Information	9	9	0	0	0	0
IX	Confidentiality	1	1	0	0	0	0
X	Grievance Systems	11	10	0	0	1	0
XI	Sub-contractual Relationships and Delegation	8	8	0	0	0	0

Note: In June 2017, Freedom had 122 MMA enrollees.

Table 3-19 shows that Freedom received *Met* scores for all methods of review, Freedom received no compliance actions in any of the standards.

Freedom was not included in the *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY16/17 Report*, which may be because Freedom had no compliance actions.

Strengths

Freedom demonstrated strong performance in all standards, scoring *Met* for all methods of review, with no compliance actions.

Opportunities for Improvement

Freedom has opportunities for improvement in all standards in that the plan needs to consolidate gains made in the year to maintain its success.

Humana

Findings

Table 3-20 below presents Humana's overall compliance results for the 11 standards reviewed by AHCA. Totals in the Compliance Actions column were compiled from AHCA's plan-specific worksheets.

Table 3-20—Humana Levels of Compliance

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
I	Availability of Services	24	24	0	0	0	13
II	Adequacy of Capacity and Services	16	16	0	0	0	7
III	Coordination and Continuity of Care	17	17	0	0	0	0
IV	Coverage and Authorization of Services	12	12	0	0	0	3
V	Quality Assessment and Performance Improvement	5	4	1	0	0	1 (Liquidated Damages)
VI	Health Information Systems	5	5	0	0	0	3
VII	Provider Selection and Credentialing/ Recredentialing	8	8	0	0	0	5
VIII	Enrollee Information	9	8*	0	0	0	0
IX	Confidentiality	1	1	0	0	0	1
X	Grievance Systems	11	11	0	0	0	9
XI	Sub-contractual Relationships and Delegation	8	8	0	0	0	0

** One method of review, Grievance and Appeal Notices, did not include a designation under "Compliance Determination."*

Note: In June 2017, Humana had 326,907 MMA enrollees and 20,693 LTC enrollees.

Table 3-20 shows that Humana received *Met* scores for all methods of review, except for a *Partially Met* score for the Quality Assessment and Performance Improvement standard; Humana was assessed

liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. Humana received no compliance actions for the following standards: Coordination and Continuity of Care, Enrollee Information, and Sub-contractual Relationships and Delegation.

Humana received compliance actions for the following standards based on the noted methods of review:

- Availability of Services—PNV Data Files (1), Quest Ratio, Time and Distance Reports (1), Online Provider Directory Analysis (4), Critical Incident Reporting (4), Participant Direction Option Report (1), Unable to Locate/Refused Services Report (1), and Corrective Action Plan Follow-up (1)
- Adequacy of Capacity and Services—PNV Data Files (1), Quest Ratio, Time and Distance Reports (1), Online Provider Directory Analysis (4), and Corrective Action Plan Follow-up (1).
- Coverage and Authorization of Services—Medicaid Complaint Hub (3)
- Confidentiality—Disclosure Form—OIG (1)
- Quality Assessment and Performance Improvement—Performance Measure Quality Standards (1)
- Health Information Systems—On Base Encounter Reports (3)
- Provider Selection and Credentialing/Recredentialing—PNV Data Files (1), Online Provider Directory Analysis (4)
- Grievance Systems—Medicaid Complaint Hub (1), Medicaid Fair Hearings (1), Denial, Reduction, Termination or Suspension of Services Report (3), and Enrollee Complaints Grievances and Appeals Report (4)

In addition, according to the *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY16/17 Report*, Humana incurred liquidated damages totaling $880,500 in the Enrollee Services and Grievances, Covered Services, Provider Network, Quality and Utilization Management, Administration and Management, Finance, and Reporting areas. Humana incurred a monetary sanction of $2,500.

Strengths

Humana demonstrated strong performance for the Coordination and Continuity of Care, Enrollee Information, and Sub-contractual Relationships and Delegation standards, scoring *Met* for all methods of review, with no compliance actions. For the Quality Assessment and Performance Improvement standard, Humana had only one compliance action that involved liquidated damages for failure to meet performance measure quality standards.

Opportunities for Improvement

Humana has opportunities for improvement in the Availability of Services, Adequacy of Capacity and Services, Coverage and Authorization of Services, Confidentiality, Quality Assessment and Performance Improvement, Health Information Systems, Provider Selection and Credentialing/Recredentialing, and Grievance Systems standards. The Quality Assessment and Performance Improvement standard received a *Partially Met* score with liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. The methods of review that identified areas needing improvement are PNV Data Files (3), Quest Ratio, Time and Distance Reports

(2), Online Provider Directory Analysis (12), Corrective Action Plan Follow-up (2), Participant Direction Option Report (1), Unable to Locate/Refused Services Report (1), Participant Direction Option Report (1), Unable to Locate/Refused Services Report (1), Critical Incident Reporting (4), On Base Encounter Reports (3), Medicaid Complaint Hub, the Denial, Reduction, Termination or Suspension of Services Report (3), Disclosure Form—OIG (1), and the Enrollee Complaints Grievances and Appeals Report (4).

Humana incurred liquidated damages in the Enrollee Services and Grievances, Covered Services, Provider Network, Quality and Utilization Management, Administration and Management, Finance, and Reporting areas and a $2,500 monetary sanction.

Magellan

Findings

Table 3-21 below presents Magellan's overall compliance results for the 11 standards reviewed by AHCA. Totals in the Compliance Actions column were compiled from AHCA's plan-specific worksheets.

Table 3-21—Magellan Levels of Compliance

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
I	Availability of Services	24	18	0	0	6	2
II	Adequacy of Capacity and Services	16	16	0	0	0	2
III	Coordination and Continuity of Care	15	14	0	0	1	0
IV	Coverage and Authorization of Services	12	8	0	0	4	0
V	Quality Assessment and Performance Improvement	5	4	1	0	0	1 (Liquidated Damages)
VI	Health Information Systems	5	5	0	0	0	1
VII	Provider Selection and Credentialing/ Recredentialing	8	8	0	0	0	2

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
VIII	Enrollee Information	9	9	0	0	0	0
IX	Confidentiality	1	1	0	0	0	0
X	Grievance Systems	11	10	0	0	1	0
XI	Sub-contractual Relationships and Delegation	8	8	0	0	0	0

Note: In June 2017, Magellan had 67,878 MMA enrollees.

Table 3-21 shows that Magellan received *Met* scores for all methods of review, except for a *Partially Met* score for the Quality Assessment and Performance Improvement standard; Magellan was assessed liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. Magellan received no compliance actions for the following standards: Coordination and Continuity of Care, Coverage and Authorization of Services, Enrollee Information, Confidentiality, Grievance Systems, and Sub-contractual Relationships and Delegation.

Magellan received compliance actions for the following standards based on the noted methods of review:

- Availability of Services—PNV Data Files (2)
- Adequacy of Capacity and Services—PNV Data Files (2)
- Quality Assessment and Performance Improvement—Performance Measure Quality Standards (1)
- Health Information Systems—On Base Encounter Reports (1)
- Provider Selection and Credentialing/Recredentialing—PNV Data Files (2)

In addition, according to the *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY16/17 Report*, Magellan incurred liquidated damages totaling $2,558,450 in the Marketing, Covered Services, Provider Network, Quality and Utilization Management, and Administration and Management areas. Magellan received no monetary sanctions.

Strengths

Magellan demonstrated strong performance for the Coordination and Continuity of Care, Coverage and Authorization of Services, Enrollee Information, Confidentiality, Grievance Systems, and Sub-contractual Relationships and Delegation standards, scoring *Met* for all methods of review, with no compliance actions. For the Quality Assessment and Performance Improvement standard, Magellan had only one compliance action that involved liquidated damages for failure to meet performance measures. For the Health Information Systems standard, Magellan received only one compliance action.

Opportunities for Improvement

Magellan has opportunities for improvement in the Availability of Services, Adequacy of Capacity and Services, Quality Assessment and Performance Improvement, Health Information Systems, and Provider Selection and Credentialing/Recredentialing standards. The Quality Assessment and Performance Improvement standard received a *Partially Met* score with liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. The methods of review that identified areas needing improvement are PNV Data Files (6) and On Base Encounter Reports (1). Magellan received liquidated damages in the Marketing, Covered Services, Provider Network, Quality and Utilization Management, and Administration and Management areas.

Molina

Findings

Table 3-22 below presents Molina's overall compliance results for the 11 standards reviewed by AHCA. Totals in the Compliance Actions column were compiled from AHCA's plan-specific worksheets.

Table 3-22—Molina Levels of Compliance

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
I	Availability of Services	24	24	0	0	0	4
II	Adequacy of Capacity and Services	16	16	0	0	0	5
III	Coordination and Continuity of Care	17	17	0	0	0	1
IV	Coverage and Authorization of Services	12	12	0	0	0	4
V	Quality Assessment and Performance Improvement	5	4	1	0	0	1 (Liquidated Damages)
VI	Health Information Systems	5	5	0	0	0	5
VII	Provider Selection and Credentialing/ Recredentialing	8	8	0	0	0	2
VIII	Enrollee Information	9	9	0	0	0	0
IX	Confidentiality	1	1	0	0	0	0

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
X	Grievance Systems	11	11	0	0	0	0
XI	Sub-contractual Relationships and Delegation	8	8	0	0	0	0

Note: In June 2017, Molina had 345,505 MMA enrollees and 6,211 LTC enrollees.

Table 3-22 shows that Molina received *Met* scores for all methods of review, except for a *Partially Met* score for the Quality Assessment and Performance Improvement standard; Molina was assessed liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. Molina received no compliance actions for the following standards: Enrollee Information, Confidentiality, Grievance Systems, and Sub-contractual Relationships and Delegation.

Molina received compliance actions for the following standards based on the noted methods of review:

- Availability of Services—PNV Data Files (2), Online Provider Directory Analysis (2)
- Adequacy of Capacity and Services—PNV Data Files (2), Quest Ratio, Time and Distance Reports (1), Online Provider Directory Analysis (2)
- Coordination and Continuity of Care—Access Complaints (1)
- Coverage and Authorization of Services—Medicaid Complaint Hub (3), Medicaid Fair Hearings (1)
- Quality Assessment and Performance Improvement—Performance Measure Quality Standards (1)
- Health Information Systems—On Base Encounter Reports (4), Managed Care Plan Self-reports (1)
- Provider Selection and Credentialing/Recredentialing—PNV Data Files (2)

In addition, according to the *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY16/17 Report*, Molina incurred liquidated damages totaling $999,600 in the Marketing, Medicaid Fair Hearing, Covered Services, Provider Network, Quality and Utilization Management, and Administration and Management areas. Molina incurred a monetary sanction of $7,500.

Strengths

Molina demonstrated strong performance for the Enrollee Information, Confidentiality, Grievance Systems, and Sub-contractual Relationships and Delegation standards, scoring *Met* for all methods of review, with no compliance actions. For the Quality Assessment and Performance Improvement standard, Molina had only one compliance action that involved liquidated damages for failure to meet performance measure quality standards. For the Coordination and Continuity of Care standard, Molina received only one compliance action.

Opportunities for Improvement

Molina has opportunities for improvement in the Availability of Services, Adequacy of Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Quality Assessment and Performance Improvement, Health Information Systems, and Provider Selection and Credentialing/Recredentialing standards. The Quality Assessment and Performance Improvement standard received a *Partially Met* score with liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. The methods of review that identified areas needing improvement are PNV Data Files (6), Quest Ratio, Time & Distance Reports (1), Access Complaints (1), Online Provider Directory Analysis (4), On Base Encounter Reports (4), Medicaid Complaint Hub (3), Medicaid Fair Hearings (1), and Managed Care Plan Self-reports (1).

Molina received liquidated damages in the Marketing, Medicaid Fair Hearing, Covered Services, Provider Network, Quality and Utilization Management, and Administration and Management areas. Molina also incurred a monetary sanction of $7,500.

Prestige

Findings

Table 3-23 below presents Prestige's overall compliance results for the 11 standards reviewed by AHCA. Totals in the Compliance Actions column were compiled from AHCA's plan-specific worksheets.

Table 3-23—Prestige Levels of Compliance

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
I	Availability of Services	24	18	0	0	6	6
II	Adequacy of Capacity and Services	16	16	0	0	0	6
III	Coordination and Continuity of Care	16	15	0	0	1	3
IV	Coverage and Authorization of Services	12	8	0	0	4	8
V	Quality Assessment and Performance Improvement	5	4	1	0	0	1 (Liquidated Damages)
VI	Health Information Systems	5	5	0	0	0	5

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
VII	Provider Selection and Credentialing/ Recredentialing	8	8	0	0	0	3
VIII	Enrollee Information	9	9	0	0	0	0
IX	Confidentiality	1	1	0	0	0	0
X	Grievance Systems	11	10	0	0	1	1
XI	Sub-contractual Relationships and Delegation	8	8	0	0	0	0

Note: In June 2017, Prestige had 324,558 MMA enrollees.

Table 3-23 shows that Prestige received *Met* scores for all methods of review, except for a *Partially Met* score for the Quality Assessment and Performance Improvement standard; Prestige was assessed liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. Prestige received no compliance actions for the following standards: Enrollee Information, Confidentiality, and Sub-contractual Relationships and Delegation.

Prestige received compliance actions for the following standards based on the noted methods of review:

- Availability of Services—PNV Data Files (3), Online Provider Directory Analysis (3)
- Adequacy of Capacity and Services—PNV Data Files (3), Access Complaints (3)
- Coordination and Continuity of Care—Access Complaints (3)
- Coverage and Authorization of Services—Medicaid Complaint Hub (4), Medicaid Fair Hearings (4)
- Quality Assessment and Performance Improvement—Performance Measure Quality Standards (1)
- Health Information Systems—On Base Encounter Reports (5)
- Provider Selection and Credentialing/Recredentialing—PNV Data Files (3)
- Grievance Systems—Enrollee Complaints Grievances and Appeals Report (1)

In addition, according to the *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY16/17 Report*, Prestige incurred liquidated damages totaling $2,085,500 in the Enrollee Services and Grievances, Medicaid Fair Hearing, Covered Services, Provider Network, Quality and Utilization Management, and Administration and Management areas. Prestige received no monetary sanctions.

Strengths

Prestige demonstrated strong performance for the Enrollee Information, Confidentiality, and Sub-contractual Relationships and Delegation standards, scoring *Met* for all methods of review, with no compliance actions. For the Quality Assessment and Performance Improvement standard, Prestige had

only one compliance action that involved liquidated damages for failure to meet performance measure quality standards. For the Grievance Systems standard, Prestige received only one compliance action.

Opportunities for Improvement

Prestige has opportunities for improvement in the Availability of Services, Adequacy of Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Quality Assessment and Performance Improvement, Health Information Systems, Provider Selection and Credentialing/Recredentialing, and Grievance Systems standards. The Quality Assessment and Performance Improvement standard received a *Partially Met* score with liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. The methods of review that identified areas needing improvement are PNV Data Files (9), Access Complaints (6), Online Provider Directory Analysis (3), On Base Encounter Reports (5), Medicaid Complaint Hub (4), Medicaid Fair Hearings (4), and Enrollee Complaints Grievances and Appeals Report (1).

Prestige received liquidated damages in the Enrollee Services and Grievances, Medicaid Fair Hearings, Covered Services, Provider Network, Quality and Utilization Management, and Administration and Management areas.

Positive

Findings

Table 3-24 below presents Positive's overall compliance results for the 11 standards reviewed by AHCA. Totals in the Compliance Actions column were compiled from AHCA's plan-specific worksheets.

Table 3-24—Positive Levels of Compliance

Standard	Standard Name	Total # of Methods of Review	*# Met*	*# Partially Met*	*# Not Met*	*# N/A or N/S*	Total # of Compliance Actions
I	Availability of Services	24	18	0	0	6	5
II	Adequacy of Capacity and Services	16	16	0	0	0	5
III	Coordination and Continuity of Care	13	12	0	0	1	0
IV	Coverage and Authorization of Services	12	8	0	0	4	0

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
V	Quality Assessment and Performance Improvement	5	4	1	0	0	1 (Liquidated Damages)
VI	Health Information Systems	5	5	0	0	0	1
VII	Provider Selection and Credentialing/ Recredentialing	8	8	0	0	0	3
VIII	Enrollee Information	9	9	0	0	0	0
IX	Confidentiality	1	1	0	0	0	0
X	Grievance Systems	11	11	0	0	0	0
XI	Sub-contractual Relationships and Delegation	8	8	0	0	0	0

Note: In June 2017, Positive had 2,029 MMA enrollees.

Table 3-24 shows that Positive received *Met* scores for all methods of review, except for a *Partially Met* score for the Quality Assessment and Performance Improvement standard; Positive was assessed liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. Positive received no compliance actions for the following standards: Coordination and Continuity of Care, Coverage and Authorization of Services, Enrollee Information, Confidentiality, Grievance Systems, and Sub-contractual Relationships and Delegation.

Positive received compliance actions for the following standards based on the noted methods of review:

- Availability of Services—PNV Data Files (1), Online Provider Directory Analysis (2), Corrective Action Plan Follow-up (2)
- Adequacy of Capacity and Services—PNV Data Files (1), Online Provider Directory Analysis (2), Corrective Action Plan Follow-up (2)
- Quality Assessment and Performance Improvement—Performance Measure Quality Standards (1)
- Health Information Systems—On Base Encounter Reports (1)
- Provider Selection and Credentialing/Recredentialing—PNV Data Files (1), Online Provider Directory Analysis (2)

In addition, according to the *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY16/17 Report*, Positive incurred liquidated damages totaling $40,200 in the Quality and Utilization Management, Administration and Management, and Finance areas. Positive incurred $2,500 in monetary sanctions.

Strengths

Positive demonstrated strong performance for the Coordination and Continuity of Care, Coverage and Authorization of Services, Enrollee Information, Confidentiality, Grievance Systems, and Sub-contractual Relationships and Delegation standards, scoring *Met* for all methods of review, with no compliance actions. For the Quality Assessment and Performance Improvement standard, Positive had only one compliance action that involved liquidated damages for failure to meet performance measure quality standards. For the Health Information Systems standard, Positive received only one compliance action.

Opportunities for Improvement

Positive has opportunities for improvement in the Availability of Services, Adequacy of Capacity and Services, Quality Assessment and Performance Improvement, Health Information Systems, and Provider Selection and Credentialing/Recredentialing standards. The Quality Assessment and Performance Improvement standard received a *Partially Met* score with liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. The methods of review that identified areas needing improvement are PNV Data Files (3), Online Provider Directory Analysis (6), Corrective Action Plan Follow-up (4), and On Base Encounter Reports (1). Positive received liquidated damages in the Quality and Utilization Management, Administration and Management, and Finance areas. Positive also incurred $2,500 in monetary sanctions.

Simply

Findings

Table 3-25 below presents Simply's overall compliance results for the 11 standards reviewed by AHCA. Totals in the Compliance Actions column were compiled from AHCA's plan-specific worksheets.

Table 3-25—Simply Levels of Compliance

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
I	Availability of Services	24	18	0	0	6	2
II	Adequacy of Capacity and Services	16	16	0	0	0	2
III	Coordination and Continuity of Care	15	14	0	0	1	1
IV	Coverage and Authorization of Services	12	8	0	0	4	0

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
V	Quality Assessment and Performance Improvement	5	4	1	0	0	1 (Liquidated Damages)
VI	Health Information Systems	5	5	0	0	0	4
VII	Provider Selection and Credentialing/ Recredentialing	8	8	0	0	0	0
VIII	Enrollee Information	9	9	0	0	0	0
IX	Confidentiality	1	1	0	0	0	0
X	Grievance Systems	11	11	0	0	0	1
XI	Sub-contractual Relationships and Delegation	8	8	0	0	0	0

Note: In June 2017, Simply had 81,909 MMA enrollees.

Table 3-25 shows that Simply received *Met* scores for all methods of review, except for a *Partially Met* score for the Quality Assessment and Performance Improvement standard; Simply was assessed liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. Simply received no compliance actions for the following standards: Coverage and Authorization of Services, Provider Selection and Credentialing/Recredentialing, Enrollee Information, Confidentiality, and Sub-contractual Relationships and Delegation.

Simply received compliance actions for the following standards based on the noted methods of review:

- Availability of Services—Online Provider Directory Analysis (2)
- Adequacy of Capacity and Services—Online Provider Directory Analysis (2)
- Coordination and Continuity of Care—Access Complaints (1)
- Quality Assessment and Performance Improvement—Performance Measure Quality Standards (1)
- Health Information Systems—On Base Encounter Reports (4)
- Grievance Systems—Notice of Adverse Benefit Determination Template (1)

In addition, according to the *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY16/17 Report*, Simply incurred liquidated damages totaling $392,200 in the Enrollee Services and Grievances, Quality and Utilization Management, Administration and Management, and Finance areas. Simply received no monetary sanctions.

Strengths

Simply demonstrated strong performance for the Coverage and Authorization of Services, Provider Selection and Credentialing/Recredentialing, Enrollee Information, Confidentiality, and Sub-contractual Relationships and Delegation standards, scoring *Met* for all methods of review, with no compliance actions. For the Quality Assessment and Performance Improvement standard, Simply had only one compliance action that involved liquidated damages for failure to meet Performance Measure Quality Standards. For the Coordination and Continuity of Care, and Grievance Systems standards, Simply received only one compliance action.

Opportunities for Improvement

Simply has opportunities for improvement in the Availability of Services, Adequacy of Capacity and Services, Coordination and Continuity of Care, Quality Assessment and Performance Improvement, Grievance Systems, and Health Information Systems standards. The Quality Assessment and Performance Improvement standard received a *Partially Met* score with liquidated damages for failure to meet certain Performance Measure Quality Standards in CYE 2015. The methods of review that identified areas needing improvement are Online Provider Directory Analysis (4), Access Complaints (1), On Base Encounter Reports (4), and Notice of Adverse Benefit Determination Template (1).

Simply incurred liquidated damages in the Enrollee Services and Grievances, Quality and Utilization Management, Administration and Management, and Finance areas.

Staywell

Findings

Table 3-26 below presents Staywell's overall compliance results for the 11 standards reviewed by AHCA. Totals in the Compliance Actions column were compiled from AHCA's plan-specific worksheets.

Table 3-26—Staywell Levels of Compliance

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
I	Availability of Services	24	18	0	0	6	8
II	Adequacy of Capacity and Services	16	16	0	0	0	8
III	Coordination and Continuity of Care	16	16	0	0	0	2

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
IV	Coverage and Authorization of Services	12	8	0	0	4	2
V	Quality Assessment and Performance Improvement	5	4	1	0	0	1 (Liquidated Damages)
VI	Health Information Systems	5	5	0	0	0	2
VII	Provider Selection and Credentialing/ Recredentialing	8	8	0	0	0	2
VIII	Enrollee Information	9	9	0	0	0	0
IX	Confidentiality	1	1	0	0	0	0
X	Grievance Systems	11	11	0	0	0	3
XI	Sub-contractual Relationships and Delegation	8	8	0	0	0	0

Note: In June 2017, Staywell had 664,534 MMA enrollees.

Table 3-26 shows that Staywell received *Met* scores for all methods of review, except for a *Partially Met* score for the Quality Assessment and Performance Improvement standard; Staywell was assessed liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. Staywell received no compliance actions for the following standards: Enrollee Information, Confidentiality, and Sub-contractual Relationships and Delegation.

Staywell received compliance actions for the following standards based on the noted methods of review:

- Availability of Services—PNV Data Files (2), Online Provider Directory Analysis (3), Access Complaints (2), Corrective Action Plan Follow-up (1)
- Adequacy of Capacity and Services—PNV Data Files (2), Online Provider Directory Analysis (3), Access Complaints (2), Corrective Action Plan Follow-up (1)
- Coordination and Continuity of Care—Access Complaints (2)
- Coverage and Authorization of Services—Medicaid Complaint Hub (2)
- Quality Assessment and Performance Improvement—Performance Measure Quality Standards (1)
- Health Information Systems—On Base Encounter Reports (2)
- Provider Selection and Credentialing/Recredentialing—PNV Data Files (2)
- Grievance Systems—Medicaid Fair Hearings (1), Enrollee Complaints Grievances and Appeals Report (2)

In addition, according to the *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY16/17 Report*, Staywell incurred liquidated damages totaling $2,747,600 in the Marketing, Enrollee Services and Grievances, Medicaid Fair Hearings, Covered Services, Quality and Utilization Management, Administration and Management, and Reporting areas. Staywell incurred $7,500 in monetary sanctions.

Strengths

Staywell demonstrated strong performance for the Enrollee Information, Confidentiality, and Sub-contractual Relationships and Delegation standards, scoring *Met* for all methods of review, with no compliance actions. For the Quality Assessment and Performance Improvement standard, Staywell had only one compliance action that involved liquidated damages for failure to meet performance measure quality standards.

Opportunities for Improvement

Staywell has opportunities for improvement in the Availability of Services, Adequacy of Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Quality Assessment and Performance Improvement, Health Information Systems, Provider Selection and Credentialing/Recredentialing, and Grievance Systems standards. The Quality Assessment and Performance Improvement standard received a *Partially Met* score with liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. The methods of review that identified areas needing improvement are PNV Data Files (6), Access Complaints (6), Online Provider Directory Analysis (6), Corrective Action Plan Follow-up (2), Medicaid Complaint Hub (2), On Base Encounter Reports (2), Medicaid Fair Hearings (1), and Enrollee Complaints Grievances and Appeals Report (2). Staywell incurred liquidated damages in the Marketing, Enrollee Services and Grievances, Medicaid Fair Hearing, Covered Services, Quality and Utilization Management, Administration and Management, and Reporting areas. Staywell also incurred $7,500 in monetary sanctions.

Sunshine

Findings

Table 3-27 below presents Sunshine's overall compliance results for the 11 standards reviewed by AHCA. Totals in the Compliance Actions column were compiled from AHCA's plan-specific worksheets.

Table 3-27—Sunshine Levels of Compliance

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
I	Availability of Services	24	24	0	0	0	15
II	Adequacy of Capacity and Services	16	16	0	0	0	8

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
III	Coordination and Continuity of Care	17	17	0	0	0	0
IV	Coverage and Authorization of Services	12	12	0	0	0	4
V	Quality Assessment and Performance Improvement	5	4	1	0	0	1 (Liquidated Damages)
VI	Health Information Systems	5	5	0	0	0	4
VII	Provider Selection and Credentialing/ Recredentialing	8	8	0	0	0	4
VIII	Enrollee Information	9	9	0	0	0	0
IX	Confidentiality	1	1	0	0	0	0
X	Grievance Systems	11	11	0	0	0	8
XI	Sub-contractual Relationships and Delegation	8	8	0	0	0	0

Note: In June 2017, Sunshine had 512,036 MMA enrollees (includes 32,348 Specialty enrollees) and 40,971 LTC enrollees.

Table 3-27 shows that Sunshine received *Met* scores for all methods of review, except for a *Partially Met* score for the Quality Assessment and Performance Improvement standard; Sunshine was assessed liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. Sunshine received no compliance actions for the following standards: Coordination and Continuity of Care, Enrollee Information, Confidentiality, and Sub-contractual Relationships and Delegation.

Sunshine received compliance actions for the following standards based on the noted methods of review:

- Availability of Services—PNV Data Files (1), Quest Ratio, Time and Distance Reports (2), Online Provider Directory Analysis (2), Missed Services Report (1), Critical Incident Reporting (5), Network Adequacy Ad Hoc Reviews (1), Corrective Action Plan Follow-up (3)
- Adequacy of Capacity and Services—PNV Data Files (1), Quest Ratio, Time and Distance Reports (2), Online Provider Directory Analysis (2), Corrective Action Plan Follow-up (3)
- Coverage and Authorization of Services—Medicaid Complaint Hub (4)
- Quality Assessment and Performance Improvement—Performance Measure Quality Standards (1)
- Health Information Systems—On Base Encounter Reports (4)

- Provider Selection and Credentialing/Recredentialing—PNV Data Files (1), Online Provider Directory Analysis (2), Printed Provider Directory Analysis (1)
- Grievance Systems—Medicaid Fair Hearings (3), Denial, Reduction, Termination or Suspension of Services Report (3), Enrollee Complaints Grievances and Appeals Report (2)

In addition, according to the *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY16/17 Report*, Sunshine incurred liquidated damages totaling $3,810,900 in the Enrollee Services and Grievances, Covered Services, Provider Network, Quality and Utilization Management, and Administration and Management areas. Sunshine received no monetary sanctions.

Strengths

Sunshine demonstrated strong performance for the Coordination and Continuity of Care, Enrollee Information, Confidentiality, and Sub-contractual Relationships and Delegation standards, scoring *Met* for all methods of review, with no compliance actions. For the Quality Assessment and Performance Improvement standard, Sunshine had only one compliance action that involved liquidated damages for failure to meet performance measure quality standards.

Opportunities for Improvement

Sunshine has opportunities for improvement in the Availability of Services, Adequacy of Capacity and Services, Coverage and Authorization of Services, Quality Assessment and Performance Improvement, Health Information Systems, Provider Selection and Credentialing/Recredentialing, and Grievance Systems standards. The Quality Assessment and Performance Improvement standard received a *Partially Met* score with liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. The methods of review that identified areas needing improvement are PNV Data Files (3), Quest Ratio, Time and Distance Reports (4), Online Provider Directory Analysis (6), On Base Encounter Reports (4), Missed Services Report (1), Critical Incident Reporting (5), Medicaid Complaint Hub (4), Corrective Action Plan Follow-up (6), Medicaid Fair Hearings (3), Denial, Reduction, Termination or Suspension of Services Report (3), Printed Provider Directory Analysis (1), Network Adequacy Ad Hoc Reviews (1), and the Enrollee Complaints Grievances and Appeals Report (2). Sunshine incurred liquidated damages in the Enrollee Services and Grievances, Covered Services, Provider Network, Quality and Utilization Management, and Administration and Management areas.

