Florida Agency for Health Care Administration

SFY 2014–2015 Annual Technical Report of External Quality Review Results

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HSAG HEALTH SERVICES ADVISORY GROUP

3133 East Camelback Road, Suite 100 • Phoenix, AZ 85016-4545

Phone 602.801.6600 • Fax 602.801.6051

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Overview and Scope of the External Quality Review

The state fiscal year (SFY) 2014–2015 Annual Technical Report of External Quality Review Results, prepared for the Florida Agency for Health Care Administration (AHCA), is presented to comply with the Code of Federal Regulations (CFR) at 42 CFR §438.364. Health Services Advisory Group, Inc. (HSAG), is the external quality review organization (EQRO) for AHCA, the State agency responsible for the overall administration of Florida's Medicaid managed care program.

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

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

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

HSAG's external quality review of the MCOs included directly performing two of the three federally mandated activities as set forth in 42 CFR §438.358—validation of performance 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. AHCA began a new, three-year review cycle in SFY 2015–2016.

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.
- Cultural Competency Focused Study—performed by HSAG.

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

- Deeming 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.

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

This report includes the following for each EQR activity conducted:

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

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

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

Quality

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

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

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

Timeliness

The National Committee for Quality Assurance (NCQA) defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[3] NCQA further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MCO or prepaid inpatient health plan (PIHP)—e.g., processing expedited appeals and providing timely follow-up care.

Access

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

Organizations Included in External Quality Review

During SFY 2014–2015, AHCA included its various MCO, PIHP, and PAHP (prepaid ambulatory health plan) model types within the scope of the EQR, as listed in Table 1-1.

AHCA is responsible for the administration of the Medicaid managed care program in Florida and has delegated responsibility for monitoring certain aspects of the long-term care (LTC) plans to DOEA. As noted in Table 1-1, and as indicated throughout this report, health maintenance organizations (HMOs) and provider service networks (PSNs) are identified as either Reform or Non-Reform. Reform refers to the Medicaid Reform Pilot Program which AHCA implemented in July 2006, operating under an 1115 Research and Demonstration Waiver 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.

During its 2011 legislative session, the Florida legislature passed legislation to expand Medicaid managed care. This legislation created the SMMC program with two components: the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) program. 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.

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

Table 1-1 describes all plan types that were reviewed during the EQR report period. (The performance measure validation [PMV] review included HMOs and PSNs with Reform and Non-Reform product lines.)

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

Model Type	MCO/PIHP /PAHP	Description of Services
Health maintenance organizations (HMOs)—Reform and Non-Reform	MCO	Prepaid, comprehensive physical and mental health services provided to enrollees—phased out between May through August 2014.
Provider service networks (PSNs)—Reform and Non-Reform	PIHP or MCO	Prepaid or fee-for-service, comprehensive physical and mental health services provided to enrollees—phased out between May through August 2014.
Prepaid mental health plans (PMHPs)	PIHP	Prepaid mental health services provided to Medicaid enrollees who are not enrolled in an HMO or PSN—phased out between May through August 2014.
Child welfare prepaid mental health plan (CWPMHP)	PIHP	Prepaid mental health services provided to children and adolescents with open cases in Florida's Safe Families Network—phased out between May through August 2014.
Prepaid Dental Health Plans (PDHPs)	PAHP	Prepaid dental services for eligible children under the age of 21 who are not enrolled in an HMO or PSN providing dental services—phased out between May through August 2014.
Managed Medical Assistance (MMA) Standard Plans	MCO	Managed medical services for the SMMC program—phased in between May through August 2014.
MMA Specialty Plans	MCO	Managed medical services for Medicaid enrollees who meet certain criteria based on age, medical condition, diagnosis, or other conditions—phased in between May through August 2014.
Long-term Care (LTC) Plans	PIHP	Prepaid long-term care services including nursing facility and home and community-based services—phased in between August 2013 through March 2014.

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

Throughout this report either shortened plan names or plan codes have been used when referencing a plan. Please refer to Appendix G for a comprehensive list of plan names, by plan type.

Summary of Findings, Conclusions, and Recommendations

Performance Improvement Projects

PIP Status

During SFY 2014–2015, the MMA plans (MMA refers to Standard and Specialty in this section) submitted four PIPs for validation, including two state-mandated topics, one additional nonclinical topic, and one additional clinical topic. For the additional clinical topic, the MMA plans were required to select a topic falling into one of three categories: a population health issue within a specific geographic area identified as in need of improvement (such as diabetes, hypertension, and asthma); integration of primary care and behavioral health; or reduction of preventable readmissions. The LTC plans submitted two PIPs for validation, including one state-mandated topic and one nonclinical topic. Comprehensive plans that offered services for both the MMA and LTC programs submitted a total of six PIPs for validation, following the PIP topic requirements for both programs. For some of the MMA Specialty plans, exceptions were made to the mandated PIP topics when the topic did not apply to the population served. All PIPs validated for SFY 2014–2015 had progressed through the Design stage (Activities I–VI) only.

Table 1-2 displays the state-mandated PIP topics for the MMA plans and the LTC plans, as well as the status of each PIP topic.

Table 1-2—Current State-mandated PIP Topics

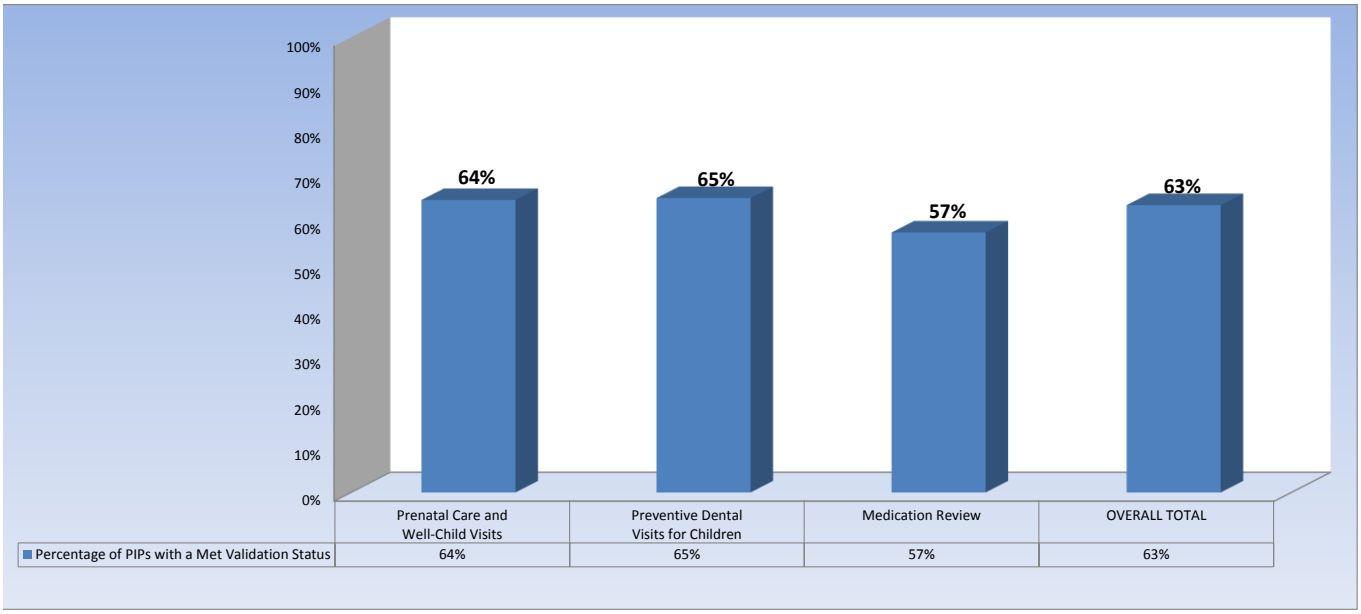
State-mandated PIP Topic	Plan Type	Status
Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	MMA Plans	Study design reported.
Preventive Dental Services for Children	MMA Plans	Study design reported.
Medication Review	LTC Plans	Study design reported.

Overall PIP Validation Findings and Conclusions

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

Figure 1-1 displays the percentage of state-mandated PIPs achieving a *Met* overall validation status by plan type and PIP topic for the SFY 2014–2015 validation year. Thirty-eight of the 88 PIPs validated focused on one of the three state-mandated topics. The blue bars represent the percentage of PIPs with an overall validation status of *Met*.

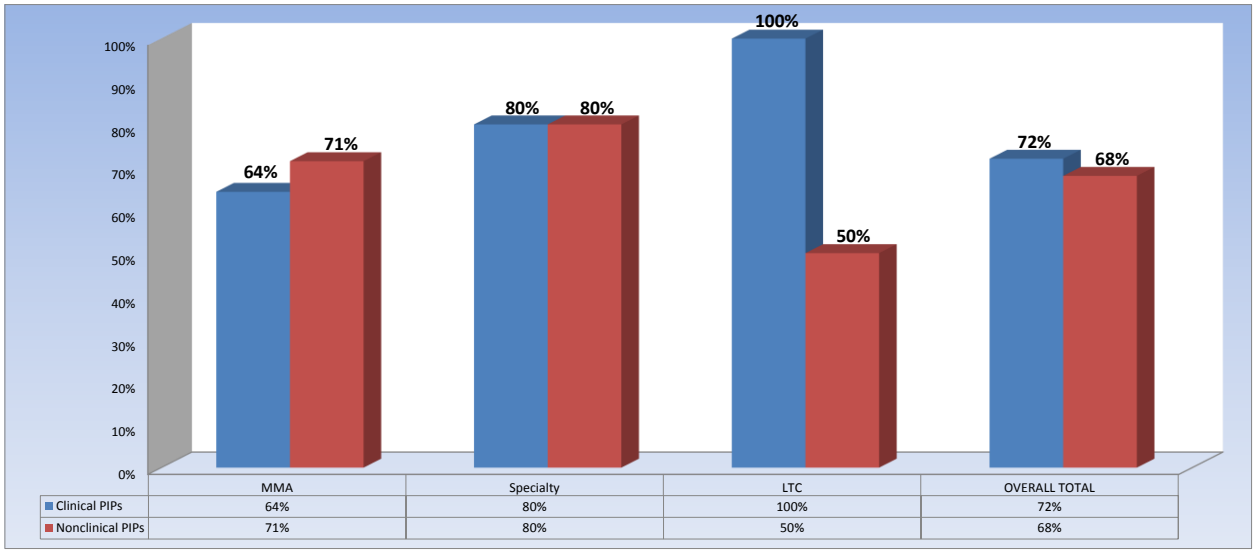
Figure 1-1—Overall *Met* Validation Status of State-mandated PIPs by PIP Topic



Across all state-mandated PIPs, 63 percent received an overall *Met* validation status. The percentage of PIPs receiving a *Met* validation status was higher for 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 *Preventive Dental Services for Children* PIPs (65 percent) than for the *Medication Review* PIPs (57 percent). Because all state-mandated PIPs had progressed only through the Design stage, these results indicate that many plans should revisit and improve the technical and methodological design and documentation of their PIPs to successfully progress to the Implementation and Outcomes stages of the PIPs. The plans have access to several resources for support in improving their PIPs: HSAG feedback provided in the PIP validation tools; HSAG PIP Completion Instructions; state-defined specifications for each state-mandated PIP topic; and technical assistance sessions with HSAG, as needed.

In addition to the 38 state-mandated PIPs displayed in Figure 1-1, HSAG validated 25 clinical PIPs and 25 nonclinical PIPs across the three plan types. Figure 1-2 displays the percentage of clinical and nonclinical PIPs achieving a *Met* overall validation status by plan type for the SFY 2014–2015 validation year. The blue bars represent the percentage of clinical PIPs with an overall validation status of *Met*, and the red bars represent the percentage of nonclinical PIPs with an overall validation status of *Met*.

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



	MMA	Specialty	LTC	OVERALL TOTAL
Clinical PIPs	64%	80%	100%	72%
Nonclinical PIPs	71%	80%	50%	68%

Across all plan types, 72 percent of the clinical PIPs received an overall *Met* validation status compared to 68 percent of the nonclinical PIPs. The pattern varied by plan type: for MMA Standard plans, more nonclinical PIPs (71 percent) than clinical PIPs (64 percent) received a *Met* validation status; for MMA Specialty plans, an equal percentage (80 percent) of clinical and nonclinical PIPs received a *Met* validation status; and for LTC plans, a greater percentage of clinical PIPs (100 percent) than nonclinical PIPs (50 percent) received a *Met* validation status. It should be noted, however, that HSAG validated only one LTC clinical PIP compared to six LTC nonclinical PIPs; therefore, the comparison of LTC clinical to nonclinical PIP performance may not be valid.

While the plans' performance on the clinical and nonclinical PIPs (which they selected) was better overall than their performance on the state-mandated PIPs, the results still suggest room for improvement in the study designs of the clinical and nonclinical PIPs. The plans should address any deficiencies in the Design stage of their PIPs to provide a solid foundation for achieving improvement in outcomes as the PIPs progress to subsequent stages. The plans have access to HSAG feedback and guidance in the PIP validation tools and PIP Completion Instructions as well as the opportunity to seek technical assistance from HSAG, as needed, to address any identified design issues.

Recommendations for AHCA and All Plans

Based on the validation results across all PIPs, HSAG made several observations about their design. HSAG offers the following recommendations to improve the structure of the PIPs, which relates to validation scores, as well as supporting progress toward improved PIP outcomes in the future.

Recommendations

- AHCA, with HSAG's assistance, should continue to identify statewide goals or expected levels of performance for the study indicators in all state-mandated PIPs.
- The plans should align documentation of the study question, study population, and study indicators with the state-defined specifications for all state-mandated PIP topics.

- The plans should accurately report the study indicator definition, including the numerator, denominator, and measurement period dates, and align the documentation with relevant measurement specifications.
- The plans should use methodologically sound sampling techniques and should fully document the methods used for sampling, when applicable.
- The plans should thoroughly describe the administrative and/or manual data collection methods used for each PIP, including manual data collection tools, when used. The documented data collection methods should clearly show how enrollees are identified for inclusion in the denominator and numerator of the study indicator(s).
- The plans should ensure that the estimated administrative data completeness is accurately calculated and documented for PIPs using claims data, when applicable. Both the estimated percentage of completeness and the methods used to determine estimated completeness should be documented in the PIP.

Performance Measure Validation

For each HEDIS measure, the range of plan performance is shown in the figures using vertical grey lines, with green horizontal bars representing the AHCA performance targets, generally established based on the HEDIS national Medicaid 75th percentiles. This provides a picture of the range of plan performance relative to the AHCA-established performance targets. The figures also include the statewide weighted averages when the AHCA performance targets are available.

MMA Plans

For the current measurement year, MMA plans demonstrated strong performance in meeting the NCQA information systems (IS) standards. All MMA plans were fully compliant with IS standards 1, 2, 3, 6, and 7. For IS standard 4, all MMA Specialty plans were compliant. One MMA Standard plan was noncompliant with this standard due to using a process that was not acceptable according to NCQA audit standards. Consequently, this plan was required to report several measures (i.e., *Comprehensive Diabetes Care [CDC]—HbA1c*, *Comprehensive Diabetes Care [CDC]—Medical Attention for Nephropathy*, *Cervical Cancer Screening [CCS]*, and *Lead Screening in Children [LSC]*) using administrative data only.

For IS Standard 5, all MMA Standard plans were fully compliant. One MMA Specialty plan was substantially compliant with this standard; however, the impact for HEDIS reporting was minimal. Both MMA Standard and Specialty plans were required to report 37 measures, which were grouped into six groups (Access/Availability of Care, Behavioral Health, Pediatric Care, Women's Care, Living With Illness, and Use of Services) (see Table 1-3). In addition, two Children's Specialty plans reported three additional measures (*HPV Vaccine for Female Adolescents [HPV]*, *Medication Management for People With Asthma [MMA]*, and *Developmental Screening in the First Three Years of Life [DEVSCR]*) specific to their population. The Serious Mental Illness plan also reported four additional measures (*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications [SSD]*, *Diabetes Monitoring for People With Diabetes and Schizophrenia [SMD]*, *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia [SMC]*, *and Adherence to Antipsychotic Medications for Individuals With Schizophrenia [SAA]).*

Table 1-3—Standard MMA Measures and Their Assignment to the Quality, Timeliness, and Access Domains				
Groups	**2015 (CY 2014) Measures**	**Quality**	**Timeliness**	**Access**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	✓		
	Well-Child Visits in the First 15 Months of Life—6+ Visits	✓		
	Well-Child Visits in the 3rd–6th Years of Life	✓		
	Lead Screening in Children	✓	✓	
	Adolescent Well-Care Visits	✓		
	Annual Dental Visit	✓		✓
	Childhood Immunization Status—Combination 2	✓	✓	
	Childhood Immunization Status—Combination 3	✓	✓	
	Immunizations for Adolescents	✓	✓	
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	✓	✓	✓
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	✓	✓	✓
	Preventive Dental Services			✓
	Dental Treatment Services			✓
	Sealants	✓		✓
Women's Care	*Cervical Cancer Screening*	✓		
	Chlamydia Screening in Women	✓		
	Breast Cancer Screening	✓		
	Prenatal Care		✓	✓
	Postpartum Care			✓
	Prenatal Care Frequency	✓		✓
	Antenatal Steroids	✓		
Living With Illness	*Diabetes Care—HbA1c Testing*	✓		
	Diabetes Care—HbA1c Poor Control	✓		
	Diabetes Care—HbA1c Control (<8%)	✓		
	Diabetes Care—Eye Exam (Retinal) Performed	✓		
	Diabetes Care—LDL-C Screening	✓		
	Diabetes Care—LDL-C Control (<100 mg/dL)	✓		
	Diabetes Care—Medical Attention for Nephropathy	✓		
	Controlling High Blood Pressure	✓		
	Adult BMI Assessment	✓		
	Use of Appropriate Medications for People with Asthma	✓		
	HIV-Related Medical Visits	✓		
	Highly Active Anti-Retroviral Treatment	✓		
	Annual Monitoring for Patients on Persistent Medications	✓		
	HIV Viral Load Suppression—18–64 Years	✓		
	HIV Viral Load Suppression—65+ Years	✓		
	Plan All-Cause Readmissions—18–64 Years	✓		
	Plan All-Cause Readmissions – 65+ Years	✓		
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*			✓
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years			✓
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years			✓
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years			✓
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years			✓
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years			✓
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years			✓
	Adults' Access to Preventive/Ambulatory Health Services—Total			✓
	Call Abandonment			✓

Table 1-3—Standard MMA Measures and Their Assignment to the Quality, Timeliness, and Access Domains				
Groups	**2015 (CY 2014) Measures**	**Quality**	**Timeliness**	**Access**
	Call Answer Timeliness		✓	
	Transportation Availability			✓
	Transportation Timeliness		✓	
Behavioral Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*		✓	
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up		✓	
	Antidepressant Medication Management—Effective Acute Phase Treatment	✓	✓	
	Antidepressant Medication Management—Effective Continuation Phase Treatment	✓	✓	
	Mental Health Readmission Rate	✓		
	Initiation of Alcohol and Other Drug Dependence Treatment	✓	✓	
	Engagement of Alcohol and Other Drug Dependence Treatment	✓	✓	
Children's Specialty	*Medication Management for People With Asthma—50% Compliance*	✓		
	Medication Management for People With Asthma—75% Compliance	✓		

Results

Measures under the **quality** domain with AHCA performance targets included all measures in the Pediatric Care, Women's Care, Living With Illness, and Behavioral Health domains, except *Preventive Dental Services*, *Dental Treatment Services*, *Timeliness of Prenatal Care*, *Postpartum Care*, and *Follow-Up After Hospitalization for Mental Illness (FHM)—7 day* and—*30 day Follow-up*. None of the measures in the Access/Availability of Care domain were identified under the quality domain.

- For Pediatric Care, only *Follow-up Care for Children Prescribed ADHD Medication* (*Initiation Phase,* and *Continuation and Maintenance Phase)* showed the statewide weighted averages exceeding the AHCA performance targets.
- For Women's Care, no measures had a statewide weighted average exceeding the associated AHCA performance target.
- For Living With Illness, the statewide weighted average exceeded the AHCA performance target for *Diabetes Care—Medical Attention for Nephropathy*, *Adult BMI Assessment*, and *Annual Monitoring for Patients on Persistent Medications—Total*.
- For Behavioral Health, only the *Alcohol & Drug Dependence Treatment—Initiation* measure showed its statewide weighted average exceeding the AHCA performance target.

Measures under the **timeliness** domain with AHCA performance targets included six Pediatric Care measures (*Lead Screening in Children*, *Childhood Immunization Status—Combos 2 and 3*, *Immunizations for Adolescents*, and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*); one Women's Care measure (*Timeliness of Prenatal Care*); one Access/Availability of Care measure (*Call Answer Timeliness*); and all Behavioral Health measures except *Mental Health Readmission Rate.*

- For Pediatric Care, only *Follow-up Care for Children Prescribed ADHD Medication (Initiation Phase* and *Continuation and Maintenance Phase*) showed the statewide weighted averages exceeding the AHCA performance targets.

- For Women's Care, the only measure (*Timeliness of Prenatal Care*) did not show the statewide weighted average reaching the AHCA performance target.
- For Access/Availability of Care, the only measure (*Call Answer Timeliness*) did not show the statewide weighted average reaching the AHCA performance target.
- For Behavioral Health, only the *Alcohol & Drug Treatment—Initiation* measure had its statewide weighted average exceeding the AHCA performance target.

Measures under the **access** domain with AHCA performance targets included six Pediatric Care measures: *Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase, Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase, Annual Dental Visit, Preventive Dental Services, Dental Treatment Services,* and *Sealants*. Three measures were included under Women's Care: *Timeliness of Prenatal Care, Postpartum Care,* and *Prenatal Care Frequency*. Finally, all Access/Availability of Care measures except *Call Answer Timeliness* are included in this domain.

- For Pediatric Care, only *Follow-up Care for Children Prescribed ADHD Medication* (*Initiation Phase* and *Continuation and Maintenance Phase*) showed the statewide weighted averages exceeding the AHCA performance targets.
- For Women's Care, the three included measures (*Timeliness of Prenatal Care, Postpartum Care,* and *Prenatal Care Frequency*) did not have their statewide weighted averages exceeding the associated AHCA performance targets.
- For Access/Availability of Care, no measures had a statewide weighted average exceeding the associated AHCA performance target.

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

LTC Plans

For calendar year (CY) 2014, the LTC plans were required to report two HEDIS and five AHCA-defined measures. Based on Final Audit Report (FAR) reviews, similar to last year, HSAG found that not all LTC plans conducted their audits according to NCQA HEDIS Compliance Audit policies and procedures. However, HSAG had no concerns with the seven LTC plans' data systems and processes used for measure calculation. The LTC plans maintained the same experienced staff members for collecting and processing data for performance measure reporting. In addition, the LTC plans continued to have sufficient processes in place to ensure data completeness and accuracy.

Table 1-4—LTC Measures and Their Assignment to the Quality, Timeliness, and Access Domains

2015 (CY 2014) Measures	Quality	Timeliness	Access
Care for Older Adults—Advanced Care Planning	✓		
Care for Older Adults—Medication Review	✓		
Care for Older Adults—Functional Status Assessment	✓		
Required Record Documentation—701B Assessment	✓		

Table 1-4—LTC Measures and Their Assignment to the Quality, Timeliness, and Access Domains			
2015 (CY 2014) Measures	**Quality**	**Timeliness**	**Access**
Required Record Documentation—Enrollee Participation	✓		
Required Record Documentation—Primary Care Physician Notification	✓		
Call Answer Timeliness		✓	
Call Abandonment			✓
Face-to-Face Encounters		✓	
Case Manager Training		✓	
Timeliness of Services		✓	

For LTC, the 11 performance measures are grouped as follows for the quality-timeliness-access domains: (quality—six; timeliness—four; and access—one). Only one performance measure had an associated AHCA performance target, *Call Answer Timeliness*, which also did not reach the performance target and represents an opportunity for improvement.

Review of Compliance

Readiness Reviews

Due to the transition to SMMC, AHCA chose not to perform compliance reviews in SFY 2013–2014; however, readiness reviews were conducted on its MMA plans during the period of time just prior to implementation of each phase of Florida's SMMC program. AHCA and DOEA conducted the readiness reviews of the LTC plans. AHCA's readiness review process included a desk review of numerous key documents, as well as an on-site review that included interviews and system demonstrations to ensure the plans met federal managed care and State requirements in 14 major standard areas.

Both AHCA and DOEA used similar processes to conduct the readiness reviews; however, as the LTC plans began providing services before the MMA plans, AHCA was able to enhance the readiness review processes for the MMA plans.

AHCA determined that the MMA plans experienced the highest number of deficiencies in the following standard areas: Administration and Management, Enrollee Materials, Grievance Systems, Prescribed Drug Services, and Provider Network.

Although all plans were approved to begin enrollment after the readiness reviews, HSAG recommends that AHCA continue its reviews and monitoring in the areas that had the highest deficiencies. In addition, AHCA may want to conduct an assessment of the plans' need for technical assistance in these areas. AHCA should ensure that its ongoing compliance monitoring is designed to cover all of the areas required by42 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.

Deeming Study

In response to a CMS inquiry as to whether AHCA planned to take advantage of the federal non-duplication regulations that allow for deemed compliance based on health plan accreditation, AHCA contracted with HSAG to review the plans' accreditation status results, submit a summary of findings, and crosswalk the applicable federal managed care regulations to the NCQA and Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) standards. This assessment was to identify which federal standards could potentially be deemed, along with any recommendations for non-duplication deeming.

HSAG found that approximately one-fifth of the deemable federal regulations would be evaluated in an NCQA accreditation review, and one-sixth of the deemable federal regulations would be evaluated in an AAAHC accreditation review. There were only four federal requirements that both NCQA and AAAHC would evaluate in an accreditation review. In addition, sometimes AHCA contract standards exceeded federal requirements; therefore, the specific AHCA contract standard that exceeded the federal requirement was not evaluated by NCQA or AAAHC in the accreditation process.

HSAG noted that AHCA's last compliance review was conducted prior to the implementation of the SMMC program, and the readiness reviews that AHCA completed prior to the implementation did not include all of the federal or State contract standards. HSAG recommended that AHCA not "deem" the plans compliant, based on their accreditation status, until the potentially deemable standards were reviewed in an annual compliance review. If AHCA decides to pursue deeming some of the standards, HSAG recommends that the deeming crosswalk be updated as NCQA and AAAHC update their standards or as AHCA changes the SMMC contract requirements. Finally, if AHCA decides to deem standards, the Florida Medicaid Revised Comprehensive Quality Strategy 2013 – 2014 Update (also referred to as the Comprehensive Quality Strategy [CQS]) will need to be updated to include information about the plan to deem compliance requirements.

Encounter Data Validation

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

During SFY 2014–15, AHCA contracted with HSAG to conduct an EDV study. The goal of the study was to examine the extent to which encounters submitted to AHCA by its contracted MCOs and PIHPs (collectively referred to as "plans") were complete and accurate. The study included several evaluation components including an encounter data file review, a comparative analysis, and a medical record review. Three types of encounter data (i.e., Dental, Inpatient/outpatient, and Physician visits) were included in the study.

Encounter Data File Review

The initial review of encounter data illustrated differences in the overall and month-to-month volume of encounters by type and source. While both professional and dental encounters exhibited similar patterns in encounter data volume and month-to-month trends when comparing AHCA and plan encounter data submissions, AHCA consistently reported approximately 2,000 more encounters per month than the plans submitted. Institutional encounters, however, exhibited a greater amount of variation when comparing the volume of encounters documented by the plans versus AHCA. Due to incomplete documentation of the admission and discharge dates in AHCA's outpatient encounters, AHCA was unable to extract these records completely. Since outpatient encounters generally comprise a large proportion of institutional encounters, the exclusion of the encounters from AHCA's encounter data had a large impact on the overall completeness of AHCA encounters. Despite this discrepancy, the assessment of volume trends suggested fairly consistent documentation and submission encounter data trends for all plans and AHCA with regard to professional and most dental encounters.

Completeness of enrollee encounters varied more by data element than by data source or specific plan. In general, the level of completeness and accuracy associated with key encounter data elements was primarily related to whether the element represented a required encounter data element or was situational. Across professional, dental, and institutional encounters, *Recipient ID*, *Primary Diagnosis Code* (excluding dental encounters), and *Procedure Code* were consistently complete and valid for at least 90 percent of encounters submitted by both plans and AHCA. Data elements with situational reporting requirements did not exhibit the same levels of completeness, validity, or consistency across plans and data sources. With regard to professional encounters, *Diagnosis Codes 2–4*, *NDC*, and both *Rendering* and *Provider NPI* fields exhibited varying levels of completeness in both plan and AHCA encounter data. However, AHCA encounters indicated a higher level of accuracy than plan encounters. With regard to dental encounters, the same pattern was observed for *Rendering Provider NPI*, with a high degree of variation in completeness rates exhibited across plans for data submitted by the plans and AHCA. The majority of data elements with situational reporting requirements had higher average *percent missing* rates from plan-based encounters versus AHCA-based encounters.

Though the importance of data elements with situational reporting requirements appears minimal by nature of their classification, their presence and accuracy were vital to the subsequent analytical components of the EDV. The comparative analysis component of assessment matched submitted plan encounters to their respective AHCA encounters and assessed how thoroughly both data sources documented key data elements. The differences in completeness and accuracy rates observed in the file review ultimately impact the omission[5], surplus[6], and accuracy rates calculated in the comparative analysis and medical record review.

[5] An "omission" is defined as a record that is not present in AHCA's encounter data but is present in a second data source (i.e., plans submitted data for the comparative analysis component or a medical record for the medical record review component).

[6] A "surplus" is defined as a record that is present in AHCA's encounter data but is not present in a second data source (i.e., plans submitted data for the comparative analysis component or a medical record for the medical record review component).