United

Findings

Table 3-28 below presents United's overall compliance results for the 11 standards reviewed by AHCA. Totals in the Compliance Actions column were compiled from AHCA's plan-specific worksheets.

Table 3-28—United Levels of Compliance

Standard	Standard Name	Total # of Methods of Review	# Met	# Partially Met	# Not Met	# N/A or N/S	Total # of Compliance Actions
I	Availability of Services	24	24	0	0	0	10
II	Adequacy of Capacity and Services	16	16	0	0	0	7
III	Coordination and Continuity of Care	17	17	0	0	0	1
IV	Coverage and Authorization of Services	12	12	0	0	0	3
V	Quality Assessment and Performance Improvement	5	4	1	0	0	1 (Liquidated Damages)
VI	Health Information Systems	5	5	0	0	0	0
VII	Provider Selection and Credentialing/ Recredentialing	8	8	0	0	0	0
VIII	Enrollee Information	9	9	0	0	0	0
IX	Confidentiality	1	1	0	0	0	1
X	Grievance Systems	11	11	0	0	0	10
XI	Sub-contractual Relationships and Delegation	8	8	0	0	0	0

Note: In June 2017, United had 272,952 MMA enrollees and 19,012 LTC enrollees.

Table 3-28 shows that United received *Met* scores for all methods of review, except for a *Partially Met* score for the Quality Assessment and Performance Improvement standard; United was assessed liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. United received no compliance actions for the following standards: Health Information Systems, Enrollee Information, Provider Selection and Credentialing/Recredentialing, and Sub-contractual Relationships and Delegation.

United received compliance actions for the following standards based on the noted methods of review:

- Availability of Services—Online Provider Directory Analysis (4), Access Complaints (1), Medicaid Fair Hearings (1), Critical Incident Reporting (2), Unable to Locate/Refused Services Report (1), Corrective Action Plan Follow-up (1)
- Adequacy of Capacity and Services—Online Provider Directory Analysis (4), Access Complaints (1), Medicaid Fair Hearings (1), Corrective Action Plan Follow-up (1)
- Coordination and Continuity of Care—Access Complaints (1)
- Coverage and Authorization of Services—Medicaid Complaint Hub (1), Medicaid Fair Hearings (2)
- Quality Assessment and Performance Improvement—Performance Measure Quality Standards (1)
- Confidentiality—Disclosure Form—OIG (1)
- Grievance Systems—Medicaid Fair Hearings (3), Denial, Reduction, Termination or Suspension of Services Report (4), Enrollee Complaints Grievances and Appeals Report (3)

In addition, according to the *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY16/17 Report*, United incurred liquidated damages totaling $1,333,500 in the Marketing, Enrollee Services and Grievances, Medicaid Fair Hearings, Covered Services, Quality and Utilization Management, and Reporting areas. United received no monetary sanctions.

Strengths

United demonstrated strong performance for the Health Information Systems, Enrollee Information, Provider Selection and Credentialing/Recredentialing, and Sub-contractual Relationships and Delegation standards, scoring *Met* for all methods of review, with no compliance actions. For the Quality Assessment and Performance Improvement standard, United had only one compliance action that involved liquidated damages for failure to meet performance measure quality standards. For the Coordination and Continuity of Care and the Confidentiality standard, United received only one compliance action.

Opportunities for Improvement

United has opportunities for improvement in the Availability of Services, Adequacy of Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Quality Assessment and Performance Improvement, Confidentiality, and Grievance Systems standards. The Quality Assessment and Performance Improvement standard received a *Partially Met* score with liquidated damages for failure to meet certain performance measure quality standards in CYE 2015. The methods of review that identified areas needing improvement are Online Provider Directory Analysis (8), Access Complaints (3), Medicaid Fair Hearings (7), Critical Incident Reporting (2), Unable to Locate/Refused Services Report (1), Corrective Action Plan Follow-up (2), Medicaid Complaint Hub (1), Denial, Reduction, Termination or Suspension of Services Report (4), Disclosure Form—OIG (1), and Enrollee Complaints Grievances and Appeals Report (3). United incurred liquidated damages in the Marketing, Enrollee Services and Grievances, Medicaid Fair Hearing, Covered Services, Quality and Utilization Management, and Reporting areas.

Recommendations

HSAG established that in accordance with 42 CFR §438.66, State Monitoring Requirements, AHCA conducted compliance and monitoring activities throughout SFY 2016–2017. AHCA has a comprehensive system that monitors all contract requirements and most of the federal standards for the plans. HSAG recommends that, in accordance with 42 CFR §438.358(b)(1)(iii), AHCA enhance the monitoring system already in place to include all federal requirements to determine each plan's adherence to the standards in subparts D and E.

In addition to an enhanced compliance review, HSAG recommends the following for AHCA:

- Establish an agency-wide methodology when conducting monitoring and review activities to provide a uniform method of ensuring that plans meet the federal and State requirements for managed care programs.
- Develop a standardized tool to allow multiple AHCA groups to document compliance with an established threshold and determine the plans as fully compliant only when all elements of the standard are present.
- Produce a summary document that details the plans' noncompliance with contract requirements and/or federal standards.
- Determine which plans and which standard categories need more TA to improve performance, based on information from the compliance review and monitoring that occurs throughout the year.

HSAG recommends the following for the plans:

- 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.
- Ensure the following findings are addressed:
  - Maintenance of the online provider network directory
  - All complaints, especially those related to access
  - On Base Encounter reports
  - PNV data files

- Concentrate improvement efforts on all standards and contract requirements, especially those related to the following:
  - Availability of Services
  - Adequacy of Capacity
  - Continuity and Coordination of Care
  - Health Information Systems
  - Enrollee Services and Grievances
  - Covered Services
  - Quality and Utilization Management
  - Administration and Management

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 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 2016–2017, AHCA contracted with HSAG to conduct an EDV study. The goal of the study was to examine the extent to which dental encounters submitted to AHCA by its contracted SMMC plans, including MMA and Specialty plans (collectively referred to as "plans" in this section) are complete and accurate.

The study was designed to produce actionable, valuable findings that will lead to recommendations to improve known areas of discrepancy in the encounter data submitted to AHCA by the plans. The SFY 2016–2017 study focused its review on all dental encounters with CDT codes for children under the age of 21.

To assess the quality of the dental encounters submitted to AHCA by the plans, the SFY 2016–2017 EDV study included two evaluation components:

- Administrative and comparative data analysis of encounter data
- Clinical record review

Encounter Data File Review

Based on the approved scope of work, HSAG worked with AHCA's EDV team and the DSS team to develop the data submission requirements for conducting the EDV study. Once finalized, the data submission requirements were submitted to both AHCA and the plans to guide the extraction and collection of study data. Data were requested for all dental claims/encounter records with dates of service between January 1, 2016, and June 30, 2016, that were finalized and submitted to AHCA before December 1, 2016. In addition to the file specifications, the data submission requirements also included the required data types (i.e., professional, dental, and institutional, if available) and the associated required data elements. HSAG also requested that AHCA provide supporting data files related to enrollment, demographics, and providers associated with the encounter files.

HSAG used the set of encounter files received from AHCA and the plans 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 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 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. Two significant observations were discovered:

- Some plans had significant differences in volume when compared to records received from AHCA (i.e., the number of records submitted by these plans was higher than the number of records received from AHCA). In many of the cases from these plans, the plan assignment (based on the *Plan Provider ID* field) associated with the encounter data received from AHCA did not match the corresponding enrollees' plan enrollment. AHCA noted that the *Plan Provider ID* field is a plan-submitted field and indicated that while an edit was in place for data received from the plans, the edit was infrequently applied. Consequently, these types of inconsistencies with the incoming data were not detected and were reported consistently.
- A few plans appeared to have "duplicate" records in AHCA's data (i.e., the number of records received from AHCA was higher than the number of records submitted by the plans for the study). However, while the ICNs were different for the "duplicate" encounter records, the TCNs and the corresponding values in each of the data elements appeared to have the same values. AHCA noted that the ICNs were assigned according to an algorithm based on the type of transaction and how they were received (e.g., original encounter submission, adjustment of paid/accepted encounter, encounter resubmission, denied encounter). If a plan submits an adjustment for a paid/approved encounter, AHCA noted that it is able to use the *Latest Paid Claim* indicator in its database (i.e., final status). However, AHCA also noted that it is not able to determine the final status for resubmissions of denied encounters. As such, to remove the apparent "duplicates," it would be necessary to run additional de-duplication logic on the encounter submissions based on combinations of fields (e.g., *Recipient ID*, *Date of Service*, and *Procedure Code*). However, since the goal of the EDV study is to determine the accuracy and completeness of AHCA's encounter data when compared to the data from the plans' claims systems, any manipulation to data received from either source was not recommended for the purpose of the study.

Examination of the volume of encounters submitted each month provided additional insights into potential problems with data completeness. Figure E-1 in Appendix E provides the overall dental encounter volume trends over time by the plans and AHCA. While AHCA's encounter data showed consistently greater encounter data volume than the volume submitted by the plans, month-to-month volume trends were relatively consistent between both data sources.

Encounter Field Completeness and Reasonableness

To determine the completeness and reasonableness of AHCA's and the plans' electronic claims/encounter data, HSAG examined the percentage of key data fields (e.g., *Provider NPI* and *Dental Procedure Code*) that contained data and were populated with expected values. The study was restricted to specific criteria with the assumption that encounters received from both sources were in their final status as requested in the data submission requirements document. Key data fields with missing values were evaluated for completeness but did not contribute to the calculations for accuracy (i.e., percent missing and percent valid). Accuracy rates were assessed based on whether submitted values were in the correct format and the data fields contained expected values (percent valid). For example, a record where the *Billing Provider ID* was populated with a value of "000000000" would be considered to have a value present but not to have a valid value.

Dental encounter data element completeness varied considerably between the two data sources (plans' versus AHCA's submissions). In general, AHCA submitted more complete encounters with relatively low percent missing rates for evaluated data elements. Differences were observed between data sources for the completeness of provider-related data elements. Plans consistently submitted records with missing values for *Billing* and *Rendering Provider ID* fields. *Billing* and *Rendering Provider NPI* fields, and the *Dental Procedure Code* field, however, had relatively small missing values across both plans' and AHCA's submitted encounters. It is important to note that while the provider Medicaid IDs were requested from AHCA and the plans for the EDV study, these fields were not required to be submitted to AHCA for providers who qualify for an NPI.

The validity of data elements associated with the dental encounter type was relatively high among the two data sources for all evaluated data elements except for the *Billing Provider ID* from the plan-based submissions. Four plans that submitted *Billing Provider ID* values showed that none of the submitted values were valid Medicaid ID values.

Comparative Analysis

The comparative analysis component of the study examined the extent to which encounters submitted by the plans and maintained in FMMIS (and 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 the dental record-level matching varied from plan to plan and generally included the enrollee's identification number, the ICN, and a numeric sequence number. These data elements were concatenated to create a unique match key, which became the unique identifier for each encounter detail line in AHCA's and each plan's data.

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 is missing from the secondary data source. For this analysis, the omission rate identifies the percentage of encounters reported by a plan that is 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 is missing from the primary data source (plan).

Table 3-29 highlights the 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). While results were classified by the three encounter types, it should be noted that the number of dental services identified from the institutional and professional encounter types was minimal.

Table 3-29—Record Omission and Surplus Rates by Plan and Encounter Type

	Dental Encounters		Institutional Encounters[1]		Professional Encounters[1]	
Plan	Omission	Surplus	Omission	Surplus	Omission	Surplus
AMG-M	1.5%	2.8%	0.0%	0.0%	8.8%	0.0%
BET-M	< 0.1%	19.4%	0.0%	85.4%	—	—
CCP-M	0.1%	0.5%	—	—	—	—
CHA-S	0.0%	8.4%	—	—	—	—
CMS-S	0.9%	38.9%	0.0%	10.8%	0.0%	0.0%
COV-M	0.9%	2.2%	—	—	0.0%	0.0%
HUM-M	0.6%	24.8%	0.0%	60.0%	0.0%	8.8%
MCC-S	11.0%	4.2%	—	—	—	—
MOL-M	< 0.1%	8.9%	11.0%	51.2%	0.0%	0.0%
PRS-M	2.4%	2.8%	73.7%	0.0%	10.9%	5.5%
SHP-M	< 0.1%	13.0%	0.0%	87.5%	—	—
STW-M	0.2%	19.7%	—	100.0%	—	100.0%
SUN-M	33.8%	28.5%	—	100.0%	29.2%	4.2%
SUN-S	49.8%	23.5%	—	100.0%	40.6%	0.0%

	Dental Encounters		Institutional Encounters[1]		Professional Encounters[1]	
Plan	Omission	Surplus	Omission	Surplus	Omission	Surplus
URA-M	10.6%	10.2%	75.0%	5.6%	—	100.0%
All Plans	**9.3%**	**16.6%**	**28.1%**	**55.0%**	**13.2%**	**56.4%**
Maximum	**49.8%**	**38.9%**	**75.0%**	**100.0%**	**40.6%**	**100.0%**
Minimum	**0.0%**	**0.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**

[1] While dental procedure codes were also identified from these encounter types (i.e., institutional and professional), the number of records was minimal; therefore, rates should be interpreted with caution.
"—" denotes there were no dental services identified from the specified encounter type.

The overall record omission rates for dental services varied across the three encounter types, with the dental encounter type having the lowest record omission rate of 9.3 percent, and the institutional encounter type having the highest record omission rate of 28.1 percent.

Similarly, the overall record surplus rates also varied across the three encounter types, with the dental encounter type having the lowest record surplus rate of 16.6 percent, while both the institutional and professional encounter types showed surplus rates greater than 50 percent. As noted in the "Encounter Data File Review" section of this report, the high surplus rates across all encounter types were attributed to records that appeared to be "duplicate" records from AHCA's encounter data submission. As previously described, while AHCA has the ability to track the final status of plan submissions related to an adjustment of paid/approved encounters, other types of submissions (e.g., resubmissions of denied encounters) may appear to be "duplicate" encounters.

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

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 results are presented by key data element and evaluate completeness based on the percentage of records with 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. The data elements are considered relatively complete when they have low element omission and surplus rates.

Table 3-30 presents the results of the two aspects of encounter data element completeness (i.e., encounter data element omission and surplus, respectively) and describes the extent to which key data elements are present in AHCA's data systems. The plan ranges for element omission and surplus rates are also presented.

Table 3-30—Element Omission and Surplus Summary

	Element Omission		Element Surplus	
Key Data Elements	**Overall Rate**	**Plan Range**	**Overall Rate**	**Plan Range**
Line First Date of Service	0.0%	All plans exhibited 0.0%	0.0%	All plans exhibited 0.0%
Line Last Date of Service	0.0%	All plans exhibited 0.0%	0.0%	All plans exhibited 0.0%
Billing Provider ID	0.1%	0.0% – 1.0%	68.6%	0.0% – 100.0%
Billing Provider NPI	0.4%	0.0% – 1.5%	8.1%	0.0% – 99.5%
Rendering Provider ID	0.1%	0.0% – 0.7%	89.4%	0.0% – 100.0%
Rendering Provider NPI	0.4%	0.0% – 7.0%	7.8%	0.0% – 26.8%
Procedure Code	0.0%	All plans exhibited 0.0%	0.0%	All plans exhibited 0.0%
Units	0.0%	All plans exhibited 0.0%	23.0%	0.0% – > 99.9%
Mouth Quadrant	8.5%	0.0% – 50.9%	1.1%	0.0% – 76.4%
Tooth Number	1.3%	0.0% – 76.5%	< 0.1%	0.0% – 0.1%
Tooth Surface 1	7.6%	3.4% – 10.8%	0.2%	0.0% – 1.4%
Tooth Surface 2	3.6%	0.0% – 7.0%	0.4%	0.0% – 3.3%
Tooth Surface 3	0.9%	0.0% – 2.1%	0.3%	0.0% – 1.4%
Tooth Surface 4	0.2%	0.0% – 0.4%	0.2%	0.0% – 0.5%
Tooth Surface 5	< 0.1%	0.0% – 0.2%	0.4%	0.0% – 0.8%
Tooth Surface 6	0.0%	All plans exhibited 0.0%	0.4%	0.0% – 0.9%
Amount Paid	0.0%	All plans exhibited 0.0%	< 0.1%	0.0% – < 0.1%

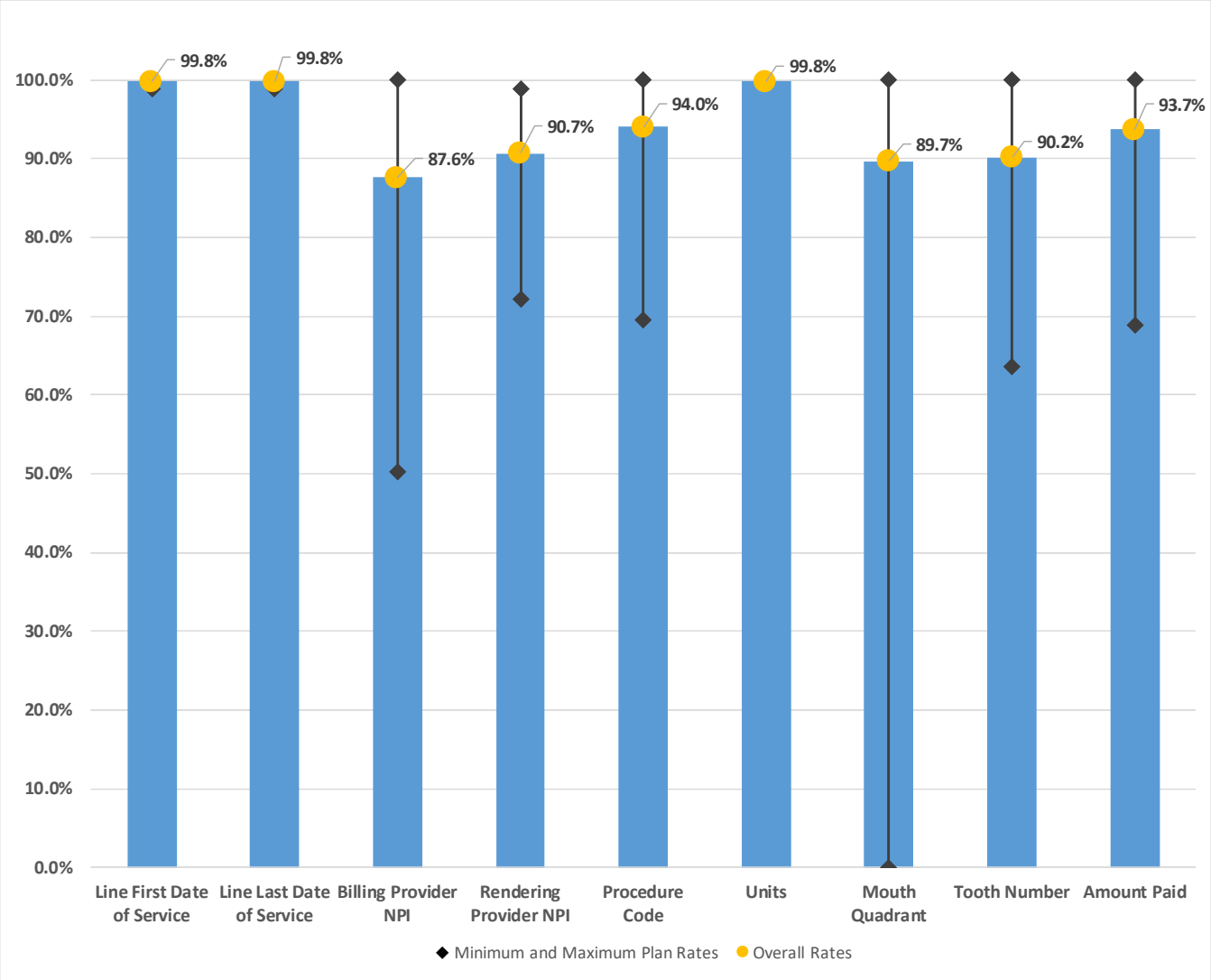
Overall, among encounters that could be matched between AHCA's and the plans' submitted dental encounter data for dental services, a high level of completeness (i.e., low overall omission and surplus rates) was exhibited, with a few exceptions. A high level of completeness was observed for the following data elements: *Line First Date of Service*; *Line Last Date of Service*; *Procedure Code*; *Tooth Number*; *Tooth Surface 3, 4, 5,* and *6*; and *Amount Paid*. Data elements associated with less completeness were generally attributed to provider ID data elements (i.e., *Billing Provider ID* and *Rendering Provider ID*).

Data Element Completeness—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 which both data sources 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 presents the overall agreement rates for each of the evaluated key data elements for dental encounters. 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 the plans' submitted encounter data was relatively high for key data elements such as *Rendering Provider NPI*, *Procedure Code*, *Units*, and *Tooth Number*, which showed at least 90.0 percent agreement. This finding suggests that encounter data elements between AHCA's and the plans' submitted encounter data have the same values when populated.

Clinical Record Review

Clinical records (including dental records) are considered the "gold standard" for documenting Medicaid enrollees' access to and quality of services. The file review and comparative analysis portions of this study seek first to determine the completeness and validity of AHCA's encounter data and then 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 clinical records for Medicaid enrollees.

Enrollees' clinical information was matched across data sources (AHCA's encounters and physician-submitted dental records) using a unique combination of the enrollee's Medicaid ID and the identification number of the rendering provider for the specific date of service. This section presents findings from the results of the dental record review to examine the extent to which services documented in dental records 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 dental records (dental record omission).

Encounter Data Completeness

HSAG evaluated encounter data completeness by identifying differences between key data elements from AHCA-based dental encounters and the corresponding dental records submitted for the analysis. These data elements included *Date of Service* and *Dental Procedure Code*. 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 omission occurred when an encounter data element (i.e., *Date of Service* or *Dental Procedure Code*) was not documented in the dental record associated with a 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 omission occurred when an encounter data element (i.e., *Dental Procedure Code*) was documented in the dental record but not found in the associated AHCA encounter. Encounter 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 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 3-31 displays the medical record and encounter data omission rates for *Date of Service* and *Dental Procedure Code* key data elements.

Table 3-31—Encounter Data Completeness Summary

	Medical Record Omission Rate		Encounter Data Omission Rate	
Key Data Elements	Statewide Rate	Plan Range	Statewide Rate	Plan Range
Date of Service	0.6%	0.0% – 1.7%		
Dental Procedure Code	5.4%	1.7% – 8.5%	9.1%	3.3% – 20.5%

The medical record omission rate associated with the date of service was 0.6 percent, with only 10 out of 1,705 cases reviewed not having dates of service supported by corresponding dental records. Reviews of the submitted dental records for these 10 cases indicated that chart notes had no supporting documentation to show dental treatments were provided on the sampled date of service. While the medical record omission rate for the date of service was low, the *Dental Procedure Code* data element exhibited a slightly higher rate of omission (5.4 percent). The encounter data omission rate of 9.1 percent for the *Dental Procedure Code* data element was nearly doubled compared to the medical record omission rate. This finding suggests that not all services documented in enrollees' dental records were submitted to or processed and stored by AHCA.

Encounter Data Accuracy

Encounter data accuracy was evaluated for dates of service that existed in both AHCA's records and the submitted dental records, with values present in both data sources for the evaluated data element. HSAG considered the encounter data element (i.e., *Dental Procedure Code*) accurate if documentation in the dental record supported the values contained in the electronic encounter data. Higher accuracy rates for each data element indicate better performance.

Table 3-32 displays the encounter data element accuracy rates associated with the dental services.

Table 3-32—Encounter Data Element Accuracy Summary

Key Data Elements	Statewide Rate	Plan Range
Dental Procedure Code	93.9%	87.4% – 98.3%
All-Element Accuracy	54.3%	43.3% – 63.9%

The assessment of the procedure codes associated with validated dates of service from the encounter data that were correctly coded on the enrollees' medical records revealed a high overall accuracy rate of 93.9 percent. Additionally, the *Dental Procedure Code* accuracy rates showed minimal variation across plans, with rates ranging from 87.4 percent to 98.3 percent. While the individual procedure code accuracy rate was high, the overall percentage of dates of service having procedure codes documented accurately (i.e., not omitted or coded correctly) was only 54.3 percent. 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.

Conclusions and 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 are related to AHCA's inability to process the encounter data based on the criteria specified for the study (i.e., preparation of the data), high rates of omission, surplus, and errors, coupled with variation between plans, suggest systemic issues with the transmission of data between the plans and FMMIS. To ensure the quality of encounter data submissions from contracted plans, the following recommendations have been identified to address potential opportunities for improvement.

- AHCA should continue to work with the plans and monitor the submission of the *Plan Provider ID* field to ensure the accuracy of the submitted field. Additionally, while AHCA noted that edits are in place, implementation of the edits should be consistently applied and reported. Accurate attribution of the enrollees' encounters to their assigned plans is critical to ensuring complete and accurate federal and State encounter-based reporting of plan and program performance.
- AHCA should work with the FMMIS data vendor to develop a standardized process to track and identify the final adjudication record of an encounter. AHCA and its data vendor should develop an algorithm that is in alignment with the assignment of the ICNs according to the type of encounter transaction and how the encounter was received. AHCA should also consider enhancing current submission requirements to ensure adjusted encounters are submitted appropriately to better identify the final status records in AHCA's encounter data. By having a standardized process, AHCA can ensure the consistency of data extraction as well as production of analytic data files for use in other units that potentially impact the State's encounter-based reporting.
- While plans are required to submit the provider NPI, the provider Medicaid ID should only be submitted by non-healthcare providers who cannot obtain an NPI. AHCA should work with the plans in ensuring accurate processing of provider information within the plans' systems. Plans may have provider data stored in separate data systems (e.g., a credentialing database versus a billing database) because of subcontracting and delegation arrangements for oversight of provider information. If plans used different data systems for provider credentialing, provider billing, and claims processing, formal policies and procedures may not exist regarding the reconciliation of provider information across data systems. The use of multiple data systems increases the likelihood of discrepancies in provider data between sources.
- AHCA should consider requiring the plans to audit provider encounter submissions for completeness and accuracy. AHCA may want to require the plans to develop periodic provider education related to dental record documentation and coding practices. These activities should include a review of both State and national coding standards, especially for new providers contracted with the plans. In addition, AHCA should consider requiring the plans to perform periodic reviews of submitted claims to verify appropriate coding and completeness to ensure encounter data quality.

Child Health Check-Up Participation Rates

Child Health Check-Up (CHCUP)

The federal CMS-416 report, which reports on children's utilization of services, is due to CMS on April 1 of each year. To increase the accuracy of the report and avoid duplication, AHCA worked with CMS to refine the data collection process to eliminate potential duplication of eligible recipients in the reported data by comparing FFS claims and encounter data.

CHCUP Targets

MMA plans, by contract and state law, must achieve a child health check-up screening rate of at least 80 percent for those enrollees who are continuously enrolled in the plan for at least eight months during the federal fiscal year (FFY) (October 1–September 30). The screening rate indicates the percentage of children that receive the number of initial and periodic screening services required by Florida's periodicity schedule, and is based on the data reported by the MMA plan in its audited CHCUP (CMS-416) and Florida 80% Screening Report that is due annually to AHCA. This requirement increased from 60 percent under the previous plan contract to 80 percent under the MMA contract. For each FFY that the MMA plan does not achieve the 80 percent screening rate, AHCA may require a CAP to be submitted and may assess liquidated damages.

In addition, the contract and CMS require that plans achieve at least an 80 percent CHCUP participation rate. The participation rate indicates the percentage of children that receive any initial and periodic screening services during the FFY and will be based on the data reported by the MMA plan in its audited CHCUP (CMS-416) and Florida 80% Screening Report that is due annually to AHCA. For each FFY that the MMA plan does not meet the 80 percent participation rate, AHCA may require a CAP to be submitted and may assess liquidated damages.

The MMA plan must also achieve a preventive dental services rate of at least 28 percent for those enrollees who are continuously eligible for CHCUP for 90 continuous days. This rate is based on the CHCUP data reported by the MMA plan in its CHCUP (CMS-416) audited report that is due annually to AHCA. Beginning with the FFY 2015 report, failure to meet the 28 percent preventive dental services rate may result in a CAP and liquidated damages.

Medicaid Health Plan Report Card

The Special Terms and Conditions of the MMA program 1115 waiver require that Florida create a health plan report card that must be posted on the State's website and present an easily understandable summary of quality, access, and timeliness of care based on performance data for each MMA plan. Recipients can use this information to compare plans and help them to decide which plan to choose.

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

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

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 has published three report cards. The current Medicaid Health Plan Report Card, published in fall 2017, is based on HEDIS 2017 data (i.e., CY 2016 data reported in 2017) and includes plan performance data for services provided under the MMA plan contracts. The SMMC Report Card can be accessed on the following website:
http://www.floridahealthfinder.gov/HealthPlans/Compare.aspx?typcd=MRC

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

MCO 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. All plans participating in the SMMC program are accredited (eight with NCQA, eight with AAAHC).

Consumer Assessment of Healthcare Providers and Systems Surveys

CAHPS surveys ask enrollees to report on and evaluate their experiences with healthcare and their health plan. CAHPS surveys are developed and maintained by the Agency for Healthcare Research and Quality (AHRQ). These confidential, standardized surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as customer service and ease of access to healthcare services.

MMA plans are contractually required to contract with an NCQA-certified CAHPS survey vendor to conduct the CAHPS Health Plan Survey each year. The surveys must be conducted according to NCQA's mixed mode protocol (mail with telephone follow-up), and plans must field an adult survey (for enrollees 18 years of age and older) and a child survey (for parents to report on the experience of a child 17 years of age or younger). To ensure that the CAHPS surveys reflect the experience of a diverse population, all surveys must be available in English and Spanish. The survey vendors are required to pull a systematic sample of enrollees to whom the surveys will be mailed, which only includes those enrollees who have been continuously enrolled in the plan for six months prior to the start of the survey. In 2016, the required adult Medicaid sample size was 1,350 and the child Medicaid sample size was 1,650.

Plans are required to report their certified results to AHCA annually. Beginning with the 2016 survey, plans were also required to report their results to NCQA so they may be included in the National Medicaid Means and Percentiles. The results of these surveys are posted on AHCA's FloridaHealthFinder.gov website so that Medicaid enrollees may use the survey results to compare plans when making enrollment decisions.

Rating of Health Plan

The CAHPS survey asks enrollees to rate their plan on a scale from 0 to 10, with 0 being the worst plan possible and 10 being the best plan possible. In the 2016 MMA survey, 73 percent of adults gave their plans ratings of 8 to 10. Among parents of children enrolled in MMA plans, 84 percent rated their children's plans an 8, 9, or 10 out of 10.

Rating of Health Care

CAHPS survey respondents are asked to rate their healthcare on a scale of 0 to 10, with 0 being the worst care possible and 10 being the best healthcare possible. In 2016, 75 percent of adults in the MMA plans rated their healthcare an 8, 9, or 10. In the 2016 child surveys, 86 percent of parents rated their children's healthcare an 8, 9, or 10.

Getting Needed Care and Getting Care Quickly

CAHPS survey respondents are asked about ease of getting specialist appointments and getting care, tests, or treatment they need through the respondent's plan. These two survey items ask how often the respondent got an appointment to see a specialist as soon as he/she needed it and how often it was easy to get the care, tests, or treatment he/she needed. The response categories for these items are Never, Sometimes, Usually, and Always. A composite called "Ease in Getting Needed Care" averages the responses for these two survey items. In the 2016 adult surveys, 80 percent of adults reported it was usually or always easy to get needed care, while in the 2016 child surveys, 83 percent of parents reported that it was usually or always easy to get needed care for their children.

Getting Care Quickly

CAHPS survey respondents are asked about how often they received care as soon as they needed it in both urgent and non-urgent/routine situations. The two survey items are averaged to make a composite score. The response categories for these items are Never, Sometimes, Usually, and Always. In the surveys of adults, 82 percent in 2016 reported that it was usually or always easy to get care as soon as they needed it. In the child surveys, 89 percent of parents reported that it was usually or always easy to get care as soon as their children needed it in 2016.

Getting Help From Customer Service

CAHPS survey respondents are asked how often their plan's customer service gave them the information or help they needed and how often the customer service staff treated them with courtesy and respect. The response categories for these two items are Never, Sometimes, Usually, and Always. The responses to the two items are averaged into one composite score. In the 2016 surveys, 88 percent of adults reported that they usually or always received the information and help they needed from their plan's customer service staff, and 88 percent of parents reported that they usually or always received the information and help they needed from the customer service staff of their children's plan.

LTC Enrollee Satisfaction Survey

LTC plans are required to conduct an annual enrollee satisfaction survey using the Enrollee Survey for Long-term Care plans and following the Survey Administration Guidelines created by AHCA. This confidential survey assesses experience with care for LTC enrollees residing in the community. The third LTC enrollee satisfaction survey (fielded in spring 2016) and subsequent submissions are due to AHCA by July 1 of each year.

LTC plans are required to contract with an AHCA-approved independent survey vendor to administer the surveys with a minimum sample size of 1,700 and a target of 411 completed surveys. The survey must be administered according to the NCQA mixed mode protocol (mail with telephone follow-up). LTC plans are required to use the core LTC Plan Enrollee Survey. Plans are able to add questions to the end of the core survey. Additional questions must be submitted to AHCA for review and approval prior to being included in the survey.

To be included in the survey sample, enrollees must have been enrolled in the LTC plan for at least six months with no more than a one-month gap in enrollment. Enrollees can have someone help them fill out the survey if needed.

Table 3-33 lists the 2016 statewide LTC enrollee survey results:

Table 3-33—2016 LTC Enrollee Survey Results

Survey Measure	Statewide Rate
LTC Plan Rating (% rating plan an 8, 9, or 10 on a 0–10 scale)	78%
Contacting Case Manager (% reporting usually or always easy)	80%
Case Manager Rating (% rating case manager an 8, 9, or 10 on a 0–10 scale)	81%
Timeliness of Services (% reporting usually or always on time)	89%
LTC Services Rating (% rating LTC services an 8, 9, or 10 on a 0–10 scale)	80%
Overall Health—Improved Since Enrolled in LTC Plan	60%
Quality of Life—Improved Since Enrolled in LTC Plan	76%

Appendix A. Methodologies for Conducting EQR Activities

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 §438.330(b)(1). 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 Balanced Budget Act of 1997 (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.[A-1] The primary objective of the PIP validation was to determine compliance with requirements set forth in 42 CFR §438. 330(b)(1), 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 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 were taken from the HSAG PIP Summary Forms completed by the plans and submitted to HSAG in August 2016. The plans submitted Remeasurement 1 study indicator results during this validation cycle, and the PIPs had progressed through the Design, Implementation, and Outcome stages.

[A-1] 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: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Jan 26, 2018.

Technical Methods of Data Collection/Analysis

The methodology HSAG used to validate the PIPs was based on CMS' 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.

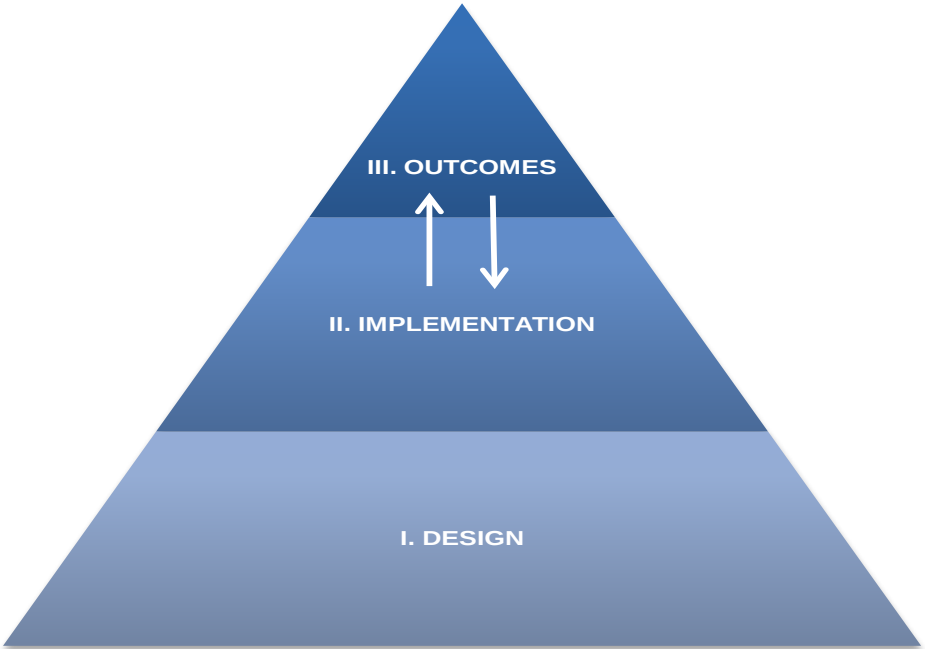
HSAG obtained the data needed to conduct the PIP validation from the plans' PIP Summary Forms. These forms provided detailed information about each plan's PIPs related to the activities completed by the plan and evaluated by HSAG for the SFY 2016–2017 validation cycle.

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 remeasure 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). This included reviewing the independent auditing process to ensure key audit activities were performed, and verifying that 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-licensed organizations (LOs). To avoid any redundancy in the auditing process, HSAG evaluated the NCQA HEDIS Compliance Audit process for consistency with the CMS protocol. AHCA required that the LTC plans undergo a PMV audit conducted by an external audit firm in accordance with the CMS protocol. However, since some of the measures required to be reported follow the HEDIS measure specifications, AHCA intended that an NCQA HEDIS Compliance Audit be conducted to the extent possible. Based on FAR reviews, HSAG found that for the current year, all LTC plans' audits were conducted following the NCQA HEDIS Compliance Audit policies and procedures.

Description of Data Obtained

Since all the plans' audits were performed by LOs during SFY 2016–2017, HSAG's role was to determine the extent to which the measures reported were calculated according to AHCA's specifications. HSAG conducted its PMV activity for these plans during SFY 2017–2018. In general, three primary data sources were used to conduct the PMV audits: the Record of Administration, Data Management, and Processes (Roadmap), the 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 requested the performance measure report and FAR generated by the LO for each plan. These documents, which were used and/or generated by the plans and their auditors during the NCQA HEDIS Compliance Audit, were reviewed by HSAG to verify 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 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.
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.

PMV Step	Associated Activities Performed by HSAG
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.

HSAG requested the FAR and performance measure report generated by the auditor for each LTC plan. 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 plan's LO.

HSAG reviewed the FARs and the performance measure reports to verify the extent to which critical audit activities were performed. The review included the following PMV activities for the LTC plans:

- Verify that key audit elements were performed by the plan's LO to ensure the audit was conducted in compliance with 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' 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.*[A-2]

[A-2] Agency for Health Care Administration. Statewide Medicaid Managed Care (SMMC) Managed Care Plan Report Guide Effective 10-1-16. Available at: https://ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/Report_Guides/Oct_2016/SMMC_Report_Guide_effective_10012016.pdf. Accessed on: Mar 4, 2018.

Encounter Data Validation

During SFY 2016–2017, AHCA contracted with HSAG to conduct an EDV study. The goal of the study was to examine the extent to which dental encounters submitted to AHCA by its contracted SMMC plans, including MMA and Specialty plans (collectively referred to as "plans" in this section), are complete and accurate.

Objectives

The SFY 2016–2017 study is a follow-up to the dental services component of the encounter data validation study conducted in SFY 2015–2016. The study was designed to produce actionable, valuable findings that will lead to recommendations to improve known areas of discrepancy in the encounter data submitted to AHCA by the plans. The SFY 2016–2017 study focused its review on all dental encounters with CDT codes for children under the age of 21.

To assess the quality of the dental encounters submitted to AHCA by the plans, the SFY 2016–2017 EDV study included two evaluation components:

- Administrative and comparative data analysis of encounter data
- Clinical record review

Description of Data Obtained

Based on activities defined in CMS' *EQR Protocol 4: Validation of Encounter Data Reported by the MCO: A Voluntary Protocol for External Quality Review (EQR),* Version 2.0, September 2012[A-3] (i.e., analyses of plan electronic encounter data for accuracy and completeness), the administrative and 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. This component of the analysis examined dental encounters with dates of service between January 1, 2016, and June 30, 2016.

The administrative and comparative analysis involved three key steps:

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

[A-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 4 Validation of Encounter Data Reported by the MCO: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-4.pdf. Accessed on: Feb 2, 2018.

HSAG prepared and submitted data submission requirements documents to AHCA and the plans in November 2016 and March 2017, respectively. These documents included a brief description of the SFY 2016–2017 EDV study, a description of the review period, requested encounter data types, required data elements, and 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, 2016, and June 30, 2016, that were submitted to AHCA before December 1, 2016, to HSAG for processing. The requested data were limited to encounters in their final status and excluded encounters associated with interim adjustment history. While the study was restricted to enrollees under the age of 21, HSAG requested that both AHCA and the plans submit dental encounters regardless of the enrollee's age. The request was designed so that HSAG could perform the calculation and restriction of enrollees' age specifications to maintain consistency throughout all data sources.

HSAG conducted multiple TA sessions with AHCA and the plans to facilitate accurate and timely submission of data. For the plans, HSAG held two TA sessions after distributing the data submission requirements documents, allowing the plans time to review and prepare questions in advance of the sessions. During these TA sessions, HSAG's EDV team introduced the SFY 2016–2017 EDV study and reviewed the data submission requirements to ensure that all questions related to data preparation and extraction were addressed. Following completion of the TA 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. Additionally, HSAG collaborated with AHCA staff to review the data request documents as well as 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 volume of 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 TA 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 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 that all encounter data were submitted according to the requested file layouts, the file review evaluated the following indicators:

- **Percent Present**—*required data fields were present on the file and have information in those fields.*
- **Percent Valid**—*data fields were of the required type—e.g., numeric fields have numbers, character fields have characters.*
- **Percent Valid Values**—*the values contained the expected values—e.g., valid CDT codes in the procedure code 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 AHCA, 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 comparative analysis was divided into two analytic components. First, for each encounter data type, 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 that were not found 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*, *Procedure Code*, *Units*, *Mouth Quadrant*, *Tooth Number*, *Tooth Surface*, *Provider Information*, 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 Surplus**—the number and percentage of records with values present in the files submitted by AHCA but not in files submitted by the plans.
- **Element Agreement**—the number and percentage of records for which the files submitted by AHCA and the files submitted by the plans contained the exact same values. The evaluation of the element agreement was limited to those records with values present in both AHCA's and the plans' submitted files.

Clinical Record Review

Clinical records (e.g., dental records) are considered the "gold standard" for documenting access to and the quality of healthcare services. The second component of the EDV study was an assessment of the completeness and accuracy of the plans' encounter data through a review of these records.

Key data elements associated with dental services that were evaluated in the clinical record review included:

- Date of service.
- CDT procedure code.

To be eligible for the clinical record review, an enrollee must have been under the age of 21; must have been enrolled in a plan as of June 30, 2016; and must have had at least one visit during the study period (January 1, 2016–June 30, 2016). In addition, the enrollee must have been continuously enrolled in the same plan between January 1, 2016, and June 30, 2016, with no gaps.

Technical Methods of Data Collection/Analysis

Encounter, enrollment, and provider data from AHCA used in the administrative and comparative analyses were also used 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) one date of service associated with the sampled enrollee was selected. First, HSAG identified all enrollees by plan based on the total enrollees receiving dental services. HSAG then randomly selected the enrollees and identified all dental encounters associated with these sampled enrollees. From these encounters, one date of service was randomly selected as the final sampled encounter per sampled enrollee. Based on the scope of work, HSAG was to maintain a total of 1,696 records to be reviewed for the clinical record review component of the study. Upon reviewing the number of cases eligible for the study from each participating plan, it was determined that Clear Health Alliance had only 25 eligible cases. Since all Clear Health Alliance eligible cases had to be included in the study, the number of cases for the remaining 14 plans had to be adjusted accordingly to ensure that a minimum of 1,696 total cases were reviewed. As such, the final sample used in the evaluation consisted of 25 cases for Clear Health Alliance and 120 cases randomly selected per plan for the remaining 14 plans, for a total of 1,705 cases reviewed. An additional 25 percent oversample (or 30 cases per plan) was selected to replace records not procured. As a result, the 14 plans with an adequate number of cases eligible for the study were responsible for procuring 150 total sampled enrollees' dental records per plan (i.e., 120 sample and 30 oversample) from their contracted providers for services that occurred during the study period.

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 the clinical record procurement procedures. To maximize its procurement rate, HSAG also conducted two TA sessions with the participating plans. During these sessions, HSAG reviewed the scope of the project and procurement protocols.

Upon receiving the sample lists, 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 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 (IRR) and rate-to-standard testing. All reviewers had to achieve a 95 percent accuracy rate before they were allowed to review and abstract clinical records and continue collecting data for the study. Additionally, during the abstraction period, HSAG conducted an ongoing IRR assessment by randomly selecting a minimum of 25 percent of cases and comparing the first reviewer results to those from a second reviewer. For cases in which review discrepancies were identified between the first and second reviewers, a third "Gold Standard" review was conducted by a nurse manager and provided a final determination regarding the appropriate result. A total of 460 cases underwent a second review for IRR (27.0 percent of the sample), and 28 cases underwent a third review (1.6 percent of the sample). To ensure consistency and accuracy among the abstractors, several discussions were held with the nurse manager to review cases and determine the appropriate response based on the documentation in the dental records. This allowed the nurse manager to evaluate the abstractor's level of understanding and provide immediate feedback. Abstractors maintained a 95 percent accuracy rate throughout the abstraction review period.

During the medical record review, trained reviewers first verified whether the sampled date of service could be found in the enrollee's clinical 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*. If the date of service matched the State's encounter data, the reviewers then examined the services provided on the selected date of service and validated the key encounter data elements. All findings were entered into an electronic clinical record abstraction tool to ensure data integrity.

Clinical Record Review Indicators

Once the clinical record abstraction was completed, HSAG's analysts exported the abstraction data from the electronic record abstraction tool, reviewed the data, and conducted the analysis for each participating plan. HSAG developed the following study indicators to report the clinical review results:

- **Medical Record Omission**—the percentage of dates of service identified in the electronic encounter data that were not found in the enrollees' clinical records. HSAG also calculated this rate for the CDT procedure code.
- **Encounter Data Omission**—the percentage of CDT procedure codes that were not found in the electronic encounter data.
- **Coding Accuracy**—the percentage of procedure codes associated with validated dates of service from the electronic encounter data that were correctly coded on the enrollees' medical records.
- **Overall Accuracy**—the percentage of dates of service with all data elements coded correctly among all validated dates of service from the electronic encounter data.

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

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*	*60% / 70% / Not Met*
	Improving Rates of CD4 and Viral Load Testing	*57% /60% / Not Met*
	Improving Satisfaction with Cultural and Language Services for People Living with HIV/AIDS	*68% / 69% / Not Met*
	Reducing Avoidable Emergency Room Visits	*61% / 67% / Not Met*
Amerigroup Community Care	*Improving Overall Member Satisfaction*	*70% / 77% / Not Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*71% / 69% / Partially Met*
	Improving Medication Management for People with Asthma	*60% / 70% / Not Met*
	Preventive Dental Services for Children	*65% / 70% / Not Met*
Better Health	*Improve Member Satisfaction*	*85% / 83% / Not Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*79% / 77% / Partially Met*
	Preventive Dental Services for Children	*90% / 90% / Partially Met*
	Reduce All-Cause Hospital Readmissions Within 30 Days	*80% / 80% / Not Met*

Plan Name	PIP Topic	Validation Scores and Status
Children's Medical Services Network	*Decreasing Behavioral Health Readmission Rates*	*64% / 73% / Not Met*
	Improving Call Center Timeliness	*60% / 70% / Not Met*
	Preventive Dental Services for Children	*70% / 80% / Partially Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*50% / 60% / Not Met*
Clear Health Alliance	*Behavioral Health Screening of CHA Members by a PCP*	*86% / 90% / Partially Met*
	Improve Member Satisfaction	*85% / 83% / Not Met*
	Improving the Percentage of Enrollees Receiving 2 or More HIV-Related Outpatient Medical Visits at Least 182 Days Apart	*85% / 90% / Partially Met*
	Preventive Dental Services for Children	*85% / 90% / Partially Met*
Coventry Health Care of Florida, Inc.	*Improving Member Management of Diabetes*	*75% / 69% / Not Met*
	Improving Member Satisfaction	*85% / 85% / Not Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*75% / 77% / Partially Met*
	Preventive Dental Services for Children	*85% / 80% / Partially Met*
Freedom Health, Inc.	*Care for Older Adults (COA)—Advance Care Planning*	*87% / 89% / Not Met*
	Comprehensive Diabetes Care (CDC)—HbA1c Poor Control > 9%	*81% / 89% / Not Met*
	Comprehensive Diabetes Care (CDC)—HbA1c Testing	*81% / 89% / Not Met*
	Plan All-Cause Readmissions (PCR)	*87% / 100% / Met*
Humana Medical Plan, Inc.	*Electronic Health Record with Meaningful Use*	*76% / 82% / Partially Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*68% / 62% / Not Met*
	Integrating Primary Care and Behavioral Health in Antidepressant Medication Management	*85% / 80% / Not Met*
	Preventive Dental Services for Children	*90% / 90% / Partially Met*

Plan Name	PIP Topic	Validation Scores and Status
Magellan Complete Care	*Improving Diabetes Screening Rates for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	*93% / 100% / Met*
	Increase the Rate of Adult Member's Overall Satisfaction (CAHPS)	*74% / 83% / Not Met*
	Plan All-Cause Readmissions (PCR)	*93% / 100% / Met*
	Preventive Dental Services for Children	*85% / 90% / Partially Met*
Molina Healthcare of Florida, Inc.	*Improving the Rate of Asthmatic Children Using Controller Medications*	*60% / 50% / Not Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*71% / 69% / Not Met*
	Practitioner Satisfaction	*79% / 85% / Not Met*
	Preventive Dental Services for Children	*55% / 50% / Not Met*
Prestige Health Choice	*Improve Rates for HbA1c Testing and Compliance Among Diabetics*	*93% / 100% / Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*86% / 85% / Partially Met*
	Overall Health Plan Rating Via CAHPS® 5.0H Adult Medicaid Survey	*81% / 77% / Not Met*
	Preventive Dental Services for Children	*55% / 60% / Not Met*
Simply Healthcare Plans, Inc.	*Improve Member Satisfaction*	*88% / 83% / Not Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*86% / 85% / Partially Met*
	Preventive Dental Services for Children	*90% / 90% / Partially Met*
	Reduce All-Cause Hospital Readmissions Within 30 Days	*81% / 80% / Not Met*

Plan Name	PIP Topic	Validation Scores and Status
South Florida Community Care Network	*Improving the Number of Health Risk Assessments*	*70% / 70% / Partially Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*86% / 92% / Partially Met*
	Increasing the Diabetic Retinal Examination Rate for Enrollees	*84% / 80% / Partially Met*
	Preventive Dental Services for Children	*80% / 80% / Partially Met*
Sunshine State Health Plan, Inc.	*Comprehensive Diabetic Care—Duval County*	*73% / 73% / Not Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*86% / 85% / Not Met*
	Member Satisfaction	*67% / 62% / Not Met*
	Preventive Dental Services for Children	*75% / 80% / Not Met*
United Healthcare of Florida, Inc.	*Annual Diabetic Retinal Eye Exam*	*86% / 91% / Partially Met*
	Call Answer Timeliness (CAT)	*94% / 100% / Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*79% / 77% / Not Met*
	Preventive Dental Services for Children	*75% / 80% / Partially Met*
Wellcare d/b/a Staywell Health Plan of Florida, Inc.	*Call Answer Timeliness (CAT)*	*63% / 70% / Not Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*75% / 77% / Partially Met*
	Improving Well-Child Visit Rates for Children Residing in Pine Hills Community	*57% / 60% / Not Met*
	Preventive Dental Services for Children	*80% / 70% / Partially 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

Plan Name	PIP Topic	Validation Scores and Status
Amerigroup Community Care	*Improving the Number of Members with Advance Directives*	*79% / 85% / Partially Met*
	Medication Review	*79% / 85% / Not Met*
Coventry Health Care of Florida, Inc.	*Medication Review*	*75% / 67% / Not Met*
	Timeliness of Services for the Long-Term Care Program	*81% / 80% / Partially Met*
Humana Medical Plan, Inc.	*Person-Centered Care Plan*	*90% / 100% / Met*
	Medication Review	*94% / 100% / Met*
Molina Healthcare of Florida, Inc.	*Medication Review*	*79% / 77% / Not Met*
	Provider Satisfaction	*71% / 69% / Not Met*
Sunshine State Health Plan, Inc.	*Medication Review*	*92% / 100% / Met*
	Timeliness of Services	*76% / 70% / Not Met*
United Healthcare of Florida, Inc.	*Documentation of an Advance Directive*	*76% / 82% / Not Met*
	Medication Review	*67% / 70% / Partially Met*

Appendix C. PIP Study Indicator Rates

Table C-1—Clinical PIP Study Indicator Rates for MMA Plans

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate
Amerigroup	*Improving Medication Management for People with Asthma*	The percentage of enrollees who remained on asthma controller medication for at least 50% of their treatment period.	50.5%	46.3%
		The percentage of enrollees who remained on asthma controller medication for at least 75% of their treatment.	25.4%	20.6%
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.	23.1%	21.9%
CCP	*Increase the Diabetic Retinal Examination Rate for Enrollees*	The percentage of enrollees age 18 to 75 with diabetes (type 1 and type 2), assigned to a PCP in one of the targeted cities, who had a diabetic retinal examination performed in the measurement year or had a negative result for a diabetic retinal examination during the year prior to the measurement year.	37.9%	NR
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%	1.2%
		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%	36.3%
		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%	53.0%
	Well-Child Visits in the First 15 Months of Life-Six or More Visits	The percentage of enrollees who had six well-child visits by the first 15 months of life.	47.3%	41.8%

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate
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.	5.0%	6.2%*
	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.	0.0%	35.2%*
Coventry	*Improving Member Management of Diabetes*	The percentage of enrollees who had an HbA1c test performed during the measurement year.	87.7%	86.6%
		The percentage of enrollees who showed poor glycemic control (HbA1c test result > 9%).	51.9%	41.1%*
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.	53.3%	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.	93.3%	NR
	Plan All-Cause Readmissions (PCR)	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	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%	54.3%
		The percentage of eligible enrollees who remained on an antidepressant medication treatment for at least 180 days during the measurement year.	37.5%	38.7%

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 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.	74.3%	NR
	Plan All-Cause Readmissions (PCR)	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.	39.2%	NR
Molina	*Improving Compliance of Asthmatic Children Using Controller Medications*	The percentage of enrollees who achieved a proportion of days covered of at least 50 percent of their asthma controller medication during the measurement year.	43.2%	42.7%
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%	0.0%
		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%	0.0%
	Improving Rates of CD4 and Viral Load Testing	The percentage of stable members who get at least two CD4 and viral load (VL) tests during the measurement year.	87.9%	83.6%
		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%	42.9%
	Reducing Avoidable Emergency Room Visits	Percentage of avoidable emergency department visits for plan enrollees during the measurement year.	4.5%	NR
		Percentage of avoidable emergency department visits with ICD 9 codes	4.4%	NR

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate
		selected for persons living with HIV/AIDS.		
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%	50.8%*
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.	20.6%	19.8%
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%	66.6%
		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%	19.6%
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%	76.8%
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%	50.0%*

* Remeasurement 1 study indicator rate demonstrated a statistically significant improvement over the baseline rate.

Note: NR (Not Reported) designates that the plan did not report the study indicator rate during the current validation cycle.

Table C-2—Nonclinical PIP Study Indicator Rates for MMA Plans

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 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%	76.8%
Better Health	*Reduce All-Cause Hospital Readmissions Within 30 Days*	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%	79.2%
		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%	86.6%
CCP	*Improving the Number of Health Risk Assessments*	The percentage of returned and completed health risk assessments for new members.	2.8%	5.5%*
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%	54.0%
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%	76.2%
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.	73.2%	77.2%
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.	70.6%	NR

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate
Humana	*Integrating Primary Care and Behavioral Health in Antidepressant Medication Management*	The percentage of eligible providers in Region 11 who reported using an Electronic Health Record in a meaningful use manner.	18.2%	23.8%*
		The percentage of eligible providers in Region 10 who reported using an Electronic Health Record in a meaningful use manner.	10.1%	30.1%*
		The percentage of eligible providers in Region 9 who reported using an Electronic Health Record in a meaningful use manner.	8.8%	34.0%*
		The percentage of eligible providers in Region 6 who reported using an Electronic Health Record in a meaningful use manner.	29.4%	24.9%
		The percentage of eligible providers in Region 1 who reported using an Electronic Health Record in a meaningful use manner.	30.4%	38.4%*
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%	51.0%
Molina	*Practitioner Satisfaction*	The percentage of practitioners surveyed who responded "very satisfied" or "somewhat satisfied" to overall satisfaction with Molina.	93.3%	91.2%
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.	75.0%	77.7%
		The percentage of enrollees who report usually or always feeling that the health care staff was sensitive to their cultural needs.	86.8%	84.0%

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate
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%	83.7%
		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%	85.1%
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%	72.8%
		The percentage of enrollees who responded to the CAHPS 5.0 Survey Question 36 with a score of 8 or higher.	83.0%	82.4%
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%	80.7%
United	*Call Answer Timeliness and Call Abandonment (CAT-CAB)*	The percentage of calls answered by a live voice within 30 seconds.	75.4%	91.6%

* Remeasurement 1 study indicator rate demonstrated a statistically significant improvement over the baseline rate.
Note: NR (Not Reported) designates that the plan did not report the study indicator rate during the current validation cycle.

Table C-3—Nonclinical PIP Study Indicator Rates for LTC Plans

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate
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%	97.7%*
Coventry-LTC	*Timeliness of Services for the Long-Term Care Program*	The percentage of newly enrolled enrollees 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%	52.8%
		The percentage of newly enrolled enrollees who received home health services within 8 business days from the effective date of enrollment.	62.9%	56.7%
		The percentage of newly enrolled enrollees who received adult day care services within 8 business days from the effective date of enrollment.	54.3%	68.6%*
		The percentage of newly enrolled enrollees who received home-delivered meal services within 8 business days from the effective date of enrollment.	18.7%	36.1%*
Humana-LTC	*Person-centered Care Plan*	The percentage of eligible enrollees that have at least four person-centered care plan updates documented.	53.0%	76.4%*
Molina-LTC	*Provider Satisfaction*	The percent of providers surveyed who responded “satisfied” or “somewhat satisfied” to overall satisfaction with Molina.	90.1%	89.7%
Sunshine-LTC	*Timeliness of Services*	Newly enrolled (eligible) LTC enrollees 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%	32.8%
United-LTC	*Documentation of an Advance Directive*	The percentage of eligible enrollees who complete an Advance Directive during the measurement year.	63.6%	62.6%

* Remeasurement 1 study indicator rate demonstrated a statistically significant improvement over the baseline rate.