Record Completeness

Overall, dental encounters exhibited the most complete data with the lowest record omission and record surplus rates, although for three plans, no dental records matched between AHCA's encounter data and the data submitted by the plans. Nonetheless, most data discrepancies were attributed to the incomplete institutional encounter data submission by AHCA for approximately 2,000,000 unique internal control numbers (ICNs) due to incomplete data for admission and discharge dates.

In general, the record omission and surplus rates were high across all plans for institutional encounters. Some of the primary factors contributing to overall record incompleteness were as follows:

- Omitted and surplus professional encounters were associated with members enrolled in plans that are providing different types of services.
- Omitted and surplus dental encounters were associated with members, rather than encounters, missing from one of the two data sources.
- Incomplete data submission due to the lack of admission and discharge dates of service in AHCA's outpatient encounters.
- Differences in the presence of duplicated encounters across data sources.

Encounter Data Element Completeness

Overall, the level of completeness for key encounter data elements across all three encounter types was high (i.e., low overall omission and surplus rates), with the overall element omission and element surplus rates below 10 percent for nearly all evaluated encounter data elements. Encounter data elements associated with less completeness were generally attributed to one of the provider fields.

At the plan level, there was considerably more variation. For professional encounters, *Referring Provider NPI* exhibited the greatest amount of variation in omission rates among the plans, while the greatest amount of variation in surplus rates was associated with the *Primary Diagnosis Code*. The level of variation in the omission rates was less dramatic among the plans for dental encounters, whereas the amount of variation in the surplus rates was considerably larger for the following data elements: *Line Date of Service*, *Billing Provider NPI*, and *Rendering Provider NPI*. For institutional encounters, the encounter data element omission and surplus rate differences between plans was mixed. While the omission rates for nearly half of the evaluated data elements exhibited minimal variation across plans (i.e., less than 10 percentage points), omission rates for the *Diagnosis Code 2*, *Diagnosis Code 3*, and *Procedure Code* elements were characterized by large differences.

Encounter Data Element Agreement

Overall, high encounter data element agreement for matching records was found between AHCA's and the plans' submitted professional encounters. Key encounter data elements such as *Procedure Code*, *NDC*, and *Primary Diagnosis Code* exhibited at least 90 percent agreement. Similarly, a high level of agreement was also noted for dental encounter data elements, with the exception of *Dental Procedure Code* which only showed a low level of agreement. While the record completeness for institutional encounters was low, for records that could be found in both data sources, the overall data element agreement was mixed. One-third of the evaluated data elements (i.e., *Admission Date*,

Primary Diagnosis Code, *Primary Surgical Code*, *Procedure Code*, *Procedure Code Modifier 1*, and *Revenue Code)* showed a high level of agreement; another third (i.e., *Discharge Date*, *Surgical Procedure Code 2*, *Surgical Procedure Code 3*, *Surgical Procedure Code 4*, *Billing Provider NPI*, and *Amount Paid*) exhibited a moderate level of agreement; and the remaining data elements showed low levels of agreement.

Medical Record Review

Medical Record Submission

Of the 1,234 sample cases requested for medical record review, 981 (79.5 percent) were submitted by the plans. Overall, 1,261 medical records were reviewed which included dates of service from the original sample cases (n=981), as well as those with an additional date of service submitted by the plan providers (n=280). Among the 253 medical records that were not submitted, provider refusal was the primary reason medical records were not submitted by the plans (75.9 percent of missing records). Of note, the medical record submission rate for original dates of service varied considerably across participating plans, ranging from 14.0 percent to 100 percent submission.

Encounter Data Completeness

The assessment of enrollees' medical records showed mixed results for medical record omission rates. While omission rates for dates of service and procedure codes identified in AHCA encounter data were moderate, diagnosis codes and procedure code modifiers exhibited high rates of omission. Both findings suggest that key elements documented in enrollees' medical records are not consistently submitted or processed into Florida Medicaid Management Information System (FMMIS). As a result of the overall date of service omission rate (i.e., 22.9 percent), the high omission rates for the diagnosis codes, procedure codes, and procedure code modifiers were anticipated and found. Preliminary file review of AHCA's encounter data demonstrated high *Percent Missing* rates for diagnosis and procedure codes according to situational reporting requirements. Furthermore, medical record omission rates for all key data elements varied considerably across plans, with differences reported for every encounter data element ranging at least 80 percentage points between the lowest and highest observed rates.

The most common reasons for medical record omission rates included provider refusal (75.9 percent), record could not be located (17.0 percent), poor documentation in the record (5.9 percent), or the record submitted was incorrect (1.2 percent). A total of 66 records could not be matched with AHCA encounter data due to different dates of service. Other reasons included the provider not performing the service(s) documented in the AHCA encounter; and system restrictions on the number of diagnosis codes, procedure codes, or procedure code modifiers processed and stored by AHCA that may differ from the encounter data elements submitted by the plans.

Assessment of encounter data omission rates revealed that not all services documented in enrollees' medical records were submitted to or processed and stored by AHCA. Though encounter data omission rates for key data elements were generally lower than medical record omission rates, 35.9 percent of diagnosis codes, 28.5 percent of procedure codes, and 45.2 percent of procedure code modifiers found in enrollees' medical records were missing from the respective AHCA encounters. Medical records with date of service discrepancies did not completely account for the omission of other key data elements. Diagnosis code, procedure code, and procedure code modifier omission

rates varied considerably for plans as well. Common reasons for encounter data omissions included coding errors made by a provider's billing office, deficiencies in managed care plans' data submission or resubmission processes (for denied or rejected encounters), and submission of nonstandard procedure codes and procedure code modifiers.

Encounter Data Element Accuracy

Overall, encounter data element accuracy was high, with 95.4 percent of diagnosis codes, 82.3 percent of procedure codes, and 99.3 percent of procedure code modifiers validated and supported by clinical documentation in enrollees' medical records. However, while accuracy for key data elements was high, only 31.9 percent of the validated dates of service were accurately represented in all three data elements (*Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) when compared to enrollees' medical record documentation. This finding suggests that submission of encounter data elements is frequently incomplete, leading to overall inaccuracy of the clinical record contained in the State's encounter data.

Focused Study

HSAG performed a statewide focused study to evaluate the cultural competency performance of each SMMC plan. Results of the study would assist AHCA and its SMMC plans in identifying areas and strategies for improvement in response to a request from CMS that additional information related to cultural considerations be included in future EQR reports. HSAG completed a review and analysis of each plan's most recent cultural competency plan (CCP) and the plan's evaluation of its CCP from the previous year. The primary objective of this review was to provide meaningful information to AHCA regarding the SMMC plans' contract and regulatory compliance (State and federal) and consistency with the National Culturally and Linguistically Appropriate Services (CLAS) Standards in the area of cultural competency. A total of 19 cultural competency plans were included in the study, which was conducted on all SMMC plans: MMA Standard plans, MMA Specialty plans, and LTC plans.

HSAG reviewed each plan's CCP and evaluation document and scored each element as *Met*, *Partially Met*, or *Not Met.* All CCPs included at least some of the components of each standard; therefore, the lowest score for any of these standards was *Partially Met*. One of the primary objectives of this review was to provide meaningful information to AHCA regarding the SMMC plans' consistency with National CLAS Standards in the area of cultural competency. Since it is not mandated that the plans adhere to these standards, in place of traditional scoring, HSAG indicated whether the plan demonstrated adherence to these standards in its CCP by marking each standard *Yes* (Y) or *No* (N).

The majority of the plans met the minimum federal and State contract requirements, as evidenced by 14 of 19 plans receiving a score of 80 percent or higher. However, common areas for improvement that are applicable to many, if not all, plans emerged from analysis of the review findings.

Demographic Description of Membership/Scope of Cultural Competence

Many plans took a narrow approach to describing their membership and the unique needs of the various communities served in that much of the information was limited to race and/or ethnicity and language preference. In many cases, plans did not specify which counties they served or if they were a MMA Specialty or LTC plan. In addition, the cultural needs of specific populations were not discussed.

Language Assistance/Translation Services

Some plans described language assistance and translation services in broad terms instead of specifically addressing how services are provided in a culturally competent manner to those enrollees with various communication needs.

Plan Evaluation of Previous Year's CCP

All plans approached the CCP and evaluation of the prior year's CCP as two distinct functions and documents. In many instances, this led to the evaluation document including much of the same information that was in the CCP (which in most cases was redundant). In some cases, information that should have been in the CCP was contained in the evaluation document. Due to the distinction between the two documents, there was no connection between the evaluation of the CCP leading to improvements or interventions for next year's CCP. Many plans included analysis of language preference and race and/or ethnicity in the evaluation document but did not demonstrate how this analysis led to revising the next year's CCP.

As noted previously, there was wide variation and depth to the CCPs and evaluation documents, with some limited to two pages and others more extensive and comprehensive. This may be the result of broad contract language that does not provide enough specificity for the plans, which may indicate a need for more direction from AHCA.

Background

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

History and Current Status of Florida Medicaid Managed Care and Demographics

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

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

The demographics of the Florida Medicaid population (excluding the fee-for-service population) as of December 2015 were as follows[7]:

- Approximately 3.1 million were enrolled in an MMA plan (includes Specialty plans).
- Approximately 91,000 were enrolled in an LTC plan.

The State's Comprehensive Quality Strategy

The Florida Medicaid Revised Comprehensive Quality Strategy 2013 – 2014 Update (also referred to as the Comprehensive Quality Strategy [CQS]) is an updated version of the State's previous Quality Assessment and Improvement Strategy (QAIS) and was expanded to include a Long-term Care Program Quality Strategy. The CQS "…reflects the state's three-part aim for continuous quality improvement through planning, designing, assessing, measuring and monitoring the health care delivery system for all Medicaid managed care organizations, prepaid inpatient health plans, long-term care services and supports, and fee-for-service populations."[8]

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

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

To meet CMS requirements and State goals, AHCA contracted with HSAG to conduct EQR mandatory and optional activities for SFY 2014–2015. The assessment of these activities and recommendations that follow, as discussed in Section 3 of this report, are an integral component of AHCA's CQS. These recommendations are used to continually improve quality of care to Medicaid enrollees in Florida.

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

[7] 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: Feb 9, 2016.
[8] Florida Medicaid Revised Comprehensive Quality Strategy 2013–2014 Update. Available at: http://ahca.myflorida.com/Medicaid/quality_mc/Archive/docs/Florida_Medicaid_Revised_Comprehensive_Quality_Strategy_2013-2014.pdf. Accessed on: Jan 30, 2015.

The SMMC program has two major components: the LTC program and the MMA program. The LTC program provides long-term care services, including nursing facility and home and community-based services. The MMA program provides primary and acute medical assistance and related services. With both programs fully implemented, all PMHPs/CWPMHP and PDHPs were phased out.

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

AHCA and HSAG reviewed and discussed the existing CMS and contract requirements for EQR activities, as well as benefits and burdens to the plans and the State, and developed guiding principles for use in making these determinations. Based on this assessment, not all plan types were reviewed for each EQR activity during SFY 2014–2015. For example, due to the time frame needed to conduct the PMV audits, HMOs/PSNs, PMHPs/CWPMHP, and PDHPs were included in the performance measure validation (PMV) process, while only MMA Standard, MMA Specialty, and LTC plans participated in PIP, compliance, encounter data validation (EDV), and focused study activities.

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

Purpose of the Report

The purpose of the SFY 2014–2015 External Quality Review Technical Report is to comply with the BBA, which requires states to prepare an annual technical report that describes the manner in which data from activities conducted in accordance with 42 CFR §438.352 were aggregated and analyzed. The report must describe how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the contracted plans. This includes assessing the degree to which the plans addressed recommendations made in the previous year.

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–G. With the exception of information pertaining to EDV, all information is organized by plan type.

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

The BBA-required information on the methodology for conducting EQR activities may be found in Appendix A. Appendices B, C, D, E, and F include plan-specific PIP, performance measure, compliance review, EDV, and focused study results, respectively. Appendix G includes a comprehensive list of plan names, by plan type.

Validation of Performance Improvement Projects

During SFY 2014–2015 the MMA plans, including both Standard and Specialty, 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, and 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 a total of six PIPs for validation, following the PIP topic requirements for both programs. For some of the MMA Specialty plans, exceptions were made to the mandated PIP topics when the topic did not apply to the population served. All PIPs validated for SFY 2014–2015 had progressed through the Design stage (Activities I–VI) only.

Background Information

As part of its quality assessment and performance improvement program, AHCA required the plans to conduct PIPs in accordance with 42 CFR §438.240, although the number of required PIPs varied. Each plan contract requires that PIPs be conducted and submitted for validation. According to the EQRO contract with AHCA, HSAG validated four PIPs for each MMA plan and two PIPs for each LTC plan. While the plans generally submitted PIPs that aligned with the state-mandated PIP topics, several exceptions were made for MMA Specialty plans when the mandated PIP topic was not appropriate for the population served. HSAG compiled and analyzed the findings from the validation process to produce this report. Plan-reported indicator results and intervention activities will be included in future validations and reports, after the PIPs have progressed to the Implementation and Outcomes stages.

Status of MMA PIPs

The MMA plans initiated four new PIPs in SFY 2014–2015. The contracts between AHCA and the MMA plans required two specific, state-mandated PIP topics, one additional nonclinical PIP topic, and a fourth PIP selected from one of three topic categories. The two state-mandated topics were *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*. All four PIPs progressed through the Design stage (Activities I–VI) during the current year. The MMA plans will report baseline study indicator results for all PIPs in SFY 2015–2016.

The dual focus of the state-mandated *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIP is improvement of well-child visit rates in

the first 15 months of life and timeliness of prenatal care. The state-defined study populations and study indicators for the PIP were based on HEDIS technical specifications.

The focus of the state-mandated *Preventive Dental Services for Children* PIP is to improve access to preventive dental services for enrollees 1 to 20 years of age. The state-defined study population and study indicator were based on the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2015 Reporting.[9]

For the nonclinical PIP, the MMA plans selected an administrative PIP topic that was approved by AHCA. The MMA plans were responsible for defining the eligible population and identifying relevant measurement specifications or internally developing appropriate measures for the PIP.

For the fourth PIP, the MMA plans were required to select a topic from one of three state-defined categories: a population health issue within a specific geographic area identified as in need of improvement (such as diabetes, hypertension, and asthma); integration of primary care and behavioral health; or reduction of preventable readmissions. The topic selected by each MMA plan was approved by AHCA prior to submission for validation. The MMA plans were responsible for defining the eligible population and identifying relevant measurement specifications or internally developing appropriate measures for the PIP.

Status of LTC PIPs

The LTC plans initiated two new PIPs in SFY 2014–2015. The contracts between AHCA and the LTC plans required one specific, state-mandated PIP topic, *Medication Review*, and one additional nonclinical PIP topic. Both PIPs progressed through the Design stage (Activities I–VI) during the current year. The LTC plans will report baseline study indicator results for all PIPs in SFY 2015–2016.

The focus of the *Medication Review* PIP is to increase the percentage of eligible enrollees whose medications are documented in their medical record or case file and who have had at least one medication review completed annually. AHCA defined the study question, study population, study indicator, and measurement periods for this PIP.

For the nonclinical PIP, the LTC plans selected an administrative PIP topic that was approved by AHCA prior to submission for validation. The LTC plans were responsible for defining the eligible population and identifying relevant measurement specifications or internally developing appropriate measures for the PIP.

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

[9] Center for Medicaid and CHIP Services. *Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2015 Reporting.* Centers for Medicare & Medicaid Services; March 2015.

In this section of the report, the PIP results are presented in a series of PIP Validation Results graphs. The PIP Validation Results graphs include a stacked bar for each activity and stage for the validation year. Each stacked bar depicts the percentage of evaluation elements that were met, partially met, and not met. The green portion of the stacked bar represents the percentage of *Met* evaluation elements, the yellow portion represents the percentage of *Partially Met* evaluation elements, and the red portion represents the percentage of *Not Met* evaluation elements.

MMA Standard Plans

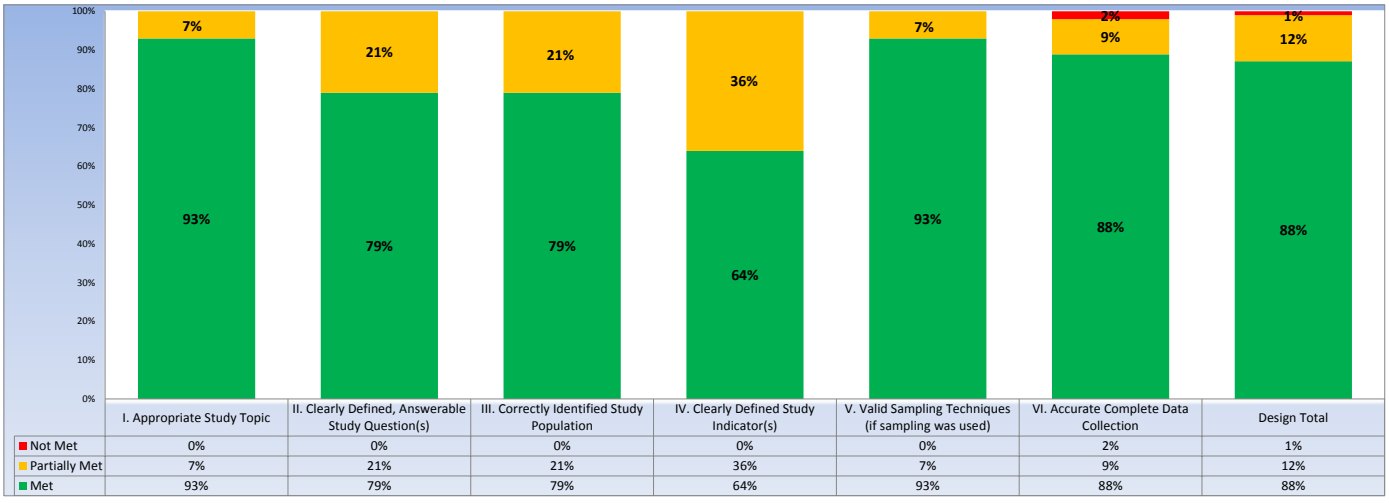
Results

SFY 2014–2015 PIP validation results for the MMA Standard plans are grouped by PIP topic. Results are presented for the two state-mandated PIP topics, *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visit* and *Preventive Dental Services for Children*, for the additional clinical PIP topics, and for the additional nonclinical PIP topics. All PIPs validated for SFY 2014–2015 had progressed through the Design stage (Activities I–VI) only; therefore, the validation status of the PIPs is based solely on performance in Activities I–VI.

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 14 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
Not Met	0%	0%	0%	0%	0%	2%	1%
Partially Met	7%	21%	21%	36%	7%	9%	12%
Met	93%	79%	79%	64%	93%	88%	88%

In the Design stage of the *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIP, the MMA plans had the greatest opportunities for

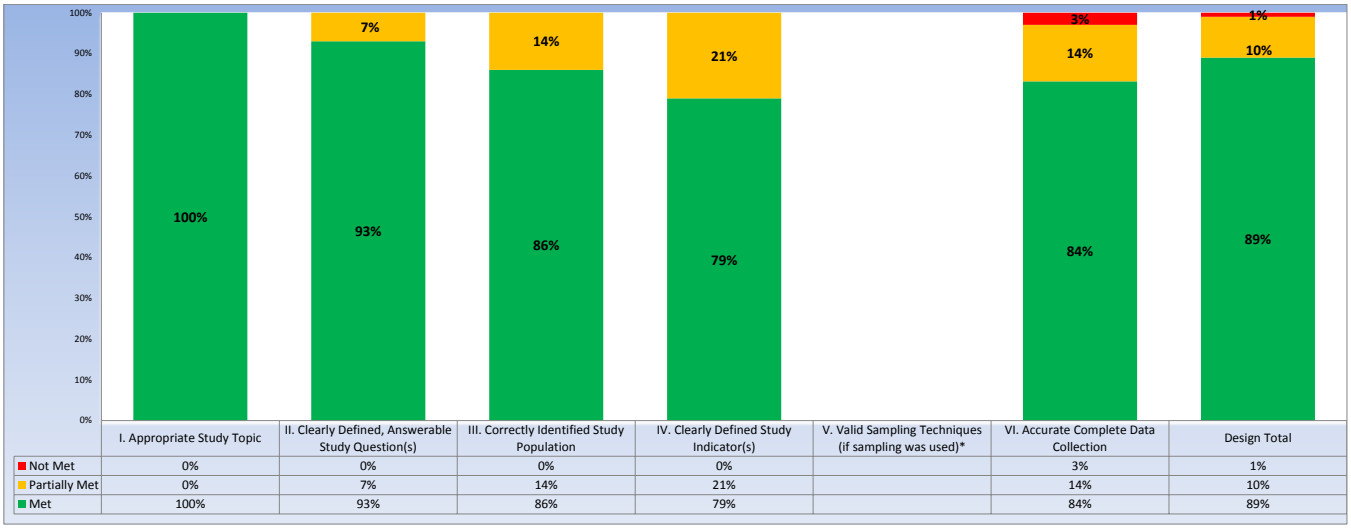
improvement in Activity IV (Clearly Defined Study Indicator[s]), where only 64 percent of the evaluation elements received a *Met* score. Activity II (Clearly Defined, Answerable Study Question[s]) and Activity III (Correctly Identified Study Population) also presented challenges for the MMA plans; only 79 percent of evaluation elements in each of these activities received a score of *Met*.

Across all six activities in the Design stage, 88 percent of the evaluation elements received a *Met* score, 12 percent received a *Partially Met* score, and 1 percent received a *Not Met* score. Because Activities I–VI set the methodological foundation for each PIP to measure and achieve improvement, the MMA plans should address all evaluation elements for the *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIP that did not receive a *Met* score. The MMA plans should use HSAG's feedback in the PIP validation tool along with the state-defined and HEDIS-based specifications for this PIP to address the deficiencies identified in the study design.

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 state-mandated *Preventive Dental Services for Children* PIPs submitted by the MMA Standard plans. HSAG validated a total of 14 *Preventive Dental Services for Children* PIPs for the MMA Standard plans. 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
Not Met	0%	0%	0%	0%		3%	1%
Partially Met	0%	7%	14%	21%		14%	10%
Met	100%	93%	86%	79%		84%	89%

*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 Standard plans had the greatest room for improvement in Activity IV (Clearly Defined Study Indicator[s]), where only 79 percent of the evaluation elements received a *Met* score. The plans' performance suggested that there were also opportunities for improvement in Activity III (Correctly Identified Study Population) and Activity VI (Accurate and Complete Data Collection), where the percentages of evaluation elements

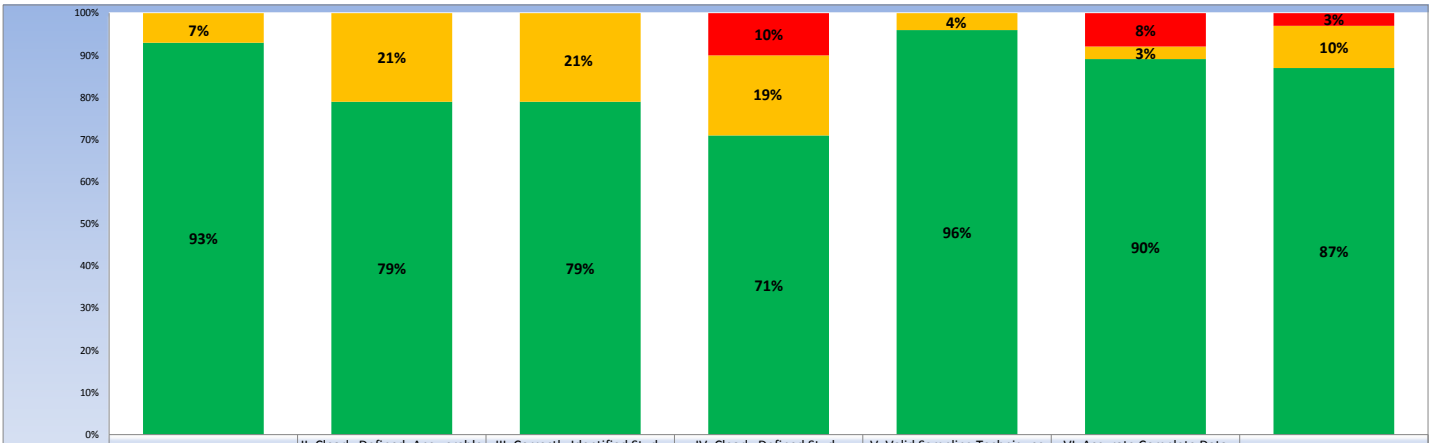
receiving a *Met* score were 86 percent and 84 percent, respectively. Because the data collection for this PIP does not rely on sampling, Activity V (Valid Sampling Techniques) was not scored.

Across the five activities completed in the Design stage, 89 percent of evaluation elements received a *Met* score, 10 percent received a *Partially Met* score, and 1 percent received a *Not Met* score. The MMA Standard plans should strengthen the methodological foundations of their *Preventive Dental Services for Children* PIPs by addressing the evaluation elements that did not receive a *Met* score. The plans can use feedback provided in the PIP validation tool along with the state-defined specifications for this PIP to address the deficiencies identified in the study design.

MMA 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 14 MMA clinical PIPs. Percentage totals may not equal 100 due to rounding.

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



	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)	VI. Accurate Complete Data Collection	Design Total
Not Met	0%	0%	0%	10%	0%	8%	3%
Partially Met	7%	21%	21%	19%	4%	3%	10%
Met	93%	79%	79%	71%	96%	90%	87%

In the Design stage of the clinical PIPs, the MMA plans demonstrated the greatest need for improvement in Activity IV (Clearly Defined Study Indicator[s]), where only 71 percent of evaluation elements received a *Met* score. The results also suggested a need for improvement in Activities II (Clearly Defined, Answerable Study Question[s]) and III (Correctly Identified Study Population), where only 79 percent of the evaluation elements in each activity received a *Met* score.

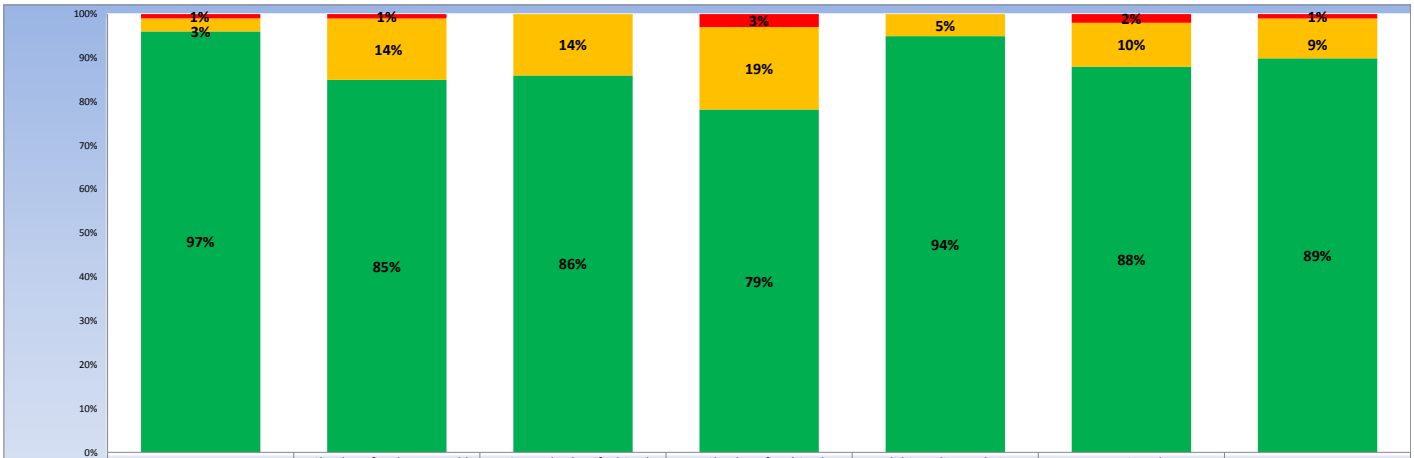
Across all six activities in the Design stage of the clinical PIPs, 87 percent of the evaluation elements received a *Met* score, 10 percent received a *Partially Met* score, and 3 percent received a *Not Met* score. To support improvement of outcomes in subsequent PIP stages, the MMA plans should address evaluation elements that did not receive a *Met* score. The MMA plans should ensure that study population and study indicators for their clinical PIPs are clearly and accurately defined and that the study question(s) are clearly and simply worded in an X/Y format (e.g., Do targeted interventions [X] result in improved outcomes [Y]?). The MMA plans should seek technical

assistance from HSAG if they need assistance beyond the feedback provided in the PIP validation tools to improve their clinical PIPs.

MMA 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 14 MMA nonclinical PIPs. Percentage totals may not equal 100 due to rounding.

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



	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)	VI. Accurate Complete Data Collection	Design Total
Not Met	1%	1%	0%	3%	0%	2%	1%
Partially Met	3%	14%	14%	19%	5%	10%	9%
Met	97%	85%	86%	79%	94%	88%	89%

In the Design stage of the nonclinical PIPs, the MMA plans demonstrated the greatest need for improvement in Activity IV (Clearly Defined Study Indicator[s]), where only 79 percent of evaluation elements received a *Met* score. Activities II (Clearly Defined, Answerable Study Question[s]) and III (Correctly Identified Study Population) also presented some challenges for the MMA plans, where 85 percent and 86 percent of the evaluation elements, respectively, received a *Met* score.

Across all six activities in the Design stage of the nonclinical PIPs, 89 percent of the evaluation elements received a *Met* score, 9 percent received a *Partially Met* score, and 1 percent received a *Not Met* score. The MMA plans should address evaluation elements that did not receive a *Met* score to provide a strong foundation for measuring and achieving improvement in outcomes. The MMA plans should ensure that the study population and study indicators for their nonclinical PIPs are clearly and accurately defined and that the study question(s) are clearly and simply worded in an X/Y format (e.g., Do targeted interventions [X] result in improved outcomes [Y]?).