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 2017 performance measure results by domain of care compared to the NCQA Quality Compass national Medicaid percentiles for HEDIS 2016 (where applicable). Except for 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. Results 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 2017 Rate columns:

Table D-1—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.

Table D-2—Abbreviations Used in the Reporting Year 2017 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.
NQ	=	*Not Required*. The organization was not required to report the measure.
BR	=	*Biased Rate*. The calculated rate was materially biased.

Aetna Better Health Performance Measure Results

Table D-3 contains the MMA performance measure rates and performance level analysis results for Aetna Better Health for RY 2017 (calendar year [CY] 2016).

Table D-3—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results
Summary Table: Aetna Better Health

Aetna Better Health Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★★★	0.99%
One Well-Child Visit	★	0.50%
Two Well-Child Visits	★	1.49%
Three Well-Child Visits	★★	4.70%
Four Well-Child Visits	★	7.43%
Five Well-Child Visits	★	10.64%
Six or More Well-Child Visits	★★★★★	74.26%
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	★★★★	77.91%
Childhood Immunization Status		
Combination 2	★★★	77.83%
Combination 3	★★★	71.70%
Lead Screening in Children		
Lead Screening in Children	★★★	71.23%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★	24.31%
Continuation and Maintenance Phase	★	18.75%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★★★	82.43%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★★	59.33%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap)	★★★	78.10%
Combination 2 (Meningococcal, Tdap, HPV)	—	24.44%
Annual Dental Visit		
2–3 Years	★★	29.80%
4–6 Years	★★	49.95%
7–10 Years	★★	57.09%
11–14 Years	★★	50.82%

Aetna Better Health Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
15–18 Years	★	40.70%
19–20 Years	—	26.01%
Total	★★	46.50%
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	—	10.98%
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★★★★	67.00%
Chlamydia Screening in Women		
16–20 Years	★★★★★	67.31%
21–24 Years	★★★★	68.36%
Total	★★★★	67.59%
Breast Cancer Screening		
Breast Cancer Screening	★★★★	68.76%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★★★★★	94.95%
Postpartum Care	★★★	64.89%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★★★	74.73%
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	★★★	87.74%
*HbA1c Poor Control (>9.0%)**	★★★★	35.61%
HbA1c Control (<8.0%)	★★★★	53.77%
Eye Exam (Retinal) Performed	★★★	57.08%
Medical Attention for Nephropathy	★★★★★	94.81%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★★★	63.88%
Adult BMI Assessment		
Adult BMI Assessment	★★★★	90.24%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[2]	★	38.61%
Medication Compliance 50%—Ages 12–18 Years[2]	★★	46.97%
Medication Compliance 50%—Ages 19–50 Years[2]	★★★★	66.67%
Medication Compliance 50%—Ages 51–64 Years[2]	NA	NA
Medication Compliance 50%—Total[2]	★	47.06%
Medication Compliance 75%—Ages 5–11 Years	★	19.62%
Medication Compliance 75%—Ages 12–18 Years	★	15.15%

Aetna Better Health Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Medication Compliance 75%—Ages 19–50 Years	★★★	41.03%
Medication Compliance 75%—Ages 51–64 Years	NA	NA
Medication Compliance 75%—Total	★	24.22%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★★	95.11%
Annual Monitoring for Members on Digoxin	NA	NA
Annual Monitoring for Members on Diuretics	★★★★★	95.02%
Total	★★★★★	94.56%
Plan All-Cause Readmissions*		
18–64 Years of Age—Total	—	23.42%
65+ Years of Age—Total	—	18.56%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	35.90%
≥2 Visits	—	51.28%
1 Visit	—	6.41%
0 Visits	—	42.31%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	87.50%
HIV Viral Load Suppression		
18–64 Years	—	48.61%
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
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	★	35.42%
Initiation of AOD Treatment—18+ Years	★	26.12%
Initiation of AOD Treatment—Total	★	27.23%
Engagement of AOD Treatment—13–17 Years	★★	12.50%
Engagement of AOD Treatment—18+ Years	★	2.81%

Aetna Better Health Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Engagement of AOD Treatment—Total	★	3.96%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	★★★	44.94%
30-Day Follow-Up	★★	58.23%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up	—	22.68%
30-Day Follow-Up	—	46.39%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependencies		
7-Day Follow-Up—13–17 Years	—	NA
7-Day Follow-Up—18+ Years	—	7.84%
7-Day Follow-Up—Total	—	6.15%
30-Day Follow-Up—13–17 Years	—	NA
30-Day Follow-Up—18+ Years	—	9.80%
30-Day Follow-Up—Total	—	7.69%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★	53.00%
Effective Continuation Phase Treatment	★★	37.46%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★	57.43%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NA
6–11 Years	NA	NA
12–17 Years	★★★★★	53.66%
Total	★★★★★	54.90%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents* [1]		
1–5 Years	NA	NA
6–11 Years	NA	NA
12–17 Years	NA	NA
Total	★★★★★	0.00%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	16.54%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★★	95.53%
25 Months–6 Years	★★★	89.91%
7–11 Years	★★	89.68%

Aetna Better Health Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
12–19 Years	★	84.58%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	68.21%
45–64 Years	★★	83.46%
65 Years and Older	★★	86.39%
Total	★	74.41%
Call Answer Timeliness		
Call Answer Timeliness	★★	83.19%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	94.59%
Use of Services		
Ambulatory Care		
Outpatient Visits—Total	—	365.25
ED Visits—Total	—	63.77
SMI-Related Measures		
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	★★★★	86.15%

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2017 (RY 2017) technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to performance targets derived using data reported for HEDIS 2016 (RY 2016).
[2] Quality Compass benchmarks were not available; therefore, the 2016 Audit Means and Percentiles were used for comparison purposes.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2016 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 (i.e., <100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For RY 2017 rates designated NA, the performance level analysis value was also NA.
2017 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*

Table D-4 provides a summary of the performance level analysis results for Aetna Better Health for RY 2017 (CY 2016).

Table D-4—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Performance Level Analysis Summary Table: Aetna Better Health

2017 Performance Level Analysis	Number of Rates	Percent of Rates
★★★★★	10	13.89%
★★★★	13	18.06%
★★★	12	16.67%
★★	17	23.61%
★	20	27.78%
Total	**72**	**100.00%**

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Amerigroup Performance Measure Results

Table D-5 contains the MMA performance measure rates and performance level analysis results for Amerigroup for RY 2017 (CY 2016).

Table D-5—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results
Summary Table: Amerigroup

Amerigroup Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★★★	1.39%
One Well-Child Visit	★	0.46%
Two Well-Child Visits	★	1.16%
Three Well-Child Visits	★	3.24%
Four Well-Child Visits	★	5.09%
Five Well-Child Visits	★★★	17.36%
Six or More Well-Child Visits	★★★★	71.30%
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	★★★	76.16%
Childhood Immunization Status		
Combination 2	★★★★★	83.56%
Combination 3	★★★★★	80.09%
Lead Screening in Children		
Lead Screening in Children	★★★	71.53%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★★★	51.67%
Continuation and Maintenance Phase	★★★★★	67.72%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★★★	78.01%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★★	59.72%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap)	★★	72.69%
Combination 2 (Meningococcal, Tdap, HPV)	—	22.45%
Annual Dental Visit		
2–3 Years	★	26.90%
4–6 Years	★★	53.19%
7–10 Years	★★	62.38%
11–14 Years	★★	55.64%

Amerigroup Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
15–18 Years	★★	48.21%
19–20 Years	—	29.48%
Total	★★	50.99%
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	—	30.14%
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★★★	60.84%
Chlamydia Screening in Women		
16–20 Years	★★★★	62.51%
21–24 Years	★★★★★	73.03%
Total	★★★★	65.29%
Breast Cancer Screening		
Breast Cancer Screening	★★★	61.93%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★★★	86.54%
Postpartum Care	★★★	66.13%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★★★	70.77%
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	★★	84.69%
*HbA1c Poor Control (>9.0%)**	★★★	37.59%
HbA1c Control (<8.0%)	★★★	51.04%
Eye Exam (Retinal) Performed	★★★	55.22%
Medical Attention for Nephropathy	★★★★★	94.90%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★★★★	66.23%
Adult BMI Assessment		
Adult BMI Assessment	★★★★	91.90%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[2]	★★	48.71%
Medication Compliance 50%—Ages 12–18 Years[2]	★★	48.04%
Medication Compliance 50%—Ages 19–50 Years[2]	★★	56.69%
Medication Compliance 50%—Ages 51–64 Years[2]	★★★	73.76%
Medication Compliance 50%—Total[2]	★★	50.16%
Medication Compliance 75%—Ages 5–11 Years	★★	21.15%
Medication Compliance 75%—Ages 12–18 Years	★★	22.42%

Amerigroup Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Medication Compliance 75%—Ages 19–50 Years	★	27.39%
Medication Compliance 75%—Ages 51–64 Years	★★	43.26%
Medication Compliance 75%—Total	★	22.93%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★★	92.76%
Annual Monitoring for Members on Digoxin	★★★★	61.54%
Annual Monitoring for Members on Diuretics	★★★★★	93.43%
Total	★★★★★	92.68%
Plan All-Cause Readmissions*		
18–64 Years of Age—Total	—	19.99%
65+ Years of Age—Total	—	16.08%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	50.39%
≥2 Visits	—	68.83%
1 Visit	—	13.25%
0 Visits	—	17.92%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	86.53%
HIV Viral Load Suppression		
18–64 Years	—	16.93%
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
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	★★★	42.83%
Initiation of AOD Treatment—18+ Years	★★★	38.16%
Initiation of AOD Treatment—Total	★★★	38.79%
Engagement of AOD Treatment—13–17 Years	★★	12.62%
Engagement of AOD Treatment—18+ Years	★	5.61%

Amerigroup Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Engagement of AOD Treatment—Total	★	6.56%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	★★★	46.61%
30-Day Follow-Up	★★	63.22%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up	—	38.21%
30-Day Follow-Up	—	54.39%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependencies		
7-Day Follow-Up—13–17 Years	—	1.56%
7-Day Follow-Up—18+ Years	—	6.31%
7-Day Follow-Up—Total	—	5.46%
30-Day Follow-Up—13–17 Years	—	4.69%
30-Day Follow-Up—18+ Years	—	8.19%
30-Day Follow-Up—Total	—	7.56%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★	50.99%
Effective Continuation Phase Treatment	★★	33.90%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★★	63.28%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NA
6–11 Years	★★★	28.73%
12–17 Years	★★★★★	46.00%
Total	★★★★	39.32%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents* [1]		
1–5 Years	NA	NA
6–11 Years	★★★★	0.52%
12–17 Years	★★★	2.02%
Total	★★★	1.45%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	32.57%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★★★	95.97%
25 Months–6 Years	★★★	90.69%
7–11 Years	★★★	91.16%

Amerigroup Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
12–19 Years	★★	88.51%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	70.05%
45–64 Years	★★	85.11%
65 Years and Older	★★★	87.72%
Total	★	74.84%
Call Answer Timeliness		
Call Answer Timeliness	★★	84.04%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	87.91%
Use of Services		
Ambulatory Care		
Outpatient Visits—Total	—	315.15
ED Visits—Total	—	66.03
SMI-Related Measures		
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	★★★★	84.05%

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2017 (RY 2017) technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to performance targets derived using data reported for HEDIS 2016 (RY 2016).
[2] Quality Compass benchmarks were not available; therefore, the 2016 Audit Means and Percentiles were used for comparison purposes.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2016 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 (i.e., <100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For RY 2017 rates designated NA, the performance level analysis value was also NA.
2017 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*

Table D-6 provides a summary of the performance level analysis results for Amerigroup for RY 2017 (CY 2016).

Table D-6—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Performance Level Analysis Summary Table: Amerigroup

2017 Performance Level Analysis	Number of Rates	Percent of Rates
★★★★★	9	11.54%
★★★★	13	16.67%
★★★	24	30.77%
★★	21	26.92%
★	11	14.10%
Total	**78**	**100.00%**

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Better Health Performance Measure Results

Table D-7 contains the MMA performance measure rates and performance level analysis results for Better Health for RY 2017 (CY 2016).

Table D-7—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results
Summary Table: Better Health

Better Health Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★★★★	0.46%
One Well-Child Visit	★★★★	3.24%
Two Well-Child Visits	★★	2.31%
Three Well-Child Visits	★★	5.09%
Four Well-Child Visits	★★	8.10%
Five Well-Child Visits	★	10.19%
Six or More Well-Child Visits	★★★★	70.60%
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	★★★★	78.94%
Childhood Immunization Status		
Combination 2	★★	74.31%
Combination 3	★★★	71.76%
Lead Screening in Children		
Lead Screening in Children	★★	69.68%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★	41.76%
Continuation and Maintenance Phase	★★	48.75%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★★	77.31%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★	56.48%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap)	★★	72.92%
Combination 2 (Meningococcal, Tdap, HPV)	—	16.90%
Annual Dental Visit		
2–3 Years	★★	31.55%
4–6 Years	★★	56.75%
7–10 Years	★★★	64.12%
11–14 Years	★★	54.92%

Better Health Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
15–18 Years	★★	43.76%
19–20 Years	—	26.89%
Total	★★	51.08%
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	—	34.34%
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★★★	57.77%
Chlamydia Screening in Women		
16–20 Years	★★★★	59.76%
21–24 Years	★★★	66.67%
Total	★★★★	61.85%
Breast Cancer Screening		
Breast Cancer Screening	★★★	59.34%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★★	78.84%
Postpartum Care	★★★★	69.07%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★★	61.16%
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	★★	85.65%
*HbA1c Poor Control (>9.0%)**	★★★	41.67%
HbA1c Control (<8.0%)	★★★	47.45%
Eye Exam (Retinal) Performed	★★	44.68%
Medical Attention for Nephropathy	★★	89.81%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★★	51.75%
Adult BMI Assessment		
Adult BMI Assessment	★★★	86.54%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[2]	★	45.94%
Medication Compliance 50%—Ages 12–18 Years[2]	★	37.84%
Medication Compliance 50%—Ages 19–50 Years[2]	★★	56.72%
Medication Compliance 50%—Ages 51–64 Years[2]	★	55.26%
Medication Compliance 50%—Total[2]	★	45.72%
Medication Compliance 75%—Ages 5–11 Years	★★	22.19%
Medication Compliance 75%—Ages 12–18 Years	★★	20.27%

Better Health Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Medication Compliance 75%—Ages 19–50 Years	★★★	37.31%
Medication Compliance 75%—Ages 51–64 Years	★★★	50.00%
Medication Compliance 75%—Total	★★	25.31%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★	91.78%
Annual Monitoring for Members on Digoxin	NA	NA
Annual Monitoring for Members on Diuretics	★★★★★	93.30%
Total	★★★★★	92.09%
Plan All-Cause Readmissions*		
18–64 Years of Age—Total	—	20.32%
65+ Years of Age—Total	—	14.17%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	39.04%
≥2 Visits	—	62.33%
1 Visit	—	19.18%
0 Visits	—	18.49%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	86.13%
HIV Viral Load Suppression		
18–64 Years	—	0.00%
65+Yyears	—	NA
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years of Age	—	19.71%
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	—	5.88%
Advising Smokers and Tobacco Users to Quit—Total	★	16.67%
Discussing Cessation Medications—18–64 Years of Age	—	11.16%
Discussing Cessation Medications—65+ Years of Age	—	3.36%
Discussing Cessation Medications—Total	★	9.44%
Discussing Cessation Strategies—18–64 Years of Age	—	11.40%
Discussing Cessation Strategies—65+ Years of Age	—	5.04%
Discussing Cessation Strategies—Total	★	10.00%
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	★	20.00%
Initiation of AOD Treatment—18+ Years	★	32.91%
Initiation of AOD Treatment—Total	★	31.34%
Engagement of AOD Treatment—13–17 Years	★	5.83%
Engagement of AOD Treatment—18+ Years	★	5.64%

Better Health Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Engagement of AOD Treatment—Total	★	5.66%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	★	33.76%
30-Day Follow-Up	★	47.56%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up	—	25.26%
30-Day Follow-Up	—	42.11%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependencies		
7-Day Follow-Up—13–17 Years	—	NA
7-Day Follow-Up—18+ Years	—	4.40%
7-Day Follow-Up—Total	—	4.37%
30-Day Follow-Up—13–17 Years	—	NA
30-Day Follow-Up—18+ Years	—	6.59%
30-Day Follow-Up—Total	—	6.31%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★	42.27%
Effective Continuation Phase Treatment	★	30.41%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★	44.70%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NA
6–11 Years	★★	24.56%
12–17 Years	★★★★	37.78%
Total	★★★	32.89%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents* [1]		
1–5 Years	NA	NA
6–11 Years	★★★★★	0.00%
12–17 Years	★★★★★	0.00%
Total	★★★★★	0.00%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	27.94%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★★	93.80%
25 Months–6 Years	★★★	88.34%
7–11 Years	★★	88.39%

Better Health Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
12–19 Years	★	81.92%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	60.43%
45–64 Years	★	80.18%
65 Years and Older	★★	84.59%
Total	★	67.63%
Call Answer Timeliness		
Call Answer Timeliness	★★★★	89.03%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	95.95%
Use of Services		
Ambulatory Care		
Outpatient Visits—Total	—	275.94
ED Visits—Total	—	70.59
SMI-Related Measures		
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	★★★★★	88.62%

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2017 (RY 2017) technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to performance targets derived using data reported for HEDIS 2016 (RY 2016).
[2] Quality Compass benchmarks were not available; therefore, the 2016 Audit Means and Percentiles were used for comparison purposes.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2016 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 (i.e., <100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For RY 2017 rates designated NA, the performance level analysis value was also NA.
2017 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*

Table D-8 provides a summary of the performance level analysis results for Better Health for RY 2017 (CY 2016).

Table D-8—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Performance Level Analysis Summary Table: Better Health

2017 Performance Level Analysis	Number of Rates	Percent of Rates
★★★★★	6	7.50%
★★★★	10	12.50%
★★★	15	18.75%
★★	26	32.50%
★	23	28.75%
Total	**80**	**100.00%**

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Children's Medical Services-S Performance Measure Results

Table D-9 contains the MMA performance measure rates and performance level analysis results for Children's Medical Services-S for RY 2017 (CY 2016).

Table D-9—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results
Summary Table: Children's Medical Services-S

Children's Medical Services-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★	3.85%
One Well-Child Visit	★★★★	3.21%
Two Well-Child Visits	★★★	3.85%
Three Well-Child Visits	★★★★	7.05%
Four Well-Child Visits	★★★★★	14.10%
Five Well-Child Visits	★★★★	22.44%
Six or More Well-Child Visits	★	45.51%
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	★★★	72.11%
Childhood Immunization Status		
Combination 2	★★★	76.64%
Combination 3	★★	70.07%
Lead Screening in Children		
Lead Screening in Children	★★	57.42%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★	39.34%
Continuation and Maintenance Phase	★★	47.38%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★	63.75%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★	55.32%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap)	★★	70.80%
Combination 2 (Meningococcal, Tdap, HPV)	—	21.65%
Annual Dental Visit		
2–3 Years	★★	31.62%
4–6 Years	★	49.18%
7–10 Years	★★	56.59%
11–14 Years	★★	52.48%

Children's Medical Services-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
15–18 Years	★★	45.79%
19–20 Years	—	33.46%
Total	★★	49.28%
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	—	19.09%
Women's Care		
Chlamydia Screening in Women		
16–20 Years	★	41.92%
21–24 Years	NA	NA
Total	★	41.92%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★	59.72%
Postpartum Care	★	43.06%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★	30.56%
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	★	81.03%
*HbA1c Poor Control (>9.0%)**	★	100.00%
HbA1c Control (<8.0%)	★	0.00%
Eye Exam (Retinal) Performed	★	34.39%
Medical Attention for Nephropathy	★	79.05%
Adult BMI Assessment		
Adult BMI Assessment	★	18.86%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[2]	★★★★★	71.99%
Medication Compliance 50%—Ages 12–18 Years[2]	★★★★★	74.53%
Medication Compliance 50%—Ages 19–50 Years[2]	★★★★★	81.82%
Medication Compliance 50%—Ages 51–64 Years[2]	NA	NA
Medication Compliance 50%—Total[2]	★★★★★	73.41%
Medication Compliance 75%—Ages 5–11 Years	★★★★★	50.35%
Medication Compliance 75%—Ages 12–18 Years	★★★★★	52.96%
Medication Compliance 75%—Ages 19–50 Years	★★★★★	66.67%
Medication Compliance 75%—Ages 51–64 Years	NA	NA
Medication Compliance 75%—Total	★★★★★	52.02%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★	85.85%
Annual Monitoring for Members on Digoxin	NA	NA

Children's Medical Services-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Annual Monitoring for Members on Diuretics	★★★★	90.32%
Total	★	82.00%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	67.95%
≥2 Visits	—	82.63%
1 Visit	—	8.11%
0 Visits	—	9.27%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	93.22%
HIV Viral Load Suppression		
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	★★★	48.94%
Initiation of AOD Treatment—18+ Years	★★★	37.93%
Initiation of AOD Treatment—Total	★★★★	44.74%
Engagement of AOD Treatment—13–17 Years	★★	12.06%
Engagement of AOD Treatment—18+ Years	★	4.60%
Engagement of AOD Treatment—Total	★★	9.21%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	★★	41.12%
30-Day Follow-Up	★★	63.04%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up	—	36.04%
30-Day Follow-Up	—	58.56%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependencies		
7-Day Follow-Up—13–17 Years	—	3.33%
7-Day Follow-Up—18+ Years	—	NA
7-Day Follow-Up—Total	—	2.22%
30-Day Follow-Up—13–17 Years	—	6.67%
30-Day Follow-Up—18+ Years	—	NA
30-Day Follow-Up—Total	—	4.44%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★★★	64.86%
Effective Continuation Phase Treatment	★★★★	52.70%

Children's Medical Services-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	★★★★★	50.00%
6–11 Years	★★★★★	38.78%
12–17 Years	★★★★★	43.57%
Total	★★★★	41.83%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents* [1]		
1–5 Years	NA	NA
6–11 Years	★★	2.08%
12–17 Years	★★	3.42%
Total	★★	2.86%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	21.40%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★★★	96.27%
25 Months–6 Years	★★★★★	94.14%
7–11 Years	★★★★★	96.46%
12–19 Years	★★★★★	95.71%
Call Answer Timeliness		
Call Answer Timeliness	★★	84.82%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	72.29%
Use of Services		
Ambulatory Care		
Outpatient Visits—Total	—	485.43
ED Visits—Total	—	73.54
SMI-Related Measures		
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	★★★	80.87%

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2017 (RY 2017) technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to performance targets derived using data reported for HEDIS 2016 (RY 2016).
[2] Quality Compass benchmarks were not available; therefore, the 2016 Audit Means and Percentiles were used for comparison purposes.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2016 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 (i.e., <100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For RY 2017 rates designated NA, the performance level analysis value was also NA.
2017 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*

Table D-10 provides a summary of the performance level analysis results for Children's Medical Services-S for RY 2017 (CY 2016).

Table D-10—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Performance Level Analysis Summary Table: Children's Medical Services-S

2017 Performance Level Analysis	Number of Rates	Percent of Rates
★★★★★	15	22.39%
★★★★	8	11.94%
★★★	8	11.94%
★★	20	29.85%
★	16	23.88%
Total	**67**	**100.00%**

★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Clear Health-S Performance Measure Results

Table D-11 contains the MMA performance measure rates and performance level analysis results for Clear Health-S for RY 2017 (CY 2016).

Table D-11—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results
Summary Table: Clear Health-S

Clear Health-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 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	★★★	76.92%
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	★★★★	85.29%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★	46.03%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap)	NA	NA
Combination 2 (Meningococcal, Tdap, HPV)	—	NA
Annual Dental Visit		
2–3 Years	NA	NA
4–6 Years	NA	NA
7–10 Years	NA	NA
11–14 Years	NA	NA

Clear Health-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
15–18 Years	NA	NA
19–20 Years	—	NA
Total	★	40.19%
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	★★★★	67.84%
Chlamydia Screening in Women		
16–20 Years	NA	NA
21–24 Years	★★★★★	72.73%
Total	★★★★★	76.71%
Breast Cancer Screening		
Breast Cancer Screening	★★★	58.09%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★	70.93%
Postpartum Care	★	48.84%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★	47.67%
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	★★★	86.21%
*HbA1c Poor Control (>9.0%)**	★	52.57%
HbA1c Control (<8.0%)	★	39.49%
Eye Exam (Retinal) Performed	★	42.29%
Medical Attention for Nephropathy	★★★★★	93.93%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★	44.29%
Adult BMI Assessment		
Adult BMI Assessment	★★★	87.24%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[2]	NA	NA
Medication Compliance 50%—Ages 12–18 Years[2]	NA	NA
Medication Compliance 50%—Ages 19–50 Years[2]	★★★★★	78.85%
Medication Compliance 50%—Ages 51–64 Years[2]	★★★★★	83.33%
Medication Compliance 50%—Total[2]	★★★★★	80.68%
Medication Compliance 75%—Ages 5–11 Years	NA	NA
Medication Compliance 75%—Ages 12–18 Years	NA	NA

Clear Health-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Medication Compliance 75%—Ages 19–50 Years	★★★★★	59.62%
Medication Compliance 75%—Ages 51–64 Years	★★★★	61.11%
Medication Compliance 75%—Total	★★★★★	60.23%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★★	98.41%
Annual Monitoring for Members on Digoxin	NA	NA
Annual Monitoring for Members on Diuretics	★★★★★	98.77%
Total	★★★★★	98.42%
Plan All-Cause Readmissions*		
18–64 Years of Age—Total	—	28.43%
65+ Years of Age—Total	—	NA
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	53.60%
≥2 Visits	—	76.39%
1 Visit	—	11.44%
0 Visits	—	12.17%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	93.85%
HIV Viral Load Suppression		
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	—	36.58%
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—Total	★	35.75%
Discussing Cessation Medications—18–64 Years of Age	—	27.43%
Discussing Cessation Medications—65+ Years of Age	—	NA
Discussing Cessation Medications—Total	★	26.67%
Discussing Cessation Strategies—18–64 Years of Age	—	24.58%
Discussing Cessation Strategies—65+ Years of Age	—	NA
Discussing Cessation Strategies—Total	★	23.87%
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	★★★★	43.00%
Initiation of AOD Treatment—Total	★★★★	43.00%
Engagement of AOD Treatment—13–17 Years	NA	NA
Engagement of AOD Treatment—18+ Years	★	4.18%

Clear Health-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Engagement of AOD Treatment—Total	★	4.18%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	★	27.78%
30-Day Follow-Up	★	38.44%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up	—	20.55%
30-Day Follow-Up	—	26.03%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependencies		
7-Day Follow-Up—13–17 Years	—	NA
7-Day Follow-Up—18+ Years	—	7.91%
7-Day Follow-Up—Total	—	7.91%
30-Day Follow-Up—13–17 Years	—	NA
30-Day Follow-Up—18+ Years	—	8.63%
30-Day Follow-Up—Total	—	8.63%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★★	54.48%
Effective Continuation Phase Treatment	★★★	39.93%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★	54.12%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NA
6–11 Years	NA	NA
12–17 Years	NA	NA
Total	NA	NA
Use of Multiple Concurrent Antipsychotics in Children and Adolescents* [1]		
1–5 Years	NA	NA
6–11 Years	NA	NA
12–17 Years	NA	NA
Total	NA	NA
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	40.74%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	NA	NA
25 Months–6 Years	★	66.67%
7–11 Years	NA	NA

Clear Health-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
12–19 Years	NA	NA
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★★★★★	86.96%
45–64 Years	★★★★★	93.44%
65 Years and Older	★★★★★	93.06%
Total	★★★★★	91.38%
Call Answer Timeliness		
Call Answer Timeliness	★★★★	91.61%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	95.13%
Use of Services		
Ambulatory Care		
Outpatient Visits—Total	—	404.38
ED Visits—Total	—	142.13
SMI-Related Measures		
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	★★★★★	98.11%

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2017 (RY 2017) technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to performance targets derived using data reported for HEDIS 2016 (RY 2016).
[2] Quality Compass benchmarks were not available; therefore, the 2016 Audit Means and Percentiles were used for comparison purposes.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2016 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 (i.e., <100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For RY 2017 rates designated NA, the performance level analysis value was also NA.
2017 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*

Table D-12 provides a summary of the performance level analysis results for Clear Health-S for RY 2017 (CY 2016).

Table D-12—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Performance Level Analysis Summary Table: Clear Health-S

2017 Performance Level Analysis	Number of Rates	Percent of Rates
★★★★★	16	34.78%
★★★★	6	13.04%
★★★	6	13.04%
★★	3	6.52%
★	15	32.61%
Total	**46**	**100.00%**

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Community Care Plan Performance Measure Results

Table D-13 contains the MMA performance measure rates and performance level analysis results for Community Care Plan for RY 2017 (CY 2016).

Table D-13—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results
Summary Table: Community Care Plan

Community Care Plan Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★★	2.13%
One Well-Child Visit	★★	1.66%
Two Well-Child Visits	★★	2.13%
Three Well-Child Visits	★	3.32%
Four Well-Child Visits	★★	8.53%
Five Well-Child Visits	★	12.56%
Six or More Well-Child Visits	★★★★	69.67%
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	★★★★	81.32%
Childhood Immunization Status		
Combination 2	★★★	75.85%
Combination 3	★★★	73.86%
Lead Screening in Children		
Lead Screening in Children	★★★	71.67%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★★	42.59%
Continuation and Maintenance Phase	★★	52.08%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★★★	78.70%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★	56.48%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap)	★★★	80.71%
Combination 2 (Meningococcal, Tdap, HPV)	—	18.33%
Annual Dental Visit		
2–3 Years	★★★	34.98%
4–6 Years	★★	59.28%
7–10 Years	★★★	65.92%
11–14 Years	★★	55.40%

Community Care Plan Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
15–18 Years	★★	41.76%
19–20 Years	—	22.75%
Total	★★★	53.23%
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	—	28.65%
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★★	54.88%
Chlamydia Screening in Women		
16–20 Years	★★★	58.08%
21–24 Years	★★★	67.22%
Total	★★★	60.24%
Breast Cancer Screening		
Breast Cancer Screening	★★★	60.74%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★★★	85.55%
Postpartum Care	★★★	66.57%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★★	63.07%
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	★★	85.38%
*HbA1c Poor Control (>9.0%)**	★★★	43.39%
HbA1c Control (<8.0%)	★★★	46.87%
Eye Exam (Retinal) Performed	★★★	58.00%
Medical Attention for Nephropathy	★★★	91.18%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★★	50.00%
Adult BMI Assessment		
Adult BMI Assessment	★★★	85.56%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[2]	★★★★	64.82%
Medication Compliance 50%—Ages 12–18 Years[2]	★★★	54.17%
Medication Compliance 50%—Ages 19–50 Years[2]	NA	NA
Medication Compliance 50%—Ages 51–64 Years[2]	NA	NA
Medication Compliance 50%—Total[2]	★★★	62.03%
Medication Compliance 75%—Ages 5–11 Years	★★★★	39.20%
Medication Compliance 75%—Ages 12–18 Years	★★★★	32.29%

Community Care Plan Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Medication Compliance 75%—Ages 19–50 Years	NA	NA
Medication Compliance 75%—Ages 51–64 Years	NA	NA
Medication Compliance 75%—Total	★★★	37.34%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★★	92.16%
Annual Monitoring for Members on Digoxin	NA	NA
Annual Monitoring for Members on Diuretics	★★★★	91.30%
Total	★★★★	91.01%
Plan All-Cause Readmissions*		
18–64 Years of Age—Total	—	20.99%
65+ Years of Age—Total	—	9.43%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	56.56%
≥2 Visits	—	77.87%
1 Visit	—	12.30%
0 Visits	—	9.84%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	91.53%
HIV Viral Load Suppression		
18–64 Years	—	29.14%
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
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	★	34.00%
Initiation of AOD Treatment—18+ Years	★★★	41.48%
Initiation of AOD Treatment—Total	★★★	40.14%
Engagement of AOD Treatment—13–17 Years	★★	10.00%
Engagement of AOD Treatment—18+ Years	★	6.11%

Community Care Plan Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Engagement of AOD Treatment—Total	★	6.81%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	★★★	46.88%
30-Day Follow-Up	★★	56.25%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up	—	7.14%
30-Day Follow-Up	—	28.57%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependencies		
7-Day Follow-Up—13–17 Years	—	NA
7-Day Follow-Up—18+ Years	—	7.27%
7-Day Follow-Up—Total	—	6.35%
30-Day Follow-Up—13–17 Years	—	NA
30-Day Follow-Up—18+ Years	—	9.09%
30-Day Follow-Up—Total	—	7.94%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★★★	65.00%
Effective Continuation Phase Treatment	★★★★★	58.33%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★★★	66.67%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NA
6–11 Years	NA	NA
12–17 Years	NA	NA
Total	★★★	33.33%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents* [1]		
1–5 Years	NA	NA
6–11 Years	NA	NA
12–17 Years	NA	NA
Total	★	6.25%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	18.46%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★★	94.47%
25 Months–6 Years	★★★	89.52%
7–11 Years	★★	90.59%

Community Care Plan Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
12–19 Years	★	83.63%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	50.42%
45–64 Years	★	70.73%
65 Years and Older	★	75.67%
Total	★	57.85%
Call Answer Timeliness		
Call Answer Timeliness	★★★	87.60%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	88.96%
Use of Services		
Ambulatory Care		
Outpatient Visits—Total	—	276.32
ED Visits—Total	—	62.67
SMI-Related Measures		
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	★★	80.25%

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2017 (RY 2017) technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to performance targets derived using data reported for HEDIS 2016 (RY 2016).
[2] Quality Compass benchmarks were not available; therefore, the 2016 Audit Means and Percentiles were used for comparison purposes.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2016 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 (i.e., <100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For RY 2017 rates designated NA, the performance level analysis value was also NA.
2017 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*

Table D-14 provides a summary of the performance level analysis results for Community Care Plan for RY 2017 (CY 2016).

Table D-14—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Performance Level Analysis Summary Table: Community Care Plan

2017 Performance Level Analysis	Number of Rates	Percent of Rates
★★★★★	2	2.90%
★★★★	10	14.49%
★★★	30	43.48%
★★	16	23.19%
★	11	15.94%
Total	**69**	**100.00%**

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Freedom-S Performance Measure Results

Table D-15 contains the MMA performance measure rates and performance level analysis results for Freedom-S for RY 2017 (CY 2016).

Table D-15—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results
Summary Table: Freedom-S

Freedom-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	NQ	NQ
One Well-Child Visit	NQ	NQ
Two Well-Child Visits	NQ	NQ
Three Well-Child Visits	NQ	NQ
Four Well-Child Visits	NQ	NQ
Five Well-Child Visits	NQ	NQ
Six or More Well-Child Visits	NQ	NQ
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	NQ	NQ
Childhood Immunization Status		
Combination 2	NQ	NQ
Combination 3	NQ	NQ
Lead Screening in Children		
Lead Screening in Children	NQ	NQ
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	NQ	NQ
Continuation and Maintenance Phase	NQ	NQ
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	NQ	NQ
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	NQ	NQ
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap)	NQ	NQ
Combination 2 (Meningococcal, Tdap, HPV)	—	NQ
Annual Dental Visit		
2–3 Years	NQ	NQ
4–6 Years	NQ	NQ
7–10 Years	NQ	NQ
11–14 Years	NQ	NQ

Freedom-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
15–18 Years	NQ	NQ
19–20 Years	—	NQ
Total	NQ	NQ
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	—	NQ
Women's Care		
Chlamydia Screening in Women		
16–20 Years	NQ	NQ
21–24 Years	NQ	NQ
Total	NQ	NQ
Breast Cancer Screening		
Breast Cancer Screening	NA	NA
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	NQ	NQ
Postpartum Care	NQ	NQ
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	NQ	NQ
Living With Illness		
Comprehensive Diabetes Care		
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	★★★★★	77.42%
Adult BMI Assessment		
Adult BMI Assessment	NA	NA
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★★	100.00%
Annual Monitoring for Members on Digoxin	NA	NA
Annual Monitoring for Members on Diuretics	★★★★★	100.00%
Total	★★★★★	98.72%
Plan All-Cause Readmissions*		
18–64 Years of Age—Total	—	NA
65+ Years of Age—Total	—	11.76%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	NA

Freedom-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
≥2 Visits	—	NA
1 Visit	—	NA
0 Visits	—	NA
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	NA
HIV Viral Load Suppression		
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	—	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	NA
30-Day Follow-Up	NA	NA
Antidepressant Medication Management		
Effective Acute Phase Treatment	NA	NA
Effective Continuation Phase Treatment	NA	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NQ	NQ
6–11 Years	NQ	NQ
12–17 Years	NQ	NQ
Total	NQ	NQ

Freedom-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Use of Multiple Concurrent Antipsychotics in Children and Adolescents* [1]		
1–5 Years	NQ	NQ
6–11 Years	NQ	NQ
12–17 Years	NQ	NQ
Total	NQ	NQ
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	NA
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	NQ	NQ
25 Months–6 Years	NQ	NQ
7–11 Years	NQ	NQ
12–19 Years	NQ	NQ
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	NA	NA
45–64 Years	NA	NA
65 Years and Older	★★★★★	97.22%
Total	★★★★★	97.67%
Call Answer Timeliness		
Call Answer Timeliness	★★★★★	94.64%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	94.44%
Use of Services		
Ambulatory Care		
Outpatient Visits—Total	—	581.66
ED Visits—Total	—	65.57
Chronic Disease-Related Measures		
Care for Older Adults		
Advance Care Planning—66+ Years	—	85.19%
Medication Review—66+ Years	—	94.44%
Functional Status Assessment—66+ Years	—	90.74%
Pain Assessment—66+ Years	—	96.30%

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2017 (RY 2017) technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to performance targets derived using data reported for HEDIS 2016 (RY 2016).
[2] Quality Compass benchmarks were not available; therefore, the 2016 Audit Means and Percentiles were used for comparison purposes.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2016 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 (i.e., <100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For RY 2017 rates designated NA, the performance level analysis value was also NA.
NQ indicates the rate was designated Not Required because the organization is not required to report the measure.
2017 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*

Table D-16 provides a summary of the performance level analysis results for Freedom-S for RY 2017 (CY 2016).

Table D-16—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Performance Level Analysis Summary Table: Freedom-S

2017 Performance Level Analysis	Number of Rates	Percent of Rates
★★★★★	7	100.00%
★★★★	0	0.00%
★★★	0	0.00%
★★	0	0.00%
★	0	0.00%
Total	**7**	**100.00%**

★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Humana Performance Measure Results

Table D-17 contains the MMA performance measure rates and performance level analysis results for Humana for RY 2017 (CY 2016).

Table D-17—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results
Summary Table: Humana

Humana Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★★	2.43%
One Well-Child Visit	★	0.97%
Two Well-Child Visits	★★	2.68%
Three Well-Child Visits	★★	4.38%
Four Well-Child Visits	★★	8.76%
Five Well-Child Visits	★	13.87%
Six or More Well-Child Visits	★★★	66.91%
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	★★★	75.43%
Childhood Immunization Status		
Combination 2	★★★	77.37%
Combination 3	★★★	72.51%
Lead Screening in Children		
Lead Screening in Children	★★	67.15%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★	26.50%
Continuation and Maintenance Phase	★	40.33%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★★★	82.24%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★	51.58%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap)	★★★	78.59%
Combination 2 (Meningococcal, Tdap, HPV)	—	20.68%
Annual Dental Visit		
2–3 Years	★★	29.89%
4–6 Years	★★	52.17%
7–10 Years	★★	59.27%
11–14 Years	★★	53.69%

Humana Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
15–18 Years	★★	44.60%
19–20 Years	—	27.31%
Total	★★	48.54%
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	—	26.92%
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★★★	57.66%
Chlamydia Screening in Women		
16–20 Years	★★★★	61.21%
21–24 Years	★★★★	68.05%
Total	★★★★	63.44%
Breast Cancer Screening		
Breast Cancer Screening	★★	56.41%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★★★	86.37%
Postpartum Care	★★★★	70.07%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★★★	71.53%
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	★★★	86.62%
*HbA1c Poor Control (>9.0%)**	★★★	38.93%
HbA1c Control (<8.0%)	★★★	47.45%
Eye Exam (Retinal) Performed	★★★★	66.91%
Medical Attention for Nephropathy	★★★★	92.94%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★★★	63.26%
Adult BMI Assessment		
Adult BMI Assessment	★★★★★	92.70%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[2]	★★	51.18%
Medication Compliance 50%—Ages 12–18 Years[2]	★★	43.40%
Medication Compliance 50%—Ages 19–50 Years[2]	★★★	61.68%
Medication Compliance 50%—Ages 51–64 Years[2]	★★	71.69%
Medication Compliance 50%—Total[2]	★★	52.15%
Medication Compliance 75%—Ages 5–11 Years	★★	23.76%
Medication Compliance 75%—Ages 12–18 Years	★★	21.12%

Humana Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Medication Compliance 75%—Ages 19–50 Years	★★★	37.72%
Medication Compliance 75%—Ages 51–64 Years	★★★	52.41%
Medication Compliance 75%—Total	★★	27.23%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★	92.11%
Annual Monitoring for Members on Digoxin	★★★	54.22%
Annual Monitoring for Members on Diuretics	★★★★★	92.66%
Total	★★★★★	91.90%
Plan All-Cause Readmissions*		
18–64 Years of Age—Total	—	21.37%
65+ Years of Age—Total	—	11.79%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	0.00%
≥2 Visits	—	40.49%
1 Visit	—	14.26%
0 Visits	—	45.25%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	70.30%
HIV Viral Load Suppression		
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	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	★	30.38%
Initiation of AOD Treatment—18+ Years	★	32.85%
Initiation of AOD Treatment—Total	★	32.71%
Engagement of AOD Treatment—13–17 Years	★	8.85%
Engagement of AOD Treatment—18+ Years	★	5.03%

Humana Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Engagement of AOD Treatment—Total	★	5.26%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	★★★	50.50%
30-Day Follow-Up	★	53.42%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up	—	36.39%
30-Day Follow-Up	—	55.75%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependencies		
7-Day Follow-Up—13–17 Years	—	8.33%
7-Day Follow-Up—18+ Years	—	20.56%
7-Day Follow-Up—Total	—	19.44%
30-Day Follow-Up—13–17 Years	—	11.11%
30-Day Follow-Up—18+ Years	—	23.80%
30-Day Follow-Up—Total	—	22.64%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★★	55.12%
Effective Continuation Phase Treatment	★★★	39.89%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★★	64.77%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NA
6–11 Years	★★★★	34.16%
12–17 Years	★★★★	42.86%
Total	★★★★	40.33%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents* [1]		
1–5 Years	NA	NA
6–11 Years	★★★	0.71%
12–17 Years	★★★	2.27%
Total	★★★	1.77%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	20.46%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★★	93.67%
25 Months–6 Years	★★	87.14%
7–11 Years	★	87.59%

Humana Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
12–19 Years	★	84.69%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	67.99%
45–64 Years	★★★	87.00%
65 Years and Older	★★★★	92.26%
Total	★★	79.29%
Call Answer Timeliness		
Call Answer Timeliness	★★★★★	97.75%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	86.59%
Use of Services		
Ambulatory Care		
Outpatient Visits—Total	—	347.58
ED Visits—Total	—	69.51
SMI-Related Measures		
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	★★★	81.78%

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2017 (RY 2017) technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to performance targets derived using data reported for HEDIS 2016 (RY 2016).
[2] Quality Compass benchmarks were not available; therefore, the 2016 Audit Means and Percentiles were used for comparison purposes.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2016 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 (i.e., <100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For RY 2017 rates designated NA, the performance level analysis value was also NA.
2017 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*

Table D-18 provides a summary of the performance level analysis results for Humana for RY 2017 (CY 2016).

Table D-18—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Performance Level Analysis Summary Table: Humana

2017 Performance Level Analysis	Number of Rates	Percent of Rates
★★★★★	4	5.13%
★★★★	13	16.67%
★★★	25	32.05%
★★	22	28.21%
★	14	17.95%
Total	**78**	**100.00%**

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Magellan-S Performance Measure Results

Table D-19 contains the MMA performance measure rates and performance level analysis results for Magellan-S for RY 2017 (CY 2016).

Table D-19—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results
Summary Table: Magellan-S

Magellan-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	NQ	NQ
One Well-Child Visit	NQ	NQ
Two Well-Child Visits	NQ	NQ
Three Well-Child Visits	NQ	NQ
Four Well-Child Visits	NQ	NQ
Five Well-Child Visits	NQ	NQ
Six or More Well-Child Visits	NQ	NQ
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	★	47.62%
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	★	0.00%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★	66.18%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★	35.04%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap)	★	54.01%
Combination 2 (Meningococcal, Tdap, HPV)	—	7.79%
Annual Dental Visit		
2–3 Years	NA	NA
4–6 Years	★	40.48%
7–10 Years	★	45.94%
11–14 Years	★	36.79%

Magellan-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
15–18 Years	★	32.19%
19–20 Years	—	20.70%
Total	★	32.23%
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	★	41.36%
Chlamydia Screening in Women		
16–20 Years	★★★★	62.91%
21–24 Years	★★★	65.19%
Total	★★★★	63.62%
Breast Cancer Screening		
Breast Cancer Screening	★	38.28%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★	64.48%
Postpartum Care	★	39.17%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★	40.15%
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	★	77.13%
*HbA1c Poor Control (>9.0%)**	★	52.80%
HbA1c Control (<8.0%)	★	39.17%
Eye Exam (Retinal) Performed	★	38.93%
Medical Attention for Nephropathy	★★	90.27%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★★★	56.20%
Adult BMI Assessment		
Adult BMI Assessment	★★	77.62%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[2]	NA	NA
Medication Compliance 50%—Ages 12–18 Years[2]	★★★★★	64.29%
Medication Compliance 50%—Ages 19–50 Years[2]	★★★★	72.00%
Medication Compliance 50%—Ages 51–64 Years[2]	★★★★	80.30%
Medication Compliance 50%—Total[2]	★★★★★	71.85%
Medication Compliance 75%—Ages 5–11 Years	NA	NA
Medication Compliance 75%—Ages 12–18 Years	★★★★★	47.62%

Magellan-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Medication Compliance 75%—Ages 19–50 Years	★★★★★	52.00%
Medication Compliance 75%—Ages 51–64 Years	★★★★	62.12%
Medication Compliance 75%—Total	★★★★★	52.22%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★	91.10%
Annual Monitoring for Members on Digoxin	NA	NA
Annual Monitoring for Members on Diuretics	★★★★	90.23%
Total	★★★★	90.70%
Plan All-Cause Readmissions*		
18–64 Years of Age—Total	—	36.83%
65+ Years of Age—Total	—	28.30%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	0.00%
≥2 Visits	—	28.25%
1 Visit	—	14.69%
0 Visits	—	57.06%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	75.71%
HIV Viral Load Suppression		
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	—	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	★★★★★	57.28%
Initiation of AOD Treatment—18+ Years	★★★★★	50.45%
Initiation of AOD Treatment—Total	★★★★★	50.93%
Engagement of AOD Treatment—13–17 Years	★★	12.25%
Engagement of AOD Treatment—18+ Years	★	6.26%

Magellan-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Engagement of AOD Treatment—Total	★	6.67%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	★★	39.06%
30-Day Follow-Up	★	46.72%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up	—	40.39%
30-Day Follow-Up	—	60.07%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependencies		
7-Day Follow-Up—13–17 Years	—	6.82%
7-Day Follow-Up—18+ Years	—	18.05%
7-Day Follow-Up—Total	—	17.39%
30-Day Follow-Up—13–17 Years	—	9.09%
30-Day Follow-Up—18+ Years	—	21.56%
30-Day Follow-Up—Total	—	20.83%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★	49.05%
Effective Continuation Phase Treatment	★★	33.35%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★★★	67.78%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NA
6–11 Years	★★★★	32.72%
12–17 Years	★★★	36.96%
Total	★★★★	35.96%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents* [1]		
1–5 Years	NA	NA
6–11 Years	★★	1.85%
12–17 Years	★★★	2.41%
Total	★★	2.28%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	36.68%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	NA	NA
25 Months–6 Years	★	64.29%
7–11 Years	★	70.55%

Magellan-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
12–19 Years	★	66.26%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	72.32%
45–64 Years	★★	85.55%
65 Years and Older	★	79.01%
Total	★★	77.29%
Call Answer Timeliness		
Call Answer Timeliness	★★	78.71%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	86.50%
Use of Services		
Ambulatory Care		
Outpatient Visits—Total	—	227.77
ED Visits—Total	—	153.73
SMI-Related Measures		
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	★	73.64%
Diabetes Monitoring for People with Diabetes and Schizophrenia		
Diabetes Monitoring for People with Diabetes and Schizophrenia	★★★	70.21%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	★★★★	88.33%

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2017 (RY 2017) technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to performance targets derived using data reported for HEDIS 2016 (RY 2016).
[2] Quality Compass benchmarks were not available; therefore, the 2016 Audit Means and Percentiles were used for comparison purposes.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2016 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 (i.e., <100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For RY 2017 rates designated NA, the performance level analysis value was also NA.
2017 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*

Table D-20 provides a summary of the performance level analysis results for Magellan-S for RY 2017 (CY 2016).

Table D-20—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Performance Level Analysis Summary Table: Magellan-S

2017 Performance Level Analysis	Number of Rates	Percent of Rates
★★★★★	8	12.31%
★★★★	12	18.46%
★★★	5	7.69%
★★	12	18.46%
★	28	43.08%
Total	**65**	**100.00%**

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Molina Performance Measure Results

Table D-21 contains the MMA performance measure rates and performance level analysis results for Molina for RY 2017 (CY 2016).

Table D-21—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results
Summary Table: Molina

Molina Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★	3.33%
One Well-Child Visit	★★★	2.22%
Two Well-Child Visits	★★	2.22%
Three Well-Child Visits	★	3.11%
Four Well-Child Visits	★★★	10.89%
Five Well-Child Visits	★★★	18.67%
Six or More Well-Child Visits	★★	59.56%
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	★★★★	80.58%
Childhood Immunization Status		
Combination 2	★★★★	79.47%
Combination 3	★★★★	76.16%
Lead Screening in Children		
Lead Screening in Children	★★	67.99%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★★★	50.98%
Continuation and Maintenance Phase	★★★★★	72.69%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★★	68.76%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★	50.45%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap)	★★	68.21%
Combination 2 (Meningococcal, Tdap, HPV)	—	18.54%
Annual Dental Visit		
2–3 Years	★★	29.74%
4–6 Years	★★	51.47%
7–10 Years	★★	59.14%
11–14 Years	★★	51.83%

Molina Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
15–18 Years	★★	43.21%
19–20 Years	—	25.53%
Total	★★	48.37%
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	★	45.21%
Chlamydia Screening in Women		
16–20 Years	★★★	57.90%
21–24 Years	★★★★	68.76%
Total	★★★	61.16%
Breast Cancer Screening		
Breast Cancer Screening	★★★	59.02%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★★★	82.33%
Postpartum Care	★★	60.47%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★★	64.19%
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	★★★	86.09%
*HbA1c Poor Control (>9.0%)**	★★	44.81%
HbA1c Control (<8.0%)	★★★	47.24%
Eye Exam (Retinal) Performed	★★★	56.95%
Medical Attention for Nephropathy	★★★	91.39%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★	42.04%
Adult BMI Assessment		
Adult BMI Assessment	★★★	84.80%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[2]	★★	48.01%
Medication Compliance 50%—Ages 12–18 Years[2]	★★	46.03%
Medication Compliance 50%—Ages 19–50 Years[2]	★★★	62.84%
Medication Compliance 50%—Ages 51–64 Years[2]	★★	70.54%
Medication Compliance 50%—Total[2]	★★	51.00%
Medication Compliance 75%—Ages 5–11 Years	★★	21.78%
Medication Compliance 75%—Ages 12–18 Years	★★	23.28%

Molina Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Medication Compliance 75%—Ages 19–50 Years	★★	34.43%
Medication Compliance 75%—Ages 51–64 Years	★	42.86%
Medication Compliance 75%—Total	★★	25.27%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★	91.61%
Annual Monitoring for Members on Digoxin	★★★	54.00%
Annual Monitoring for Members on Diuretics	★★★★	91.59%
Total	★★★★	91.19%
Plan All-Cause Readmissions*		
18–64 Years of Age—Total	—	23.82%
65+ Years of Age—Total	—	NA
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	47.75%
≥2 Visits	—	72.59%
1 Visit	—	13.28%
0 Visits	—	14.13%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	86.43%
HIV Viral Load Suppression		
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
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	★	28.10%
Initiation of AOD Treatment—18+ Years	★★	35.80%
Initiation of AOD Treatment—Total	★★	35.16%
Engagement of AOD Treatment—13–17 Years	★	5.44%
Engagement of AOD Treatment—18+ Years	★	6.00%

Molina Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Engagement of AOD Treatment—Total	★	5.95%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	★★	39.18%
30-Day Follow-Up	★★	57.98%†
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up	—	22.79%
30-Day Follow-Up	—	40.11%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependencies		
7-Day Follow-Up—13–17 Years	—	0.96%
7-Day Follow-Up—18+ Years	—	5.68%
7-Day Follow-Up—Total	—	5.05%
30-Day Follow-Up—13–17 Years	—	0.96%
30-Day Follow-Up—18+ Years	—	7.77%
30-Day Follow-Up—Total	—	6.86%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★	52.91%
Effective Continuation Phase Treatment	★★	37.41%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★★	61.38%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NA
6–11 Years	★★★★	33.60%
12–17 Years	★★★	36.78%
Total	★★★★	35.53%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents* [1]		
1–5 Years	NA	NA
6–11 Years	★★★★	0.54%
12–17 Years	★★★★★	0.00%
Total	★★★★	0.22%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	47.79%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★★	93.25%
25 Months–6 Years	★★	86.23%
7–11 Years	★	87.58%

Molina Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
12–19 Years	★	84.50%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	66.22%
45–64 Years	★★	82.64%
65 Years and Older	★★	84.56%
Total	★	72.14%
Call Answer Timeliness		
Call Answer Timeliness	★	76.49%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	88.42%
Use of Services		
Ambulatory Care		
Outpatient Visits—Total	—	308.57
ED Visits—Total	—	70.42
SMI-Related Measures		
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	★★★	82.36%

** For this indicator, a lower rate indicates better performance.*
† The FHM measure rate presented in this report for Molina differs from the audited rate reported in the custom rate template due to an issue with the custom rate template (would only allow one eligible population to be entered for both indicators).
[1] Due to changes in the HEDIS 2017 (RY 2017) technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to performance targets derived using data reported for HEDIS 2016 (RY 2016).
[2] Quality Compass benchmarks were not available; therefore, the 2016 Audit Means and Percentiles were used for comparison purposes.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2016 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 (i.e., <100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For RY 2017 rates designated NA, the performance level analysis value was also NA.
2017 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*

Table D-22 provides a summary of the performance level analysis results for Molina for RY 2017 (CY 2016).

Table D-22—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Performance Level Analysis Summary Table: Molina

2017 Performance Level Analysis	Number of Rates	Percent of Rates
★★★★★	2	2.56%
★★★★	12	15.38%
★★★	20	25.64%
★★	30	38.46%
★	14	17.95%
Total	**78**	**100.00%**

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Positive-S Performance Measure Results

Table D-23 contains the MMA performance measure rates and performance level analysis results for Positive-S for RY 2017 (CY 2016).

Table D-23—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results
Summary Table: Positive-S

Positive-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 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)	NA	NA
Combination 2 (Meningococcal, Tdap, HPV)	—	NA
Annual Dental Visit		
2–3 Years	NA	NA
4–6 Years	NA	NA
7–10 Years	NA	NA
11–14 Years	NA	NA

Positive-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
15–18 Years	NA	NA
19–20 Years	—	NA
Total	NA	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	★★★★	65.90%
Chlamydia Screening in Women		
16–20 Years	NA	NA
21–24 Years	NA	NA
Total	NA	NA
Breast Cancer Screening		
Breast Cancer Screening	★★★	58.10%
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
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	★★★★	90.48%
*HbA1c Poor Control (>9.0%)**	★★★★	34.13%
HbA1c Control (<8.0%)	★★★	49.21%
Eye Exam (Retinal) Performed	★	27.78%
Medical Attention for Nephropathy	★★★★	92.06%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★★★★	65.75%
Adult BMI Assessment		
Adult BMI Assessment	★★★★★	92.70%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[2]	NA	NA
Medication Compliance 50%—Ages 12–18 Years[2]	NA	NA
Medication Compliance 50%—Ages 19–50 Years[2]	NA	NA
Medication Compliance 50%—Ages 51–64 Years[2]	NA	NA
Medication Compliance 50%—Total[2]	NA	NA
Medication Compliance 75%—Ages 5–11 Years	NA	NA
Medication Compliance 75%—Ages 12–18 Years	NA	NA

Positive-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
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	★★★★★	98.40%
Annual Monitoring for Members on Digoxin	NA	NA
Annual Monitoring for Members on Diuretics	★★★★★	98.32%
Total	★★★★★	97.74%
Plan All-Cause Readmissions*		
18–64 Years of Age—Total	—	15.70%
65+ Years of Age—Total	—	18.42%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	51.22%
≥2 Visits	—	74.54%
1 Visit	—	12.73%
0 Visits	—	12.73%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	96.57%
HIV Viral Load Suppression		
18–64 Years	—	86.22%
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
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	★★★	38.28%
Initiation of AOD Treatment—Total	★★★	38.28%
Engagement of AOD Treatment—13–17 Years	NA	NA
Engagement of AOD Treatment—18+ Years	★	4.69%

Positive-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Engagement of AOD Treatment—Total	★	4.69%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	★	16.67%
30-Day Follow-Up	★	18.06%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up	—	NA
30-Day Follow-Up	—	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependencies		
7-Day Follow-Up—13–17 Years	—	NA
7-Day Follow-Up—18+ Years	—	NA
7-Day Follow-Up—Total	—	NA
30-Day Follow-Up—13–17 Years	—	NA
30-Day Follow-Up—18+ Years	—	NA
30-Day Follow-Up—Total	—	NA
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★★★	66.67%
Effective Continuation Phase Treatment	★★★★★	57.58%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★	32.26%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NA
6–11 Years	NA	NA
12–17 Years	NA	NA
Total	NA	NA
Use of Multiple Concurrent Antipsychotics in Children and Adolescents* [1]		
1–5 Years	NA	NA
6–11 Years	NA	NA
12–17 Years	NA	NA
Total	NA	NA
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	19.18%
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

Positive-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
12–19 Years	NA	NA
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★★★★★	91.96%
45–64 Years	★★★★★	93.49%
65 Years and Older	NA	NA
Total	★★★★★	93.01%
Call Answer Timeliness		
Call Answer Timeliness	★★	80.30%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	94.05%
Use of Services		
Ambulatory Care		
Outpatient Visits—Total	—	351.49
ED Visits—Total	—	202.98
SMI-Related Measures		
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	★★★★★	97.83%

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2017 (RY 2017) technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to performance targets derived using data reported for HEDIS 2016 (RY 2016).
[2] Quality Compass benchmarks were not available; therefore, the 2016 Audit Means and Percentiles were used for comparison purposes.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2016 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 (i.e., <100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For RY 2017 rates designated NA, the performance level analysis value was also NA.
2017 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*

Table D-24 provides a summary of the performance level analysis results for Positive-S for RY 2017 (CY 2016).