Plan Comparison

The 2014–2015 validation results for the MMA PIPs suggest that the MMA Standard plans performed similarly across the two state-mandated PIP topics, the clinical PIP topics, and the nonclinical PIP topics. The overall percentage of evaluation elements receiving a *Met* score across

all MMA Standard plans for each topic was 88 percent for the *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIP (Figure 3-1), 89 percent for the *Preventive Dental Services for Children* PIP (Figure 3-2), 87 percent for the clinical PIP topics (Figure 3-3), and 89 percent for the nonclinical PIP topics (Figure 3-4). The MMA PIPs validated for SFY 2014–2015 progressed through the Design stage (Activities I–VI) only and did not include study indicator results. A comparison of plan performance based on PIP study indicator results will be included in subsequent technical reports, after the MMA Standard plans have progressed to reporting baseline and remeasurement study indicator results for the PIPs.

Conclusion and Recommendations

During the SFY 2014–2015 validation cycle, HSAG determined that opportunities for improvement in the Design stage of the PIPs existed for the MMA Standard plans. HSAG provided feedback in each PIP's validation tool that included specific guidance for addressing evaluation elements that did not receive a *Met* score. By addressing HSAG's feedback, the MMA Standard plans will strengthen the foundation of their PIPs to support the measurement and achievement of improved PIP outcomes in subsequent PIP stages. Due to the sequential nature of the PIP process, in which one stage provides the foundation for the next stage, addressing opportunities for improvement in the Design stage is critical to achieving success in the subsequent Implementation and Outcomes stages of the PIP.

HSAG's recommendations for improving the study design of the MMA Standard PIPs are consistent with those identified for the MMA Specialty PIPs and the LTC PIPs. The recommendations address steps to improve the PIP study question, study population definition, study indicators, sampling, and data collection methods.

The MMA Standard plans should review the state-defined specifications for the state-mandated PIP topics and ensure that their documented study questions, study population criteria, and study indicator definitions align with the specifications. The MMA Standard plans should ensure that the documentation and measurement of study indicators for all PIPs using nationally recognized measures, such as HEDIS or Child Core Set measures, align with the measure specifications. Alignment with the state-defined or nationally recognized specifications ensures that the PIPs are comparable, methodologically sound, and that they are addressing the State's quality strategy as intended.

In addition to ensuring alignment of the PIPs with relevant measurement specifications, the MMA Standard plans should ensure the use of sound PIP data collection methods. Sampling techniques should be methodologically sound and fully documented to ensure the sample is representative of the entire member population. Manual and administrative data collection processes should be fully documented; the PIP documentation should include a copy of the manual data collection tool and/or the estimated administrative data completeness, as appropriate. Thorough and accurate documentation of the data collection process ensures consistent measurement of study indicator outcomes and provides for an accurate assessment of progress toward improvement.

MMA Specialty Plans

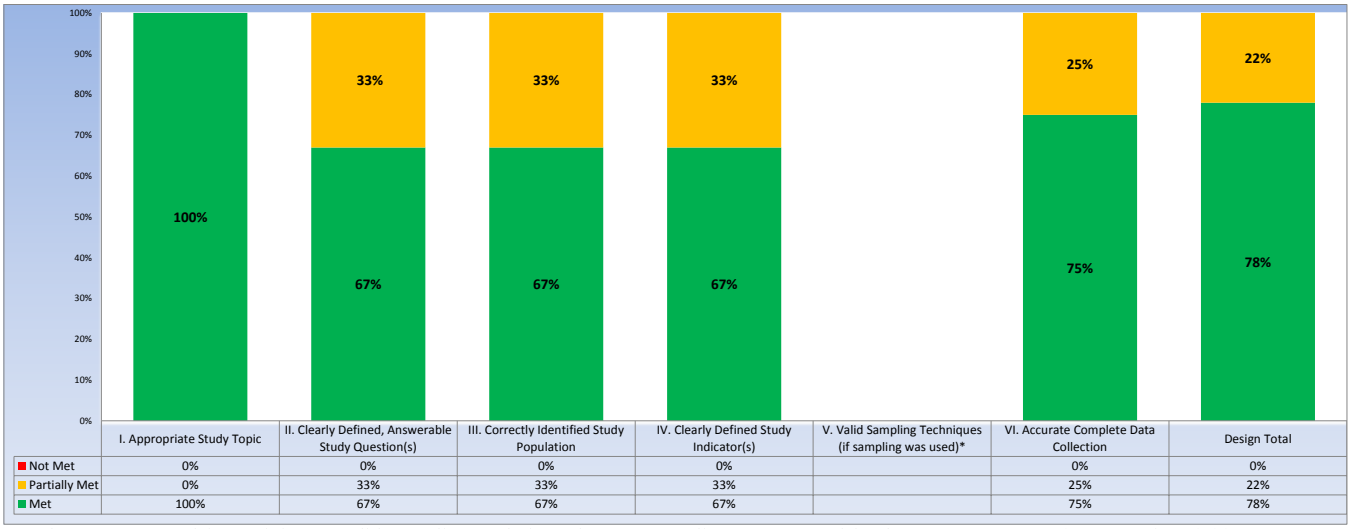
Results

SFY 2014–2015 PIP validation results for the MMA Specialty plans are grouped by PIP topic. Results are presented for the state-mandated PIP topic, *Preventive Dental Services for Children*; for additional clinical PIP topics; and for the additional nonclinical PIP topics. All PIPs validated for SFY 2014–2015 had progressed through the Design stage (Activities I–VI) only; therefore, the validation status of the PIPs is based solely on performance in Activities I–VI.

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

Figure 3-5 displays the percentage of evaluation elements achieving a *Met*, *Partially Met,* and *Not Met* validation score by activity and stage for the state-mandated *Preventive Dental Services for Children* PIPs submitted by the MMA Specialty plans. HSAG validated a total of three *Preventive Dental Services for Children* PIPs for the MMA Specialty plans. Percentage totals may not equal 100 due to rounding.

Figure 3-5—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
Not Met	0%	0%	0%	0%		0%	0%
Partially Met	0%	33%	33%	33%		25%	22%
Met	100%	67%	67%	67%		75%	78%

*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 Specialty plans had the greatest room for improvement in Activity II (Clearly Defined, Answerable Study Question[s]), Activity III (Correctly Identified Study Population), and Activity IV (Clearly Defined Study Indicator[s]), where only 67 percent of the evaluation elements in each of these activities received a *Met* score. The plans' performance suggested that there were also opportunities for improvement in Activity VI (Accurate and Complete Data Collection), where the percentage of evaluation elements receiving a *Met* score was 75 percent. Because the data collection for this PIP does not rely on sampling, Activity V (Valid Sampling Techniques) was not scored.

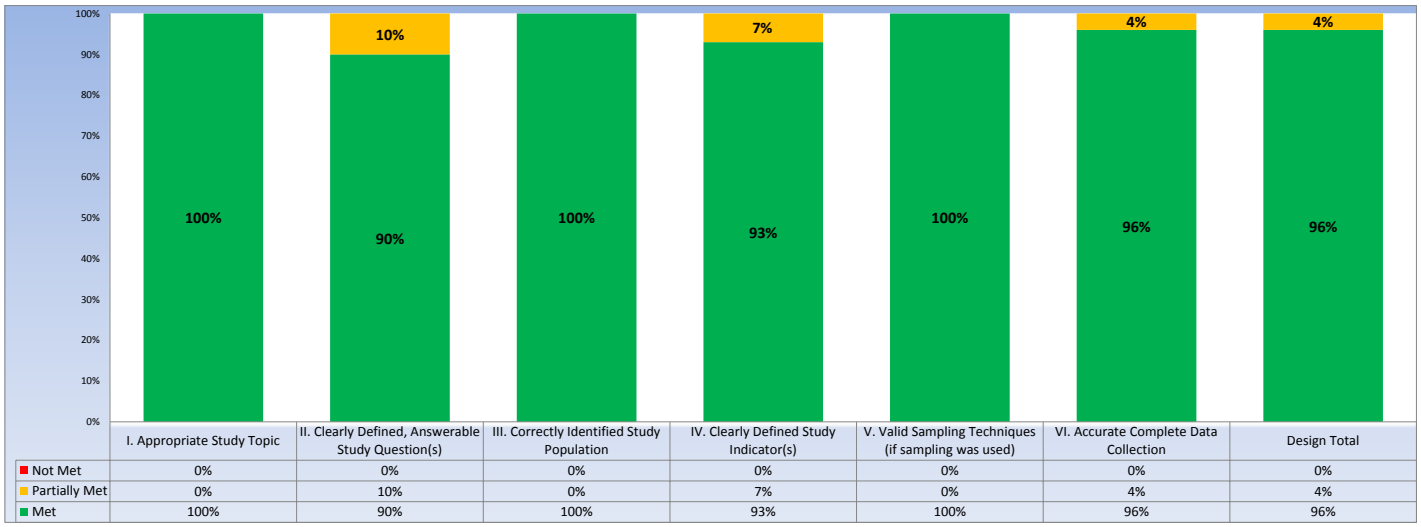
Across the five activities completed in the Design stage, 78 percent of evaluation elements received a *Met* score and 22 percent received a *Partially Met* score. The MMA Specialty plans should

strengthen the methodological foundations of their *Preventive Dental Services for Children* PIPs by addressing the evaluation elements that did not receive a *Met* score. The plans can use feedback provided in the PIP validation tool along with the state-defined specifications for this PIP to address the deficiencies identified in the study design.

Specialty Clinical PIPs

Figure 3-6 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 Specialty plans. HSAG validated a total of 10 specialty clinical PIPs. Percentage totals may not equal 100 due to rounding.

Figure 3-6—Specialty Clinical PIP Validation Scores by Activity and Study Stage



	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)	VI. Accurate Complete Data Collection	Design Total
Not Met	0%	0%	0%	0%	0%	0%	0%
Partially Met	0%	10%	0%	7%	0%	4%	4%
Met	100%	90%	100%	93%	100%	96%	96%

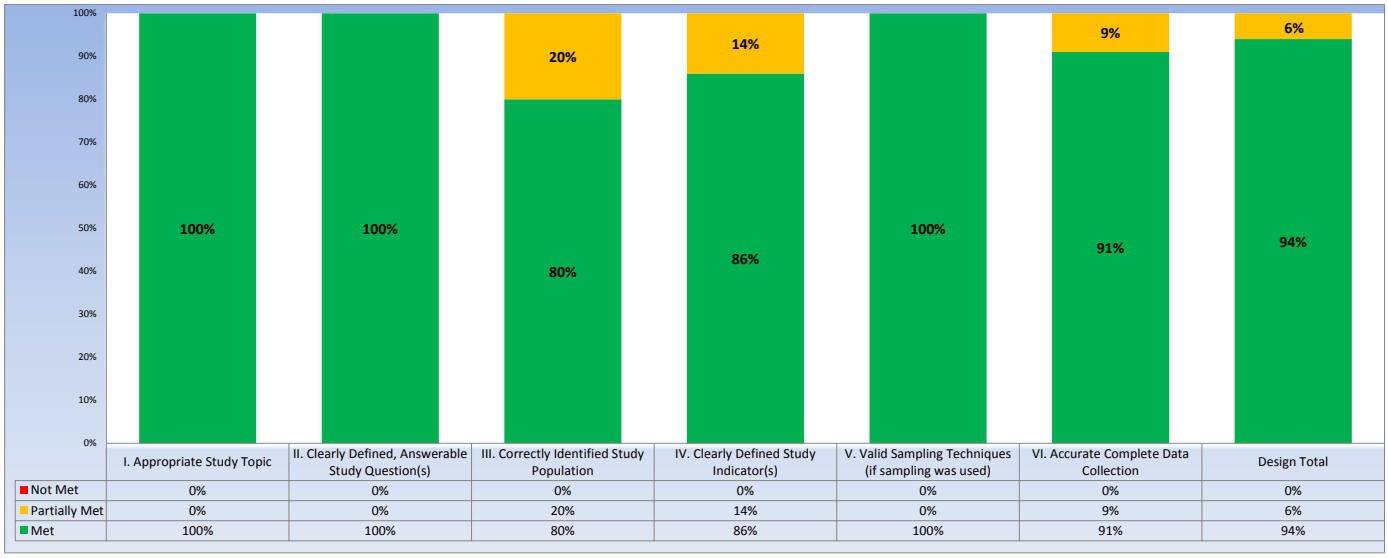
The MMA Specialty plans received a *Met* score for 100 percent of evaluation elements in Activities I (Appropriate Study Topic), III (Correctly Identified Study Population), and V (Valid Sampling Techniques) for their clinical PIPs. Activity II (Clearly Defined, Answerable Study Question[s]) was the greatest challenge for the MMA Specialty plans, where 90 percent of the evaluation elements received a *Met* score.

Across all six activities in the Design stage of the specialty clinical PIPs, 96 percent of the evaluation elements received a *Met* score and 4 percent received a *Partially Met* score; none of the evaluation elements were scored *Not Met*. The MMA Specialty plans demonstrated strong performance in the Design stage of their clinical PIPs. The plans should refer to HSAG's feedback in the PIP validation tools to address any evaluation elements that did not receive a *Met* score.

Specialty Nonclinical PIPs

Figure 3-7 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 Specialty plans. HSAG validated a total of five specialty nonclinical PIPs. Percentage totals may not equal 100 due to rounding.

Figure 3-7—Specialty Nonclinical PIP Validation Scores by Activity and Study Stage



	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)	VI. Accurate Complete Data Collection	Design Total
Not Met	0%	0%	0%	0%	0%	0%	0%
Partially Met	0%	0%	20%	14%	0%	9%	6%
Met	100%	100%	80%	86%	100%	91%	94%

In their nonclinical PIPs, the MMA Specialty plans received a *Met* score for 100 percent of evaluation elements in Activities I (Appropriate Study Topic), II (Clearly Defined, Answerable Study Question[s]), and V (Valid Sampling Techniques). Activity III (Correctly Identified Study Population) presented the greatest opportunity for improvement, where only 80 percent of evaluation elements received a *Met* score.

Across all six activities in the Design stage of the nonclinical PIPs, 94 percent of the evaluation elements received a *Met* score, and 6 percent of the evaluation elements received a *Partially Met* score. In general, the MMA Specialty plans documented methodologically sound study designs for their nonclinical PIPs. The plans should refer to HSAG's feedback in the PIP validation tools for guidance on addressing those evaluation elements that did not receive a *Met* score.

Plan Comparison

The 2014–2015 validation results for the MMA Specialty PIPs suggest that the MMA Specialty plans performed better on the clinical and nonclinical PIP topics than on the state-mandated PIP topic, *Preventive Dental Services for Children*. The overall percentage of evaluation elements receiving a *Met* score across all MMA Specialty plans for each topic was 78 percent for the *Preventive Dental Services for Children* PIP (Figure 3-5), 96 percent for the clinical PIP topics (Figure 3-6), and 94 percent for the nonclinical PIP topics (Figure 3-7). The MMA Specialty PIPs validated for SFY 2014–2015 progressed through the Design stage (Activities I–VI) only and did not include study indicator results. A comparison of plan performance based on PIP study indicator results will be included in subsequent technical reports, after the MMA Specialty plans have progressed to reporting baseline and remeasurement study indicator results for the PIPs.

Conclusion and Recommendations

During the SFY 2014–2015 validation cycle, HSAG determined that opportunities for improvement in the Design stage of the PIPs existed for the MMA Specialty plans. HSAG provided feedback in each PIP's validation tool that included specific guidance for addressing evaluation elements that

did not receive a *Met* score. By addressing HSAG's feedback, the MMA Specialty plans will strengthen the foundation of their PIPs to support the measurement and achievement of improved PIP outcomes in subsequent PIP stages. Due to the sequential nature of the PIP process, in which one stage provides the foundation for the next stage, addressing opportunities for improvement in the Design stage is critical to achieving success in the subsequent Implementation and Outcomes stages of the PIP.

HSAG's recommendations for improving the study design of the MMA Specialty PIPs are consistent with those identified for the MMA Standard PIPs and the LTC PIPs. The recommendations address steps to improve the PIP study question, study population definition, study indicators, sampling, and data collection methods.

The MMA Specialty plans should review the state-defined specifications for the state-mandated PIP topics and ensure that their documented study questions, study population criteria, and study indicator definitions align with the specifications. The MMA Specialty plans should ensure that the documentation and measurement of study indicators for all PIPs using nationally recognized measures, such as HEDIS or Child Core Set measures, align with the measure specifications. Alignment with the state-defined or nationally recognized specifications ensures that the PIPs are comparable, methodologically sound, and that they are addressing the State's quality strategy as intended.

In addition to ensuring alignment of the PIPs with relevant measurement specifications, the MMA Specialty plans should ensure the use of sound PIP data collection methods. Sampling techniques should be methodologically sound and fully documented to ensure the sample is representative of the entire member population. Manual and administrative data collection processes should be fully documented; the PIP documentation should include a copy of the manual data collection tool and/or the estimated administrative data completeness, as appropriate. Thorough and accurate documentation of the data collection process ensures consistent measurement of study indicator outcomes and provides for an accurate assessment of progress toward improvement.

LTC Plans

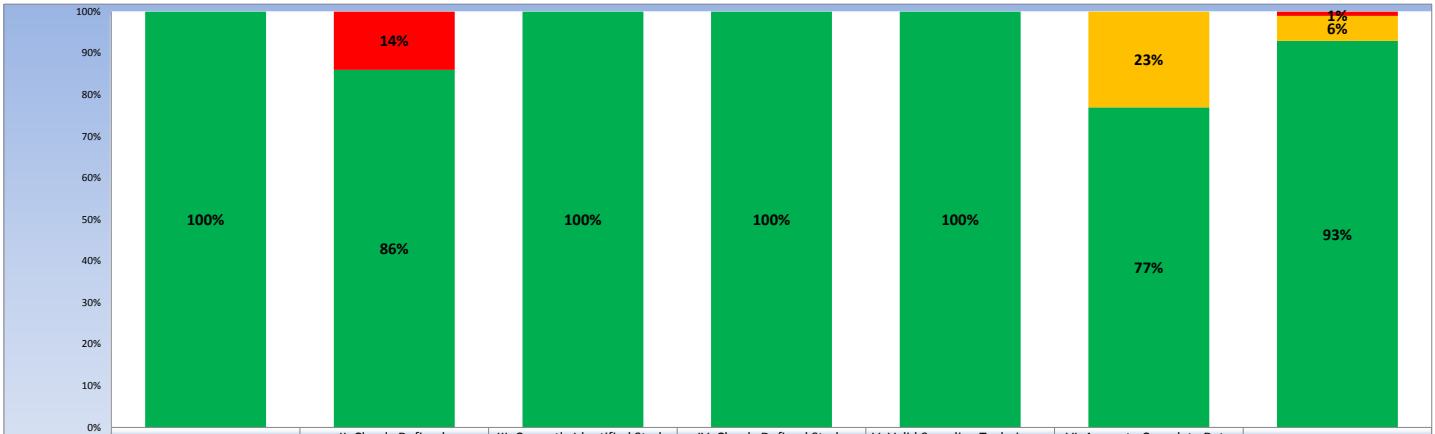
Results

SFY 2014–2015 PIP validation results for the LTC plans are grouped by PIP topic. Results are presented for the state-mandated PIP topic, *Medication Review*, for additional clinical PIP topics, and for the additional nonclinical PIP topics. All PIPs validated for SFY 2014–2015 had progressed through the Design stage (Activities I–VI) only; therefore, the validation status of the PIPs is based solely on performance in Activities I–VI.

Validation Status of the *Medication Review* PIPs

Figure 3-8 displays the percentage of evaluation elements achieving a *Met*, *Partially Met*, and *Not Met* validation score by activity and stage for the *Medication Review* PIP. HSAG validated a total of seven LTC PIPs for this topic. Percentage totals may not equal 100 due to rounding.

Figure 3-8—State-Mandated PIP Validation Scores by Activity and Study Stage: *Medication Review*



	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)	VI. Accurate Complete Data Collection	Design Total
Not Met	0%	14%	0%	0%	0%	0%	1%
Partially Met	0%	0%	0%	0%	0%	23%	6%
Met	100%	86%	100%	100%	100%	77%	93%

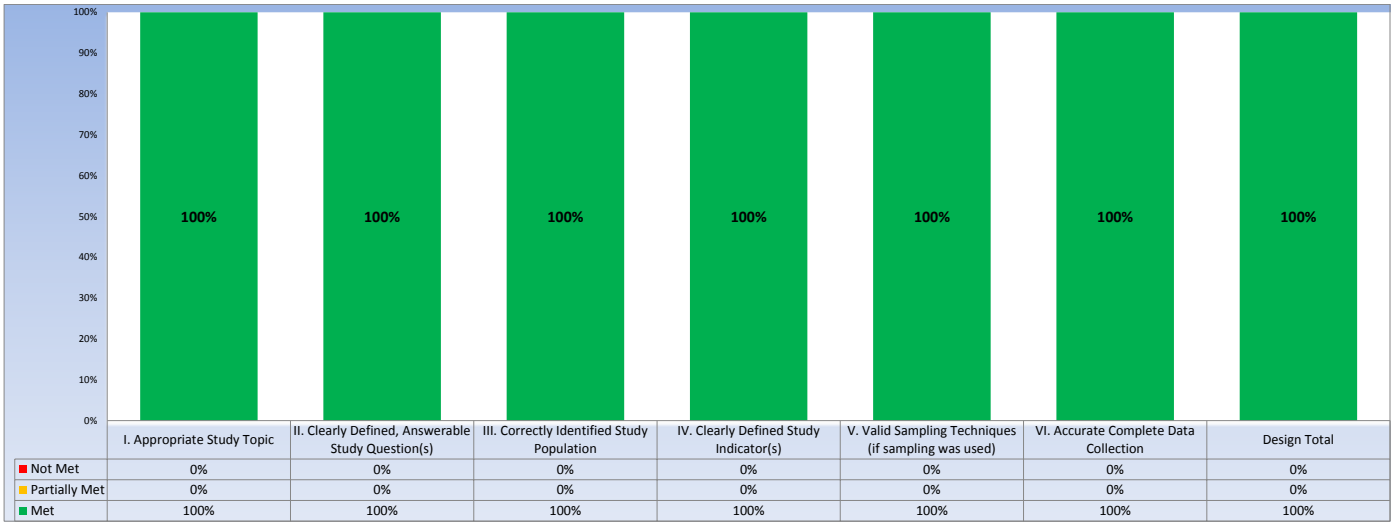
In the Design stage of the *Medication Review* PIP, the LTC plans received a *Met* score for 100 percent of evaluation elements in Activities I (Appropriate Study Topic), III (Correctly Identified Study Population), IV (Clearly Defined Study Indicator[s]), and V (Valid Sampling Techniques). The LTC plans' greatest challenge was Activity VI (Accurate and Complete Data Collection), where only 77 percent of evaluation elements were scored *Met*. The plans also had opportunities for improvement in Activity II (Clearly Defined, Answerable Study Question[s]), where 86 percent of evaluation elements received a *Met* score.

Across all six activities in the Design stage, 93 percent of evaluation elements received a *Met* score, 6 percent received a *Partially Met* score, and 1 percent received a *Not Met* score. The LTC plans should address the evaluation elements that did not receive a *Met* score by incorporating the feedback provided in the PIP validation tools and reviewing the state-defined specifications for the *Medication Review* PIP. Strengthening the methodological foundation of the PIPs will support outcomes improvement in subsequent PIP stages.

LTC Clinical PIP

Figure 3-9 displays the percentage of evaluation elements achieving a *Met, Partially Met,* and *Not Met* validation score by activity and stage for the clinical PIP submitted by the LTC plan. HSAG validated one LTC clinical PIP.

Figure 3-9—LTC Clinical PIP Validation Scores by Activity and Study Stage



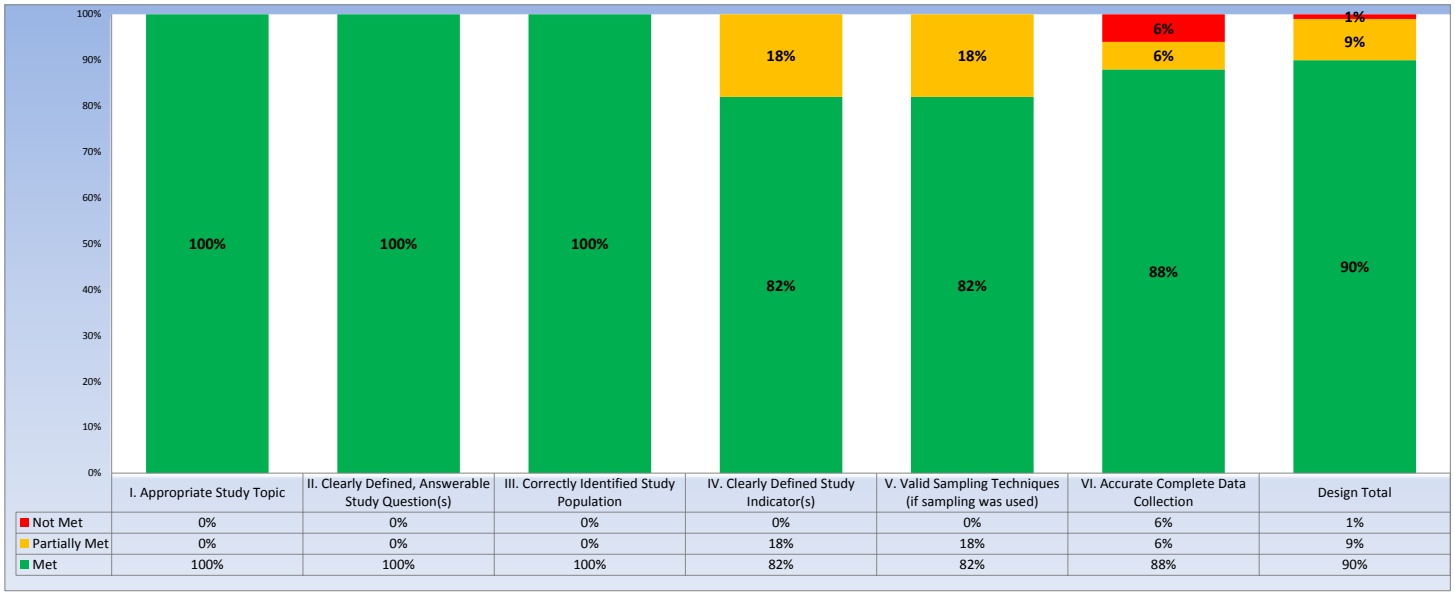
	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)	VI. Accurate Complete Data Collection	Design Total
Not Met	0%	0%	0%	0%	0%	0%	0%
Partially Met	0%	0%	0%	0%	0%	0%	0%
Met	100%	100%	100%	100%	100%	100%	100%

The LTC clinical PIP received a *Met* score for 100 percent of evaluation elements in all six activities of the Design stage. The PIP design was methodologically sound and should support the measurement and achievement of improvement in outcomes as the PIP progresses to subsequent stages.

LTC 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 a total of six LTC nonclinical PIPs. Percentage totals may not equal 100 due to rounding.

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



	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)	VI. Accurate Complete Data Collection	Design Total
Not Met	0%	0%	0%	0%	0%	6%	1%
Partially Met	0%	0%	0%	18%	18%	6%	9%
Met	100%	100%	100%	82%	82%	88%	90%

In Activities I (Appropriate Study Topic), II (Clearly Defined, Answerable Study Question[s]), and III (Correctly Identified Study Population) of the LTC nonclinical PIPs, 100 percent of the evaluation elements received a *Met* score. The greatest areas for improvement in the Design stage of the PIPs were Activity IV (Clearly Defined Study Indicator[s]) and Activity V (Valid Sampling Techniques), where 82 percent of evaluation elements in each activity received a *Met* score.

Across the six activities of the Design stage of the LTC nonclinical PIPs, 90 percent of evaluation elements received a *Met* score, 9 percent received a *Partially Met* score, and 1 percent received a *Not Met* score. The LTC plans should ensure that the study indicators are correctly defined so that PIP outcomes are accurately measured and monitored. The plans should also review and revise the sampling methods used for the PIPs, as needed and when applicable.

Plan Comparison

The 2014–2015 validation results for the LTC PIPs suggest that the LTC plans performed similarly across the state-mandated PIP topic, the clinical PIP topics, and the nonclinical PIP topics. The overall percentage of evaluation elements receiving a *Met* score across all LTC plans for each topic was 93 percent for the *Medication Review* PIP (Figure 3-8), 100 percent for the clinical PIP topic (Figure 3-9), and 90 percent for the nonclinical PIP topics (Figure 3-10). The LTC PIPs validated for SFY 2014–2015 progressed through the Design stage (Activities I–VI) only and did not include study indicator results. A comparison of plan performance based on PIP study indicator results will be included in subsequent technical reports, after the LTC plans have progressed to reporting baseline and remeasurement study indicator results for the PIPs.

Conclusion and Recommendations

During the SFY 2014–2015 validation cycle, HSAG determined that opportunities for improvement in the Design stage of the PIPs existed for the LTC plans. HSAG provided feedback in each PIP's validation tool that included specific guidance for addressing evaluation elements that did not receive a *Met* score. By addressing HSAG's feedback, the LTC plans will strengthen the foundation of their PIPs to support the measurement and achievement of improved PIP outcomes in subsequent PIP stages. Due to the sequential nature of the PIP process, in which one stage provides the foundation for the next stage, addressing opportunities for improvement in the Design stage is critical to achieving success in the subsequent Implementation and Outcomes stages of the PIP.

HSAG's recommendations for improving the study design of the LTC PIPs are consistent with those identified for the MMA Standard PIPs and the MMA Specialty PIPs. The recommendations address steps to improve the PIP study question, study population definition, study indicators, sampling, and data collection methods.

The LTC plans should review the state-defined specifications for the state-mandated PIP topic and ensure that their documented study questions, study population criteria, and study indicator definitions align with the specifications. The LTC plans should ensure that the documentation and measurement of study indicators for all PIPs using nationally recognized measures, such as HEDIS or Child Core Set measures, align with the measure specifications. Alignment with the state-defined or nationally recognized specifications ensures that the PIPs are comparable, methodologically sound, and that they are addressing the State's quality strategy as intended.

In addition to ensuring alignment of the PIPs with relevant measurement specifications, the LTC plans should ensure the use of sound PIP data collection methods. Sampling techniques should be methodologically sound and fully documented to ensure the sample is representative of the entire member population. Manual and administrative data collection processes should be fully documented; the PIP documentation should include a copy of the manual data collection tool and/or the estimated administrative data completeness, as appropriate. Thorough and accurate documentation of the data collection process ensures consistent measurement of study indicator outcomes and provides for an accurate assessment of progress toward improvement.

Validation of Performance Measures

The BBA requires states to ensure that their contracted plans collect and report performance measure data annually in accordance with 42 CFR §438.358. States can choose to directly perform the PMV activity mandated by CMS, or they can contract either with an agent that is not a managed care organization, or with an EQRO. AHCA contracted with HSAG to conduct the validation of performance measures for measures calculated and reported by MCOs and PIHPs for the CY 2014 measurement period.

HSAG was contracted to perform validation of performance measures 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[10] (CMS Performance Measure Validation Protocol). To determine if performance measure rates were collected, reported, and calculated according to the specifications required by the State, HSAG performed PMV audits for the MMA Standard/Specialty plans and LTC plans during SFY 2015–2016. This section of the report includes the PMV audit findings and results for these plans. Detailed PMV results may be found in the aggregate SFY 2015–2016 *Performance Measure Validation Findings Report.* Please refer to Appendix A of this report where the PMV methodology is described in greater detail.

MMA Standard/Specialty Plans

AHCA required that each MMA plan undergo an NCQA HEDIS Compliance Audit on the performance measures selected for reporting. These audits were performed by NCQA-licensed organizations (LOs) during SFY 2014–2015.

Table 3-1 depicts the MMA Standard/Specialty plan HEDIS and AHCA-defined performance measures that were subject to validation. The table is organized by domains, such as Pediatric Care and Women's Care.

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

Table 3-1—Florida Medicaid HEDIS 2015 (CY 2014) Standard and Specialty MMA Performance Measures	
Measures by Domain	**Measure Source**
Pediatric Care	
Well-Child Visits in the First 15 Months of Life (W15) *Zero Visits* *Six or More Visits*	HEDIS
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	HEDIS
Childhood Immunization Status (Combinations 2 and 3) *Combo 2* *Combo 3*	HEDIS
Lead Screening in Children (LSC)	HEDIS
Follow-up Care for Children Prescribed ADHD Medication (ADD) *Initiation Phase* *Continuation and Maintenance Phase*	HEDIS
Adolescent Well-Care Visits (AWC)	HEDIS
Immunizations for Adolescents (IMA)	HEDIS
Annual Dental Visit (ADV)	HEDIS
Preventive Dental Services (PDENT)	Child Core Set
Dental Treatment Services (TDENT)	AHCA-Defined (Formerly Child Core Set)
Sealants (SEA)	AHCA-Defined
Women's Care	
Cervical Cancer Screening (CCS)	HEDIS
Chlamydia Screening in Women (CHL)	HEDIS
Breast Cancer Screening (BCS)	HEDIS
Prenatal and Postpartum Care (PPC)	HEDIS
Prenatal Care Frequency (PCF)	HEDIS & AHCA-Defined
Antenatal Steroids (ANT)	Adult Core Set
Living With Illness	
Comprehensive Diabetes Care (CDC) *Hemoglobin A1c (HbA1c) Testing* *HbA1c Poor Control* *HbA1c Control (<8%)* *Eye Exam (Retinal) Performed* *LDL-C Screening* *LDL-C Control (<100 mg/dL)* *Medical Attention for Nephropathy*	HEDIS
Controlling High Blood Pressure (CBP)	HEDIS
Adult BMI Assessment (ABA)	HEDIS
Use of Appropriate Medications for People With Asthma (ASM)	HEDIS
Annual Monitoring for Patients on Persistent Medications (MPM)	HEDIS

Table 3-1—Florida Medicaid HEDIS 2015 (CY 2014) Standard and Specialty MMA Performance Measures	
HIV-Related Medical Visits (HIVV)	AHCA-Defined
Highly Active Anti-Retroviral Treatment (HAART)	AHCA-Defined
Viral Load Suppression Among Persons in Human Immunodeficiency Virus (HIV) Medical Care (VLS)	Adult Core Set
Plan All-Cause Readmissions (PCR)	Adult Core Set
Use of Services	
Ambulatory Care (Outpatient and ED Visits per 1,000 MM) (AMB)	HEDIS
Access/Availability of Care	
Adults' Access to Preventive/Ambulatory Health Services (AAP)	HEDIS
Children and Adolescents' Access to Primary Care Practitioners (CAP)	HEDIS
Call Abandonment (CAB)	AHCA-Defined
Call Answer Timeliness (CAT)	HEDIS
Transportation Availability (TRA)	AHCA-Defined
Transportation Timeliness (TRT)	AHCA-Defined
Behavioral Health	
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	HEDIS
Follow-Up After Hospitalization for Mental Illness (FHM)	HEDIS & AHCA-Defined
Antidepressant Medication Management (AMM)	HEDIS
Mental Health Readmission Rate (RER)	AHCA-Defined
Children's Specialty*	
HPV Vaccine for Female Adolescents (HPV)	Child Core Set
Medication Management for People With Asthma (MMA)	Child Core Set
Developmental Screening in the First Three Years of Life (DEVSCR)	Child Core Set
Serious Mental Illness	
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	HEDIS
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	HEDIS
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	HEDIS
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	HEDIS
*Measures required to be reported by Children's Medical Services-S and Sunshine Child Welfare Specialty Plan-S.	

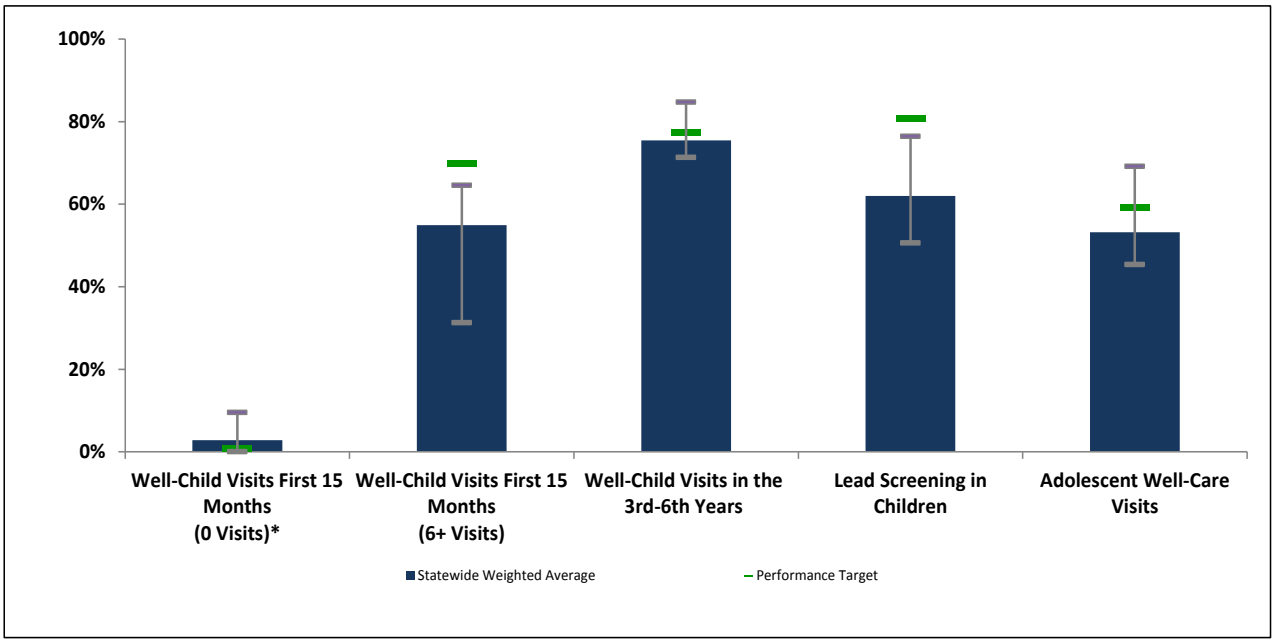
For this section of the report, performance measures, results, and plan comparisons are discussed by domain of care. AHCA developed performance targets for most of the HEDIS measures, using HEDIS national Medicaid health plan 75th percentiles, both applicable to Florida's MMA Standard/Specialty plans.

Pediatric Care

Pediatric Care had 14 measures, which are displayed in the next three figures. Figure 3-11 displays the statewide weighted averages and the performance targets for *Well-Child Visits in the First 15*

Months of Life—Zero Visits and *6+ Visits*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life*; *Lead Screening in Children*; and *Adolescent Well-Care Visits*. The *Well-Child Visits in the First 15 Months of Life—Zero Visits* measure was an inverse measure; a lower rate indicated better performance. All of these measures have corresponding AHCA performance targets, as indicated by the green horizontal bars in Figure 3-11. The vertical grey line in each bar denotes the range of performance rates among the 13 MMA Standard and five MMA Specialty plans (i.e., longer vertical lines indicate more variation).

Figure 3-11—Florida Medicaid HEDIS 2015 (CY 2014)
Weighted Average Compared With the AHCA Performance Target—Pediatric Care (Well-Care Visits and Lead Screening)

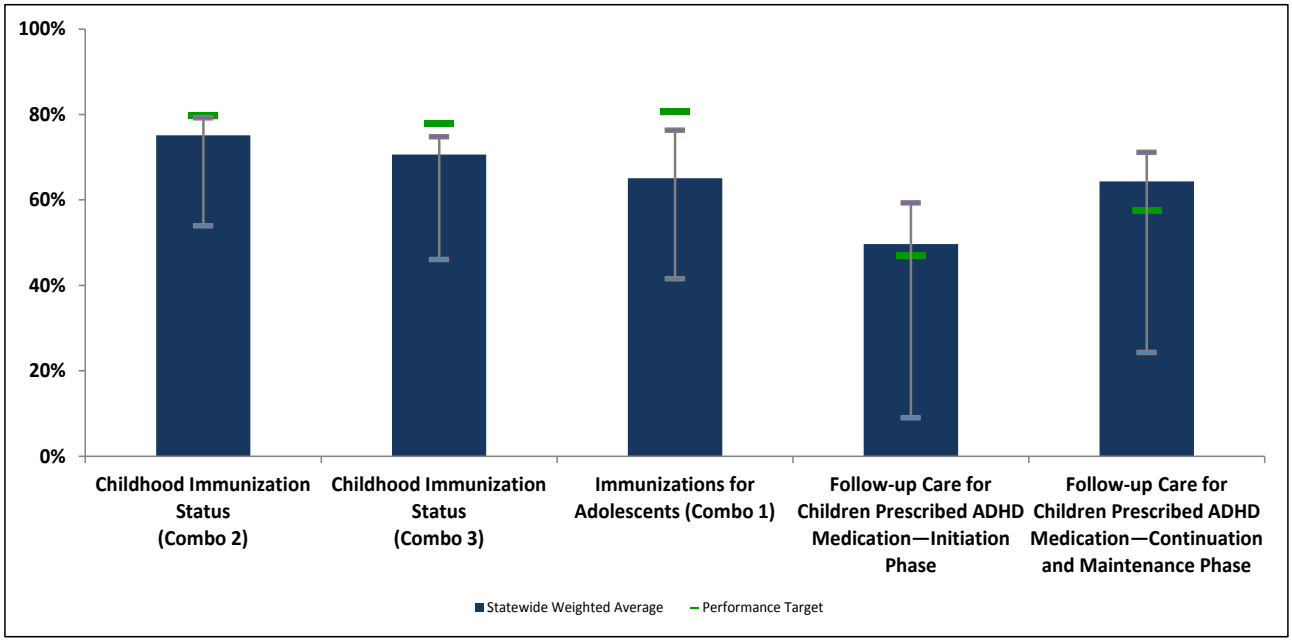


None of the statewide weighted averages in this domain met the AHCA performance targets, although the performance targets were met by some plans (as denoted by the vertical grey lines reaching above the green horizontal bars). For the *Well-Child Visits in the First 15 Months of Life—6+ Visits* and *Lead Screening in Children* measures, no plans reached the corresponding AHCA performance target. Overall, for the statewide weighted average's percentage deviation from the AHCA performance target, the *Lead Screening in Children* measure showed the greatest opportunity for improvement, falling below the AHCA performance target by 18.8 percentage points, followed by the *Well-Child Visits in the First 15 Months of Life—6+ Visits* statewide weighted average, which was 14.8 percentage points below the AHCA performance target. The greatest range of plan results for these measures was observed for *Well-Child Visits in the First 15 Months of Life—6+Visits*, at 33.3 percentage points, followed by *Lead Screening in Children*, at 25.8 percentage points. The statewide weighted average for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life* measure was within 1.8 percentage points of the AHCA performance target.

Figure 3-12 displays the statewide weighted averages and the performance targets for *Childhood Immunization Status (Combinations 2 and 3)*, *Immunizations for Adolescents (Combination 1*), and *Follow-up Care for Children Prescribed ADHD Medication* (*Initiation Phase* and *Continuation and*

Maintenance Phase) measures. Performance targets, indicated by the horizontal green bars in Figure 3-12, were available for each of these measures. The vertical grey line in each bar denotes the range of performance rates among plans (i.e., longer vertical lines indicate more variation).

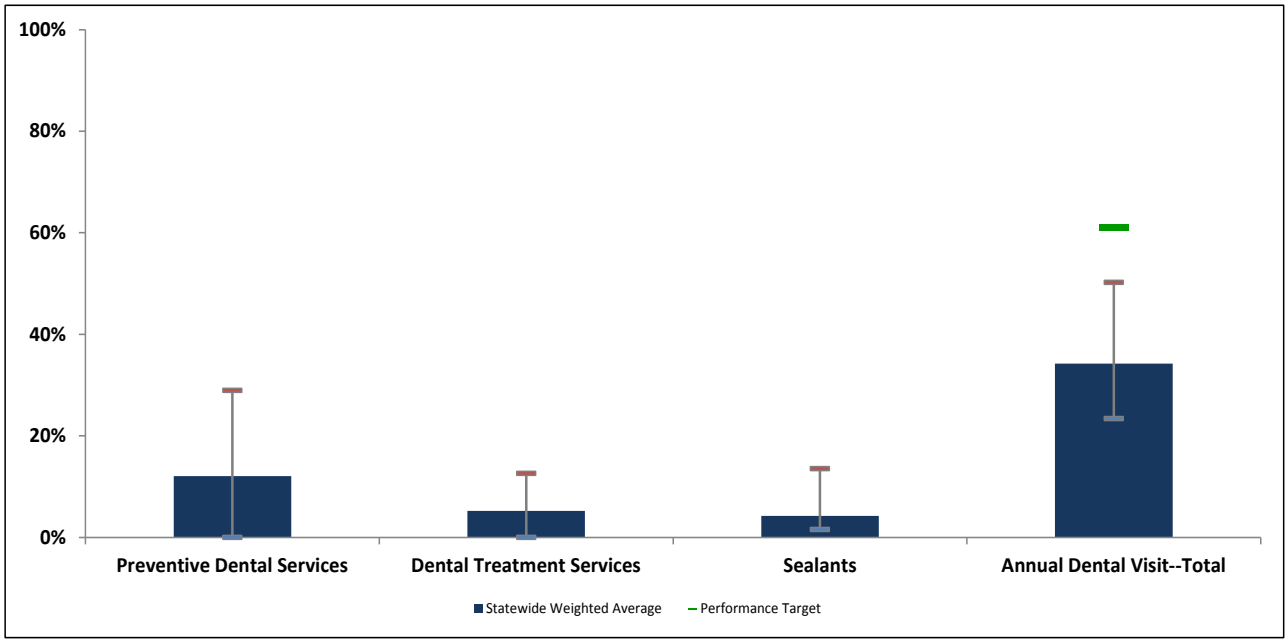
Figure 3-12—Florida Medicaid HEDIS 2015 (CY 2014)
Weighted Average Compared With the AHCA Performance Target—Pediatric Care (Immunizations and ADHD Medication)



The statewide weighted averages exceeded the AHCA performance targets for *Follow-up Care for Children Prescribed ADHD Medication (Initiation Phase and Continuation and Maintenance Phase)* by 2.7 and 6.8 percentage points, respectively. The *Childhood Immunization Status (Combination 3)* and *Immunizations for Adolescents (Combination 1)* measures showed statewide weighted averages that were more than 5.0 percentage points from the respective AHCA performance targets, although the *Childhood Immunization Status (Combination 2)* measure was 4.6 percentage points from the AHCA performance target. The widest range of performance rates was observed for *Follow-up Care for Children Prescribed ADHD Medication (Initiation Phase)* at 50.4 percentage points, followed by *Follow-up Care for Children Prescribed ADHD Medication (Continuation and Maintenance Phase)* at 46.9 percentage points.

Figure 3-13 displays the statewide weighted averages and the performance targets for *Preventive Dental Services*, *Dental Treatment Services*, *Sealants*, and *Annual Dental Visit—Total*. An AHCA performance target, indicated by the horizontal green bar in Figure 3-13, was only available for *Annual Dental Visit—Total*. The vertical grey line in each bar denotes the range of performance rates among plans (i.e., longer vertical lines indicate more variation).

Figure 3-13—Florida Medicaid HEDIS 2015 (CY 2014)
Weighted Average Compared With the AHCA Performance Target—Pediatric Care (Dental Visits)



The statewide weighted average for *Annual Dental Visit—Total* was 56.0 percent of the AHCA performance target (i.e., 34.2 percent versus 61.1 percent). The widest range of plan performance was observed for *Preventive Dental Services*, at 28.9 percentage points, followed by *Annual Dental Visit—Total*, with a range of 26.8 percentage points.

Plan Comparison

From the 13 MMA Standard and five MMA Specialty plans in the assessment, a total of 152 performance measure rates had an AHCA performance target and sufficient data to be ranked using the three-star rating system.[11] Of these performance measure rates, 11 rates were above the 90th percentile of the national Medicaid results. Of these 11 high-performing rates, eight rates were associated with the *Follow-up Care for Children Prescribed ADHD Medication* measure, with three rates for the *Initiation Phase* and five for the *Continuation and Maintenance Phase*. *Well-Child Visits in the First 15 Months of Life—Zero Visits*, *Well-Child Visits in the Third–Sixth Years of Life*, and *Adolescent Well-Care Visits* each had one rate above the 90th percentile. Sunshine had the greatest number of measures with three stars (i.e., three MMA Specialty plan measures and one MMA Standard plan measure).

Fifty-two rates indicated performance below the 25th percentile of the national Medicaid results. Of the measures with sufficient populations and sufficient data to be ranked using the three-star rating

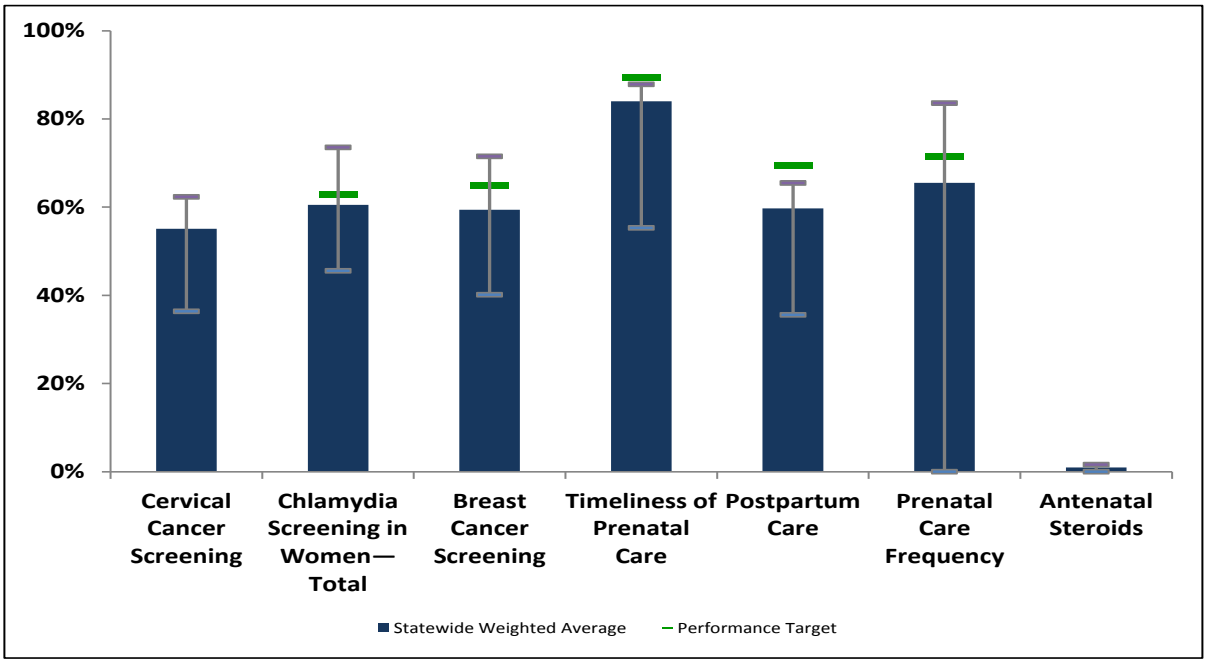
[11] To highlight excellent and poor performance, HSAG developed a three-star rating system in which measures with rates at or above the 90th percentile of the national Medicaid results receive three stars (★★★), at or above the 25th percentile but below the 90th national percentile receive two stars (★★), and below the 25th percentile receive one star (★). Discussion of results primarily focuses on measures with three stars or one star.

system, only the *Well-Child Visits in the First 15 Months of Life—Zero Visits* measure for Sunshine-S displayed a rate of 0.0 percent, indicating better performance for this inverse measure.

Women's Care

Figure 3-14 displays the statewide weighted averages and the performance targets for *Cervical Cancer Screening*, *Chlamydia Screening in Women—Total*, *Breast Cancer Screening*, *Timeliness of Prenatal Care*, *Postpartum Care*, *Prenatal Care Frequency*, and *Antenatal Steroids*. AHCA performance targets, indicated by the horizontal green bars in Figure 3-14, were available for five of the six measures, excluding *Cervical Cancer Screening* and *Antenatal Steroids*. The vertical grey line in each bar denotes the range of performance rates across the 13 Standard and five MMA Specialty plans (i.e., longer vertical lines indicate more variation).

Figure 3-14—Florida Medicaid HEDIS 2015 (CY 2014)
Weighted Average Compared With the AHCA Performance Target—Women's Care



None of the statewide weighted averages in this domain met the AHCA performance targets, although the performance targets were met by some individual plans (as denoted by the vertical grey lines reaching above the green horizontal bars) for *Chlamydia Screening in Women—Total*, *Breast Cancer Screening*, and *Prenatal Care Frequency*. The range in performance across plans was greatest for *Prenatal Care Frequency* (at 83.6 percentage points) and smallest for *Antenatal Steroids* (at 1.6 percentage points).

Plan Comparison

From the 13 MMA Standard and five MMA Specialty plans, a total of 71 performance measure rates for five measures had an AHCA performance target and sufficient data to be ranked using the three-star rating system. Of these rates, four were above the 90th percentile of the national Medicaid results, receiving three stars: *Breast Cancer Screening*, *Chlamydia Screening in Women—Total*

(two plans), and *Prenatal Care Frequency*. The four plans associated with these four measures were Amerigroup, Coventry, Humana, and Sunshine-S.

Sixteen measures for nine plans had a one-star ("★") rating, which indicates rates under the 25th percentile of the national Medicaid results. The plan with the most one-star ratings was Magellan-S, a Specialty plan, which had three measures receiving one star. Eight other plans had at least one measure receiving one star.

Living With Illness

The Living With Illness domain had 19 measures, which are displayed in the next three figures. Figure 3-15 displays the statewide weighted averages and the performance targets for *HbA1c Testing*, *HbA1c Poor Control*, *HbA1c Control (<8%)*, *LDL-C Screening*, *LDL-C Control (<100 mg/dL)*, *Eye Exam (Retinal) Performed*, and *Medical Attention for Nephropathy*. AHCA performance targets were established for five of these measures which did not include *LDL-C Screening* or *LDL-C Control (<100 mg/dL)* in the current reporting cycle. The AHCA performance targets are indicated by the horizontal green bars in Figure 3-15. The vertical grey line in each bar denotes the range of performance rates across the 13 MMA Standard and five MMA Specialty plans (i.e., longer vertical lines indicate more variation).

Figure 3-15—Florida Medicaid HEDIS 2015 (CY 2014) Weighted Average Compared With the AHCA Performance Target – Living With Illness (Comprehensive Diabetes Care)

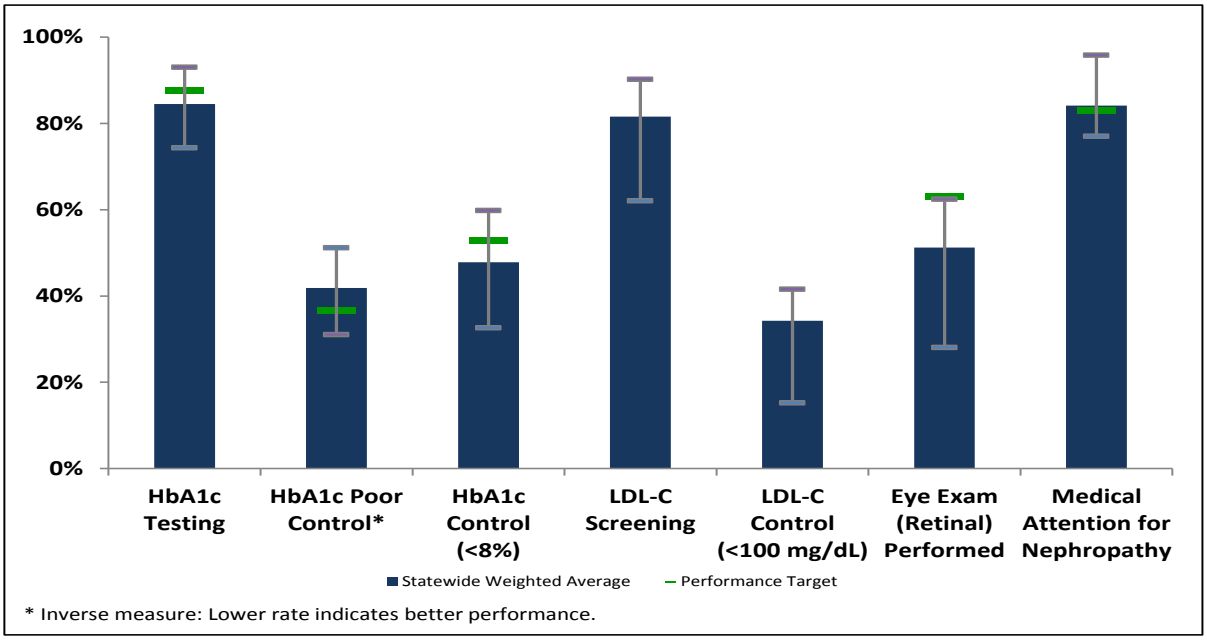
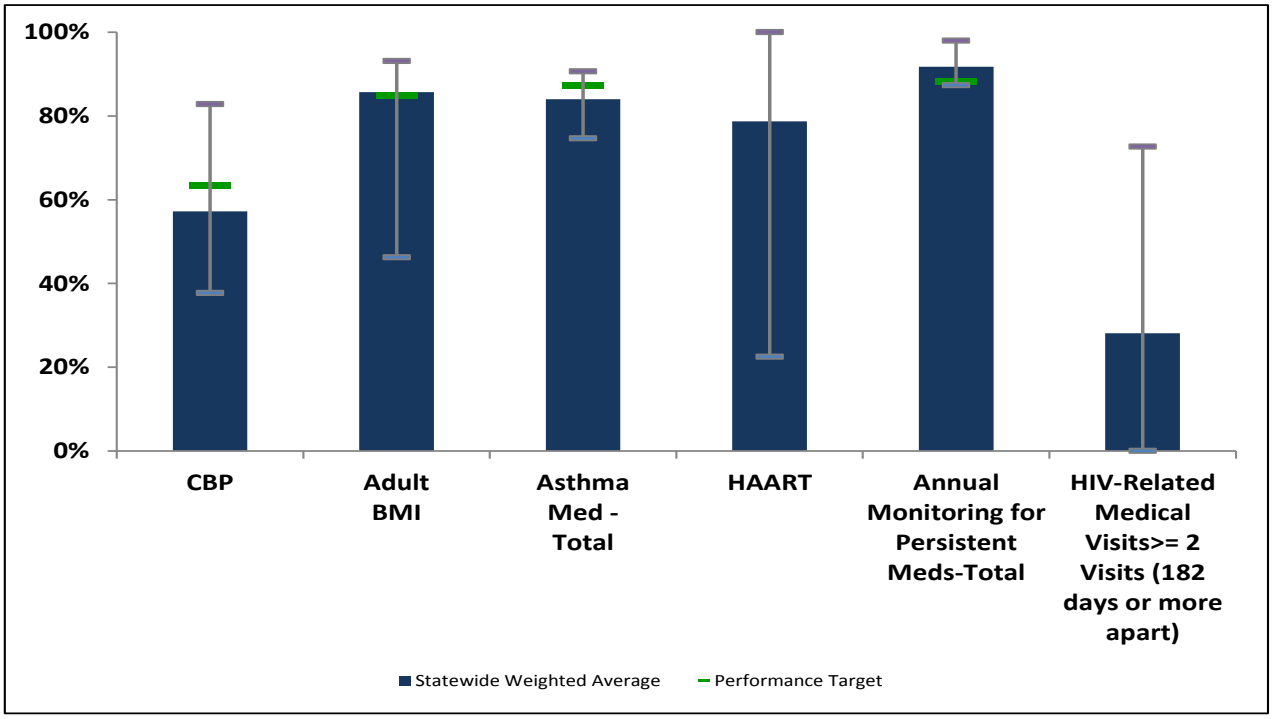


Figure 3-15 shows that only the statewide weighted average for *Medical Attention for Nephropathy* exceeded the AHCA performance target (by 1.1 percentage points). For *Eye Exam (Retinal) Performed*, no plans reached the AHCA performance target, and this measure had the widest range in plan rates (34.3 percentage points). The statewide weighted average for *HbA1c Testing* was within 3.0 percentage points of the AHCA performance target.