Table D-24—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Performance Level Analysis Summary Table: Positive-S

2017 Performance Level Analysis	Number of Rates	Percent of Rates
★★★★★	9	34.62%
★★★★	6	23.08%
★★★	4	15.38%
★★	1	3.85%
★	6	23.08%
Total	**26**	**100.00%**

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Prestige Performance Measure Results

Table D-25 contains the MMA performance measure rates and performance level analysis results for Prestige for RY 2017 (CY 2016).

Table D-25—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results
Summary Table: Prestige

Prestige Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★★	2.31%
One Well-Child Visit	★★	1.85%
Two Well-Child Visits	★★★	3.47%
Three Well-Child Visits	★★	5.32%
Four Well-Child Visits	★★	9.03%
Five Well-Child Visits	★★★	16.90%
Six or More Well-Child Visits	★★★	61.11%
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	★★	66.67%
Childhood Immunization Status		
Combination 2	★★★	78.01%
Combination 3	★★★★	75.69%
Lead Screening in Children		
Lead Screening in Children	★★	62.50%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★★★	52.25%
Continuation and Maintenance Phase	★★★★★	71.20%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★★★	80.79%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★	45.60%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap)	★★	69.21%
Combination 2 (Meningococcal, Tdap, HPV)	—	20.37%
Annual Dental Visit		
2–3 Years	★★	28.06%
4–6 Years	★★	50.83%
7–10 Years	★★	57.06%
11–14 Years	★★	50.89%

Prestige Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
15–18 Years	★★	43.01%
19–20 Years	—	26.80%
Total	★★	46.87%
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	★★★	56.41%
Chlamydia Screening in Women		
16–20 Years	★★★	57.31%
21–24 Years	★★★	65.85%
Total	★★★	60.11%
Breast Cancer Screening		
Breast Cancer Screening	★★	57.28%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★★★	85.95%
Postpartum Care	★★	59.48%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★★	67.68%
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	★	82.64%
*HbA1c Poor Control (>9.0%)**	★★	51.27%
HbA1c Control (<8.0%)	★	38.54%
Eye Exam (Retinal) Performed	★★	49.84%
Medical Attention for Nephropathy	★★★	90.61%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★★	51.33%
Adult BMI Assessment		
Adult BMI Assessment	★★	84.03%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[2]	★★	50.53%
Medication Compliance 50%—Ages 12–18 Years[2]	★★★	53.15%
Medication Compliance 50%—Ages 19–50 Years[2]	★★★	65.52%
Medication Compliance 50%—Ages 51–64 Years[2]	★★★★	78.51%
Medication Compliance 50%—Total[2]	★★	54.90%
Medication Compliance 75%—Ages 5–11 Years	★★	24.05%
Medication Compliance 75%—Ages 12–18 Years	★★★	27.78%

Prestige Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Medication Compliance 75%—Ages 19–50 Years	★★★	41.95%
Medication Compliance 75%—Ages 51–64 Years	★★★★	57.02%
Medication Compliance 75%—Total	★★	29.42%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★	88.64%
Annual Monitoring for Members on Digoxin	★★	52.94%
Annual Monitoring for Members on Diuretics	★★★	89.21%
Total	★★★	88.45%
Plan All-Cause Readmissions*		
18–64 Years of Age—Total	—	19.18%
65+ Years of Age—Total	—	20.00%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	45.59%
≥2 Visits	—	67.43%
1 Visit	—	12.64%
0 Visits	—	19.92%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	85.12%
HIV Viral Load Suppression		
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	—	74.07%
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—Total	★★	74.61%
Discussing Cessation Medications—18–64 Years of Age	—	46.35%
Discussing Cessation Medications—65+ Years of Age	—	NA
Discussing Cessation Medications—Total	★★	47.45%
Discussing Cessation Strategies—18–64 Years of Age	—	42.93%
Discussing Cessation Strategies—65+ Years of Age	—	NA
Discussing Cessation Strategies—Total	★★	43.59%
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	★	29.43%
Initiation of AOD Treatment—18+ Years	★★★	38.83%
Initiation of AOD Treatment—Total	★★★	38.17%
Engagement of AOD Treatment—13–17 Years	★★★	15.47%
Engagement of AOD Treatment—18+ Years	★★	7.48%

Prestige Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Engagement of AOD Treatment—Total	★★	8.04%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	★	18.77%
30-Day Follow-Up	★	48.38%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up	—	24.97%
30-Day Follow-Up	—	48.04%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependencies		
7-Day Follow-Up—13–17 Years	—	2.50%
7-Day Follow-Up—18+ Years	—	7.10%
7-Day Follow-Up—Total	—	6.71%
30-Day Follow-Up—13–17 Years	—	3.75%
30-Day Follow-Up—18+ Years	—	10.36%
30-Day Follow-Up—Total	—	9.80%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★	53.33%
Effective Continuation Phase Treatment	★★	36.16%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★★	64.76%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NA
6–11 Years	★★★★	29.82%
12–17 Years	★★★	34.20%
Total	★★★	32.57%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents* [1]		
1–5 Years	NA	NA
6–11 Years	★★★	1.04%
12–17 Years	★★★★	0.46%
Total	★★★★	0.69%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	14.66%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★★	93.28%
25 Months–6 Years	★	84.06%
7–11 Years	★	85.13%

Prestige Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
12–19 Years	★	80.47%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	66.97%
45–64 Years	★★	83.15%
65 Years and Older	★★	82.57%
Total	★	71.99%
Call Answer Timeliness		
Call Answer Timeliness	★★★★★	92.76%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	92.69%
Use of Services		
Ambulatory Care		
Outpatient Visits—Total	—	296.78
ED Visits—Total	—	74.95
SMI-Related Measures		
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	★★★	80.98%

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2017 (RY 2017) technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to performance targets derived using data reported for HEDIS 2016 (RY 2016).
[2] Quality Compass benchmarks were not available; therefore, the 2016 Audit Means and Percentiles were used for comparison purposes.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2016 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 (i.e., <100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For RY 2017 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 RY 2017 rates designated BR, the performance level analysis value was also BR.
2017 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*

Table D-26 provides a summary of the performance level analysis results for Prestige for RY 2017 (CY 2016).

Table D-26—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Performance Level Analysis Summary Table: Prestige

2017 Performance Level Analysis	Number of Rates	Percent of Rates
★★★★★	2	2.47%
★★★★	8	9.88%
★★★	26	32.10%
★★	35	43.21%
★	10	12.35%
Total	**81**	**100.00%**

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Simply Performance Measure Results

Table D-27 contains the MMA performance measure rates and performance level analysis results for Simply for RY 2017 (CY 2016).

Table D-27—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results
Summary Table: Simply

Simply Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★★★	1.62%
One Well-Child Visit	★	0.93%
Two Well-Child Visits	★★	2.31%
Three Well-Child Visits	★★	4.17%
Four Well-Child Visits	★★★	9.72%
Five Well-Child Visits	★	11.81%
Six or More Well-Child Visits	★★★★	69.44%
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	★★★★	81.25%
Childhood Immunization Status		
Combination 2	★★★	75.69%
Combination 3	★★	69.68%
Lead Screening in Children		
Lead Screening in Children	★★	68.52%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★	36.93%
Continuation and Maintenance Phase	★★★	57.14%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★★★	84.72%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★★	62.27%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap)	★★	71.53%
Combination 2 (Meningococcal, Tdap, HPV)	—	28.47%
Annual Dental Visit		
2–3 Years	★★	32.64%
4–6 Years	★★	54.47%
7–10 Years	★★	62.61%
11–14 Years	★★	56.55%

Simply Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
15–18 Years	★★	46.49%
19–20 Years	—	32.20%
Total	★★	51.52%
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	—	29.60%
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★★★	61.16%
Chlamydia Screening in Women		
16–20 Years	★★★★	64.90%
21–24 Years	★★★★	68.18%
Total	★★★★	65.49%
Breast Cancer Screening		
Breast Cancer Screening	★★★★	67.99%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★★★	87.18%
Postpartum Care	★★★	63.17%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★★	68.53%
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	★★★★	89.56%
*HbA1c Poor Control (>9.0%)**	★★★★	34.80%
HbA1c Control (<8.0%)	★★★	52.20%
Eye Exam (Retinal) Performed	★★	50.35%
Medical Attention for Nephropathy	★★★★★	96.75%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★★★★	64.19%
Adult BMI Assessment		
Adult BMI Assessment	★★★★	90.28%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[2]	★	44.95%
Medication Compliance 50%—Ages 12–18 Years[2]	★★	46.08%
Medication Compliance 50%—Ages 19–50 Years[2]	★★★	63.54%
Medication Compliance 50%—Ages 51–64 Years[2]	★★★★★	86.00%
Medication Compliance 50%—Total[2]	★★★	57.06%
Medication Compliance 75%—Ages 5–11 Years	★★	23.74%
Medication Compliance 75%—Ages 12–18 Years	★	16.67%

Simply Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Medication Compliance 75%—Ages 19–50 Years	★★★	42.71%
Medication Compliance 75%—Ages 51–64 Years	★★★★★	68.00%
Medication Compliance 75%—Total	★★★	34.88%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★★	93.47%
Annual Monitoring for Members on Digoxin	★	48.65%
Annual Monitoring for Members on Diuretics	★★★★★	93.98%
Total	★★★★★	93.25%
Plan All-Cause Readmissions*		
18–64 Years of Age—Total	—	25.19%
65+ Years of Age—Total	—	19.34%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	31.30%
≥2 Visits	—	54.20%
1 Visit	—	16.03%
0 Visits	—	29.77%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	82.76%
HIV Viral Load Suppression		
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	—	15.73%
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	—	11.46%
Advising Smokers and Tobacco Users to Quit—Total	★	13.48%
Discussing Cessation Medications—18–64 Years of Age	—	9.87%
Discussing Cessation Medications—65+ Years of Age	—	7.64%
Discussing Cessation Medications—Total	★	8.69%
Discussing Cessation Strategies—18–64 Years of Age	—	9.60%
Discussing Cessation Strategies—65+ Years of Age	—	7.40%
Discussing Cessation Strategies—Total	★	8.44%
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	★★★★	51.06%
Initiation of AOD Treatment—18+ Years	★	21.52%
Initiation of AOD Treatment—Total	★	22.96%
Engagement of AOD Treatment—13–17 Years	★★★	17.02%
Engagement of AOD Treatment—18+ Years	★	2.39%

Simply Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Engagement of AOD Treatment—Total	★	3.10%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	★★	36.88%
30-Day Follow-Up	★★	58.30%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up	—	23.42%
30-Day Follow-Up	—	47.47%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependencies		
7-Day Follow-Up—13–17 Years	—	NA
7-Day Follow-Up—18+ Years	—	15.57%
7-Day Follow-Up—Total	—	13.87%
30-Day Follow-Up—13–17 Years	—	NA
30-Day Follow-Up—18+ Years	—	16.39%
30-Day Follow-Up—Total	—	15.33%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★★	58.06%
Effective Continuation Phase Treatment	★★★★	43.94%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★★	61.34%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NA
6–11 Years	NA	NA
12–17 Years	★★★★★	52.22%
Total	★★★★★	54.31%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents* [1]		
1–5 Years	NA	NA
6–11 Years	NA	NA
12–17 Years	★★★★★	0.00%
Total	★★★★★	0.00%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	32.63%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★★	95.08%
25 Months–6 Years	★★★	90.78%
7–11 Years	★★★	92.18%

Simply Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
12–19 Years	★	85.32%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	69.92%
45–64 Years	★★★★	89.88%
65 Years and Older	★★★★★	93.21%
Total	★★★	83.40%
Call Answer Timeliness		
Call Answer Timeliness	★★★	87.94%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	93.63%
Use of Services		
Ambulatory Care		
Outpatient Visits—Total	—	360.46
ED Visits—Total	—	54.83
SMI-Related Measures		
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	★★★★	84.23%

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2017 (RY 2017) technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to performance targets derived using data reported for HEDIS 2016 (RY 2016).
[2] Quality Compass benchmarks were not available; therefore, the 2016 Audit Means and Percentiles were used for comparison purposes.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2016 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 (i.e., <100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For RY 2017 rates designated NA, the performance level analysis value was also NA.
2017 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*

Table D-28 provides a summary of the performance level analysis results for Simply for RY 2017 (CY 2016).

Table D-28—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Performance Level Analysis Summary Table: Simply

2017 Performance Level Analysis	Number of Rates	Percent of Rates
★★★★★	11	13.92%
★★★★	16	20.25%
★★★	20	25.32%
★★	18	22.78%
★	14	17.72%
Total	**79**	**100.00%**

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Staywell Performance Measure Results

Table D-29 contains the MMA performance measure rates and performance level analysis results for Staywell for RY 2017 (CY 2016).

Table D-29—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results
Summary Table: Staywell

Staywell Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★★★	1.23%
One Well-Child Visit	★	0.99%
Two Well-Child Visits	★★	2.47%
Three Well-Child Visits	★★★	5.68%
Four Well-Child Visits	★★	8.89%
Five Well-Child Visits	★★	16.30%
Six or More Well-Child Visits	★★★	64.44%
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	★★★★	79.13%
Childhood Immunization Status		
Combination 2	★★★	78.10%
Combination 3	★★★	74.21%
Lead Screening in Children		
Lead Screening in Children	★★	63.99%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★★★	54.01%
Continuation and Maintenance Phase	★★★★★	71.42%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★★★	80.99%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★	55.61%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap)	★★	69.83%
Combination 2 (Meningococcal, Tdap, HPV)	—	20.44%
Annual Dental Visit		
2–3 Years	★★	28.78%
4–6 Years	★★	52.31%
7–10 Years	★★	60.01%
11–14 Years	★★	53.95%

Staywell Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
15–18 Years	★★	46.96%
19–20 Years	—	29.15%
Total	★★	49.84%
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	—	54.82%
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★★★	63.66%
Chlamydia Screening in Women		
16–20 Years	★★★★	60.16%
21–24 Years	★★★★	69.22%
Total	★★★★	62.67%
Breast Cancer Screening		
Breast Cancer Screening	★★★	62.72%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★★★	83.70%
Postpartum Care	★★★	65.68%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★★	68.89%
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	★★	85.40%
*HbA1c Poor Control (>9.0%)**	★★	44.04%
HbA1c Control (<8.0%)	★★	46.23%
Eye Exam (Retinal) Performed	★★★★	64.72%
Medical Attention for Nephropathy	★★★	91.48%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★★★	55.72%
Adult BMI Assessment		
Adult BMI Assessment	★★★	87.21%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[2]	★★	50.72%
Medication Compliance 50%—Ages 12–18 Years[2]	★★	47.43%
Medication Compliance 50%—Ages 19–50 Years[2]	★★	58.67%
Medication Compliance 50%—Ages 51–64 Years[2]	★★	70.61%
Medication Compliance 50%—Total[2]	★★	51.44%
Medication Compliance 75%—Ages 5–11 Years	★★	22.46%
Medication Compliance 75%—Ages 12–18 Years	★★	21.22%

Staywell Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Medication Compliance 75%—Ages 19–50 Years	★★	32.67%
Medication Compliance 75%—Ages 51–64 Years	★★	45.04%
Medication Compliance 75%—Total	★	24.14%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★	92.08%
Annual Monitoring for Members on Digoxin	★★★★	61.90%
Annual Monitoring for Members on Diuretics	★★★★	91.94%
Total	★★★★	91.73%
Plan All-Cause Readmissions*		
18–64 Years of Age—Total	—	22.88%
65+ Years of Age—Total	—	16.51%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	59.87%
≥2 Visits	—	78.95%
1 Visit	—	8.22%
0 Visits	—	12.83%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	78.15%
HIV Viral Load Suppression		
18–64 Years	—	0.00%
65+Yyears	—	0.00%
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years of Age	—	74.55%
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	—	NA
Advising Smokers and Tobacco Users to Quit—Total	★★	76.47%
Discussing Cessation Medications—18–64 Years of Age	—	53.57%
Discussing Cessation Medications—65+ Years of Age	—	NA
Discussing Cessation Medications—Total	★★★★	54.17%
Discussing Cessation Strategies—18–64 Years of Age	—	40.91%
Discussing Cessation Strategies—65+ Years of Age	—	NA
Discussing Cessation Strategies—Total	★★	39.83%
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	★★	39.14%
Initiation of AOD Treatment—18+ Years	★★★	40.08%
Initiation of AOD Treatment—Total	★★★	39.99%
Engagement of AOD Treatment—13–17 Years	★★	11.72%
Engagement of AOD Treatment—18+ Years	★★	7.92%

Staywell Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Engagement of AOD Treatment—Total	★★	8.30%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	★★	37.69%
30-Day Follow-Up	★	53.29%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up	—	30.96%
30-Day Follow-Up	—	45.48%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependencies		
7-Day Follow-Up—13–17 Years	—	1.15%
7-Day Follow-Up—18+ Years	—	7.28%
7-Day Follow-Up—Total	—	6.29%
30-Day Follow-Up—13–17 Years	—	3.45%
30-Day Follow-Up—18+ Years	—	9.93%
30-Day Follow-Up—Total	—	8.88%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★	48.52%
Effective Continuation Phase Treatment	★	32.48%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★	57.19%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NA
6–11 Years	★★★	27.89%
12–17 Years	★★★	34.84%
Total	★★★	32.02%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents* [1]		
1–5 Years	NA	NA
6–11 Years	★★★	1.28%
12–17 Years	★★★	2.36%
Total	★★★	1.90%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	19.90%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★★★	96.04%
25 Months–6 Years	★★★	89.32%
7–11 Years	★★	89.41%

Staywell Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
12–19 Years	★★	86.91%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	71.02%
45–64 Years	★★★	86.85%
65 Years and Older	★★	86.83%
Total	★	76.31%
Call Answer Timeliness		
Call Answer Timeliness	★★★★	89.70%
Transportation Availability		
Transportation Availability	—	98.37%
Transportation Timeliness		
Transportation Timeliness	—	76.24%
Use of Services		
Ambulatory Care		
Outpatient Visits—Total	—	350.16
ED Visits—Total	—	73.49
SMI-Related Measures		
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	★★★	82.12%

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2017 (RY 2017) technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to performance targets derived using data reported for HEDIS 2016 (RY 2016).
[2] Quality Compass benchmarks were not available; therefore, the 2016 Audit Means and Percentiles were used for comparison purposes.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2016 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 (i.e., <100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For RY 2017 rates designated NA, the performance level analysis value was also NA.
2017 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*

Table D-30 provides a summary of the performance level analysis results for Staywell for RY 2017 (CY 2016).

Table D-30—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Performance Level Analysis Summary Table: Staywell

2017 Performance Level Analysis	Number of Rates	Percent of Rates
★★★★★	1	1.23%
★★★★	13	16.05%
★★★	26	32.10%
★★	35	43.21%
★	6	7.41%
Total	**81**	**100.00%**

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Sunshine Performance Measure Results

Table D-31 contains the MMA performance measure rates and performance level analysis results for Sunshine for RY 2017 (CY 2016).

Table D-31—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results
Summary Table: Sunshine

Sunshine Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★	3.33%
One Well-Child Visit	★★★	2.75%
Two Well-Child Visits	★★★	3.85%
Three Well-Child Visits	★★★	6.29%
Four Well-Child Visits	★★★★	11.95%
Five Well-Child Visits	★★★★	20.76%
Six or More Well-Child Visits	★	51.08%
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	★★★	71.81%
Childhood Immunization Status		
Combination 2	★★★	77.16%
Combination 3	★★★	72.60%
Lead Screening in Children		
Lead Screening in Children	★★	64.11%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★★★	54.78%
Continuation and Maintenance Phase	★★★★★	69.46%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★★★	80.29%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★	46.97%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap)	★★	67.31%
Combination 2 (Meningococcal, Tdap, HPV)	—	15.14%
Annual Dental Visit		
2–3 Years	★★	27.13%
4–6 Years	★	48.52%
7–10 Years	★★	56.14%
11–14 Years	★★	49.00%

Sunshine Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
15–18 Years	★	40.82%
19–20 Years	—	24.04%
Total	★★	45.34%
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	★	46.19%
Chlamydia Screening in Women		
16–20 Years	★★★★	62.14%
21–24 Years	★★★★	69.97%
Total	★★★★	64.74%
Breast Cancer Screening		
Breast Cancer Screening	★	35.63%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★★	78.85%
Postpartum Care	★★	60.58%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★★	60.58%
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	★	66.44%
*HbA1c Poor Control (>9.0%)**	★	57.64%
HbA1c Control (<8.0%)	★	33.56%
Eye Exam (Retinal) Performed	★★	46.53%
Medical Attention for Nephropathy	★	83.80%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★	45.19%
Adult BMI Assessment		
Adult BMI Assessment	★★★	84.62%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[2]	★	44.11%
Medication Compliance 50%—Ages 12–18 Years[2]	★★	43.44%
Medication Compliance 50%—Ages 19–50 Years[2]	★	55.71%
Medication Compliance 50%—Ages 51–64 Years[2]	★★	71.65%
Medication Compliance 50%—Total[2]	★	46.44%
Medication Compliance 75%—Ages 5–11 Years	★	19.15%
Medication Compliance 75%—Ages 12–18 Years	★	16.80%

Sunshine Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Medication Compliance 75%—Ages 19–50 Years	★★★	37.86%
Medication Compliance 75%—Ages 51–64 Years	★★★	50.39%
Medication Compliance 75%—Total	★	21.94%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★	91.49%
Annual Monitoring for Members on Digoxin	★★★★★	62.18%
Annual Monitoring for Members on Diuretics	★★★★	91.72%
Total	★★★★	91.24%
Plan All-Cause Readmissions*		
18–64 Years of Age—Total	—	21.63%
65+ Years of Age—Total	—	NA
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	40.32%
≥2 Visits	—	60.17%
1 Visit	—	16.35%
0 Visits	—	23.47%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	64.39%
HIV Viral Load Suppression		
18–64 Years	—	14.71%
65+ Years	—	11.29%
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	★★★	77.14%
Discussing Cessation Medications—18–64 Years of Age	—	NA
Discussing Cessation Medications—65+ Years of Age	—	NA
Discussing Cessation Medications—Total	★★★★	55.56%
Discussing Cessation Strategies—18–64 Years of Age	—	NA
Discussing Cessation Strategies—65+ Years of Age	—	NA
Discussing Cessation Strategies—Total	★★★	46.30%
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	★★	39.58%
Initiation of AOD Treatment—18+ Years	★★★★	43.68%
Initiation of AOD Treatment—Total	★★★★	43.37%
Engagement of AOD Treatment—13–17 Years	★★	10.11%
Engagement of AOD Treatment—18+ Years	★	5.97%

Sunshine Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Engagement of AOD Treatment—Total	★	6.28%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	★★	42.08%
30-Day Follow-Up	★★	54.87%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up	—	22.41%
30-Day Follow-Up	—	35.13%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependencies		
7-Day Follow-Up—13–17 Years	—	1.60%
7-Day Follow-Up—18+ Years	—	6.05%
7-Day Follow-Up—Total	—	5.59%
30-Day Follow-Up—13–17 Years	—	6.40%
30-Day Follow-Up—18+ Years	—	8.34%
30-Day Follow-Up—Total	—	8.14%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★	47.55%
Effective Continuation Phase Treatment	★	32.34%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★★	64.34%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NA
6–11 Years	★★★★	30.04%
12–17 Years	★★★★	38.95%
Total	★★★★	35.43%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents* [1]		
1–5 Years	NA	NA
6–11 Years	★★★★	0.62%
12–17 Years	★★★★	1.33%
Total	★★★★	1.05%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	30.33%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★	92.34%
25 Months–6 Years	★★	85.65%
7–11 Years	★	86.30%

Sunshine Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
12–19 Years	★	81.15%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	62.92%
45–64 Years	★	78.19%
65 Years and Older	★	64.78%
Total	★	66.89%
Call Answer Timeliness		
Call Answer Timeliness	★★	82.92%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	89.43%
Use of Services		
Ambulatory Care		
Outpatient Visits—Total	—	282.31
ED Visits—Total	—	66.20
SMI-Related Measures		
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	★★★	82.75%

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2017 (RY 2017) technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to performance targets derived using data reported for HEDIS 2016 (RY 2016).
[2] Quality Compass benchmarks were not available; therefore, the 2016 Audit Means and Percentiles were used for comparison purposes.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2016 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 (i.e., <100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For RY 2017 rates designated NA, the performance level analysis value was also NA.
2017 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*

Table D-32 provides a summary of the performance level analysis results for Sunshine for RY 2017 (CY 2016).

Table D-32—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Performance Level Analysis Summary Table: Sunshine

2017 Performance Level Analysis	Number of Rates	Percent of Rates
★★★★★	2	2.47%
★★★★	19	23.46%
★★★	14	17.28%
★★	18	22.22%
★	28	34.57%
Total	**81**	**100.00%**

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Sunshine-S Performance Measure Results

Table D-33 contains the MMA performance measure rates and performance level analysis results for Sunshine-S for RY 2017 (CY 2016).

Table D-33—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results
Summary Table: Sunshine-S

Sunshine-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★★★	1.20%
One Well-Child Visit	★	0.60%
Two Well-Child Visits	★★★	3.46%
Three Well-Child Visits	★★★	5.87%
Four Well-Child Visits	★★★★★	18.37%
Five Well-Child Visits	★★★★★	31.93%
Six or More Well-Child Visits	★	38.55%
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	★★★★	78.39%
Childhood Immunization Status		
Combination 2	★★★★★	86.30%
Combination 3	★★★★	78.61%
Lead Screening in Children		
Lead Screening in Children	★★	70.92%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★★★★	71.03%
Continuation and Maintenance Phase	★★★★★	78.16%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★★★	83.65%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★	57.18%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap)	★★	68.27%
Combination 2 (Meningococcal, Tdap, HPV)	—	17.07%
Annual Dental Visit		
2–3 Years	★★★	41.58%
4–6 Years	★★★★	72.19%
7–10 Years	★★★★	70.67%
11–14 Years	★★★	62.19%

Sunshine-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
15–18 Years	★★★★	60.50%
19–20 Years	—	30.11%
Total	★★★★	62.82%
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	★★★★★	71.05%
21–24 Years	NA	NA
Total	★★★★★	71.05%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★	73.04%
Postpartum Care	★	49.57%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★	47.83%
Living With Illness		
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[2]	★★★	57.65%
Medication Compliance 50%—Ages 12–18 Years[2]	★★★★	56.36%
Medication Compliance 50%—Ages 19–50 Years[2]	NA	NA
Medication Compliance 50%—Ages 51–64 Years[2]	NA	NA
Medication Compliance 50%—Total[2]	★★★	56.74%
Medication Compliance 75%—Ages 5–11 Years	★★★	31.76%
Medication Compliance 75%—Ages 12–18 Years	★★★	27.27%
Medication Compliance 75%—Ages 19–50 Years	NA	NA
Medication Compliance 75%—Ages 51–64 Years	NA	NA
Medication Compliance 75%—Total	★★	29.79%
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
HIV Viral Load Suppression		
18–64 Years	—	NA
65+ Years	—	NA

Sunshine-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Behavioral Health		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—13–17 Years	★★★	47.41%
Initiation of AOD Treatment—18+ Years	★★★★★	46.22%
Initiation of AOD Treatment—Total	★★★★★	47.12%
Engagement of AOD Treatment—13–17 Years	★★★	14.99%
Engagement of AOD Treatment—18+ Years	★★	7.56%
Engagement of AOD Treatment—Total	★★★	13.17%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	★★★★	60.42%
30-Day Follow-Up	★★★★★	79.21%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up	—	60.11%
30-Day Follow-Up	—	71.81%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependencies		
7-Day Follow-Up—13–17 Years	—	6.19%
7-Day Follow-Up—18+ Years	—	NA
7-Day Follow-Up—Total	—	6.31%
30-Day Follow-Up—13–17 Years	—	9.28%
30-Day Follow-Up—18+ Years	—	NA
30-Day Follow-Up—Total	—	9.01%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NA
6–11 Years	★★★★★	43.43%
12–17 Years	★★★★★	55.15%
Total	★★★★★	51.27%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents* [1]		
1–5 Years	NA	NA
6–11 Years	★★★★	0.31%
12–17 Years	★★★★	1.24%
Total	★★★★	0.92%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	66.84%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★★★★★	97.94%
25 Months–6 Years	★★★★	91.26%

Sunshine-S Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
7–11 Years	★★★	92.50%
12–19 Years	★★★	90.66%
Call Answer Timeliness		
Call Answer Timeliness	★★	84.00%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	86.49%
Use of Services		
Ambulatory Care		
Outpatient Visits—Total	—	297.97
ED Visits—Total	—	55.25
SMI-Related Measures		
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	★★	80.00%

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2017 (RY 2017) technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to performance targets derived using data reported for HEDIS 2016 (RY 2016).
[2] Quality Compass benchmarks were not available; therefore, the 2016 Audit Means and Percentiles were used for comparison purposes.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2016 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 (i.e., <100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For RY 2017 rates designated NA, the performance level analysis value was also NA.
2017 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*

Table D-34 provides a summary of the performance level analysis results for Sunshine-S for RY 2017 (CY 2016).