Figure 3-16 displays the statewide weighted averages and the performance targets for *Controlling High Blood Pressure*, *Adult BMI Assessment*, *Use of Appropriate Medications for People With Asthma—Total*, *Highly Active Anti-Retroviral Treatment*, *Annual Monitoring for Patients on Persistent Medications—Total*, and *HIV-Related Medical Visits—>= 2 Visits (182 days or more apart)*. AHCA performance targets were established for four of these measures in the current reporting cycle. The AHCA performance targets are indicated by the horizontal green bars in Figure 3-16. The vertical grey line in each bar denotes the range of performance rates across the 13 MMA Standard and five MMA Specialty plans (i.e., longer vertical lines indicate more variation).

Figure 3-16—Florida Medicaid HEDIS 2015 (CY 2014) Weighted Average Compared With the AHCA Performance Target – Living With Illness



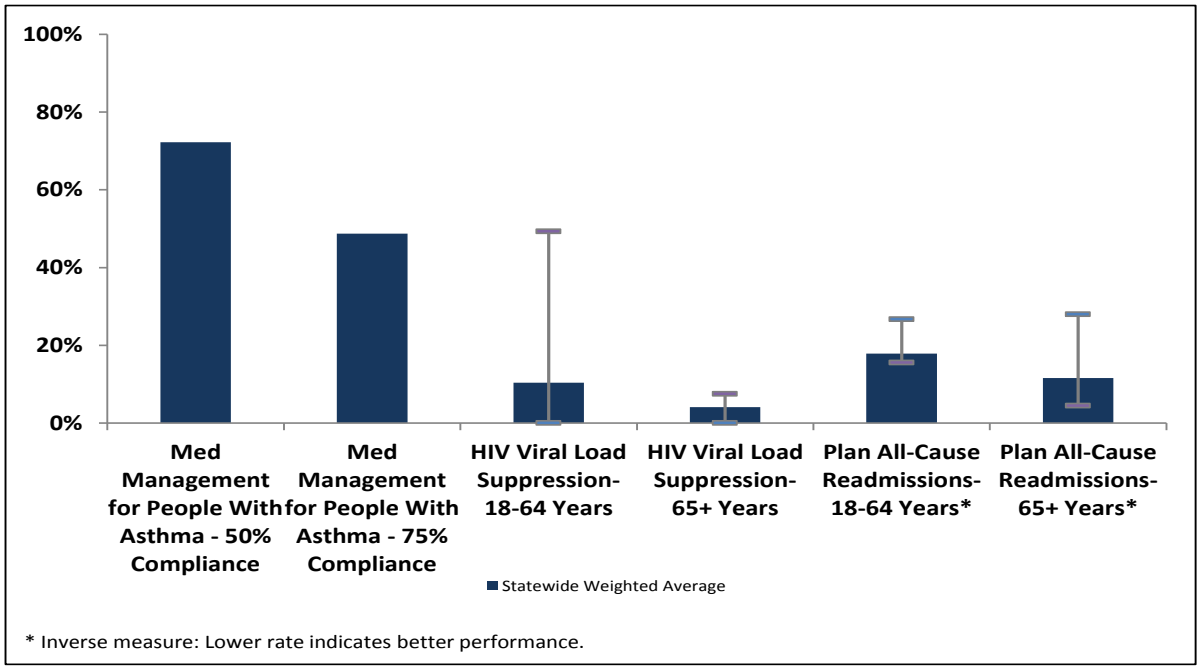
CBP	=	*Controlling High Blood Pressure*
Adult BMI	=	*Adult Body Mass Index (BMI) Assessment*
Asthma Med - Total	=	*Use of Appropriate Medications for People With Asthma—Total*
HAART	=	*Highly Active Anti-Retroviral Treatment*

Figure 3-16 shows that two measures, *Adult BMI Assessment* and *Annual Monitoring for Patients on Persistent Medications—Total*, exceeded their associated AHCA performance targets by 0.8 and 3.5 percentage points, respectively. *HAART* and *HIV-Related Medical Visits—>= 2 Visits (182 days or more apart)* showed the widest ranges of plan rates, at 77.5 and 72.7 percentage points, respectively. These two measures had no associated AHCA performance targets in the current reporting cycle.

Figure 3-17 displays the statewide weighted averages for *Medication Management for People With Asthma—50% Compliance*, *Medication Management for People With Asthma—75% Compliance*, *HIV Viral Load Suppression—18–64 Years*, *HIV Viral Load Suppression—65+ Years*, *Plan All-Cause Readmissions—18–64 Years*, and *Plan All-Cause Readmissions—65+ Years*. AHCA performance targets were not established for any of these measures. The vertical grey line in the

HIV and readmissions bars denote the range of performance rates across the 13 MMA Standard and five MMA Specialty plans (i.e., longer vertical lines indicate more variation). Only one plan rate was reportable for each asthma measure, so there is no vertical bar on either measure showing the range of plan rates.

Figure 3-17—Florida Medicaid HEDIS 2015 (CY 2014) Weighted Average Compared With the AHCA Performance Target – Living With Illness (Continued)



Children's Medical Services-S was the only plan that had a reportable rate for the two asthma medication management measures. *HIV Viral Load Suppression—18–64 Years* showed the widest range of reportable rates, at 49.3 percentage points, followed by *Plan All-Cause Readmissions—65+ Years* at 23.5 percentage points.

Plan Comparison

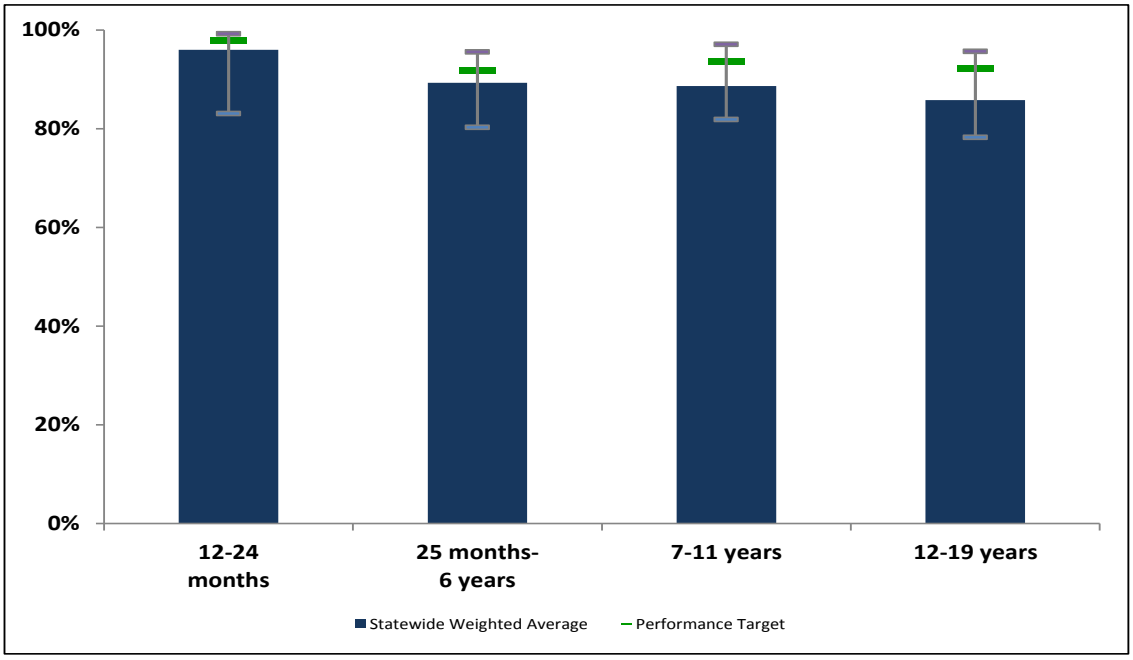
From the 13 MMA Standard and the five MMA Specialty plans in the assessment, a total of 132 Living With Illness performance measure rates for nine measures had an AHCA performance target and sufficient data to be ranked using the three-star rating system (*Adult BMI Assessment, Annual Monitoring for Patients on Persistent Medications—Total, Controlling High Blood Pressure, Eye Exam [Retinal] Performed*, *HbA1c Poor Control*, *HbA1c Control [<8%]*, *HbA1c Testing*, *Medical Attention for Nephropathy*, and *Use of Appropriate Medications for People With Asthma—Total*). Of these rates, 23 were found to be above the 90th percentile of the national Medicaid results: *Annual Monitoring for Patients on Persistent Medications—Total* (12 plans)*; Medical Attention for Nephropathy* (five plans); *HbA1c Poor Control* (two plans); and one plan each for *Adult BMI Assessment*, *Controlling High Blood Pressure*, *HbA1c Control (<8%)*, and *HbA1c Testing*. Humana and Simply each had four measures with three-star ratings.

Twenty-five rates for six measures (*Adult BMI Assessment*, *Controlling High Blood Pressure*, *Eye Exam [Retinal] Performed*, *HbA1c Control [<8%]*, *HbA1c Testing*, and *Use of Appropriate Medications for People With Asthma—Total)* received a one-star rating, which is below the 25th national percentile rate. Both Integral and Molina Healthcare had four measures that received a one-star rating. Of the MMA Standard plans, Amerigroup and Staywell, had no measures that received a one-star rating.

Access/Availability of Care

Figure 3-18 displays the statewide weighted averages and the performance targets for *Children and Adolescents' Access to Primary Care Practitioners: 12–24 Months, 25 Months to 6 Years, 7–11 Years,* and *12–19 Years*. The AHCA performance targets are indicated by the horizontal green bars for each measure. The vertical grey lines denote the range of performance rates across the 13 MMA Standard and five MMA Specialty plans (i.e., longer vertical lines indicate more variation).

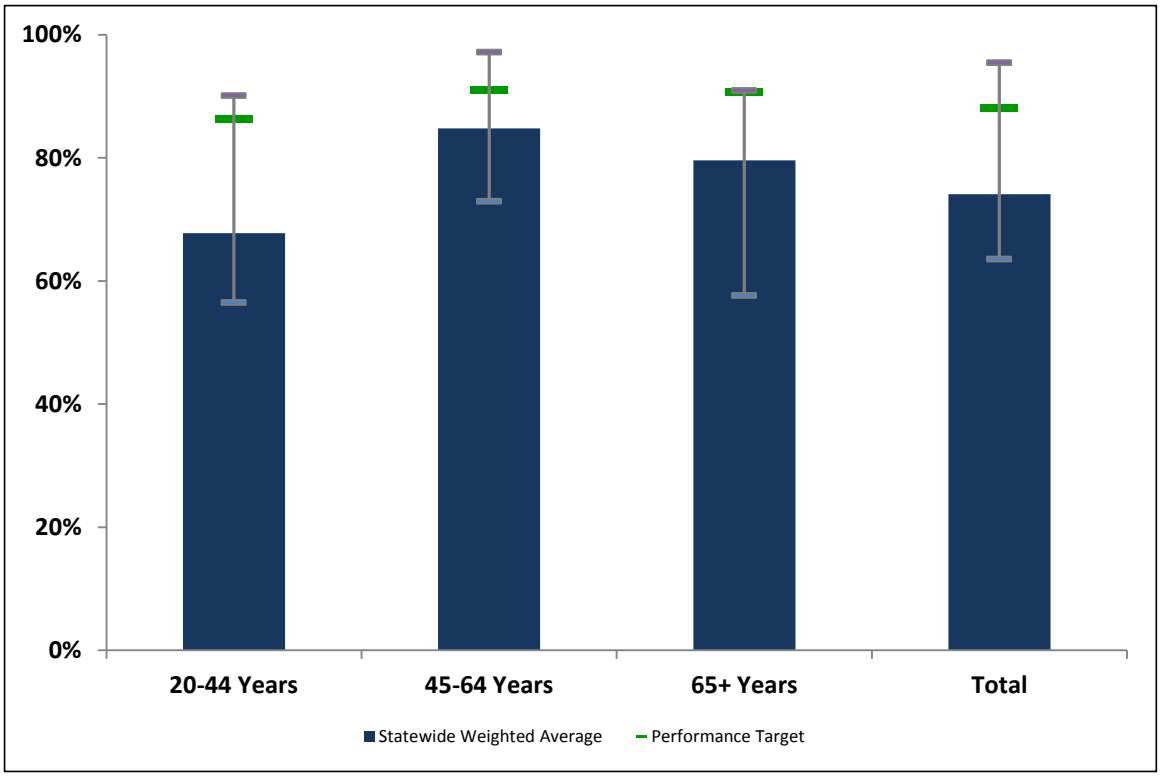
Figure 3-18—Florida Medicaid HEDIS 2015 (CY 2014) Weighted Average Compared With the AHCA Performance Target – Access/Availability of Care (Children and Adolescents' Access to Primary Care Practitioners)



None of the statewide weighted averages in this domain met the AHCA performance targets, although some plans met each of the performance targets (as denoted by the vertical grey lines reaching above the green horizontal bars). The performance range among plans was almost identical across the four measures in Figure 3-18, ranging from 15.2 to 17.4 percentage points.

Figure 3-19 displays the statewide weighted averages and the performance targets for *Adults' Access to Preventive/Ambulatory Health Services: 20–44 Years, 45–64 Years, 65+ Years,* and *Total.* The AHCA performance targets are indicated by the horizontal green bars for each measure. The vertical grey lines denote the range of performance rates across the 13 MMA Standard and five MMA Specialty plans (i.e., longer vertical lines indicate more variation).

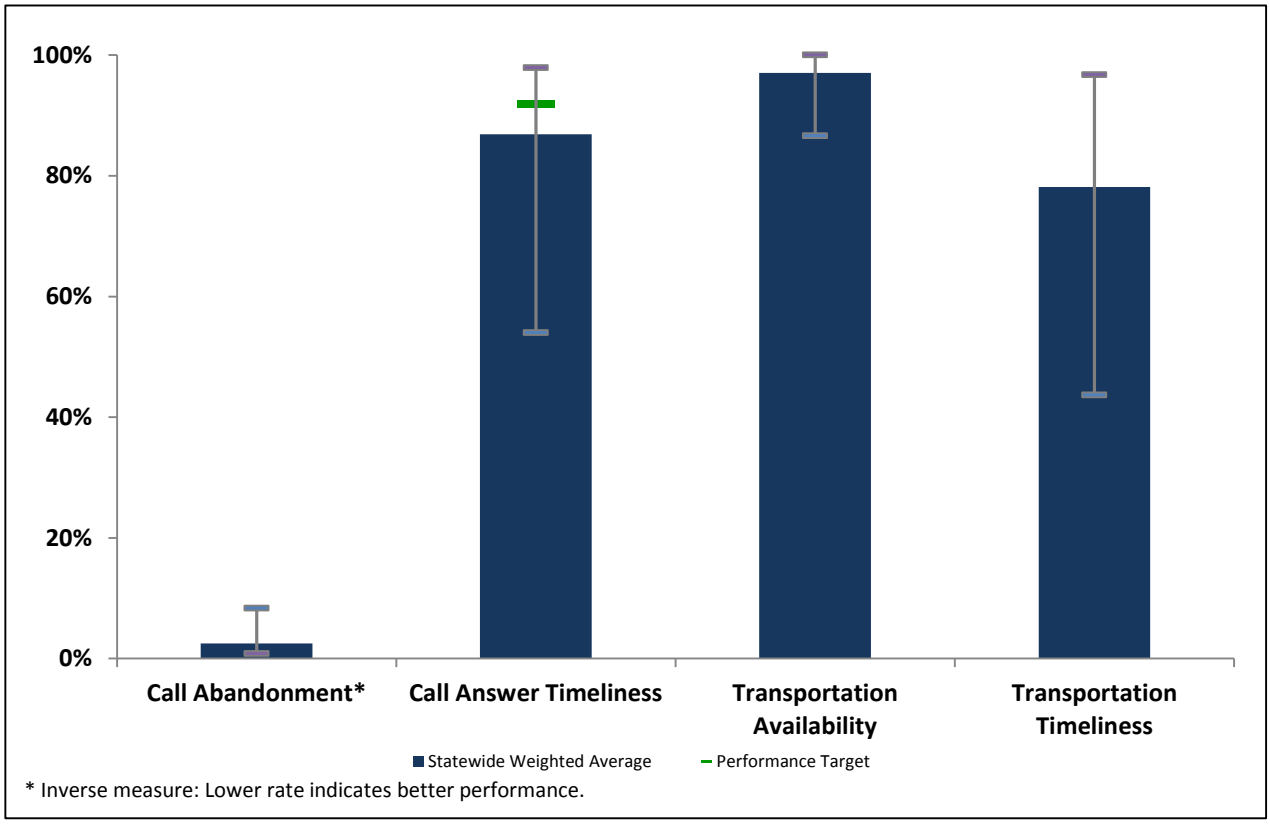
Figure 3-19—Florida Medicaid HEDIS 2015 (CY 2014) Weighted Average Compared With the AHCA Performance Target – Access/Availability of Care (Adults' Access to Preventive/Ambulatory Health Services)



None of the statewide weighted averages in this domain met the AHCA performance targets, although some plans met each of the performance targets (as denoted by the vertical grey lines reaching above the green horizontal bars). The AHCA performance target for *Adults' Access to Preventive/Ambulatory Health Services–65+ Years* was exceeded by two plans, Clear Health-S and Amerigroup by 0.21 and 0.16 percentage points, respectively. The range of performance across plans was almost identical across three of the four measures in Figure 3-19, ranging from 31.9 to 33.7 percentage points. The remaining measure, *Adults' Access to Preventive/Ambulatory Health Service—45–64 Years*, showing a range of 24.3 percentage points.

Figure 3-20 displays the statewide weighted averages and the performance targets for *Call Abandonment*, *Call Answer Timeliness*, *Transportation Availability*, and *Transportation Timeliness*. The AHCA performance target is indicated by the horizontal green bar. The vertical grey lines denote the range of performance rates across the 13 MMA Standard and five MMA Specialty plans (i.e., longer vertical lines indicate more variation).

Figure 3-20—Florida Medicaid HEDIS 2015 (CY 2014) Weighted Average Compared With the AHCA Performance Target – Access/Availability of Care (Calls and Transport)



The only measure with an AHCA performance standard, *Call Answer Timeliness*, showed a statewide weighted average that was 4.9 percentage points below the performance standard, although it was exceeded by one plan, Humana, with a rate of 97.9 percent. The widest range of plan rates was observed for *Transportation Timeliness* at 53.0 percentage points, followed by *Call Answer Timeliness* at 43.9 percentage points.

Plan Comparison

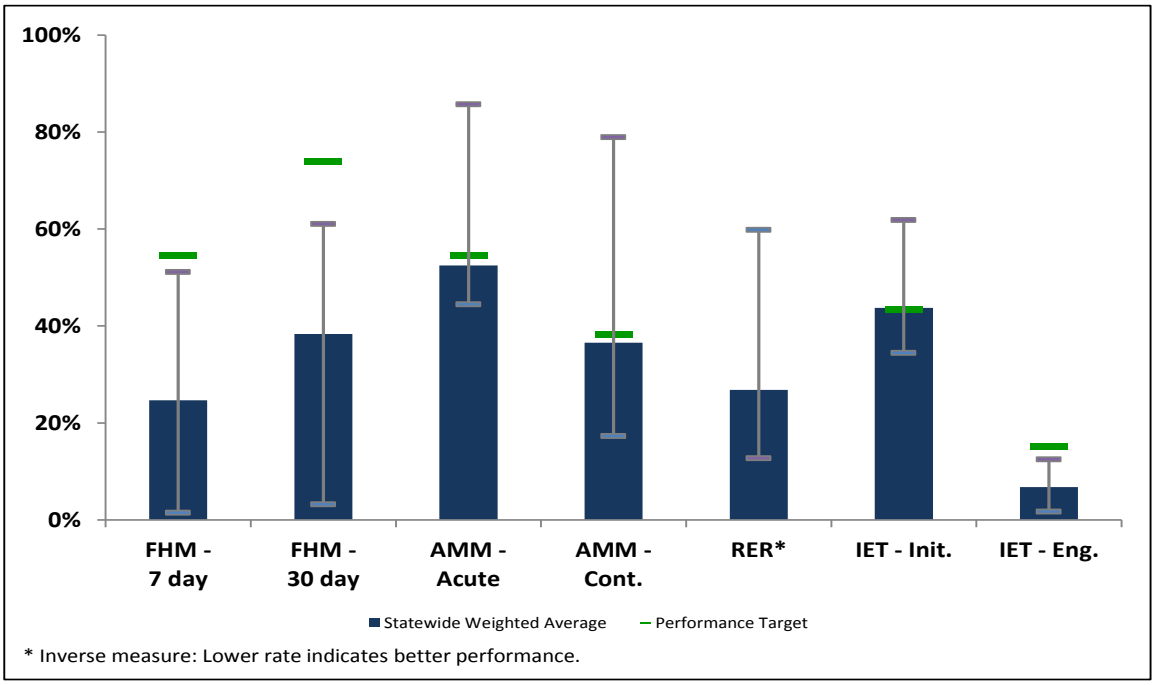
From the 13 MMA Standard and five MMA Specialty plans in the assessment, a total of 137 Access/Availability of Care performance measure rates for nine measures had an AHCA performance target and sufficient data to be ranked using the three-star rating system (all measures except *Call Abandonment*, *Transportation Availability*, and *Transportation Timeliness*). Of these rates, 13 were found to be above the 90th percentile of the national Medicaid results: *Adults' Access to Preventive/Ambulatory Health Services:20–44 Years* (2 plans), *45–64 Years* (2 plans) and *Total* (2 plans), *Call Answer Timeliness* (1 plan), and *Access to Primary Care Practitioners: 12–24 Months* (2 plans), *25 Months to 6 Years* (2 plans), *7–11 Years* (1 plan), and *12–19 Years* (1 plan). Of these 13 rates, four were from Children's Medical Services-S.

Sixty-four measures received a one-star rating, representing nine measures and 14 plans. The plans that had no one-star ratings were all MMA Specialty plans and included Positive-S, Clear Health-S, Magellan-S, and Sunshine-S.

Behavioral Health

Figure 3-21 displays the statewide weighted averages and the performance targets for *Follow-up After Hospitalization for Mental Illness—7-Day* and *30-Day*, *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*, *Mental Health Readmission Rate*, and *Alcohol and Other Drug Dependence Treatment—Initiation* and *Engagement*. AHCA established performance targets for each of the measures except *Mental Health Readmission Rate*, which is an inverse measure where lower rates indicate better performance. The AHCA performance target is indicated by the horizontal green bar in Figure 3-21. The vertical grey lines denote the range of performance rates across the 13 MMA Standard and five MMA Specialty plans (i.e., longer vertical lines indicate more variation).

Figure 3-21—Florida Medicaid HEDIS 2015 (CY 2014) Weighted Average Compared With the AHCA Performance Target – Behavioral Health



FHM—7 day	=	*Follow-up After Hospitalization for Mental Illness—7-Day*
FHM—30 day	=	*Follow-up After Hospitalization for Mental Illness—30-Day*
AMM—Acute	=	*Antidepressant Medication Management—Effective Acute Phase Treatment*
AMM—Cont.	=	*Antidepressant Medication Management—Effective Continuation Phase Treatment*
RER	=	*Mental Health Readmission Rate*
IET—Init.	=	*Initiation and Engagement of Alcohol and Drug Dependence Treatment—Initiation*
IET—Eng.	=	*Initiation and Engagement of Alcohol and Drug Dependence Treatment—Engagement*

The statewide weighted average for the *Alcohol and Other Drug Dependence Treatment—Initiation* measure exceeded the AHCA performance target by 0.3 percentage points. Although some plans exceeded the AHCA performance target for *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*, as well as for *Alcohol and*

Other Drug Dependence Treatment—Initiation, no plan reached the AHCA performance target for *Follow-up After Hospitalization for Mental Illness—7-Day* and *30-Day* or for *Alcohol and Other Drug Dependence Treatment—Engagement*. The widest range of rates was seen for *Antidepressant Medication Management—Effective Continuation Phase Treatment* at 61.6 percentage points, followed by *Follow-up After Hospitalization for Mental Illness—30-Day* at 57.9 percentage points.

Plan Comparison

From the 13 MMA Standard and the five MMA Specialty plans in the assessment, a total of 94 performance measure rates for six measures had an AHCA performance target and sufficient data to be ranked using the three-star rating system including all measures but *Mental Health Readmission Rate*. Of these rates, 11 were found to be above the 90th percentile of the national Medicaid results: *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*, and *Alcohol and Other Drug Dependence Treatment—Initiation* from a total of seven plans. Better Health reported three measures with three stars.

The plans that had no one-star ratings included three of the MMA Standard plans (Amerigroup, Sunshine, and United) and two MMA Specialty plans (Children's Medical Services-S and Sunshine-S). Preferred posted the greatest number of measures receiving a one-star rating (four).

Conclusion and Recommendations

During SFY 2014–2015, all plans were required to undergo an NCQA HEDIS Compliance Audit for the performance measures they were contracted to report to AHCA. Based on the final audit statements and supporting documents submitted for HSAG's PMV (conducted during SFY 2015–2016), all MMA Standard plans except one were fully compliant with six of the seven IS standards. One MMA Standard plan (Preferred) was not compliant with IS 4.0 (Medical Record Review Processes), due to using a process that was not acceptable according to NCQA audit standards. Consequently, this plan was required to report several measures (i.e., *Comprehensive Diabetes Care [CDC]—HbA1c*, *Comprehensive Diabetes Care [CDC]—Nephropathy*, *Cervical Cancer Screening [CCS]*, and *Lead Screening in Children [LSC])* using administrative data only. All but one MMA Specialty plan were fully compliant with six out of seven IS standards. One MMA Specialty plan (Positive-S) was substantially compliant with IS 5.0 (Supplemental Data) due to accuracy concerns with capturing complete rides for the *Transportation Availability* (TRA) and *Transportation Timeliness* (TRT) AHCA measures. However, this issue had minimal impact on measure reporting.

Overall, 62 of 586 measures (10.6 percent) subject to the three-star rating system and having an AHCA performance target demonstrated outstanding performance at or above the 90th percentile of the national Medicaid results (i.e., ★★★). There were 334 performance measures (57.0 percent) that received moderate or good performance ratings (i.e., ★★, for performance at or the above the 25th percentile but below the 90th percentile of the national Medicaid results). The remaining 190 rates (32.4 percent) that were below the 25th percentile (i.e., ★) of the national Medicaid results showed the most opportunity for improvement.

Of the 11 measures in the Pediatric Care group with an AHCA performance target, five measures showed at least one plan meeting or exceeding the associated target's rate: *Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase* (seven plans) and *Continuation and*

Maintenance Phase (five plans), *Adolescent Well-Care Visits* (three plans), *Well-Child Visits in the 3rd–6th Years of Life* (four plans), and *Well-Child Visits in the First 15 Months of Life—Zero Visits* (two plans). The six measures with no plans reaching the AHCA performance target include all three immunization measures (*Childhood Immunization Status—Combinations 2 and 3* and *Immunizations for Adolescents—Combination 1*), *Annual Dental Visit—Total*, *Lead Screening in Children*, and *Well-Child Visits in the First 15 Months of Life—6+ Visits*. By empirical definition, and having an AHCA performance target, these six measures for which no plans reached the target demonstrate the most opportunity for improvement in this domain.

For Women's Care, five measures had an associated AHCA performance target in the current assessment cycle. Of these measures, three had at least one plan that met or exceeded the associated target: *Chlamydia Screening in Women—Total* (six plans), *Breast Cancer Screening* (three plans), and *Prenatal Care Frequency* (three plans). Neither *Postpartum Care* nor *Timeliness of Prenatal Care* had any plans reach the target which empirically demonstrates the most opportunity for improvement in this domain.

The Living With Illness group had nine measures with an associated AHCA performance standard. Of these nine measures, eight had at least one plan that met or exceeded the AHCA performance standard: *Annual Monitoring for Patients on Persistent Medications—Total* (12 plans—the best for any assessed measure), *Medical Attention for Nephropathy* (nine plans), *Controlling High Blood Pressure* (two plans), *Adult BMI Assessment* (eight plans), *HbA1c Testing* (three plans), *HbA1c Poor Control* (two plans), *HbA1c Control [<8%]* (two plans), and *Use of Appropriate Medications for People With Asthma—Total* (two plans). *Eye Exam (Retinal) Performed* was the only measure which did not have at least one plan that met or exceeded the AHCA performance target and empirically demonstrates the most opportunity for improvement in this domain.

All nine measures with an associated AHCA performance standard in the Access/Availability of Care group had at least one plan that met or exceeded the AHCA standard. *Children and Adolescents' Access to Primary Care Practitioners: 25 Months to 6 Years* had the most plans meeting or exceeding the performance standard (four plans). With the exception of *Children and Adolescents' Access to Primary Care Practitioners: 7–11 Years*, which had only one plan meeting the performance standard, all other performance standards in this domain had two plans meeting the standard. Clear Health-S had five of the 19 rates meeting or exceeding the AHCA performance target, followed by Children's Medical Services-S, both of which are MMA Specialty plans.

Of the six measures in the Behavioral Health domain with associated AHCA performance targets (all except *Mental Health Readmission Rate*), eight plans exceeded the target for *Alcohol and Other Drug Dependence Treatment—Initiation*, and seven plans exceeded the associated targets for *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*. With no plan exceeding the AHCA performance targets for *Alcohol and Other Drug Dependence Treatment—Engagement* or *Follow-up After Hospitalization for Mental Illness—7-Day* and *30-Day*, these areas are empirically highlighted as opportunities for improvement.