Table D-34—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Performance Level Analysis Summary Table: Sunshine-S

2017 Performance Level Analysis	Number of Rates	Percent of Rates
★★★★★	14	26.42%
★★★★	13	24.53%
★★★	15	28.30%
★★	7	13.21%
★	4	7.55%
Total	**53**	**100.00%**

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

United Performance Measure Results

Table D-35 contains the MMA performance measure rates and performance level analysis results for United for RY 2017 (CY 2016).

Table D-35—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results
Summary Table: United

United Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	★★★	1.56%
One Well-Child Visit	★	1.04%
Two Well-Child Visits	★★★★	4.95%
Three Well-Child Visits	★★	5.21%
Four Well-Child Visits	★	5.47%
Five Well-Child Visits	★★	15.36%
Six or More Well-Child Visits	★★★	66.41%
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	★★★	72.42%
Childhood Immunization Status		
Combination 2	★★	74.45%
Combination 3	★★	69.83%
Lead Screening in Children		
Lead Screening in Children	★★	62.36%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	★★★	47.38%
Continuation and Maintenance Phase	★★★★★	68.39%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	★★★	75.88%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	★★★	53.04%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap)	★	65.91%
Combination 2 (Meningococcal, Tdap, HPV)	—	14.96%
Annual Dental Visit		
2–3 Years	★	25.98%
4–6 Years	★	47.44%
7–10 Years	★★	55.01%
11–14 Years	★★	48.49%

United Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
15–18 Years	★★	41.90%
19–20 Years	—	25.42%
Total	★★	44.63%
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	—	30.52%
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	★★★	57.91%
Chlamydia Screening in Women		
16–20 Years	★★★	55.97%
21–24 Years	★★★	66.48%
Total	★★★	59.54%
Breast Cancer Screening		
Breast Cancer Screening	★★★	61.18%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	★★★★	88.86%
Postpartum Care	★★★	62.28%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	★★★	66.08%
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	★	82.00%
*HbA1c Poor Control (>9.0%)**	★★★	42.34%
HbA1c Control (<8.0%)	★★	46.23%
Eye Exam (Retinal) Performed	★★	52.80%
Medical Attention for Nephropathy	★★★★	91.97%
Controlling High Blood Pressure		
Controlling High Blood Pressure	★	45.99%
Adult BMI Assessment		
Adult BMI Assessment	★★★	87.44%
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[2]	★★	48.68%
Medication Compliance 50%—Ages 12–18 Years[2]	★★	46.40%
Medication Compliance 50%—Ages 19–50 Years[2]	★★★	63.14%
Medication Compliance 50%—Ages 51–64 Years[2]	★	66.93%
Medication Compliance 50%—Total[2]	★★	51.75%
Medication Compliance 75%—Ages 5–11 Years	★★	24.91%
Medication Compliance 75%—Ages 12–18 Years	★★	22.30%

United Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Medication Compliance 75%—Ages 19–50 Years	★★★	40.88%
Medication Compliance 75%—Ages 51–64 Years	★★	46.46%
Medication Compliance 75%—Total	★★	28.38%
Annual Monitoring for Patients on Persistent Medications		
Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★★★	92.82%
Annual Monitoring for Members on Digoxin	★	44.71%
Annual Monitoring for Members on Diuretics	★★★★★	92.39%
Total	★★★★★	92.16%
Plan All-Cause Readmissions*		
18–64 Years of Age—Total	—	20.82%
65+ Years of Age—Total	—	4.01%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	—	43.96%
≥2 Visits	—	67.65%
1 Visit	—	12.76%
0 Visits	—	19.59%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	—	88.54%
HIV Viral Load Suppression		
18–64 Years	—	56.75%
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
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	★★★	46.18%
Initiation of AOD Treatment—18+ Years	★★★★★	48.51%
Initiation of AOD Treatment—Total	★★★★★	48.36%
Engagement of AOD Treatment—13–17 Years	★★★	16.87%
Engagement of AOD Treatment—18+ Years	★★★	9.74%

United Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
Engagement of AOD Treatment—Total	★★★	10.19%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	★★★	55.24%
30-Day Follow-Up	★★★	69.20%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up	—	24.74%
30-Day Follow-Up	—	39.27%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependencies		
7-Day Follow-Up—13–17 Years	—	3.77%
7-Day Follow-Up—18+ Years	—	8.32%
7-Day Follow-Up—Total	—	7.96%
30-Day Follow-Up—13–17 Years	—	3.77%
30-Day Follow-Up—18+ Years	—	10.28%
30-Day Follow-Up—Total	—	9.76%
Antidepressant Medication Management		
Effective Acute Phase Treatment	★★	51.95%
Effective Continuation Phase Treatment	★★	36.45%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	★★★	62.59%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NA
6–11 Years	★★★★	31.58%
12–17 Years	★★★★★	44.79%
Total	★★★★	40.21%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents* [1]		
1–5 Years	NA	NA
6–11 Years	★★★	1.12%
12–17 Years	★★★★	0.42%
Total	★★★★	0.66%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	—	21.25%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	★★	94.08%
25 Months–6 Years	★★	87.00%
7–11 Years	★★	89.03%

United Reporting Year 2017 Measure	Performance Level Analysis	Reporting Year 2017 Rate
12–19 Years	★	85.57%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	★	70.00%
45–64 Years	★★	84.78%
65 Years and Older	★	75.33%
Total	★	74.36%
Call Answer Timeliness		
Call Answer Timeliness	★★★★	92.53%
Transportation Availability		
Transportation Availability	—	100.00%
Transportation Timeliness		
Transportation Timeliness	—	86.14%
Use of Services		
Ambulatory Care		
Outpatient Visits—Total	—	319.34
ED Visits—Total	—	73.63
SMI-Related Measures		
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	★★★	81.16%

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the HEDIS 2017 (RY 2017) technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to performance targets derived using data reported for HEDIS 2016 (RY 2016).
[2] Quality Compass benchmarks were not available; therefore, the 2016 Audit Means and Percentiles were used for comparison purposes.
— Indicates that the measure was not presented in the previous year's HEDIS aggregate report; therefore, the 2016 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 (i.e., <100 for CAHPS-based measures and <30 for all other measures) to report a valid rate. For RY 2017 rates designated NA, the performance level analysis value was also NA.
2017 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*

Table D-36 provides a summary of the performance level analysis results for United for RY 2017 (CY 2016).

Table D-36—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Performance Level Analysis Summary Table: United

2017 Performance Level Analysis	Number of Rates	Percent of Rates
★★★★★	7	8.97%
★★★★	8	10.26%
★★★	26	33.33%
★★	24	30.77%
★	13	16.67%
Total	**78**	**100.00%**

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Summary of MMA Standard/Specialty Plans Measure Results

Table D-37 displays the summary of RY 2017 (CY 2016) performance level analysis for the Standard MMA and Specialty MMA plans.

Table D-37—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Performance Level Analysis Summary Table

MMA Plan Name	★	★★	★★★	★★★★	★★★★★
Aetna Better Health	27.78%	23.61%	16.67%	18.06%	13.89%
Amerigroup	14.10%	26.92%	30.77%	16.67%	11.54%
Better Health	28.75%	32.50%	18.75%	12.50%	7.50%
Children's Medical Services-S	23.88%	29.85%	11.94%	11.94%	22.39%
Clear Health-S	32.61%	6.52%	13.04%	13.04%	34.78%
Community Care Plan	15.94%	23.19%	43.48%	14.49%	2.90%
Freedom-S	0.00%	0.00%	0.00%	0.00%	100.00%
Humana	17.95%	28.21%	32.05%	16.67%	5.13%
Magellan-S	43.08%	18.46%	7.69%	18.46%	12.31%
Molina	17.95%	38.46%	25.64%	15.38%	2.56%
Positive-S	23.08%	3.85%	15.38%	23.08%	34.62%
Prestige	12.35%	43.21%	32.10%	9.88%	2.47%
Simply	17.72%	22.78%	25.32%	20.25%	13.92%
Staywell	7.41%	43.21%	32.10%	16.05%	1.23%
Sunshine	34.57%	22.22%	17.28%	23.46%	2.47%
Sunshine-S	7.55%	13.21%	28.30%	24.53%	26.42%
United	16.67%	30.77%	33.33%	10.26%	8.97%

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Statewide Weighted Average Measure Results

Table D-38 through Table D-44 display the MMA statewide weighted averages for RY 2016 (CY 2015) and RY 2017 (CY 2016). Cells shaded in gray indicate that AHCA established a performance target for that measure. Cells shaded in yellow indicate that the rate exceeded the national Medicaid 50th percentile. Please note that only measures with an established performance target were compared to the national Medicaid 50th percentile.

Table D-38—Florida Medicaid Performance Measure Result Summary Table, Pediatric Care

Measure	Reporting Year 2016	Reporting Year 2017
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	2.35%	1.97%
Six or More Well-Child Visits	58.26%	63.50%
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	75.43%	75.66%
Childhood Immunization Status		
Combination 2	77.48%	78.21%
Combination 3	72.41%	74.22%
Lead Screening in Children		
Lead Screening in Children	60.50%	65.85%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	49.94%	48.55%
Continuation and Maintenance Phase	62.70%	65.09%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	62.45%	78.40%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	52.85%	52.91%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap)	67.32%	70.62%
Combination 2 (Meningococcal, Tdap, HPV)	—	19.43%
Annual Dental Visit		
Total	46.67%	48.55%
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk		
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	25.22%†	30.41%

** Indicates that lower rates are better for this measure.*
— Indicates the measure was not presented in the previous year's HEDIS aggregate report; therefore, only the 2017 rate is 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.

Indicates that AHCA established a performance target for the measure for RY 2017.

Indicates that the performance measure rate for RY 2017 met or exceeded the national Medicaid 50th Percentile.

Table D-39—Florida Medicaid Performance Measure Result Summary Table, Women's Care

Measure	Reporting Year 2016	Reporting Year 2017
Cervical Cancer Screening		
Cervical Cancer Screening	51.27%	56.08%
Chlamydia Screening in Women		
Total	61.80%	62.55%
Breast Cancer Screening		
Breast Cancer Screening	61.16%	54.83%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	82.91%	84.26%
Postpartum Care	58.62%	63.55%
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	66.52%	66.59%

Indicates that AHCA established a performance target for the measure for RY 2017.

Indicates that the performance measure rate for RY 2017 met or exceeded the national Medicaid 50th Percentile.

Table D-40—Florida Medicaid Performance Measure Result Summary Table, Living With Illness

Measure	Reporting Year 2016	Reporting Year 2017
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	81.04%	81.95%
*HbA1c Poor Control (>9.0%)**	47.81%	45.41%
HbA1c Control (<8.0%)	43.61%	44.09%
Eye Exam (Retinal) Performed	51.06%	55.87%
Medical Attention for Nephropathy	91.65%	90.91%
Controlling High Blood Pressure		
Controlling High Blood Pressure	50.33%	54.85%
Adult BMI Assessment		
Adult BMI Assessment	86.68%	87.21%
Medication Management for People With Asthma		
Medication Compliance 50%—Total	53.57%	54.00%
Medication Compliance 75%—Total	29.90%	28.82%
Annual Monitoring for Patients on Persistent Medications		
Total	91.01%	91.75%

Measure	Reporting Year 2016	Reporting Year 2017
Plan All-Cause Readmissions*		
Total 18–64 Years of Age—Total	22.82%	24.01%
Total 65+ Years of Age—Total	10.52%	13.45%
HIV-Related Outpatient Medical Visits		
2 Visits (≥182 days)	27.88%	47.21%
Highly Active Anti-Retroviral Treatment		
Highly Active Anti-Retroviral Treatment	65.09%	86.70%
HIV Viral Load Suppression[1]		
18–64 Years	13.08%	13.03%
65+ Years	8.97%	6.27%
Medical Assistance With Smoking and Tobacco Use Cessation[2]		
Advising Smokers and Tobacco Users to Quit—18–64 Years of Age	74.18%	46.79%
Advising Smokers and Tobacco Users to Quit—65+ Years of Age	61.15%	19.65%
Advising Smokers and Tobacco Users to Quit—Total	71.49%	41.23%
Discussing Cessation Medications—18–64 Years of Age	46.45%	31.54%
Discussing Cessation Medications—65+ Years of Age	41.30%	12.41%
Discussing Cessation Medications—Total	45.39%	27.64%
Discussing Cessation Strategies—18–64 Years of Age	41.74%	29.20%
Discussing Cessation Strategies—65+ Years of Age	33.94%	11.52%
Discussing Cessation Strategies—Total	40.13%	25.59%

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

[1]Due to issues associated with the plans obtaining complete HIV/AIDS lab data for this measure, low rates may be associated with a lack of complete data rather than cases of non-suppression of HIV viral load. Therefore, caution should be exercised when interpreting results.

[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 AHCA established a performance target for the measure for RY 2017.

Indicates that the performance measure rate for RY 2017 met or exceeded the national Medicaid 50th percentile.

Table D-41—Florida Medicaid Performance Measure Result Summary Table, Behavioral Health

Measure	Reporting Year 2016	Reporting Year 2017
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—Total	39.99%	40.11%
Engagement of AOD Treatment—Total	6.39%	7.05%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	35.71%	43.01%
30-Day Follow-Up	53.77%	56.24%†
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up	—	33.05%
30-Day Follow-Up	—	51.14%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence		
7-Day Follow-Up—Total	—	9.69%
30-Day Follow-Up—Total	—	12.30%
Antidepressant Medication Management		
Effective Acute Phase Treatment	51.85%	51.38%
Effective Continuation Phase Treatment	36.81%	35.72%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	59.04%	63.31%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
Total	37.77%	38.06%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*[1]		
Total	1.77%	1.64%
Mental Health Readmission Rate*		
Mental Health Readmission Rate	26.62%	33.52%
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	—	80.62%

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

† Molina had issues with reporting the correct denominator for FHM due to limitations with the custom rate template (i.e., the template would only allow one eligible population to be entered for all components). This issue has been corrected in the custom rate template for July 1, 2018, reporting.

[1] Due to changes in the HEDIS 2017 technical specifications for this measure, exercise caution when trending rates between 2017 and prior years and when comparing HEDIS 2017 rates for this measure to performance targets derived using data reported for HEDIS 2016.

— Indicates the measure was not presented in the previous year's HEDIS aggregate report; therefore, only the 2017 rate is presented in this report.

Indicates that AHCA established a performance target for the measure for RY 2017.

Indicates that the performance measure rate for RY 2017 met or exceeded the national Medicaid 50th percentile.

Table D-42—Florida Medicaid Performance Measure Result Summary Table, Access/Availability of Care

Measure	Reporting Year 2016	Reporting Year 2017
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	94.81%	94.37%
25 Months–6 Years	88.74%	87.82%
7–11 Years	89.28%	88.75%
12–19 Years	86.28%	85.16%
Adults' Access to Preventive/Ambulatory Health Services		
Total	74.93%	74.11%
Call Answer Timeliness		
Call Answer Timeliness	83.63%	87.70%
Transportation Availability		
Transportation Availability	98.75%	99.74%
Transportation Timeliness		
Transportation Timeliness	79.32%	86.04%

Indicates that AHCA established a performance target for the measure for RY 2017.

Indicates that the performance measure rate for RY 2017 met or exceeded the national Medicaid 50th percentile.

Table D-43—Statewide Ambulatory Care Weighted Averages

Measure	Reporting Year 2016	Reporting Year 2017
AMB—Outpatient Visits per 1,000 MM	304.82	320.89
*AMB—ED Visits per 1,000 MM**	69.06	71.22

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

Indicates that AHCA established a performance target for the measure for RY 2017.

Indicates that the performance measure rate for RY 2017 met or exceeded the national Medicaid 50th percentile.

Table D-44—Florida Medicaid MMA Weighted Averages for MMA Specialty Performance Measures
SMI Measures

Measure	Reporting Year 2016	Reporting Year 2017
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	66.25%	70.21%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	88.33%

NA (i.e., Small Denominator) indicates that the organizations followed the specifications, but the denominator was too small (<30) to report valid rates.

Indicates that AHCA established a performance target for the measure for RY 2017.

Indicates that the performance measure rate for RY 2017 met or exceeded the national Medicaid 50th percentile.

LTC Plans

This section represents the Florida Medicaid RY 2017 (CY 2016) performance measure results for the LTC plans. For all tables presented in this appendix, the following legend applies to the RY 2017 rate columns:

Table D-45—Abbreviation Used in the Reporting Year 2017 Rate Column

Acronym	Definition
NA	*Small Denominator*. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

Aetna Better Health-LTC Performance Measure Results

Table D-46 contains the LTC performance measure rates for Aetna Better Health-LTC for RY 2017 (CY 2016).

Table D-46—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results Summary Table: Aetna Better Health-LTC

Aetna Better Health-LTC Reporting Year 2017 Measure	Reporting Year 2017 Rate
Care for Adults	
Advance Care Planning—18–60 Years	75.44%
Advance Care Planning—61–65 Years	NA
Advance Care Planning—66+ Years	79.67%
Advance Care Planning—Total	78.44%
Medication Review—18–60 Years†	8.33%
Medication Review—61–65 Years†	NA
Medication Review—66+ Years†	16.13%
Medication Review—Total†	14.86%
Functional Status Assessment—18–60 Years	79.63%
Functional Status Assessment—61–65 Years	93.75%
Functional Status Assessment—66+ Years	90.38%
Functional Status Assessment—Total	89.33%
Call Answer Timeliness	
Call Answer Timeliness	92.46%
Required Record Documentation	
701B Assessment	90.67%
Care Plan—Enrollee Participation	74.67%
Care Plan—Primary Care Physician Notification	70.22%
Freedom of Choice Form	82.67%
*Plan of Care/LTC Service Authorizations**	0.00%
Face-to-Face Encounters	
Face-to-Face Encounters	97.49%
Case Manager Training	
Case Manager Training	82.98%
Timeliness of Services	
Timeliness of Services	86.22%

** For this indicator, a lower rate indicates better performance.*
NA indicates that the rate was designated Small Denominator because the organization followed the specifications, but the denominator was too small (i.e., <100 for CAHPS-based measures and <30 for all other measures) to report a valid rate.
† Aetna Better Health-LTC acknowledged that the reported rate for this measure may not be valid; therefore, exercise caution when interpreting these results.

Amerigroup-LTC Performance Measure Results

Table D-47 contains the LTC performance measure rates for Amerigroup-LTC for RY 2017 (CY 2016).

Table D-47—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results
Summary Table: Amerigroup-LTC

Amerigroup-LTC Reporting Year 2017 Measure	Reporting Year 2017 Rate
Care for Adults	
Advance Care Planning—18–60 Years	88.57%
Advance Care Planning—61–65 Years	NA
Advance Care Planning—66+ Years	90.98%
Advance Care Planning—Total	90.51%
Medication Review—18–60 Years	96.88%
Medication Review—61–65 Years	NA
Medication Review—66+ Years	NA
Medication Review—Total	90.48%
Functional Status Assessment—18–60 Years	94.74%
Functional Status Assessment—61–65 Years	NA
Functional Status Assessment—66+ Years	95.74%
Functional Status Assessment—Total	95.83%
Call Answer Timeliness	
Call Answer Timeliness	53.90%
Required Record Documentation	
701B Assessment	72.69%
Care Plan—Enrollee Participation	79.40%
Care Plan—Primary Care Physician Notification	62.96%
Freedom of Choice Form	83.56%
*Plan of Care/LTC Service Authorizations**	0.23%
Face-to-Face Encounters	
Face-to-Face Encounters	80.46%
Case Manager Training	
Case Manager Training	98.85%
Timeliness of Services	
Timeliness of Services	83.64%

** For this indicator, a lower rate indicates better performance.*
NA indicates that the rate was designated Small Denominator because the organization followed the specifications, but the denominator was too small (i.e., <100 for CAHPS-based measures and <30 for all other measures) to report a valid rate.

Humana-LTC Performance Measure Results

Table D-48 contains the LTC performance measure rates for Humana-LTC for RY 2017 (CY 2016).

Table D-48—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results Summary Table: Humana-LTC

Humana-LTC Reporting Year 2017 Measure	Reporting Year 2017 Rate
Care for Adults	
Advance Care Planning—18–60 Years	65.99%
Advance Care Planning—61–65 Years	66.44%
Advance Care Planning—66+ Years	70.18%
Advance Care Planning—Total	69.52%
Medication Review—18–60 Years	98.88%
Medication Review—61–65 Years	97.06%
Medication Review—66+ Years	100.00%
Medication Review—Total	98.84%
Functional Status Assessment—18–60 Years	94.61%
Functional Status Assessment—61–65 Years	92.29%
Functional Status Assessment—66+ Years	93.91%
Functional Status Assessment—Total	93.89%
Call Answer Timeliness	
Call Answer Timeliness	97.75%
Required Record Documentation	
701B Assessment	90.24%
Care Plan—Enrollee Participation	95.00%
Care Plan—Primary Care Physician Notification	63.57%
Freedom of Choice Form	90.71%
*Plan of Care/LTC Service Authorizations**	1.67%
Face-to-Face Encounters	
Face-to-Face Encounters	93.95%
Case Manager Training	
Case Manager Training	83.50%
Timeliness of Services	
Timeliness of Services	93.27%

** For this indicator, a lower rate indicates better performance.*

Molina-LTC Performance Measure Results

Table D-49 contains the LTC performance measure rates for Molina-LTC for RY 2017 (CY 2016).

Table D-49—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results Summary Table: Molina-LTC

Molina-LTC Reporting Year 2017 Measure	Reporting Year 2017 Rate
Care for Adults	
Advance Care Planning—18–60 Years	95.12%
Advance Care Planning—61–65 Years	NA
Advance Care Planning—66+ Years	94.72%
Advance Care Planning—Total	94.70%
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	96.77%
Functional Status Assessment—61–65 Years	NA
Functional Status Assessment—66+ Years	96.08%
Functional Status Assessment—Total	96.25%
Call Answer Timeliness	
Call Answer Timeliness	76.49%
Required Record Documentation	
701B Assessment[1]	98.02%
Care Plan—Enrollee Participation	90.47%
Care Plan—Primary Care Physician Notification	98.45%
Freedom of Choice Form	90.02%
*Plan of Care/LTC Service Authorizations**[,1]	1.55%
Face-to-Face Encounters	
Face-to-Face Encounters	87.51%
Case Manager Training	
Case Manager Training	98.39%
Timeliness of Services	
Timeliness of Services	91.98%

** For this indicator, a lower rate indicates better performance.*
NA indicates that the rate was designated Small Denominator because the organization followed the specifications, but the denominator was too small (i.e., <100 for CAHPS-based measures and <30 for all other measures) to report a valid rate.
[1] Molina had issues with reporting the correct eligible population for the RRD—701B Assessment and Plan of Care/LTC Service Authorizations measure indicators due to limitations with the custom rate template (would only allow one eligible population to be entered for all components). This has been corrected in the custom rate template for July 1, 2018 reporting.

Sunshine-LTC Performance Measure Results

Table D-50 contains the LTC performance measure rates for Sunshine-LTC for RY 2017 (CY 2016).

Table D-50—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results
Summary Table: Sunshine-LTC

Sunshine-LTC Reporting Year 2017 Measure	Reporting Year 2017 Rate
Care for Adults	
Advance Care Planning—18–60 Years	95.30%
Advance Care Planning—61–65 Years	95.64%
Advance Care Planning—66+ Years	92.45%
Advance Care Planning—Total	93.05%
Medication Review—18–60 Years	82.13%
Medication Review—61–65 Years	71.54%
Medication Review—66+ Years	36.95%
Medication Review—Total	65.34%
Functional Status Assessment—18–60 Years	95.23%
Functional Status Assessment—61–65 Years	96.23%
Functional Status Assessment—66+ Years	95.59%
Functional Status Assessment—Total	95.58%
Call Answer Timeliness	
Call Answer Timeliness	76.47%
Required Record Documentation	
701B Assessment	98.05%
Care Plan—Enrollee Participation	57.66%
Care Plan—Primary Care Physician Notification	44.53%
Freedom of Choice Form	87.83%
*Plan of Care/LTC Service Authorizations**	0.00%
Face-to-Face Encounters	
Face-to-Face Encounters	83.43%
Case Manager Training	
Case Manager Training	99.69%
Timeliness of Services	
Timeliness of Services	55.07%

** For this indicator, a lower rate indicates better performance.*

United-LTC Performance Measure Results

Table D-51 contains the LTC performance measure rates for United-LTC for RY 2017 (CY 2016).

Table D-51—Florida Medicaid Reporting Year 2017 (Calendar Year 2016) Results Summary Table: United-LTC

United-LTC Reporting Year 2017 Measure	Reporting Year 2017 Rate
Care for Adults	
Advance Care Planning—18–60 Years	70.21%
Advance Care Planning—61–65 Years	70.00%
Advance Care Planning—66+ Years	72.75%
Advance Care Planning—Total	72.26%
Medication Review—18–60 Years	17.46%
Medication Review—61–65 Years	NA
Medication Review—66+ Years	14.80%
Medication Review—Total	15.09%
Functional Status Assessment—18–60 Years	80.95%
Functional Status Assessment—61–65 Years	NA
Functional Status Assessment—66+ Years	77.64%
Functional Status Assessment—Total	78.10%
Call Answer Timeliness	
Call Answer Timeliness	92.12%
Required Record Documentation	
701B Assessment	69.10%
Care Plan—Enrollee Participation	58.39%
Care Plan—Primary Care Physician Notification	24.09%
Freedom of Choice Form	56.93%
*Plan of Care/LTC Service Authorizations**	0.49%
Face-to-Face Encounters	
Face-to-Face Encounters	40.22%
Case Manager Training	
Case Manager Training	99.34%
Timeliness of Services	
Timeliness of Services	69.63%

** For this indicator, a lower rate indicates better performance.*
NA indicates that the rate was designated Small Denominator because the organization followed the specifications, but the denominator was too small (i.e., <100 for CAHPS-based measures and <30 for all other measures) to report a valid rate.

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 AHCA and Plan (January 1, 2016–June 30, 2016)

Plan	Dental Encounters			Institutional Encounters			Professional Encounters		
	Records Submitted[1]		Volume Difference[2]	Records Submitted[1]		Volume Difference[2]	Records Submitted[1]		Volume Difference[2]
	AHCA	Plan		AHCA	Plan		AHCA	Plan	
AMG-M	596,036	587,817	8,219	11	11	0	155	170	-15
BET-M	206,621	166,532	40,089	48	7	41	—	—	—
CCP-M	74,805	74,499	306	—	—	—	—	—	—
CHA-S	214	196	18	—	—	—	—	—	—
CMS-S	187,424	115,676	71,748	74	66	8	47	47	0
COV-M	73,631	72,614	1,017	—	—	—	1	1	0
HUM-M	611,719	462,593	149,126	45	18	27	34	31	3
MCC-S	18,629	20,053	-1,424	—	—	—	—	—	—
MOL-M	490,728	446,986	43,742	215	118	97	15	15	0
PRS-M	371,423	369,706	1,717	10	38	-28	181	192	-11
SHP-M	106,412	92,617	13,795	8	1	7	—	—	—
STW-M	1,246,362	1,002,867	243,495	90	0	90	543	0	543
SUN-M	636,775	687,152	-50,377	1	0	1	71	96	-25
SUN-S	192,088	292,810	-100,722	2	0	2	19	32	-13
URA-M	394,895	396,875	-1,980	18	68	-50	98	0	98
All Plans	**5,207,762**	**4,788,993**	**418,769**	**522**	**327**	**195**	**1,164**	**584**	**580**

[1] Records submitted denotes records for which HSAG has performed restrictions according to study specifications.
[2] Volume difference was calculated by subtracting the number of records submitted by the plans from the number of records submitted by AHCA.
"—" denotes there were no dental services meeting the study specifications for the specified encounter type.

Table E-2 provides a general overview of the average utilization per enrollee by plan from the beginning of calendar year (CY) 2016 through the second quarter of CY 2016 (January 1, 2016–June 30, 2016) for dental encounters.

Table E-2—Encounter Data Overview

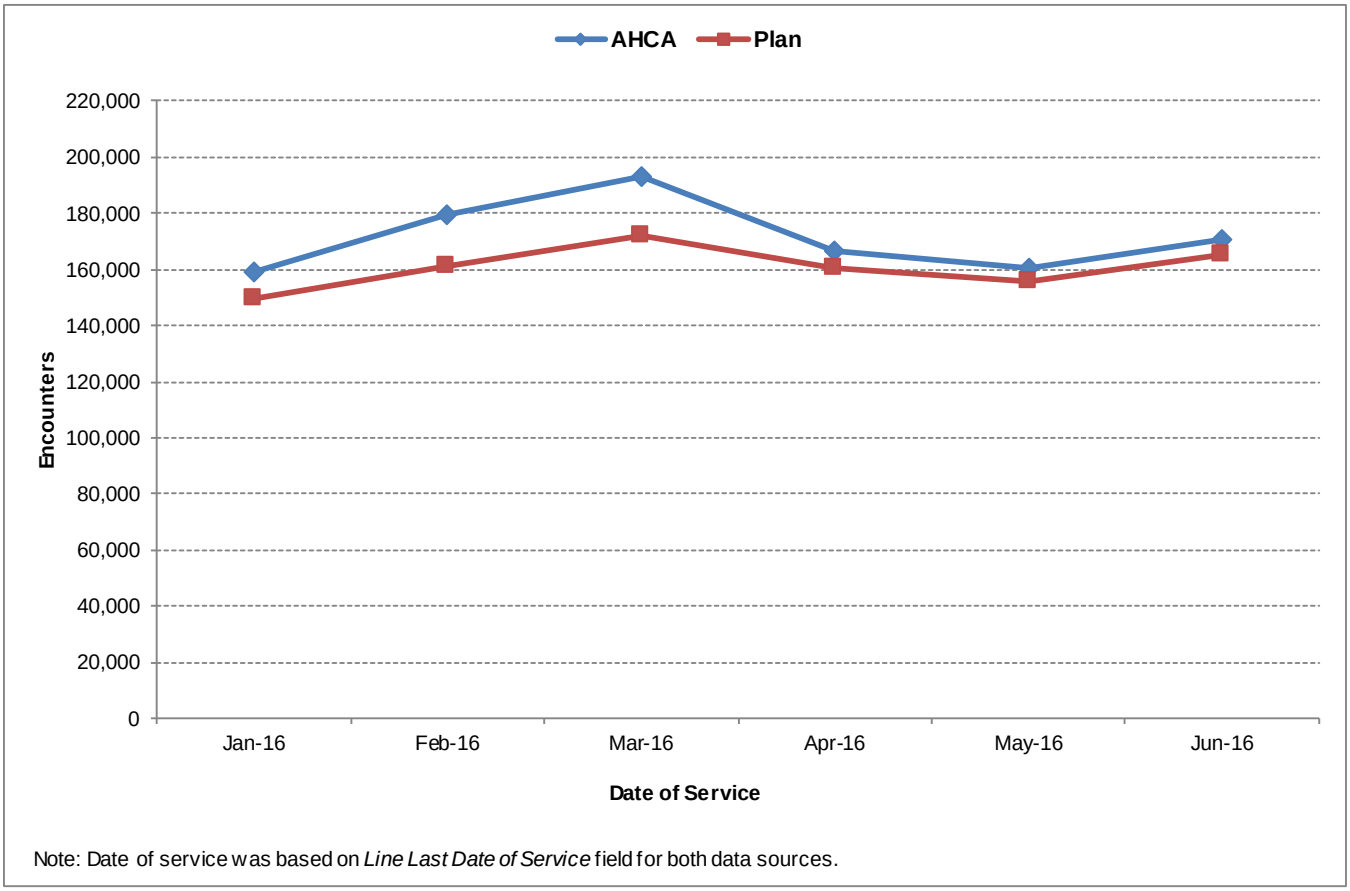
Plan	Average Number of Enrollees Under 21[1]	Total Number of Encounters[2]	Total Encounters PMPM[3]
AMG-M	266,337	127,967	0.08
BET-M	74,900	33,032	0.07
CCP-M	35,188	15,222	0.07
CHA-S	234	53	0.04
CMS-S	53,229	28,851	0.09
COV-M	37,527	15,353	0.07
HUM-M	221,891	98,237	0.07
MCC-S	14,715	4,376	0.05
MOL-M	226,683	99,140	0.07
PRS-M	210,708	91,494	0.07
SHP-M	40,692	19,791	0.08
STW-M	510,367	240,829	0.08
SUN-M	321,433	139,189	0.07
SUN-S	30,641	46,063	0.25
URA-M	177,717	70,374	0.07
All Plans	**2,222,260**	**1,029,971**	**0.08**

[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, 2016, through June 30, 2016. Due to rounding, the individual plan's average number of enrollees may not sum to the "All Plans" average number of enrollees.
[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.

Monthly Variations of Encounters for Dates of Service

Examination of the volume of encounters submitted each month provided additional insight into potential problems with data completeness observed in greater context in the comparative analysis and clinical record review portions of this assessment. The monthly assessment of encounter volume included only those encounters documented within the plans' systems and submitted to AHCA with a date of service during the study period. Figure E-1 illustrates the overall encounter data volume trends over time by the plans and AHCA for dental encounters. To uniquely define an encounter, a combination of *Plan*, *Recipient ID*, *Provider Identification Number*, and *Date of Service* fields was used.

Figure E-1—Monthly Variations in Dental Encounters for AHCA and the Plans



Note: Date of service was based on *Line Last Date of Service* field for both data sources.

Encounter Field Completeness and Reasonableness

Table E-3 shows the percent missing and valid rates for key data fields associated with the dental services for data extracted from the plans' and AHCA's claims/encounter systems.

Table E-3—Completeness (Percent Missing) and Accuracy (Percent Valid) for Key Dental Services Data Elements by AHCA and the Plans

	Billing Provider ID[1]		Billing Provider NPI[1]		Rendering Provider ID[1, 2]		Rendering Provider NPI[1, 2]		Dental Procedure Code	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
AHCA										
AMG-M	0.1%	> 99.9%	0.1%	96.0%	0.1%	99.7%	0.1%	94.7%	0.0%	100.0%
BET-M	1.4%	100.0%	1.4%	89.6%	5.9%	99.8%	5.9%	93.8%	0.0%	100.0%
CCP-M	< 0.1%	99.8%	< 0.1%	98.8%	< 0.1%	99.8%	< 0.1%	98.8%	0.0%	100.0%
CHA-S	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	99.5%
CMS-S	8.7%	99.9%	8.7%	94.4%	1.3%	99.9%	1.3%	95.5%	0.0%	100.0%
COV-M	0.2%	99.7%	0.2%	94.0%	0.3%	99.7%	0.3%	93.9%	0.0%	100.0%
HUM-M	5.1%	> 99.9%	5.1%	88.0%	0.1%	99.4%	0.1%	90.5%	0.0%	100.0%
MCC-S	0.3%	100.0%	0.3%	94.3%	0.2%	99.7%	0.2%	95.0%	0.0%	100.0%
MOL-M	1.0%	99.9%	1.0%	92.0%	< 0.1%	99.8%	< 0.1%	93.6%	0.0%	100.0%
PRS-M	< 0.1%	100.0%	< 0.1%	94.2%	0.8%	100.0%	0.8%	94.5%	0.0%	> 99.9%
SHP-M	0.1%	> 99.9%	0.1%	93.4%	0.1%	> 99.9%	0.1%	95.0%	0.0%	100.0%
STW-M	0.4%	99.9%	0.4%	93.5%	< 0.1%	99.8%	< 0.1%	94.5%	0.0%	100.0%
SUN-M	0.4%	99.9%	0.4%	92.7%	0.1%	99.9%	0.1%	94.5%	0.0%	> 99.9%
SUN-S	0.5%	100.0%	0.5%	91.1%	0.1%	99.9%	0.1%	95.0%	0.0%	> 99.9%
URA-M	0.5%	99.6%	0.5%	96.1%	0.7%	99.7%	0.7%	96.2%	0.0%	100.0%
Plans										
AMG-M	100.0%	—	0.0%	98.4%	100.0%	—	0.0%	99.4%	0.0%	100.0%
BET-M	0.0%	0.0%	0.0%	91.5%	100.0%	—	1.0%	99.2%	0.0%	100.0%
CCP-M	100.0%	—	0.0%	99.6%	100.0%	—	0.0%	99.6%	0.0%	100.0%
CHA-S	0.0%	0.0%	0.0%	100.0%	100.0%	—	0.0%	100.0%	0.0%	99.5%
CMS-S	100.0%	—	0.0%	97.8%	100.0%	—	0.0%	98.8%	0.0%	100.0%
COV-M	0.2%	99.6%	0.0%	98.1%	0.2%	99.6%	0.0%	98.1%	0.0%	100.0%
HUM-M	100.0%	—	0.0%	93.6%	100.0%	—	26.7%	98.8%	0.0%	100.0%
MCC-S	0.9%	89.7%	0.0%	93.6%	0.1%	94.5%	0.1%	98.2%	0.0%	100.0%

	Billing Provider ID[1]		Billing Provider NPI[1]		Rendering Provider ID[1, 2]		Rendering Provider NPI[1, 2]		Dental Procedure Code	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
MOL-M	100.0%	—	0.0%	95.8%	100.0%	—	0.0%	98.9%	0.0%	100.0%
PRS-M	100.0%	—	< 0.1%	99.4%	100.0%	—	20.2%	99.3%	0.0%	> 99.9%
SHP-M	0.0%	0.0%	0.0%	97.0%	100.0%	—	0.0%	98.0%	0.0%	100.0%
STW-M	0.0%	0.0%	0.0%	96.6%	100.0%	—	14.0%	99.7%	0.0%	> 99.9%
SUN-M	100.0%	—	0.0%	92.1%	100.0%	—	0.0%	99.5%	0.0%	100.0%
SUN-S	100.0%	—	0.0%	92.2%	100.0%	—	0.0%	99.6%	0.0%	100.0%
URA-M	100.0%	—	> 99.9%	100.0%	0.0%	< 0.1%	0.0%	99.2%	0.0%	100.0%

[1] Missing (i.e., percent missing) and Valid (i.e., percent 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.
[2] *Rendering Provider ID* and *NPI* fields are situational (i.e., not required for every encounter transaction).
"—" denotes all records had missing values for this data element; therefore, validity could not be assessed.
Note: Plan-submitted data consistently have missing values for *Billing* and *Rendering Provider ID*. However, *Billing Provider NPI*, *Rendering Provider NPI*, and *Dental Procedure Code* have few missing values.

Data Element Completeness

Table E-4 presents the percentage of records with values present in files submitted by the plans but not present in AHCA's files (element omission) from the dental encounters. **For this indicator, lower rates indicate better performance.**

Table E-4—Data Element Omission

	Element Omission		
Key Data Elements	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Line First Date of Service	0.0%	All plans exhibited 0.0%	All plans exhibited 0.0%
Line Last Date of Service	0.0%	All plans exhibited 0.0%	All plans exhibited 0.0%
Billing Provider ID	0.1%	0.0% – 1.0%	Ten plans exhibited 0.0% (AMG-M, CCP-M, CHA-S, CMS-S, HUM-M, MOL-M, PRS-M, SUN-M, SUN-S, and URA-M) STW-M (0.3%) MCC-S (0.3%) BET-M (1.0%)

	Element Omission		
Key Data Elements	**Overall Rate**	**Plan Range**	**Top Three and Bottom Three Plans**
Billing Provider NPI	0.4%	0.0% – 1.5%	Four plans exhibited 0.0% (AMG-M, CCP-M, CHA-S, and PRS-M) BET-M (1.0%) CMS-S (1.1%) HUM-M (1.5%)
Rendering Provider ID	0.1%	0.0% – 0.7%	All plans exhibited 0.0% except for COV-M (< 0.1%), MCC-S (0.2%), and URA-M (0.7%)
Rendering Provider NPI	0.4%	0.0% – 7.0%	Three plans exhibited 0.0% (AMG-M, CCP-M, and CHA-S) PRS-M (0.6%) URA-M (0.7%) BET-M (7.0%)
Procedure Code	0.0%	All plans exhibited 0.0%	All plans exhibited 0.0%
Units	0.0%	All plans exhibited 0.0%	All plans exhibited 0.0 %
Mouth Quadrant	8.5%	0.0% – 50.9%	Ten plans exhibited 0.0% (AMG-M, BET-M, CHA-S, CMS-S, COV-M, HUM-M, MCC-S, MOL-M, PRS-M, and URA-M) SUN-M (4.6%) STW-M (29.6%) SHP-M (50.9%)
Tooth Number	1.3%	0.0% – 76.5%	Four plans exhibited 0.0% (CHA-S, CMS-S, MOL-M, and STW-M) SUN-S (4.1%) SUN-M (4.6%) MCC-S (76.5%)

	Element Omission		
Key Data Elements	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Tooth Surface 1	7.6%	3.4% – 10.8%	CMS-S (3.4%) CHA-S (4.1%) PRS-M (4.6%) AMG-M (9.7%) SHP-M (9.8%) SUN-M (10.8%)
Tooth Surface 2	3.6%	0.0% – 7.0%	MCC-S (0.0%), PRS-M (0.0%), CHA-S (2.0%) AMG-M (5.4%) SUN-S (6.5%) SUN-M (7.0%)
Tooth Surface 3	0.9%	0.0% – 2.1%	MCC-S (0.0%), PRS-M (0.0%), CHA-S (0.5%) CCP-M (1.4%) SUN-S (1.8%) SUN-M (2.1%)
Tooth Surface 4	0.2%	0.0% – 0.4%	Three plans exhibited 0.0% (CHA-S, MCC-S, and PRS-M) CCP-M (0.2%) SUN-S (0.3%) SUN-M (0.4%)
Tooth Surface 5	< 0.1%	0.0% – 0.2%	Three plans exhibited 0.0% (CHA-S, MCC-S, and PRS-M) SUN-S (0.1%) BET-M (0.1%) CCP-M (0.2%)
Tooth Surface 6	0.0%	All plans exhibited 0.0%	All plans exhibited 0.0%
Amount Paid	0.0%	All plans exhibited 0.0%	All plans exhibited 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 are not presented.

Table E-5 presents the element surplus results for each of the key data elements from the dental encounter type. **For this indicator, lower rates indicate better performance**.

Table E-5—Data Element Surplus

	Element Surplus		
Key Data Elements	**Overall Rate**	**Plan Range**	**Top Three and Bottom Three Plans**
Line First Date of Service	0.0%	All plans exhibited 0.0%	All plans exhibited 0.0%
Line Last Date of Service	0.0%	All plans exhibited 0.0%	All plans exhibited 0.0%
Billing Provider ID	68.6%	0.0% – 100.0%	Four plans exhibited 0.0% (BET-M, CHA-S, SHP-M, and STW-M) Three plans exhibited 100.0% (AMG-M, CCP-M, PRS-M)
Billing Provider NPI	8.1%	0.0% – 99.5%	All plans exhibited 0.0% except for URA-M (99.5%)
Rendering Provider ID	89.4%	0.0% – 100.0%	MCC-S (0.0%), URA-M (0.0%), COV-M (0.2%) Three plans exhibited 100.0% (AMG-M, CHA-S, CCP-M)
Rendering Provider NPI	7.8%	0.0% – 26.8%	11 plans exhibited 0.0% (AMG-M, CCP-M, CHA-S, CMS-S, COV-M, MCC-S, MOL-M, SHP-M, SUN-M, and SUN-S, URA-M) STW-M (14.0%) PRS-M (20.2%) HUM-M (26.8%)
Procedure Code	0.0%	All plans exhibited 0.0%	All plans exhibited 0.0%
Units	23.0%	0.0% – > 99.9%	All plans exhibited 0.0% except for STW-M (> 99.9%)

	Element Surplus		
Key Data Elements	**Overall Rate**	**Plan Range**	**Top Three and Bottom Three Plans**
Mouth Quadrant	1.1%	0.0% – 76.4%	Ten plans exhibited 0.0% (AMG-M, BET-M, CCP-M, CHA-S, CMS-S, HUM-M, MOL-M, PRS-M, SHP-M, and URA-M) SUN-S (4.0%) SUN-M (4.9%) MCC-S (76.4%)
Tooth Number	< 0.1%	0.0% – 0.1%	All plans exhibited 0.0% except for BET-M (0.1%)
Tooth Surface 1	0.2%	0.0% – 1.4%	Five plans exhibited 0.0% (AMG-M, CCP-M, CHA-S, HUM-M, and MOL-M) SUN-S (1.0%) SUN-M (1.1%) MCC-S (1.4%)
Tooth Surface 2	0.4%	0.0% – 3.3%	Four plans exhibited 0.0% (AMG-M, CCP-M, CHA-S, and HUM-M) SUN-M (0.9%) PRS-M (3.2%) MCC-S (3.3%)
Tooth Surface 3	0.3%	0.0% – 1.4%	AMG-M (0.0%), CCP-M (0.0%), CMS-S (0.2%) SUN-S (0.5%) SUN-M (0.6%) MCC-S (1.4%)
Tooth Surface 4	0.2%	0.0% – 0.5%	Three plans exhibited 0.0% (AMG-M, CCP-M, and PRS-M) SUN-M (0.3%) CHA-S (0.5%) MCC-S (0.5%)

	Element Surplus		
Key Data Elements	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Tooth Surface 5	0.4%	0.0% – 0.8%	Three plans exhibited 0.0% (AMG-M, CCP-M, and CHA-S) SUN-S (0.6%) COV-M (0.7%) MCC-S (0.8%)
Tooth Surface 6	0.4%	0.0% – 0.9%	CCP-M (0.0%), CHA-S (0.0%), PRS-M (0.2%) HUM-M (0.6%) SHP-M (0.7%) MCC-S (0.9%)
Amount Paid	< 0.1%	0.0% – < 0.1%	All plans exhibited 0.0% except for HUM-M (< 0.1%)

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 are not presented.

Table E-6 presents the overall agreement rates for each of the evaluated data elements for the dental encounters. The minimum and maximum plan agreement rates and the high and low plan performers are also provided.

Table E-6—Data Element Agreement

	Element Agreement		
Key Data Elements	**Overall Rate**	**Plan Range**	**Top Three and Bottom Three Plans**
Line First Date of Service	99.8%	98.8% – 100.0%	Six plans exhibited 100.0% (BET-M, CHA-S, HUM-M, MOL-M, PRS-M, and SHP-M) MCC-S (99.6%) COV-M (99.5%) CMS-S (98.8%)
Line Last Date of Service	99.8%	98.8% – 100.0%	Seven plans exhibited 100.0% (BET-M, CHA-S, COV-M, HUM-M, PRS-M, SHP-M, and STW-M) AMG-M (99.6%) MOL-M (99.2%) CMS-S (98.8%)
Billing Provider ID	4.5%	0.0% – 75.0%	COV-M (75.0%) MCC-S (40.9%) Four plans exhibited 0.0% (BET-M, CHA-S, SHP-M, and STW-M) Note: Nine other plans had no records present in both data sources with values present in both sources.
Billing Provider NPI	87.6%	50.3% – 100.0%	URA-M (100.0%) CCP-M (98.8%) CHA-S (98.5%) MCC-S (73.8%) SUN-S (72.1%) SUN-M (50.3%)

	Element Agreement		
Key Data Elements	**Overall Rate**	**Plan Range**	**Top Three and Bottom Three Plans**
Rendering Provider ID	15.3%	0.0% – 76.7%	MCC-S (76.7%) COV-M (75.0%) URA-M (0.0%) Note: Twelve other plans had no records present in both data sources with values present in both sources.
Rendering Provider NPI	90.7%	72.2% – 98.8%	CCP-M (98.8%) URA-M (95.8%) STW-M (95.7%) SUN-S (87.0%) BET-M (72.4%) SUN-M (72.2%)
Procedure Code	94.0%	69.6% – 100.0%	AMG-M (100.0%) MOL-M (100.0%) CCP-M (> 99.9%) URA-M (81.9%) SUN-S (74.2%) SUN-M (69.6%)
Units	99.8%	99.2% – 100.0%	10 plans exhibited 100.0% (AMG-M, BET-M, CCP-M, CHA-S, CMS-S, HUM-M, MCC-S, MOL-M, SHP-M, and STW-M) URA-M (99.7%) SUN-S (99.2%) SUN-M (99.2%)
Mouth Quadrant	89.7%	0.0% – 100.0%	Three plans exhibited 100.0% (AMG-M, HUM-M, and MOL-M) Three plans exhibited 0.0% (MCC-S, SUN-M, and SUN-S)

	Element Agreement		
Key Data Elements	**Overall Rate**	**Plan Range**	**Top Three and Bottom Three Plans**
			Note: Eight plans had no records present in both data sources with values present in both sources.
Tooth Number	90.2%	63.6% – 100.0%	Three plans exhibited 100.0% (CHA-S, HUM-M, and MOL-M) CMS-S (71.0%) SUN-S (66.6%) SUN-M (63.6%) Note: One plan (STW-M) had no records present in both data sources with values present in both sources.
Tooth Surface 1	96.9%	77.3% – 100.0%	CHA-S (100.0%) COV-M (100.0%) HUM-M (> 99.9%) URA-M (95.5%) SUN-S (78.6%) SUN-M (77.3%) Note: One plan (CCP-M) had no records present in both data sources with values present in both sources.
Tooth Surface 2	97.7%	88.9% – 100.0%	CHA-S (100.0%) COV-M (100.0%) MOL-M (> 99.9%) URA-M (98.3%) SUN-S (90.3%) SUN-M (88.9%) Note: Four plans (AMG-M, CCP-M, MCC-S, and PRS-M) had no records present in both data sources with values present in both sources.

	Element Agreement		
Key Data Elements	**Overall Rate**	**Plan Range**	**Top Three and Bottom Three Plans**
Tooth Surface 3	90.1%	88.0% – 100.0%	CHA-S (100.0%) COV-M (92.0%) SHP-M (91.7%) SUN-M (88.7%) CMS-S (88.1%) SUN-S (88.1%) Note: Four plans (AMG-M, CCP-M, MCC-S, and PRS-M) had no records present in both data sources with values present in both sources.
Tooth Surface 4	85.0%	81.2% – 95.8%	COV-M (95.8%) SUN-M (90.5%) SUN-S (89.0%) MOL-M (84.4%) CMS-S (81.4%) HUM-M (81.2%) Note: Five plans (AMG-M, CCP-M, CHA-S, MCC-S, and PRS-M) had no records present in both data sources with values present in both sources.
Tooth Surface 5	80.3%	65.8% – 100.0%	COV-M (100.0%) SUN-S (89.5%) SUN-M (86.6%) MOL-M (75.4%) URA-M (74.2%) CMS-S (65.8%) Note: Five plans (AMG-M, CCP-M, CHA-S, MCC-S, and PRS-M) had no records present in both data sources with values present in both sources.

	Element Agreement		
Key Data Elements	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Tooth Surface 6	—	—	Note: There are no plans with records present in both data sources and with values present in both sources.
Amount Paid	93.7%	68.8% – 100.0%	Seven plans exhibited 100.0% (BET-M, CHA-S, CMS-S, HUM-M, MCC-S, SHP-M, and STW-M) URA-M (75.2%) SUN-S (73.3%) SUN-M (68.8%)

Note: While dental procedure codes were also identified from the institutional and/or professional encounters, the number of records was minimal; therefore, element agreement rates for these encounters are not presented.
"—" denotes there are no records present in both data sources and with values present in both sources.

Clinical Record Submission

Table E-7 and Table E-8 highlight the percentage of dental record documentation submissions and the major reasons dental record documentation was not submitted by each plan, respectively.

Table E-7—Summary of Dental Records Requested, Received, and Not Received

		Dental Documentation Received		Dental Documentation Not Received	
Plan	Number of Records Requested	Number	Percent	Number	Percent
AMG-M	150	147	98.0%	3	2.0%
BET-M	150	150	100.0%	0	0.0%
CCP-M	150	147	98.0%	3	2.0%
CHA-S	25	25	100.0%	0	0.0%
CMS-S	150	147	98.0%	3	2.0%
COV-M	150	148	98.7%	2	1.3%
HUM-M	150	149	99.3%	1	0.7%
MCC-S	150	147	98.0%	3	2.0%
MOL-M	150	139	92.7%	11	7.3%
PRS-M	150	149	99.3%	1	0.7%
SHP-M	150	146	97.3%	4	2.7%
STW-M	150	142	94.7%	8	5.3%
SUN-M	150	139	92.7%	11	7.3%
SUN-S	150	143	95.3%	7	4.7%
URA-M	150	124	82.7%	26	17.3%
All Plans	**2,125**	**2,042**	**96.1%**	**83**	**3.9%**

Table E-8—Reasons Dental Records Not Submitted for Date of Service by Plan

		Provider Refused		Dental Record Not at Facility		No Documentation for Selected Date of Service		Other	
Plan	Dental Records Not Submitted	Number	Percent	Number	Percent	Number	Percent	Number	Percent
AMG-M	3	0	0.0%	2	66.7%	1	33.3%	0	0.0%
BET-M	0	—	—	—	—	—	—	—	—
CCP-M	3	0	0.0%	0	0.0%	0	0.0%	3	100.0%
CHA-S	0	—	—	—	—	—	—	—	—
CMS-S	3	0	0.0%	0	0.0%	0	0.0%	3	100.0%
COV-M	2	0	0.0%	0	0.0%	2	100.0%	0	0.0%
HUM-M	1	0	0.0%	1	100.0%	0	0.0%	0	0.0%
MCC-S	3	0	0.0%	0	0.0%	1	33.3%	2	66.7%
MOL-M	11	0	0.0%	0	0.0%	11	100.0%	0	0.0%
PRS-M	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
SHP-M	4	0	0.0%	2	50.0%	1	25.0%	1	25.0%
STW-M	8	4	50.0%	0	0.0%	2	25.0%	2	25.0%
SUN-M	11	1	9.1%	3	27.3%	3	27.3%	4	36.4%
SUN-S	7	3	42.9%	2	28.6%	2	28.6%	0	0.0%
URA-M	26	0	0.0%	1	3.8%	1	3.8%	24	92.3%
All Plans	**83**	**8**	**9.6%**	**11**	**13.3%**	**24**	**28.9%**	**40**	**48.2%**

"—" denotes all requested dental records were submitted.

Encounter Data Completeness

Table E-9 presents the percentage of dates of service identified in the encounter data that were not found in the enrollees' dental records for the dates of service by each of the participating plans. Analysis was conducted at the date of service level.

Table E-9—Medical Record Omission

		Date of Service Not Supported by Documentation in Dental Record	
Plan	Date of Service Identified in Encounter Data	Number	Percent
AMG-M	120	2	1.7%
BET-M	120	0	0.0%
CCP-M	120	0	0.0%
CHA-S	25	0	0.0%
CMS-S	120	1	0.8%
COV-M	120	0	0.0%
HUM-M	120	0	0.0%
MCC-S	120	1	0.8%
MOL-M	120	1	0.8%
PRS-M	120	1	0.8%
SHP-M	120	0	0.0%
STW-M	120	1	0.8%
SUN-M	120	1	0.8%
SUN-S	120	0	0.0%
URA-M	120	2	1.7%
All Plans	**1,705**	**10**	**0.6%**

Table E-10 presents the percentage of dental procedure codes identified in the encounter data that were not found in the enrollees' dental records (i.e., medical record omission) and the percentage of dental procedure codes from enrollees' dental records that were not found in the encounter data.

Table E-10—Medical Record Omission and Encounter Data Omission for Procedure Code

	Medical Record Omission		Encounter Data Omission	
Plan	Number of Procedure Codes Identified in Encounter Data	Percent Not Documented in the Enrollee's Dental Records	Number of Procedure Codes Found in Enrollee's Dental Record	Percent Not Present in the Encounter Data
AMG-M	574	8.5%	566	8.3%
BET-M	633	7.1%	628	6.4%
CCP-M	647	3.9%	674	7.7%
CHA-S	105	3.8%	109	7.3%
CMS-S	495	5.5%	546	14.8%
COV-M	635	1.7%	681	8.4%
HUM-M	627	7.5%	609	4.8%
MCC-S	550	4.5%	594	13.0%
MOL-M	596	3.5%	608	6.4%
PRS-M	563	2.3%	568	4.0%
SHP-M	653	6.7%	662	8.0%
STW-M	589	5.4%	585	5.0%
SUN-M	492	5.9%	581	20.5%
SUN-S	511	6.1%	592	18.9%
URA-M	673	7.3%	633	3.3%
All Plans	**8,343**	**5.4%**	**8,636**	**9.1%**

Table E-11 presents the percentage of procedure codes associated with validated dates of service from the encounter data that were correctly coded based on enrollees' dental records.

Table E-11—Accuracy Results for Procedure Code

		Number of Procedure Codes Correctly Coded Based on Enrollee's Dental Record	
Plan	Number of Procedure Codes Present in the Encounter Data and Enrollee's Dental Record	Number	Percent
AMG-M	519	487	93.8%
BET-M	588	532	90.5%
CCP-M	622	601	96.6%
CHA-S	101	94	93.1%
CMS-S	465	445	95.7%
COV-M	624	604	96.8%
HUM-M	580	507	87.4%
MCC-S	517	508	98.3%
MOL-M	569	525	92.3%
PRS-M	545	514	94.3%
SHP-M	609	573	94.1%
STW-M	556	537	96.6%
SUN-M	462	425	92.0%
SUN-S	480	444	92.5%
URA-M	612	576	94.1%
All Plans	**7,849**	**7,372**	**93.9%**

Table E-12 presents the percentage of dates of service present in both AHCA's encounter data and in the medical records with the exact same values for all key data elements (i.e., *Dental Procedure Code*). 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 the exact 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 dental records.

Table E-12—All Element Accuracy

		Number of Dates of Service With the Exact Same Values for All Key Data Elements	
Plan	Number of Dates of Service Present in Both the Encounter Data and Enrollee's Dental Record	Number	Percent
AMG-M	118	65	55.1%
BET-M	120	58	48.3%
CCP-M	120	73	60.8%
CHA-S	25	13	52.0%
CMS-S	119	56	47.1%
COV-M	120	75	62.5%
HUM-M	120	53	44.2%
MCC-S	119	75	63.0%
MOL-M	119	66	55.5%
PRS-M	119	76	63.9%
SHP-M	120	66	55.0%
STW-M	119	73	61.3%
SUN-M	119	54	45.4%
SUN-S	120	52	43.3%
URA-M	118	65	55.1%
All Plans	**1,695**	**920**	**54.3%**

Appendix F. Plan Names/Abbreviations

SFY 2016–2017 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., d/b/a Aetna Better Health of Florida, Inc.	COV-M	Aetna Better Health
Humana Medical Plan, Inc.	HUM-M	Humana
Molina Healthcare of Florida, Inc.	MOL-M	Molina
Prestige Health Choice	PRS-M	Prestige
South Florida Community Care Network, d/b/a Community Care Plan	CCP-M	Community Care Plan*
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. d/b/a 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		
Amerigroup Community Care	AMG-L	Amerigroup-LTC
Coventry Health Care of Florida, Inc., d/b/a Aetna Better Health of Florida, Inc.	COV-L	Aetna Better Health-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

* Community Care Plan was referred to as CCP during SFY 2016–2017 in the PIP reports.