LTC Plans

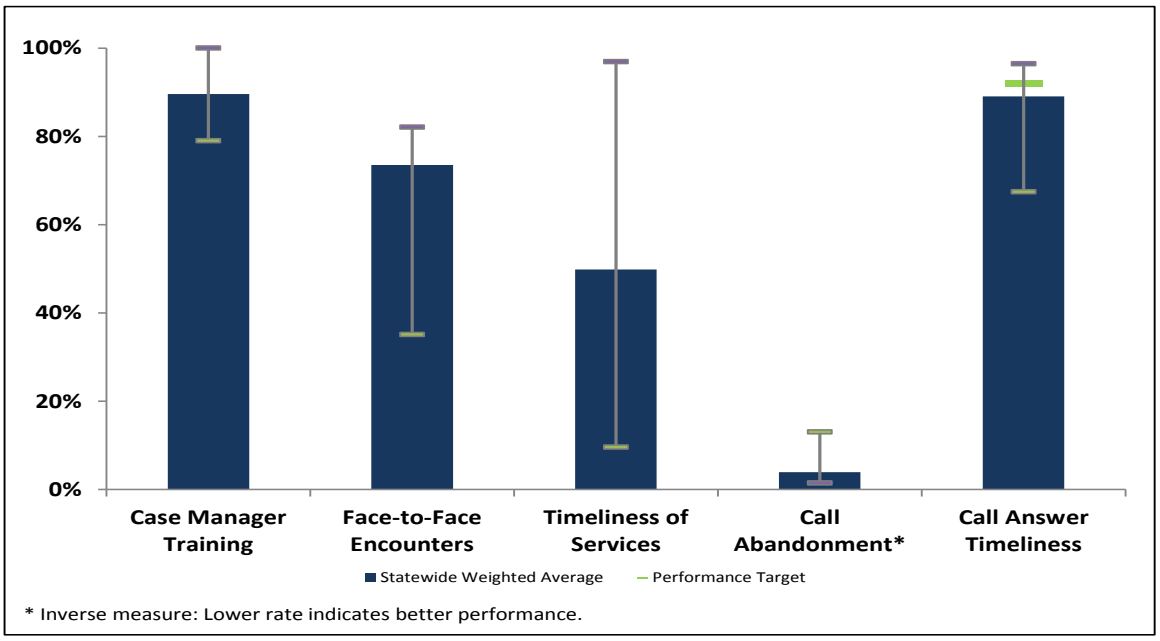
Seven LTC plans contracted with AHCA for providing long-term care services to their Medicaid enrollees were required to report select performance measures. For SFY 2014–2015, AHCA required the LTC plans to calculate and report seven performance measures using CY 2014 data (see Table 3-2). The LTC plans underwent a performance measure review to ensure that the rates calculated and reported for these measures were valid and accurate. For CY 2014, the LTC plans were required to report two HEDIS and five AHCA-defined measures. AHCA intended that an NCQA HEDIS Compliance Audit be conducted to the extent possible. All LTC plans contracted external audit firms to perform the audit during SFY 2014–2015. All audits were conducted by NCQA-licensed organizations (LOs).

Table 3-2—List of CY 2014 Performance Measures

Measure	Calculation Responsibility	Measurement Period
Care for Older Adults (COA)	LTC Plan	CY 2014
Call Answer Timeliness (CAT)	LTC Plan	CY 2014
Call Abandonment (CAB)	LTC Plan	CY 2014
Required Record Documentation (RRD)	LTC Plan	CY 2014
Timeliness of Services (TOS)	LTC Plan	CY 2014
Case Manager Training (CMT)	LTC Plan	CY 2014
Face-to-Face Encounters (F2F)	LTC Plan	CY 2014

Figure 3-22 displays the statewide weighted averages for *Case Manager Training*, *Face-to-Face Encounters*, *Timeliness of Services*, *Call Abandonment*, and *Call Answer Timeliness*. Of these measures, only *Call Answer Timeliness* had an associated AHCA performance standard for the currently reported measurement cycle. The AHCA performance target is indicated by the horizontal green bar in Figure 3-22. The vertical grey lines denote the range of performance rates across the seven LTC plans (i.e., longer vertical lines indicate more variation).

Figure 3-22—Florida Medicaid HEDIS 2015 (CY 2014) Weighted Average Compared With the AHCA Performance Target – Long-term Care



The statewide weighted average for *Call Answer Timeliness* did not reach the performance target, although it was exceeded by three plans (Coventry-LTC, Humana-LTC, and Sunshine-LTC). The widest range of plan rates was seen for *Timeliness of Services*, 87.3 percentage points.

Figure 3-23 displays the statewide weighted averages for *Care for Older Adults—Advance Care Planning*, *Functional Status Assessment*, and *Medication Review*. No AHCA performance targets were set for these three measures. The vertical grey lines denote the range of performance rates across the seven LTC plans (i.e., longer vertical lines indicate more variation).

Figure 3-23—Florida Medicaid HEDIS 2015 (CY 2014) Weighted Average Compared With the AHCA Performance Target – Long-term Care (Care for Older Adults)

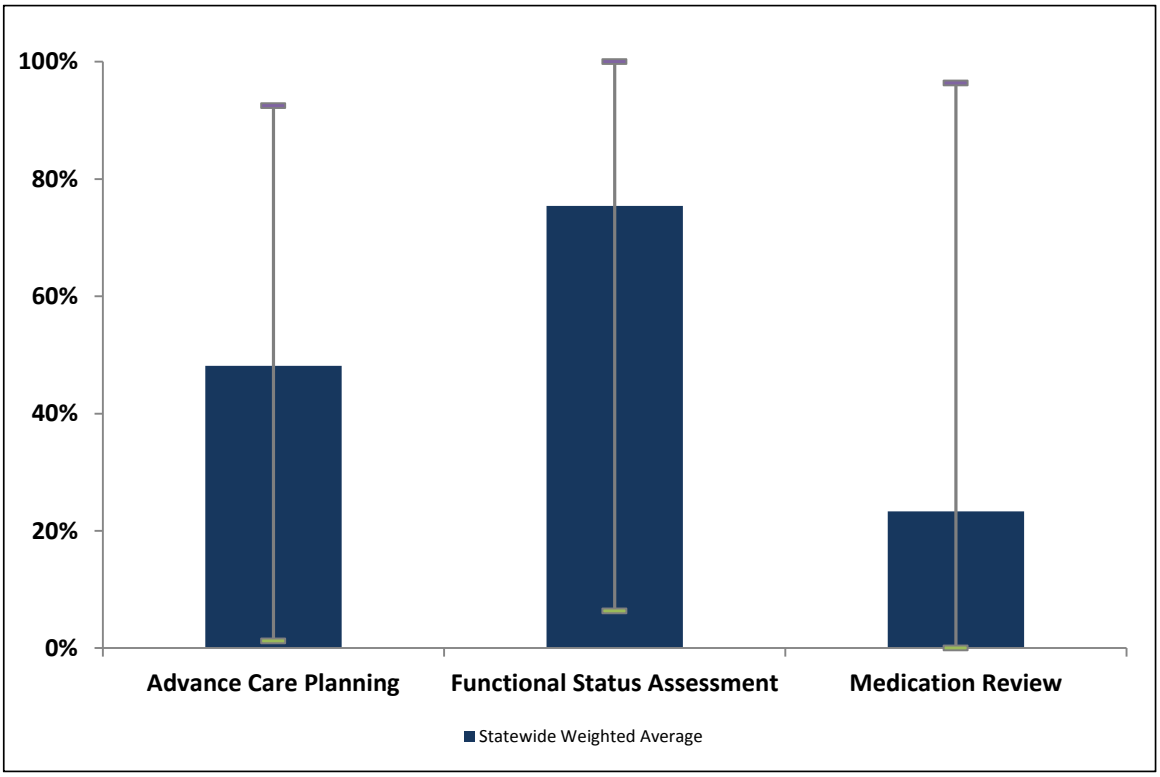


Figure 3-23 shows a large variation in rates for all three displayed measures, ranging from 91.3 to 96.4 percentage points. While all seven plans reported rates for all three measures, the rates were not subjected to the three-star rating system.

Figure 3-24 displays the statewide weighted averages for *Required Record Documentation—701B Assessment*, *Enrollee Participation in Care Plan*, and *Primary Care Physician Notification*. No AHCA performance targets were set for these three measures. The vertical grey lines denote the range of performance rates across the seven LTC plans (i.e., longer vertical lines indicate more variation).

Figure 3-24—Florida Medicaid HEDIS 2015 (CY 2014) Weighted Average Compared With the AHCA Performance Target – Long-term Care (Required Record Documentation)

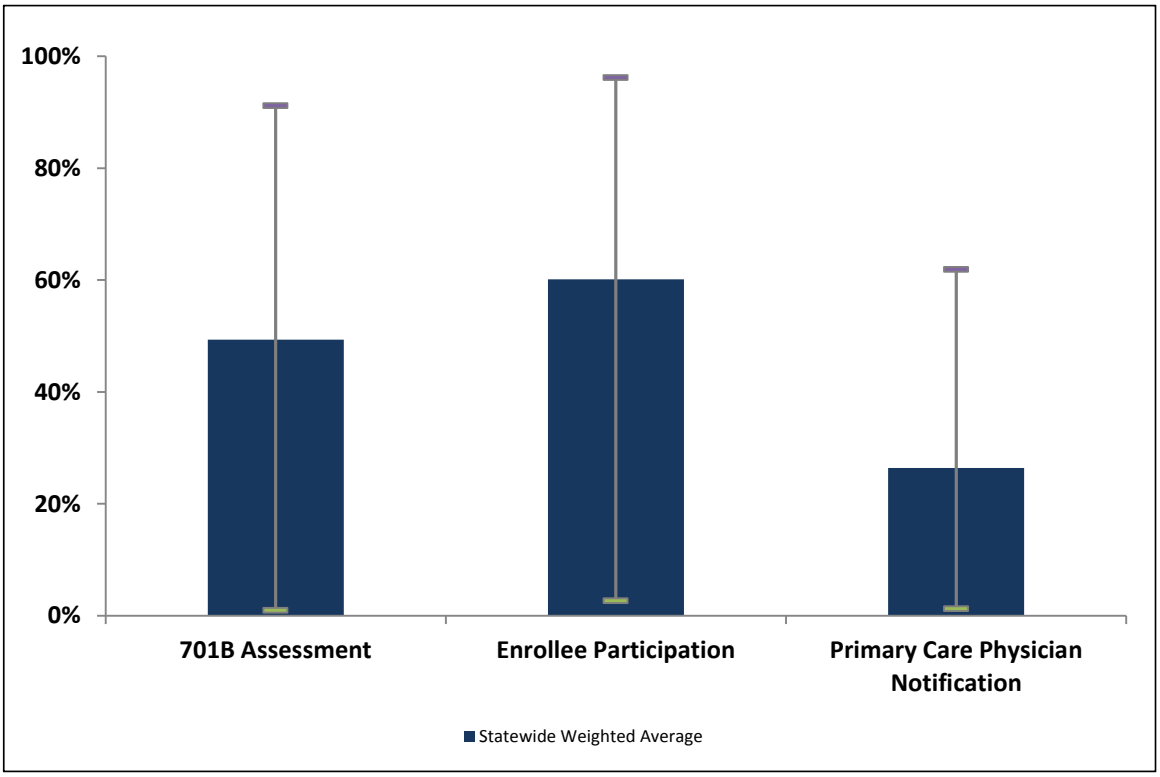


Figure 3-24 shows a large variation in rates for *701B Assessment* and *Enrollee Participation*. While all seven plans reported rates for all three measures, the rates were not subjected to the three-star rating system.

Plan Comparison

Only *Call Answer Timeliness* had rates that were subject to the three-star rating system. For that measure, Humana-LTC and Sunshine-LTC each received a three-star rating; American Eldercare-LTC, Coventry-LTC, Molina-LTC, and United-LTC all received a two-star rating; and Amerigroup-LTC received a one-star rating.

Conclusions and Recommendations

Based on the FAR reviews, HSAG found that all seven LTC plans maintained the same experienced staff members for collecting and processing data for performance measure reporting. In addition, the LTC plans continue to have sufficient processes in place to ensure data completeness and data accuracy.

HSAG offers the following recommendations:

- Although there was some improvement in the *Case Manager Training* measure among the LTC plans, not all LTC plans reported 100 percent for this measure. Since this measure suggests LTC plan compliance with a mandate to report abuse, neglect, and exploitation, LTC plans with less

than 100 percent performance should investigate the root cause of the noncompliance and assure proper and timely training for their case managers.

- Three of the six measures the LTC plans were required to report were new measures. The 2015 statewide LTC rates for these first-year measures were low, and plan performance was diverse. Specifically, the *Required Record Documentation* measure components showed very wide plan variation in performance. Since the measure assesses the percentage of enrollees who have specific documents to be maintained by the LTC plans in their records, less than 100 percent would imply failure to comply with AHCA's expectation. HSAG recommends that plans with poor performance develop corrective action plans to ensure timely remedial actions to improve care.
- Despite AHCA's expectation, not all LTC plans' audits were conducted following NCQA HEDIS Compliance Audit policies and procedures. Since some of the measures rely on data that are collected outside the usual data systems included in a typical NCQA HEDIS Compliance Audit, HSAG recommends that the Final Audit Report (FAR) include a brief description of these data systems used for calculating AHCA-defined measures. The FAR should also include specific compliance findings related to each Information Systems (IS) standard.

Within the LTC domain, only *Call Answer Timeliness* had an associated AHCA performance target, which was met by three plans, Coventry-LTC, Humana-LTC, and Sunshine-LTC. The other four LTC plans (American Eldercare-LTC, Amerigroup-LTC, Molina-LTC, and United-LTC) empirically showed the most opportunity for improvement in this domain.

Follow-Up on Prior Year Recommendations

Based on the SFY 2013–2014 review, HSAG offered the following recommendations for the LTC plans:

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

HSAG found that for the current review period, five out of seven LTCs were still reporting rates less than 100 percent for the *Case Management Training* measure. HSAG also found that audits conducted for some of the LTC plans still did not follow NCQA's HEDIS Compliance Audit policies and procedures. In addition, the FARs continued to show lack of information regarding the data systems that were being used to calculate some of the AHCA-defined measures (e.g., *Call Abandonment [CAB]* and *Case Manager Training [CMT]*). These results suggested that the LTC plans did not take HSAG's prior-year recommendations into consideration.

Review of Compliance With Access, Structure, and Operations Standards

Overview of Compliance Review Activity

The Balanced Budget Act (BBA), as set forth in 42 CFR §438.358, requires that a state or its designee conduct a review to determine each MCO's and PIHP's compliance with federal Medicaid managed care regulations and the state's standards. Oversight activities must focus on evaluating quality outcomes and the timeliness of, and access to, care and services provided to Medicaid beneficiaries by the MCO/PIHP. To fulfill this requirement, AHCA conducted readiness reviews of each of its MMA Standard and Specialty plans[12] during the period of time just prior to implementation of each phase of Florida's SMMC program. AHCA and DOEA conducted the readiness reviews for the LTC plans. Because the SMMC program required the plans to operate under a new set of contract requirements and, in many cases, in a new geographical service area; the readiness reviews initiated a new three-year cycle of determining compliance for the Florida Medicaid plans, as required by the federal regulations.

Table 3-3—Readiness Review Time Periods

SMMC Plan Type Reviewed	Time Period for Conducting the Reviews
LTC plans	February 2013–December 2013
MMA Standard plans	November 2013–June 2014
MMA Specialty plans	November 2013–June 2014

Objectives

The primary objectives of AHCA's readiness reviews were to:

- Give the State assurance of each plan's ability to fulfill its contractual obligations to become operational as a managed care plan under Florida's new SMMC program.

[12] AHCA did not conduct a readiness review of Freedom-S because Freedom-S was already operating as a Dual-eligible Special Needs (D-SNP) plan and providing services in the SMMC program.

- Ensure that enrollees' care and services were provided in a coordinated and continuous manner during the transition to SMMC.
- Provide meaningful information to the State and each plan regarding contract compliance with standards and any areas requiring correction or performance improvement.

Technical Methods of Data Collection and Analysis

MMA Standard and Specialty Plans

Consistent with the CMS protocol for conducting compliance reviews (*EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012[13]), AHCA's readiness review process included a pre-on-site desk audit of numerous key documents and an on-site review with interviews and system demonstrations to assess the degree to which the plans met federal managed care and State requirements in the 14 major standard areas AHCA selected.

During its review process, AHCA assessed the following standard areas for plan compliance and readiness in preparation to launch the SMMC program:

- Administration and Management
- Care Coordination/Case Management
- Claims Management
- Covered Services
- Enrollee Materials
- Enrollee Services
- Finance
- Grievance System
- Information Systems
- Marketing
- Prescribed Drug Services
- Program Integrity
- Provider Network
- Quality and Utilization Management

Prior to beginning the readiness reviews, AHCA developed customized data collection tools, including checklists and worksheets, to use in the review of each plan. The content of the tools was based on applicable federal and State regulations and the plans' SMMC contracts. To initiate the

[13] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2013.

review process, AHCA requested documentation from the plans, and the plans uploaded the information to AHCA's secure file transfer protocol (sFTP) site.

AHCAs contract management staff assigned to each plan and other AHCA staff with content area expertise reviewed the plan-submitted documentation and participated in the on-site portion of the readiness reviews. The review process evaluated not only each plan's compliance with the standards and its readiness to become operational, but also the plan's progress in implementing key functions and activities as outlined in its Invitation to Negotiate response (the plan's proposal upon which the SMMC contract award was made).

AHCA's analysis of the documents and other data gathered from the desk and on-site reviews resulted in a determination of readiness, which was communicated to the plan in a formal letter. Determination letters described AHCA's assessment and indicated that either:

- The plan was ready to accept enrollees and could ensure the provision of continuity of their care; had the capacity to provide the array of covered services through a regional network of providers to meet established access standards; and could fulfill any and all the obligations and requirements under the contract; OR
- The plan was identified to have deficiencies that required correction through AHCA's Implementation Action Plan (IAP) process. This process included development of a corrective action plan, review and approval of the IAP by AHCA, and re-review of the areas of deficiency once the action plan had been implemented.

For plans with deficiencies requiring correction, AHCA performed additional desk reviews and, as needed, an on-site review of the plans' IAP implementation. AHCA issued a final letter of findings with a readiness determination once the plan demonstrated it met the requirement(s). The SMMC plans were required to substantially meet all readiness requirements prior to AHCA's allowance of recipient enrollment in the plan.

LTC Plans

The readiness review process for the LTC plans was similar to the process used for the MMA plans. Once the LTC plans were selected, AHCA staff members, along with staff members from DOEA, were placed on teams and tasked with performing readiness reviews for each plan. AHCA contracted with an independent contractor to assist with the SMMC implementation readiness reviews. As part of this contract, the independent contractor created a readiness tool to be used in determining if each LTC plan was ready to go live on their specified "go-live" date. Staff members from AHCA and DOEA were assigned different sections of the tool to review as part of the desk review process. Using the independent contractor's tool, staff members verified that the plans had submitted all required documentation. Three different possible results occurred while verifying information: met, not met, or requires additional information. If any of the items were identified as "not met" or "requires additional information," this was automatically notated in the tool. Once all areas had been reviewed, information was submitted to the plan from a central point within AHCA (a slightly different process was followed during the MMA reviews which involved sending an initial determination letter). Once the plan was notified of its deficiencies, the plans were allowed to resubmit information to achieve compliance with the desk reviews. Once a plan had successfully submitted all information required during the desk reviews, AHCA and DOEA moved forward with

the on-site reviews. During the on-site reviews, AHCA and DOEA reviewed additional standards, as well as systems and any standards identified during the desk review that required verification.

During its review process, AHCA and DOEA assessed the following standard areas for LTC plan compliance and readiness (using both core and LTC-specific contract requirements) in preparation to launch the SMMC program:

- Eligibility and Enrollment
- Enrollee Services, Community Outreach, and Marketing
- Enrollee Handbook
- Covered Services
- Care Coordination/Case Management
- Behavioral Health Coordination
- Provider Network
- Quality Management
- Utilization Management
- Transition of Care
- Caregiver Support and Disease Management
- Grievance System
- Administration and Management: Core
- Administration and Management: Claims and Provider Payment
- Information Management and Systems
- Reporting
- Method of Payment
- Sanctions
- Financial Requirements
- Terms and Conditions
- Liquidated Damages

Although AHCA and DOEA found that all of the LTC plans required IAPs to correct deficiencies, the initial numbers of deficiencies were not submitted to HSAG. All LTC plans were in complete compliance with all standards prior to "going live" and providing services.

Description of Data Obtained

To assess the plans' compliance and readiness, AHCA and DOEA obtained information from a wide range of written documents and data provided by each plan for the desk review and observations during on-site interviews, presentations, and system demonstrations. The requested documentation illustrated the plan's approach and progress in each of the areas under review and included items such as:

- Policies and procedures related to each standard area under review.

- Provider network listings and reports.
- Provider/Contractor oversight, and evaluation audit tools and monitoring reports.
- Key operational area plans and program descriptions (e.g., utilization management, quality improvement, cultural competency).
- Preferred Drug Listing and associated procedures.
- Member handbooks, and member informational and marketing materials.
- Customer service line scripts, performance measures, and description of translation services.
- Provider handbooks and manuals.
- Provider agreements and delegation contract templates.
- Organizational charts and training descriptions.
- Descriptions of systems used for enrollment, encounters, prior authorizations, claims payment, providers, care management, etc.

Throughout each of the plan readiness reviews, AHCA tracked the information received from each plan and any outstanding requests for additional or resubmission of information, and compiled the monitoring results into a "readiness dashboard." This completed dashboard, the formal communications from AHCA and DOEA to the plans, and the completed review tools serve as documentation of the readiness review results and the IAP process, and were used as the basis of this section of the EQR technical report.

Results, Conclusions, and Plan Strengths and Weaknesses

The following table illustrates, for each plan, the initial determination results following completion of AHCA's readiness review, the number of standard areas requiring an IAP (if any), and the date of the final determination letter of readiness.

Table 3-4—SMMC Plans' Readiness Determinations

SMMC Plan Reviewed	Initial Readiness Determination	# Areas Requiring IAP	Final Readiness Determination Date
MMA Standard Plans			
AMG-M	Not ready, IAP required	50	6/16/14
BET-M	Not ready, IAP required	47	5/20/14
COV-M	Not ready, IAP required	46	5/20/14
HUM-M	Not ready, IAP required	36	6/16/14
IHP-M	Not ready, IAP required	56	6/16/14
MOL-M	Not ready, IAP required	30	6/16/14
PRE-M	Not ready, IAP required	36	5/20/14
PRS-M	Not ready, IAP required	45	6/16/14

Table 3-4—SMMC Plans' Readiness Determinations			
SMMC Plan Reviewed	**Initial Readiness Determination**	**# Areas Requiring IAP**	**Final Readiness Determination Date**
NBD-M	Not ready, IAP required	45	5/20/14
SHP-M	Not ready, IAP required	43	5/20/14
SUN-M	Not ready, IAP required	21	6/16/14
URA-M	Not ready, IAP required	36	6/16/14
STW-M	Not ready, IAP required	17	6/16/14
MMA Specialty Plans			
POS-S	Not ready, IAP required	32	5/20/14
CMS-S*	Not ready, IAP required	__	7/15/14
CHA-S	Not ready, IAP required	21	6/16/14
MCC-S	Not ready, IAP required	39	7/17/14
SUN-S**	Not ready, IAP required	21**	6/16/14
LTC Plans* **			
AEC-L	Not ready, IAP required	N/A	12/1/13
AMG-L	Not ready, IAP required	N/A	9/1/13
COV-L	Not ready, IAP required	N/A	11/1/13
HUM-L	Not ready, IAP required	N/A	12/1/13
MOL-L	Not ready, IAP required	N/A	11/1/13
SUN-L	Not ready, IAP required	N/A	12/1/13
URA-L	Not ready, IAP required	N/A	12/1/13

*The CMS Plan's readiness was handled differently as this contract is with the Florida Department of Health for a non-risk prepaid inpatient health plan (non-risk PIHP) with a payment methodology that includes a settlement back to expense based on fee-for-service Medicaid.
**Same as the MMA plan.
***Initial IAPs were not submitted to HSAG.

Of the 25 plans reviewed for readiness, all plans had deficiencies in one or more of the standard areas reviewed and were required to correct the deficiencies through the IAP process before AHCA issued a "readiness" determination.

The following table illustrates, for each MMA Standard and Specialty plan, the specific standard areas and number of deficiencies for which issues were identified and corrections were

implemented. (All of the LTC plans required IAPs to correct deficiencies: however, the initial numbers of deficiencies were not submitted to HSAG.)

Table 3-5—Summary of MMA Standard and Specialty Areas Requiring IAPs

SMMC Plan	Administration and Management	Care Coor./ Case Mgmt	Claims Mgmt	Covered Services	Enrollee Materials	Enrollee Services	Finance	Grievance System	Information Systems	Marketing	Prescribed Drug Services	Program Integrity	Provider Network	Quality and Utilization Mgmt	TOTALS PER PLAN
MMA Standard Plans															
AMG-M	6	0	5	4	6	0	0	5	3	4	6	1	9	1	50
BET-M	5	0	3	3	3	0	0	5	2	6	4	6	8	2	47
COV-M	7	0	0	0	4	1	0	7	2	3	4	5	13	0	46
HUM-M	6	0	2	1	4	2	0	7	1	3	2	4	4	0	36
IHP-M	5	0	5	5	1	1	2	8	3	4	7	6	6	3	56
MOL-M	7	0	1	1	4	4	0	2	0	1	3	0	7	0	30
PRE-M	7	0	3	1	4	1	0	2	0	7	7	0	4	0	36
PRS-M	6	0	4	1	4	2	0	9	4	4	5	0	5	1	45
NBD-M	7	0	4	3	5	2	1	6	0	0	4	3	6	4	45
SHP-M	5	0	4	3	4	2	0	8	2	1	5	1	5	3	43
SUN-M	6	0	2	1	4	1	0	1	0	1	1	0	4	0	21
URA-M	4	1	1	2	3	3	0	7	2	2	1	4	4	2	36
STW-M	6	0	0	1	2	0	0	1	0	2	2	0	3	0	17
TOTALS	**77**	**1**	**34**	**26**	**48**	**19**	**3**	**68**	**19**	**38**	**51**	**30**	**78**	**16**	
MMA Specialty Plans															
POS-S	8	0	0	2	7	2	0	1	0	0	1	3	5	3	32
CMS-S*	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
CHA-S	6	0	0	2	3	0	0	2	0	1	2	0	4	1	21
MCC-S	7	0	0	1	5	2	0	8	0	1	2	3	10	0	39
SUN-S**	6	0	2	1	4	1	0	1	0	1	1	0	4	0	21
TOTALS	**27**	**0**	**2**	**6**	**19**	**5**	**0**	**12**	**0**	**3**	**6**	**6**	**23**	**4**	
TOTAL for both MMA and Specialty	**104**	**1**	**36**	**32**	**67**	**24**	**3**	**80**	**19**	**41**	**57**	**36**	**101**	**20**	

*The CMS Plan's readiness was handled differently as this contract is with the Florida Department of Health for a non-risk prepaid inpatient health plan (non-risk PIHP) with a payment methodology that includes a settlement back to expense based on fee-for-service Medicaid.

**Same as the MMA plan.

Of the 14 standard areas AHCA reviewed for readiness, the MMA Standard plans had fewer deficiencies in the Care Coordination/Case Management (1) and Finance (3) standard areas. The highest number of deficiencies for the MMA Standard plans were in the Administration and Management (77), Enrollee Materials (48), Grievance System (68), Prescribed Drug Services (51), and Provider Network (78) standard areas. The lowest number of deficiencies for an individual MMA Standard plan was 17, and the highest was 56.

The MMA Specialty plans had fewer deficiencies than the MMA Standard plans. The MMA Specialty plans had no deficiencies in the areas of Care Coordination, Finance and Information Systems and less than five deficiencies in the areas of Claims Management, Marketing, and Quality and Utilization Management. The highest numbers of deficiencies for the MMA Specialty plans were in the Administration and Management (27), Enrollee Materials (19), Grievance System (12) and Provider Network (23) standard areas. The lowest number of deficiencies for an individual MMA Specialty plan was 21, and the highest was 39.

For the MMA Standard and Specialty plans combined, the plans had fewer deficiencies in the Care Coordination/Case Management (1) and Finance (3) standard areas. The highest numbers of deficiencies for the combined MMA Standard and Specialty plans were in the Administration and Management (104), Enrollee Materials (67), Grievance System (80), Prescribed Drug Services (57), and Provider Network (101) standard areas.

Overall, following implementation of the IAPs and continued review by AHCA to ensure compliance, the plans were assessed to have strengths in meeting the requirements for SMMC program operations and for providing care and services to enrollees that met the quality, timeliness, and access standards of Florida's Medicaid program.

Recommendations

AHCA and DOEA conducted comprehensive document and on-site readiness reviews for the SMMC plans from February 2013–June 2014. All of the SMMC plans had areas that required an IAP before AHCA allowed the plan to begin enrollment. All plans completed the work required on the IAP and began enrollment within the allowed time period.

Based on the results of the readiness reviews, HSAG has the following recommendations for the MMA Standard and Specialty plans.

- 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
- Even though not all of the LTC plans were consolidated plans at the time of the readiness reviews, currently all of the LTC plans have been consolidated and are owned and operated by MMA Standard plans. Although the standards that were reviewed for the MMA Standard plans

are slightly different from the LTC plan reviews, the same standard areas may be targeted and reviewed for the LTC plans.

- AHCA may want to provide technical assistance for the SMMC plans to assist the plans in understanding and meeting requirements in these areas that had the highest numbers of deficiencies; which were the Administration and Management, Enrollee Materials, Grievance System, Prescribed Drug Services, and Provider Network standard areas.
- AHCA should ensure that its ongoing compliance monitoring is designed to cover all of the areas required by 42 CFR §438.358, which cites that a state must conduct a review within a three-year period to determine a Medicaid MCO's compliance with federal requirements and standards established by the state for access to care, structure and operations, and quality measurement and improvement.

Deeming Study

Overview

As part of AHCA's CQS review process during SFY 2013–2014, CMS inquired if AHCA was planning on taking advantage of the non-duplication regulations that allow for deemed compliance based on plan accreditation. AHCA responded that it would explore this option with its contracted EQRO, HSAG, to determine if deemed compliance would be beneficial to Florida once the SMMC program was fully implemented.

42 CFR §438.360 gives the option to use information obtained from a Medicare or private accreditation review to demonstrate MCO compliance with the access to care, structure and operations, and measurement and improvement standards. MCOs may be "deemed" compliant when these standards reviewed by an accrediting organization are duplicative of the state's standards for access, structure and operations, and measurement and improvement.

One exception, however, relates to activities required under 42 CFR §438.240(b)(1–2) (for conducting performance improvement projects [PIPs] and for calculating performance measures). These activities present a deeming option only for plans that serve dual-eligible members. Related discussion in the Federal Register, (Vol. 68, No. 16, dated January 24, 2003), page 3,603, supports CMS' decision to continue to require validation activities for PIPs and performance measures regardless of whether compliance is being deemed.

Certain requirements must be met for a state to exercise the deeming option to prevent duplication of reviews of its contracted MCOs:

- The MCO must be in compliance with Medicare or national accreditation organization standards, and those standards must be comparable to the state's standards to comply with 438.204(g) and the EQR-related activity under 438.358 (b)(3).
- The MCO must have achieved "fully accredited" status from the accrediting organization in the areas to be deemed. Fully accredited means that the standards within the deeming category have been surveyed by the accrediting organization and determined to be fully met or otherwise acceptable without significant findings, recommendations, or corrective actions.

- MCO compliance with standards must have been determined by CMS for its Medicare Advantage product line or a private accrediting organization approved by CMS under 422.158. The preamble states that this accreditation is not required to have been performed on an MCO's Medicaid product/population. The MCO must provide all results applicable to standards in 438.204(g) of the Medicare or private accreditation organization review to the state; the state must in turn provide the results to the EQRO.
- The State must identify in its quality strategy the standards for which it will use information from a Medicare or private accreditation organization review and the rationale for why it is duplicative.

As a result of the inquiry by CMS, AHCA contracted with HSAG to conduct the following activities during contract year 2014–2015: (1) review the plans' accreditation status results and submit a summary of findings; and (2) crosswalk the applicable federal managed care regulations to NCQA and Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) standards indicating which federal standards could potentially be deemed, along with any recommendations for non-duplication deeming.

HSAG found that seven Florida Medicaid plans were accredited by NCQA as Medicaid HMOs. Four of these plans received an accreditation status level of "commendable" (a higher status level than "accredited"). One plan received "interim" accreditation, which NCQA awards to plans for 18 months as opposed to three years. Eight plans were accredited by the AAAHC as MCOs. All plans received a score of "substantial" or "full compliance" on all standards reviewed. Only one plan received a majority of "substantial" compliance scores.

HSAG developed and populated crosswalks for the NCQA and AAAHC standards. These national accrediting bodies represented the two predominant types of accreditations achieved or being pursued by the Florida plans. HSAG assessed the degree to which NCQA and AAAHC standards matched the intent of similar federal managed care standards, and thus could be considered "duplicative." HSAG included the applicable federal managed care regulations pertaining to access, structure and operations, and measurement and improvement in the crosswalks. The main standard areas include Access, Structure and Operations, Quality Measurement and Improvement, Grievance System, and Information Requirements. In addition, HSAG included the applicable SMMC core contract provisions in the crosswalks to further describe the State's contract expectations and determine the degree of equivalency between those contract requirements and the standards of each accrediting organization.

HSAG reviewed the NCQA Medicaid Managed Care Toolkit 2014 Health Plan Accreditation Standards (effective July 1, 2014–June 30, 2015), the corresponding Standards Crosswalk, and the 2014 Accreditation Handbook for Health Plans. HSAG also reviewed the 2014 Medicaid Supplement for Health Plans provided by AAAHC which, according to information obtained directly from AAAHC, is the equivalent of a crosswalk of the AAAHC standards to the federal Medicaid managed care requirements.

To determine comparability, HSAG assessed whether each NCQA or AAAHC accreditation standard met the relevant federal requirement in its entirety, partially, or not at all.

Findings

HSAG had the following findings:

- Regarding the actual crosswalks, there were 150 rows in each crosswalk listing the applicable federal requirements. Thirty-five of the 150 rows were either found to be a "state-level requirement" or "not eligible for deeming." An additional five requirements were given an equivalency rating of *Not Applicable*. In summary, 110 rows listed deemable regulations.
- Both NCQA and AAAHC received a majority of *Partially Met* or *Not Met* equivalency ratings. For NCQA, HSAG assessed that 22 percent of the deemable federal regulations would be evaluated (i.e., received a *Met* equivalency) in an NCQA accreditation review. For AAAHC, 16 percent of the deemable federal regulations would be evaluated in an AAAHC accreditation review.
- There were only four federal requirements for which both NCQA and AAAHC received a *Met* equivalency. (See Appendix D.)
- AAAHC received more *Met* equivalency ratings than NCQA in the areas of access, structure and operations, and measurement and improvement.
- AAAHC did not provide information pertaining to Grievance System or Information Requirements in its Medicaid Supplement; therefore, HSAG gave all of those requirements a *Not Met* equivalency rating. As a result, NCQA received far more *Met* equivalency ratings in the areas of Grievance System and Information Requirements.
- In some cases, AHCA contract standards exceeded federal requirements. Therefore, the NCQA and AAAHC crosswalks indicated a *Met* designation for equivalency to the federal requirement, but HSAG noted that the specific AHCA contract standard which exceeded the federal requirement would not be evaluated by NCQA or AAAHC in the accreditation process.

Conclusions and Recommendations

A limited number of federal managed care requirements received a *Met* equivalency rating when compared to NCQA and AAAHC accreditation standards. HSAG recommended that AHCA not "deem" the plans compliant, based on their accreditation status, for any standards that have not been reviewed in the annual compliance reviews. HSAG's recommendation was based on the following:

- As new SMMC plans, none have yet been thoroughly evaluated (i.e., subject to a compliance review in accordance with the CMS protocol) against their current contract requirements. AHCA's last compliance review (SFY 2011–2012) was a limited scope review and previous to implementation of the SMMC program. More recently, AHCA completed readiness reviews for all of the SMMC plans; however, the reviews only covered some of the standards and, although all SMMC plans had been operating in Florida before becoming MMA plans, they were not technically accepting enrollees.
- For eight of the requirements that received a *Met* equivalency for one or both accrediting organizations, the AHCA contract provisions exceeded (are more stringent than) the federal requirements. As such, those standards should be reviewed by AHCA during its compliance review to ensure contract compliance.

If AHCA were to decide to deem plans compliant for those standards that were given a *Met* equivalency, HSAG recommended the following:

- The NCQA and AAAHC standards that received a Met equivalency may be eligible for deeming during the next comprehensive compliance review of standards by AHCA. As noted above, however, AHCA contract provisions exceed (are more stringent than) the federal requirements for eight of these standards. Those eight standards should be reviewed by AHCA.
- To be eligible for deeming, the plan must have received full compliance with the applicable accreditation standard by NCQA or AAAHC. Based on the documentation provided by AHCA for the assessment of plans' accreditation status, HSAG recommended that, where needed, the plans provide additional detail regarding scoring results.
- Based on the timing of the comprehensive compliance review, some plans may have pursued reaccreditation, and those results will need to be obtained and reviewed by AHCA. As noted in the Assessment of Plans' Accreditation Status tables, accreditation with NCQA and AAAHC will expire by February 2016 for 10 plans.

Additionally, regarding the administrative resources necessary to maintain the deemed compliance crosswalks and the Assessment of Plans' Accreditation Status tables, HSAG recommended that AHCA consider the following:

- The deeming crosswalk will need to be reviewed and updated as NCQA and AAAHC update their standards.
- The deeming crosswalk will need to be reviewed and updated as the State's managed care contract is amended to reflect changes in core standards.
- As referenced above, each time a plan is reaccredited, the relevant scores will need to be obtained as these results may make a plan ineligible for deemed status for particular standards.
- Plans may choose to pursue a different accreditation type, such as URAC,[14] which would necessitate completing a crosswalk of those standards.

Finally, if AHCA decides to pursue granting deemed compliance to the plans for specific federal managed care requirements, it must first amend its State quality strategy to include information about AHCA's plan to deem compliance, indicate the scope of the deeming, and list the areas of duplication (federal requirements it intends to deem compliant).

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

[14] URAC is an independent nonprofit organization formerly known as the Utilization Review Accreditation Commission. The organization is now simply referred to as URAC.

and accuracy of these data are essential in the state's overall management and oversight of its Medicaid managed care program.

During SFY 2014–2015, AHCA contracted with HSAG to conduct an EDV study. The goal of the study was to examine the extent to which encounters submitted to AHCA by its MCOs and PIHPs, collectively referred to as "plans," were complete and accurate.

Encounter Date File Review

Based on the approved scope of work, HSAG worked with AHCA to develop the data submission requirements for conducting the EDV study. Once finalized, the data submission requirements were submitted to both the plans and AHCA to guide the extraction and collection of study data. Data were requested for all claims/encounter records with dates of service between January 1, 2013, and March 31, 2014, that were finalized and submitted to AHCA before October 1, 2014. In addition to the file specifications, the data submission requirements also included information on the required data types (i.e., professional, dental, and institutional) and the associated required data elements. HSAG also requested AHCA to provide other supporting data files related to enrollment, demographics, and providers associated with the encounter files.

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

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

Encounter Volume Completeness and Reasonableness

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

Results and MCO Comparison

Overall, total numbers of encounters and total encounters per-member-per-month (PMPM) were reasonably consistent and within expectations across all plans for professional, dental, and institutional encounters. Expectedly, the LTC plans showed higher professional PMPM counts than did the MMA plans. Nonetheless, the review of the encounter data volume highlighted variation in

the overall and month-to-month submission of encounters by type (i.e., professional, dental, and institutional) and source (i.e., AHCA's and plans' submitted encounters).

The largest variation in utilization statistics was noted among institutional encounters. While differences in the volume of encounters existed for professional encounters, these differences were comparatively less disparate when comparing AHCA's and the plans' data. Month-to-month volume trends were also relatively consistent across the data sources. Similarly, differences in the volume of dental encounters also exhibited comparatively equivalent trends in month-to-month encounter data volume. Across professional, dental, and institutional encounters, required data elements such as *Recipient ID*, *Procedure Code*, and *Primary Diagnosis* (excluding dental encounters which did not have diagnosis codes) were consistently complete and contained reasonable values for at least 90 percent of encounters reviewed for AHCA and the plans.

Data volume was not consistent across sources, with AHCA's encounter data showing a consistently greater encounter data volume than the volume reported by the plans. Substantial differences in the volume of institutional encounters were observed when comparing the volume of encounters submitted by plans and AHCA. This discrepancy was largely attributable to the incomplete submission of outpatient encounters by AHCA. Due to incomplete admission and discharge dates in AHCA's outpatient encounter data, at least 2,000,000 ICNs, representing unique encounters, were not extracted for this study. Without the population of key data elements, subsequent processing and reporting of encounter data is affected, severely limiting HSAG's ability to accurately assess the true encounter volume difference for institutional encounters. Further affecting an accurate assessment, one plan (i.e., Amerigroup) stated it submitted plan-denied encounters to both AHCA and HSAG. Inconsistency in the documentation and submission of encounters to AHCA by the plans affects both the completeness and accuracy of encounter data.

Figure 3-25, Figure 3-26, and Figure 3-27 present the overall agreement rates for each of the evaluated data elements for professional, dental, and institutional encounters, respectively.

Figure 3-25—Element Agreement by Key Element for Professional Encounters

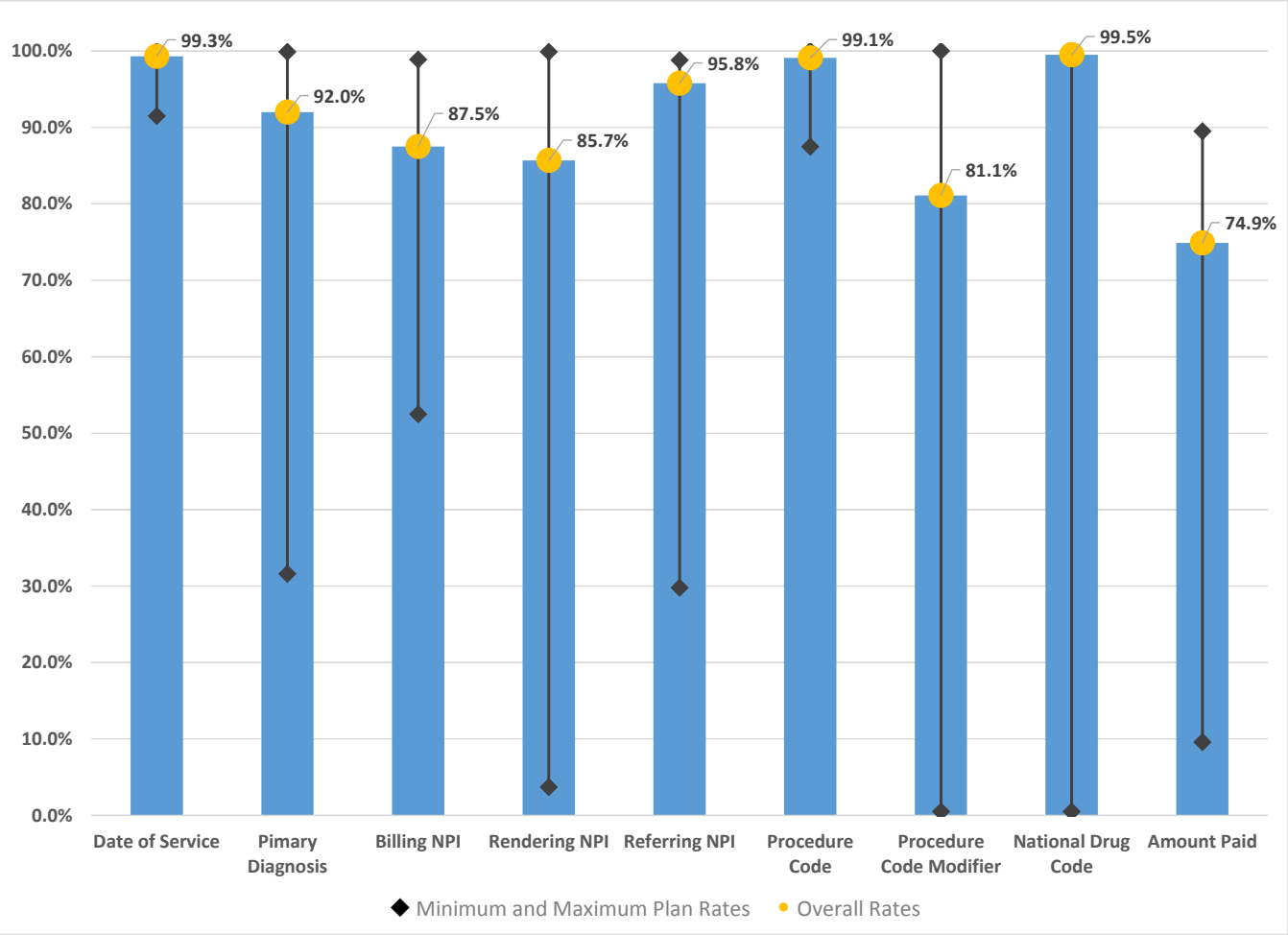


Figure 3-26—Element Agreement by Key Element for Dental Encounters

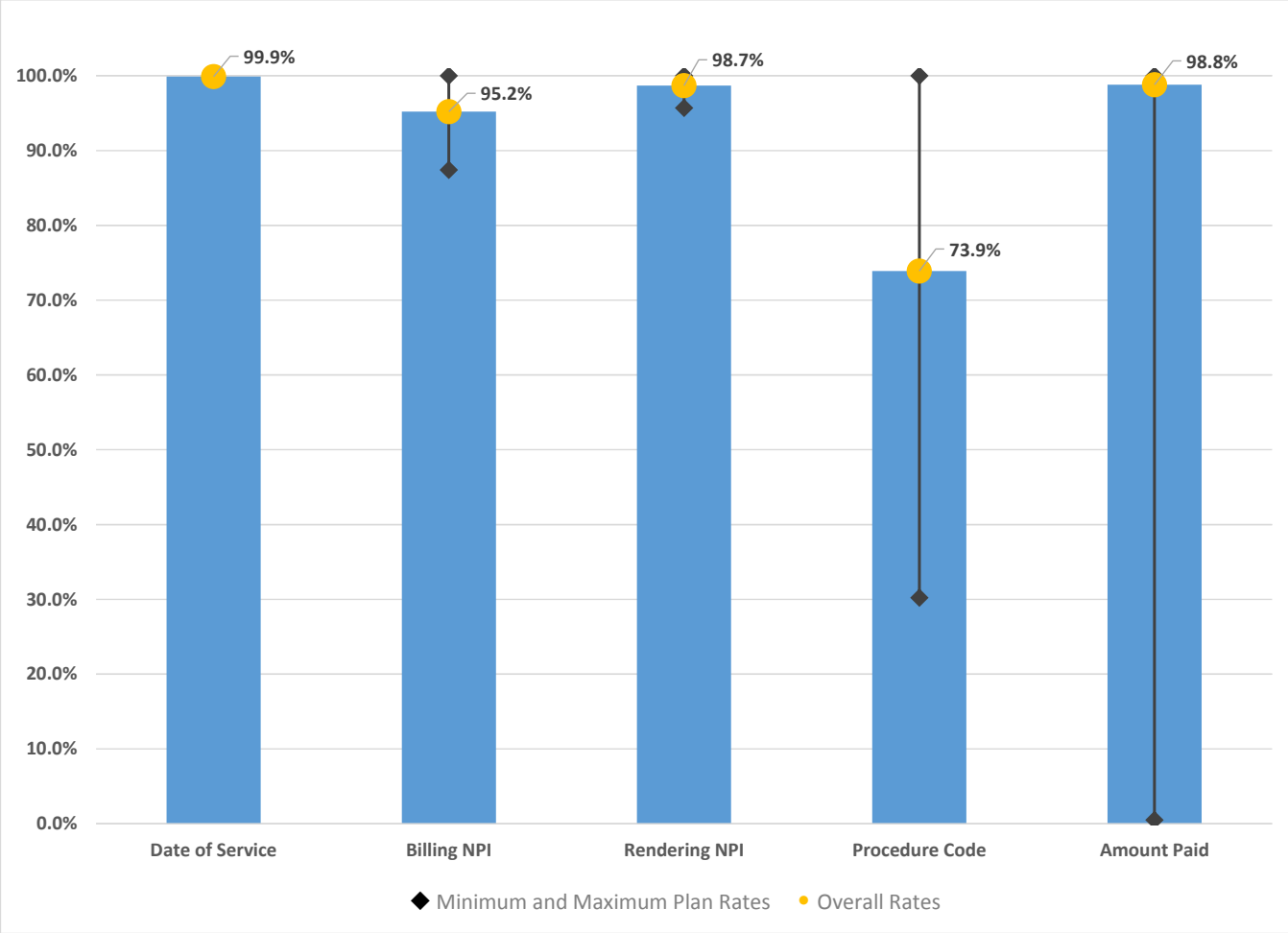
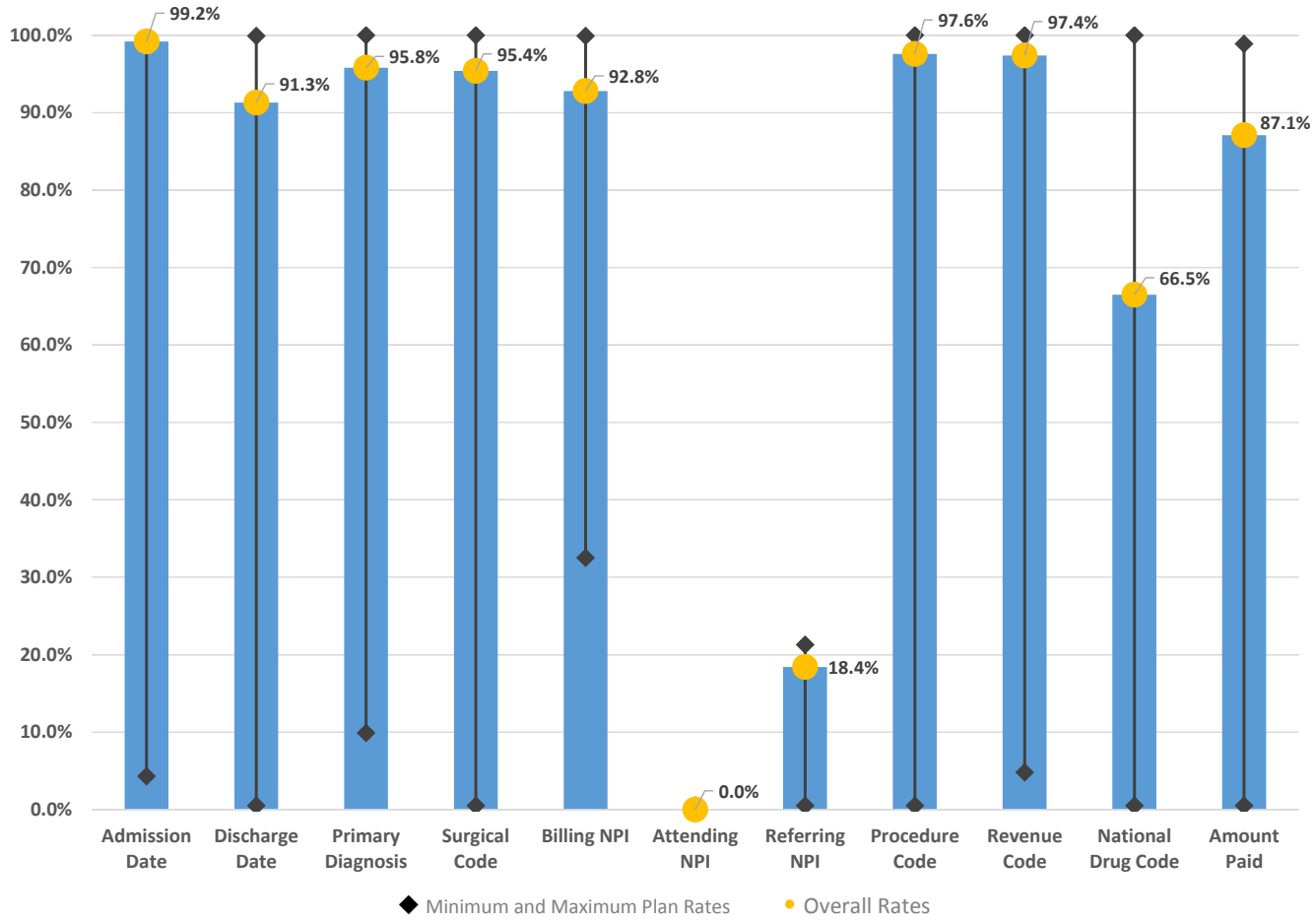


Figure 3-27—Element Agreement by Key Element for Institutional Encounters



Overall, encounter data element agreement for records that could be matched between AHCA's and the plans' submitted professional encounters was high. Key encounter data elements such as *Procedure Code*, *NDC*, and *Primary Diagnosis Code* exhibited at least 90 percent agreement. Similarly, a high level of agreement was also noted for dental encounter data elements, with the exception of *Dental Procedure* Code which only showed a low level of agreement. While the record completeness for institutional encounters was low (i.e., high record omission and surplus), for records that could be found and matched in both data sources, the overall data element agreement was mixed, with some fields exhibiting low levels of agreement. For record-level data completeness, high record omission signifies that a high number of records were present in the plans' submitted files that were not present in Florida's MMIS. Conversely, a high record surplus signifies that a high number of records were present in Florida's MMIS that were not present in the plans' submitted files.

Key encounter data elements associated with situational reporting requirements (e.g., *Diagnosis Code 2*) exhibited considerable variation in the degree of completeness and validity across plans, and in relation to AHCA's encounter data. While these encounter data elements had lower levels of completeness across both sources of data, AHCA's encounters tended to have greater accuracy for populated encounters than the plans' encounters. Incomplete data elements associated with

situational reporting requirements impact the State's ability to identify key clinical populations and the quality of studies that rely on these 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 the purpose of 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 (the plans).

Table 3-6 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.

Table 3-6—Record Omission and Surplus Rates by Encounter Type

Plan	Professional Encounters		Dental Encounters		Institutional Encounters	
	Omission	Surplus	Omission	Surplus	Omission	Surplus
AMG-L	3.9%	14.7%	100.0%	100.0%	14.4%	57.1%
AMG-M	50.4%	23.9%	100.0%	100.0%	90.4%	20.6%
BET-M[1]	1.6%	84.0%	0.1%	45.3%	0.0%	100.0%
CHA-S	0.3%	56.7%	0.0%	87.5%	97.4%	96.5%
COV-L	24.0%	53.4%	10.0%	10.0%	46.0%	66.8%
COV-M	0.2%	21.6%			83.8%	26.0%
FRE-S	0.4%	6.0%	12.8%	0.2%	0.2%	56.6%
HEA-M	0.4%	31.7%	40.0%	92.5%	84.6%	19.4%
HUM-L	12.8%	65.8%			60.7%	77.1%
HUM-M	13.2%	42.1%	1.5%	16.8%	83.7%	29.0%
IHP-M	1.5%	12.3%	66.6%	69.4%	87.8%	15.5%
MCC-S	7.4%	29.0%	3.9%	66.6%	58.2%	41.3%
MOL-L	0.3%	30.1%	0.0%	0.0%	31.2%	21.2%
MOL-M	1.7%	13.9%	0.1%	11.9%	88.7%	42.4%
PHC-S[2]	2.0%	14.1%	0.0%	100.0%	99.7%	99.1%
PRE-M	6.3%	13.6%	43.6%	18.0%	9.3%	35.4%
PRS-M	29.2%	34.0%	0.8%	1.6%	85.3%	70.8%
SHP-M	1.9%	52.3%	55.1%	93.5%	99.7%	99.1%
STW-M	1.2%	27.5%	0.9%	13.1%	83.9%	19.8%

Table 3-6—Record Omission and Surplus Rates by Encounter Type						
Plan	Professional Encounters		Dental Encounters		Institutional Encounters	
	Omission	Surplus	Omission	Surplus	Omission	Surplus
SUN-L	45.5%	63.2%	66.8%	22.2%	66.9%	47.7%
SUN-M	25.6%	20.0%	15.9%	18.2%	83.8%	18.7%
UFS-M	99.5%	99.1%	100.0%	100.0%	99.9%	45.8%
URA-L	36.1%	11.5%	57.8%	3.2%	64.2%	44.4%
URA-M	58.1%	39.3%	74.4%	4.6%	98.1%	71.8%
VIS-M	0.1%	13.5%			86.8%	17.4%
All Plans	**23.7%**	**30.6%**	**11.9%**	**30.0%**	**84.7%**	**41.1%**
Maximum	**99.5%**	**99.1%**	**100.0%**	**100.0%**	**99.9%**	**100.0%**
Minimum	**0.1%**	**6.0%**	**0.0%**	**0.0%**	**0.0%**	**15.5%**

[1] The plan submitted no institutional encounter records and there were less than 30 institutional encounter records submitted by AHCA; therefore, rates should be interpreted with caution.

[2] The plan submitted no dental encounter records and there were less than 30 dental encounter records submitted by AHCA; therefore, rates should be interpreted with caution.

Gray shading indicates no encounter records were submitted by the plan or AHCA.

Table 3-6 highlights the range of omitted and surplus encounters. Of note, dental encounter omissions were the smallest, at 11.9 percent overall, and institutional encounter omissions were the largest, averaging 84.7 percent across plans.

As noted in the Encounter File Review section of this report, the high omission rate for institutional encounters was mostly attributed to the incomplete institutional encounter data submission by AHCA for outpatient encounters. As described earlier, AHCA extracted the institutional encounters based on the admission and discharge dates, which were not consistently collected and populated for outpatient encounters. Consequently, approximately 2,000,000 ICNs were not submitted to HSAG and were classified as omitted from AHCA's data.

Unlike the record omission rates, the record surplus rates showed less variation across the three encounter types. Dental encounters had the lowest record surplus rate of 30.0 percent, while the professional and institutional encounters reported 30.6 percent and 41.1 percent, respectively.

For professional encounters, the record omission rates for 13 of the plans (AMG-L, BET-M, CHA-S, COV-M, FRE-S, HEA-M, IHP-M, MOL-L, MOL-M, PHC-S, SHP-M, STW-M, and VIS-M) were less than 5 percent, indicating that relatively few professional encounters reported by these plans were not reported by their respective plans in AHCA's encounter data. However, the remaining plans exhibited record omission rates ranging from 12.8 percent (HUM-L) to 99.5 percent (UFS-M).

For professional encounters, the record surplus rates were greater than 10 percent for all plans except one (FRE-S), indicating that relatively high numbers of professional encounters were reported by these plans in AHCA's encounter data but were not found in the respective professional encounters the plans submitted to HSAG. The individual plan rates ranged from 6.0 percent (FRE-S) to 99.1 percent (UFS-M).

Of the plans with dental encounter records, the record omission rates were less than 5.0 percent for eight plans (BET-M, CHA-S, HUM-M, MCC-S, MOL-L, MOL-M, PRS-M, and STW-M). The remaining plans exhibited record omission rates that ranged from 10.0 percent (COV-L) to 100.0 percent (AMG-L, AMG-M, and UFS-M). The plans exhibited record surplus rates ranging from 10.0 percent (COV-L) to 100 percent (AMG-L, AMG-M, PHC-S, and UFS-M).

Of the 25 plans reporting institutional encounters, all except five (AMG-L, COV-L, FRE-S, MOL-L, and PRE-M) reported record omission rates greater than 50 percent. While these results would generally indicate that large numbers of institutional encounter records reported by more than three-fourths of the plans were not reported by their respective plans in AHCA's institutional encounters, these results were skewed due to AHCA's incomplete institutional encounter data submission for outpatient encounters.

Of the 25 plans reporting institutional encounters, nine of the plans (AMG-M, COV-M, HEA-M, HUM-M, IHP-M, MOL-L, STW-M, SUN-M, and VIS-M) reported surplus rates less than 30 percent. The remaining plans exhibited record surplus rates ranging from 35.4 percent (PRE-M) to 100.0 percent (BET-M). It is important to note that while the record surplus rate was 100.0 percent, there were fewer than 10 of such records. For seven of the plans (COV-L, FRE-S, HUM-L, PRE-M, SUN-L, URA-L, and URA-M), the majority of records that were reported in AHCA's institutional encounter data but not in the plans' data consisted of either outpatient or LTC encounters. Also, the surplus rates for four plans (SUN-L, SUN-M, URA-L, and URA-M) were attributed to duplicate records that had either different paid amounts or paid dates in AHCA's encounter data.

Encounter Field Completeness and Reasonableness

To determine the completeness and reasonableness of the plans' and AHCA's electronic claims/encounter data, HSAG examined the percentage of key data fields (e.g., *Recipient ID*, *Provider NPI*, *Diagnosis Code*, *Procedure Code*, *Revenue Code*, *NDC*, etc.) that contained data and were populated with expected values. Percentages were based on all records submitted with the assumption that encounters were in their final status as requested in the data submission requirements document. Key data fields with missing values were evaluated for completeness, but they did not contribute to calculations for accuracy (i.e., 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 for which the *Recipient ID* field was populated with a value of "000000000" would be considered to have a value present, but the value would not be considered valid.

Results and MCO Comparison

For professional encounters, the completeness and validity fluctuated across data sources and elements, and for individual plans. *Recipient ID* was the sole data element with less than 0.1 percent missing values and at least 95 percent valid values across both plans' and AHCA's data. *Primary Diagnosis Code* and *Procedure Code* completeness was relatively high for plans' and AHCA's encounters, though validity for both data elements varied for AHCA encounters.

The professional encounter data from AHCA were generally less complete for key data elements than encounter data from plans, though AHCA values simultaneously demonstrated higher ranges of validity for eight of 10 elements. Although this trend could be somewhat expected among data

elements with situational submission requirements, it is important to note that plan-specific AHCA completeness values were generally lower than those observed in the corresponding plans' encounter data. Rate differences ranged from a low of 0.1 percent for *Recipient ID*, to a high of 24.3 percent for *Rendering Provider NPI*. Many elements had substantial differences between plan-specific, percent-missing rates for plan and AHCA data values. For example, COV-L and HUM-L had rate differences of 74.2 percent and 61.8 percent, respectively, for *Primary Diagnosis Code*, where plan data were nearly 100 percent complete, but the corresponding AHCA encounters for these plans had many missing values. Contrarily, there were also instances of plan data having higher percent-missing rates than AHCA data. This was observed to a greater extent among the *Billing Provider NPI*, *Rendering Provider NPI*, and *Referring Provider NPI* elements.

For dental encounter data, completeness and validity fluctuated for two of the four key data elements. Data completeness was consistently high for plan- and AHCA-based encounter data for *Recipient ID* and *Procedure Code* (both data sources had average percent missing rates at or below 1 percent). There was also consistency between percent valid rates for plan- and AHCA-based data for *Procedure Code* (both data sources had rate ranges spanning less than 2 percentage points). For *Recipient ID,* percent valid rates from the plans' data demonstrated much more variation than rates based on AHCA's data (rate range spans of 100 percentage points versus 0 percentage points, respectively). There were two plans with percent valid rates of 0.0 percent (AMG-L and AMG-M) for *Recipient ID*, which greatly affected the range of values for this specific data element. Considerable variation in plan-specific percent-missing and percent-valid rates was observed among both data sources for the data elements *Billing Provider NPI* and *Rendering Provider NPI*. The differences in plan-specific percent-missing rates across data sources were also considerably high for *Billing Provider NPI* and *Rendering Provider NPI*. Average rate differences for these data elements were 24.6 and 30.8 percent, respectively.

The completeness and validity of institutional encounters fluctuated across data sources, data elements, and individual plans. Twenty-four of 25 plans submitted data for institutional encounters, which included inpatient and outpatient visits. (BET-M submitted no institutional encounters, and AHCA submitted four institutional encounters for this specific plan). The most complete data elements in regard to plan- and AHCA-based electronic encounters were the following: *Recipient ID*, *Primary Diagnosis Code*, *Procedure Code,* and *Revenue Code.* These elements had average percent-missing rates less than 1.0 percent from both data sources. Percent-valid rates were generally high across both data sources, although some outliers were observed. For *Primary Diagnosis Code*, the range of percent-valid rates from the plans' data had a low value of 70.7 percent (PHC-S), while the range for AHCA's data had a low value of 99.7 percent (HUM-L). The range of percent-valid rates from AHCA's data also exhibited low values for *Procedure Code* and *Revenue Code* (for MCC-S, both elements had low values of 80.4 percent). Percent-valid rates were consistently above 90.0 percent for all data elements with situational reporting requirements except for NDC (average percent-valid rate of 60.3 percent). Percent-valid rates were not calculated for plans that did not submit institutional encounter data for particular elements, and encounters that had missing values were not incorporated into percent-valid calculations.

The completeness and accuracy of AHCA's documentation for key data elements also varied across plans. High numbers of missing values were observed for some data elements with situational reporting requirements (*Surgical Code 2, Surgical Code 3, Surgical Code 4,* and *NDC*), though others had moderate to very minimal rates of missing values. However, many of these elements displayed wide ranges of plan-specific rates for missing values in spite of low averages. Though

three plans (AMG-L, COV-L, and HUM-L) had percent-missing rates greater than 80.0 percent for this data element, this finding does not account for 19 of 23 plans having percent-valid rates of 0.0 percent.

Of particular interest for the institutional datasets are the discrepancies in completeness for plan- and AHCA-based encounter data. In some instances, plan-based, percent-missing rates were lower than AHCA-based, percent-missing rates, and vice versa. When plan-based, percent-missing rates were higher than AHCA-based, percent-missing rates, one of two assumptions could be made: the plan did not submit data to HSAG for assessment, or the plan had inconsistent documentation of specific data elements in its records (which could only be verified through medical record review). The former assumption is especially relevant to the higher average percent-missing rate differences observed for some of the data elements with situational reporting requirements (*Diagnosis Code 2*, *Diagnosis Code 3*, *Diagnosis Code 4*, *Primary Surgical Code*, *Surgical Code 2*, *Surgical Code 4,* and *Referring Provider NPI*).

Medical Record Review

Medical records are considered the "gold standard" for documenting Medicaid enrollees' access to and quality of services. The file review and comparative analysis portions of the study seek first to determine the completeness and validity of AHCA encounter data, and then to determine how comparable these data are to the plan data on which they are based. Medical record review further assesses data quality through investigating the completeness and accuracy of AHCA encounters compared to the information documented in the corresponding medical records of Medicaid enrollees.

Enrollees' medical information was matched across data sources (AHCA encounters and physician-submitted medical records) using the unique combination of the enrollee's Medicaid ID and the identification number of the rendering provider for a specific date of service. A back-match file was created containing encounters for enrollees who were seen more than once by the same provider within the study period, and these encounters represented additional dates of service. This section presents findings from the results of the medical record review to examine the extent to which services documented in the medical record were not present in the encounter data (an encounter data omission), as well as the extent to which services documented in the encounter data were not present in the enrollees' corresponding medical records (a medical record omission).

A total of 1,234 cases were requested from the 25 plans reporting into FMMIS for medical record cross validation of AHCA encounter data. Overall, 1,261 medical records were reviewed which included dates of service from the original sample cases (n=981), as well as those with an additional date of service submitted by the plan providers (n=280). Of note, the medical record submission rate for original dates of service varied considerably across participating plans, ranging from 14.0 percent to 100 percent submission.

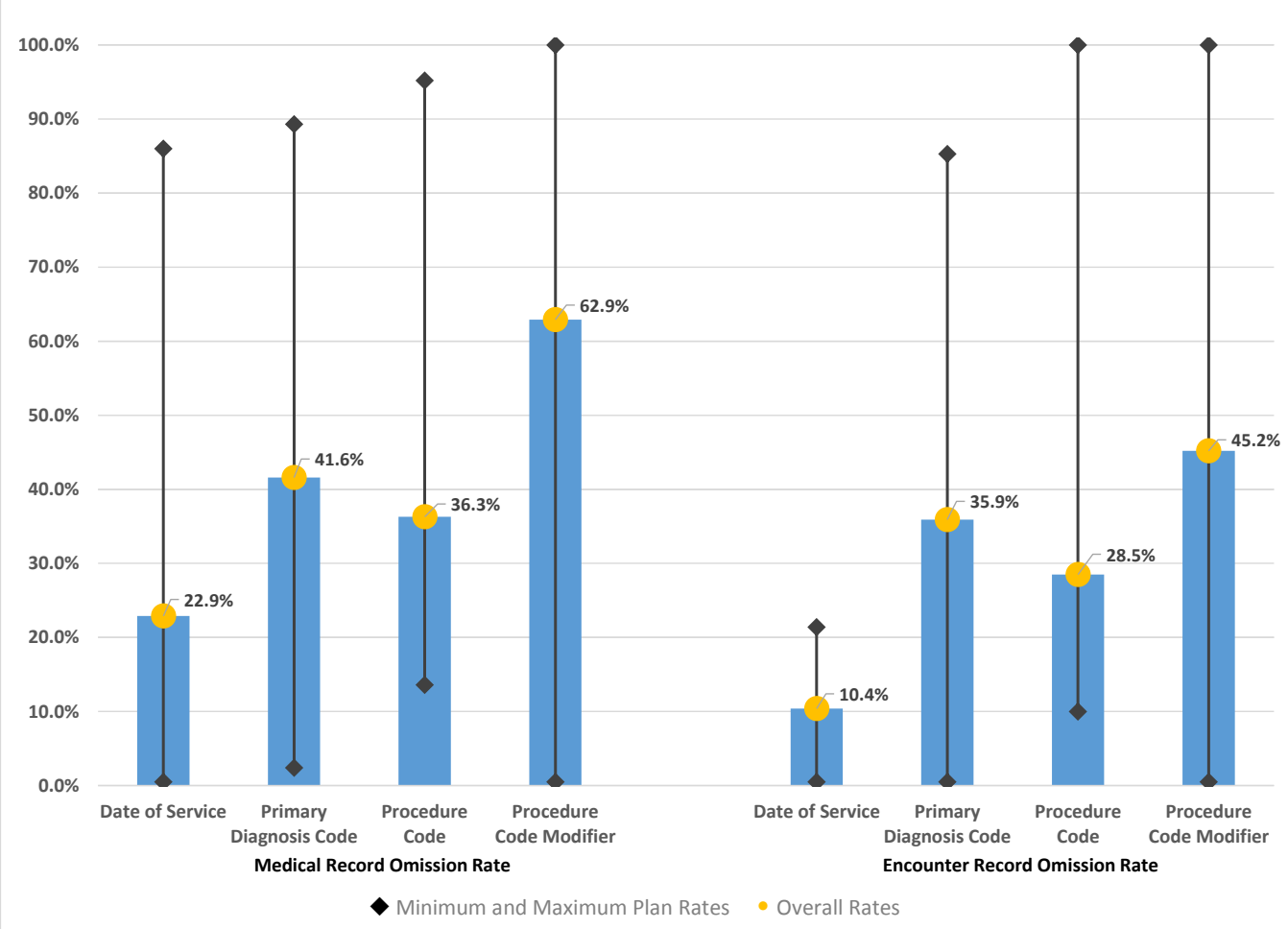
Encounter Data Completeness

HSAG evaluated encounter data completeness by identifying differences between key elements of AHCA-based encounters and the corresponding medical records submitted for the analysis. These elements included date of service, diagnosis codes, procedure codes, and procedure code modifiers.

Medical record omission and encounter data omission represent two aspects of encounter data completeness through their identification of vulnerabilities in the process of claims documentation and communication between providers, plans, and AHCA.

Medical record omissions occurred when an encounter data element was not documented in the medical record associated with that specific AHCA encounter. Encounter data omissions occurred when an encounter data element was documented in the medical record but was not found in the associated AHCA encounter, or when there was no corresponding AHCA encounter for an additional date of service submitted by a provider. Both situations suggest opportunities for improvement in the areas of claims submissions and/or processing routes among the providers, plans, and AHCA. Figure 3-28 displays the medical record and encounter record omission rates by key element.

Figure 3-28—Medical Record and Encounter Record Omission Rates by Key Element



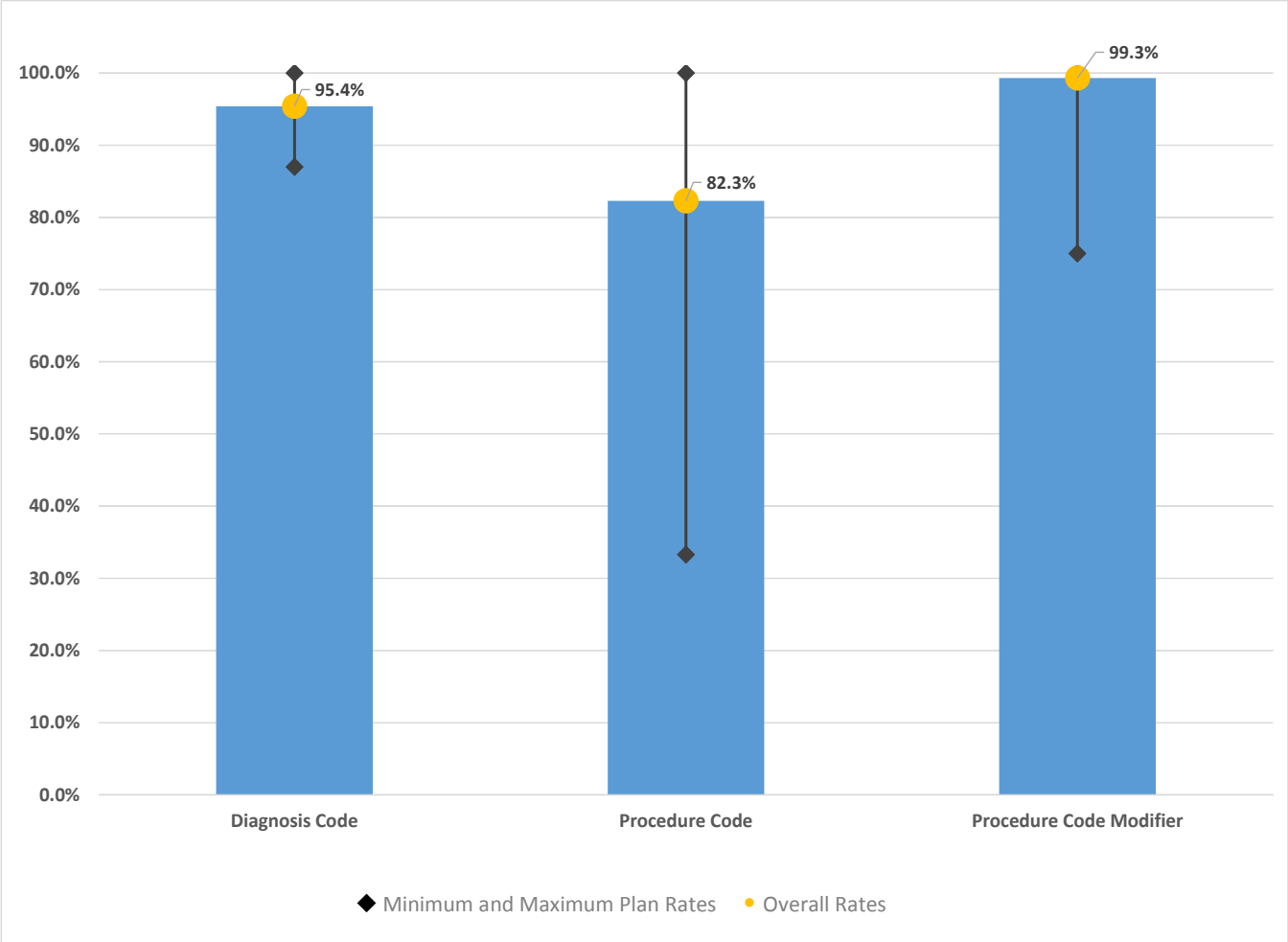
Overall, Medical record omission and encounter data omission varied substantially across all plans for all key data elements. Omissions identified in the medical records and in the encounter data suggest substantive discrepancies in the completeness of AHCA's encounter data, which was only moderately supported by the clinical documentation in enrollees' medical records. More specifically, 22.9 percent of the dates of service, 41.6 percent of diagnosis codes, 36.3 percent of

procedure codes, and 62.9 percent of procedure code modifiers identified in AHCA's encounter data were not present in enrollees' corresponding medical records. These findings show that, relative to enrollees' medical records, FMMIS contains incomplete and inaccurate data, and that additional evaluations should be conducted to understand factors impacting data transmissions between the plans and AHCA. Similarly, 10.4 percent of the dates of service, 35.9 percent of diagnosis codes, 28.5 percent of procedure codes, and 45.2 percent of procedure code modifiers identified in enrollees' medical records were not present in AHCA's encounter data. This finding shows that some data elements recorded and available in enrollees' medical records are not submitted, or not accepted, into FMMIS.

Encounter Data Accuracy

Encounter data accuracy was evaluated for dates of service that existed in both AHCA records and submitted medical records, with values present in both data sources for the evaluated data element. HSAG assessed the accuracy of encounter data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) based on medical record documentation and support of values contained in analogous fields in AHCA encounter records. Higher accuracy rates for each data element indicate better performance. Figure 3-29 displays the encounter data element accuracy rates.

Figure 3-29—Encounter Data Element Accuracy Rates



Results and MCO Comparison

Overall, encounter data element accuracy was high, with 95.4 percent of diagnosis codes, 82.3 percent of procedure codes, and 99.3 percent of procedure code modifiers validated and supported by clinical documentation in enrollees' medical records. While accuracy for key data elements was high, only 31.9 percent of the validated dates of service were accurately represented in all three data elements (*Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) when compared to enrollees' medical record documentation. This finding suggests that submission of encounter data elements is frequently deficient, leading to overall inaccuracy of the clinical record contained in the State's encounter data.

Table 3-7 presents the percentage of each type of error associated with errors found in the procedure codes. The types of errors found in the procedure codes are categorized into the following three categories:

- **Inaccurate codes:** Procedure codes for which the documentation in the medical records did not support the procedure codes billed, or an incorrect procedure code was used in the encounter for scenarios other than the two mentioned above, were classified as incorrect coding errors.
- **Higher level of service in medical records:** Focusing on Evaluation and Management (E & M) codes, procedure codes for which medical records reflected a higher level of service than that documented in AHCA encounter records were classified as higher level of service errors.
- **Lower level of service in medical records:** Focusing on E & M codes, procedure codes for which medical records reflected a lower level of service than that documented in AHCA encounter records were classified as lower level of service errors. This would include instances in which a provider's notes were missing or were lacking critical documentation elements of the E & M service, or the problem treated did not warrant a high-level visit.

Inaccurate codes and codes with a higher/lower level of service in medical records were collectively considered as the denominator for the error type rates in Table 3-7.

Table 3-7—Error Types for Procedure Code by Plan

Plan	Percent From Inaccurate Code	Percent From Higher Level of Service in Medical Records	Percent From Lower Level of Service in Medical Records
AMG-L	0.0%	0.0%	100.0%
AMG-M	20.0%	60.0%	20.0%
BET-M	58.8%	11.8%	29.4%
CHA-S	9.1%	27.3%	63.6%
COV-L	75.0%	25.0%	0.0%
COV-M	10.0%	30.0%	60.0%
FRE-S	33.3%	22.2%	44.4%
HEA-M	21.4%	50.0%	28.6%
HUM-L	NA	NA	NA
HUM-M	46.7%	40.0%	13.3%
IHP-M	38.9%	38.9%	22.2%
MCC-S	65.4%	7.7%	26.9%
MOL-L	100.0%	0.0%	0.0%

Table 3-7—Error Types for Procedure Code by Plan			
Plan	**Percent From Inaccurate Code**	**Percent From Higher Level of Service in Medical Records**	**Percent From Lower Level of Service in Medical Records**
MOL-M	47.1%	5.9%	47.1%
PHC-S	21.1%	0.0%	78.9%
PRE-M	0.0%	100.0%	0.0%
PRS-M	21.7%	30.4%	47.8%
SHP-M	33.3%	50.0%	16.7%
STW-M	40.9%	22.7%	36.4%
SUN-L	100.0%	0.0%	0.0%
SUN-M	27.3%	45.5%	27.3%
UFS-M	NA	NA	NA
URA-L	NA	NA	NA
URA-M	25.0%	0.0%	75.0%
VIS-M	37.5%	31.3%	31.3%
All Plans	**37.0%**	**26.4%**	**36.6%**
Minimum	**0.0%**	**0.0%**	**0.0%**
Maximum	**100.0%**	**100.0%**	**100.0%**

"NA" indicates there were no records present; therefore, rates were not able to be reported.

Overall, of the 273 procedure code agreement errors, 37.0 percent were due to inaccurate coding, 26.4 percent were due to higher level of service miscoding, and the remaining 36.6 percent were due to lower level of service miscoding.

Conclusions

Encounter Data File Review

The initial review of encounter data illustrated differences in the overall and month-to-month volume of encounters by type and source. While both professional and dental encounters exhibited similar patterns in encounter data volume and month-to-month trends when comparing AHCA and plan encounter data submissions, AHCA consistently reported approximately 2,000 more encounters per month than the plans submitted. Institutional encounters, however, exhibited a greater amount of variation when comparing the volume of encounters documented by the plans versus AHCA. Due to incomplete documentation of the admission and discharge dates in AHCA's outpatient encounters, AHCA was unable to extract these records completely. Since outpatient encounters generally comprise a large proportion of institutional encounters, the exclusion of the encounters from AHCA's encounter data had a large impact on the overall completeness of AHCA encounters. Despite this discrepancy, the assessment of volume trends suggested fairly consistent documentation and submission encounter data trends for all plans and AHCA with regard to professional and most dental encounters.

Completeness of enrollee encounters varied more by data element than by data source or specific plan. In general, the level of completeness and accuracy associated with key encounter data elements was primarily related to whether the element represented a required encounter data element or was situational. Across professional, dental, and institutional encounters, *Recipient ID*, *Primary Diagnosis Code* (excluding dental encounters, which had no diagnosis codes) and *Procedure Code* were consistently complete and valid for at least 90 percent of encounters submitted from both plans and AHCA. Data elements with situational reporting requirements did not exhibit the same levels of completeness, validity, or consistency across plans and data sources. With regard to professional encounters, *Diagnosis Codes 2–4*, *NDC*, and both *Rendering* and *Provider NPI* fields exhibited varying levels of completeness in both plan and AHCA encounter data. However, AHCA encounters indicated a higher level of accuracy than plan encounters. Differences in the completeness and accuracy are likely due either to incomplete documentation of key data elements by the plans or AHCA or the possibility that AHCA and the plans may have submitted incomplete and/or invalid encounters to HSAG. With regard to dental encounters, the same pattern was observed for *Rendering Provider NPI*, with a high degree of variation in completeness rates exhibited across plans for data submitted by the plans and AHCA. The majority of data elements with situational reporting requirements had higher average percent-missing rates from plan-based versus AHCA-based encounters.

Though the importance of data elements with situational reporting requirements appears minimal by nature of their classification, their presence and accuracy were vital to the subsequent analytical components of the EDV. The comparative analysis component of assessment matched submitted plan encounters to their respective AHCA encounters and assessed how thoroughly both data sources documented key data elements. The differences in completeness and accuracy rates observed in the file review ultimately impact the omission, surplus, and accuracy rates calculated in the comparative analysis and medical record review.

Comparative Analysis

Record Completeness

Overall, among the three encounter types (i.e., professional, dental, and institutional), dental encounters exhibited the most complete data with the lowest record omission and record surplus rates—i.e., 11.9 percent and 30.0 percent, respectively. Institutional encounters were comparatively incomplete with the highest record omission and record surplus rates—i.e., 84.7 percent and 41.1 percent, respectively. These discrepancies were mostly attributed to the incomplete institutional encounter data submission by AHCA for approximately 2,000,000 unique ICNs due to incomplete data for admission and discharge dates.

Record omission and record surplus rates varied considerably across plans for each of the three encounter types. For professional encounters, FRE-S reported some of the lowest record omission and record surplus rates (i.e., 0.4 percent and 6.0 percent, respectively), indicating relatively complete professional encounter records. Conversely, UFS-M had the highest record omission and record surplus rates of 99.5 percent and 99.1 percent, respectively, indicating incomplete professional encounters. The discrepancies for professional encounters for UFS-M were due to enrollment in different types of services—i.e., "Transportation Only" and "Behavioral Health Only." PRS-M showed the most complete dental encounter records with low record omission and record surplus rates of 0.8 percent and 1.6 percent, respectively, while AMG-L, AMG-M, and UFS-

M demonstrated the least complete dental encounter records. For these three plans, no dental records matched between AHCA's encounter data and the data submitted by the plans.

In general, the record omission and surplus rates were high across all plans for institutional encounters. While the record omission and surplus rates were high across all plans, MOL-L, comparatively, showed the most complete institutional encounter records with a record omission rate of 31.2 percent and a record surplus rate of 21.2 percent. Three plans, CHA-S, PHC-S, and SHP-M, reported record omission and surplus rates of more than 95 percent. Some of the primary factors contributing to overall record incompleteness were as follows:

- Omitted and surplus professional encounters were associated with enrollees enrolled in different types of services (e.g., transportation only services versus behavioral health services only).
- Omitted and surplus dental encounters were associated with enrollees, rather than encounters, missing from one of the two data sources.
- Incomplete data submission due to the lack of admission and discharge dates of service in AHCA's outpatient encounters.
- Differences in the presence of duplicated encounters across data sources.

Encounter Data Element Completeness

Overall, the level of completeness for key encounter data elements across all three encounter types was high (i.e., low overall omission and surplus rates), with the overall element omission and element surplus rates below 10 percent for nearly all evaluated encounter data elements. Encounter data elements associated with less completeness were generally attributed to one of the provider fields.

At the plan level, there was considerably more variation. For professional encounters, *Referring Provider NPI* exhibited the greatest amount of variation in omission rates among the plans, while the greatest amount of variation in surplus rates was associated with *Primary Diagnosis Code*. The level of variation in the omission rates was less dramatic among the plans for dental encounters, whereas the amount of variation in the surplus rates was considerably larger for the following data elements: *Line Date of Service*, *Billing Provider NPI*, and *Rendering Provider NPI*. For institutional encounters, the encounter data element omission and surplus rate differences between plans was mixed. While the omission rates for nearly half of the evaluated data elements exhibited minimal variation across plans (i.e., a difference of less than 10 percentage points), omission rates for the *Diagnosis Code 2*, *Diagnosis Code 3*, and *Procedure Code* were characterized by large differences.

Encounter Data Element Agreement

Overall, high encounter data element agreement for matching records was found between AHCA's and the plans' submitted professional encounters. Key encounter data elements such as *Procedure Code*, *NDC*, and *Primary Diagnosis Code* exhibited at least 90 percent agreement. Similarly, a high level of agreement was also noted for dental encounter data elements, with the exception of *Dental Procedure Code* which showed only a low level of agreement. While the record completeness for institutional encounters was low, for records that could be found in both data sources, the overall data element agreement was mixed, with some encounter data elements exhibiting low levels of agreement.

The agreement rate varied across plans and evaluated data elements for each of the assessed encounter types. For professional encounters, large variations among plans were noted for one-fourth of the evaluated data elements, while for the remaining data elements, rate differences were less than 15 percent. The agreement rate variations among plans for the majority of the evaluated dental data elements were minimal, with plan rate differences of no more than 15 percentage points. Likewise, the agreement rates among plans also varied substantially for the majority of the evaluated institutional data elements, with the exception of data element *Referring Provider NPI*. Nearly half of the evaluated date elements (*Diagnosis Code 2*, *Diagnosis Code 3*, *Primary Surgical Procedure*, *Surgical Procedure Code 3*, *Surgical Procedure Code 4*, *Procedure Code*, *Procedure Code Modifier 1*, and *NDC*) had plan-specific agreement rates ranging from 0.0 percent to 100.0 percent. Of note, seven plans (AMG-L, AMG-M, COV-M, MOL-L, MOL-M, URA-M, and VIS-M) reported agreement rates of at least 95 percent in all but two of the evaluated data elements. Conversely, two plans (CHA-S and SHP-M) reported less than 75 percent in all of the evaluated data elements.

Medical Record Review

Medical Record Submission

Of the 1,234 sample cases requested for medical record review, 981 (79.5 percent) were submitted by the plans. Overall, 1,261 medical records were reviewed which included dates of service from the original sample cases (n=981), as well as those with an additional date of service submitted by the plan providers (n=280). Among the 253 medical records that were not submitted, provider refusal was the primary reason medical records were not submitted by the participating plans, responsible for 192 of the 253 missing records (75.9 percent). Of note, the medical record submission rate for original dates of service varied considerably across participating plans, ranging from 14.0 percent to 100 percent submission.

Encounter Data Completeness

The assessment of enrollees' medical records showed mixed results related to medical record omission rates. While omission rates for dates of service and procedure codes identified in AHCA encounter data were moderate, diagnosis codes and procedure code modifiers exhibited high rates of omission. Both findings suggest key elements documented in enrollees' medical records are not consistently submitted or processed into FMMIS. As a result of the overall date of service omission rate (i.e., 22.9 percent), the high omission rates for the diagnosis codes, procedure codes, and procedure code modifiers (i.e., 41.6 percent, 36.3 percent, and 62.9 percent, respectively) were anticipated. Importantly, preliminary file review of AHCA's encounter data demonstrated high percent-missing rates for diagnosis and procedure codes according to situational reporting requirements. Furthermore, medical record omission rates for all key data elements varied considerably across plans, with differences reported for every encounter data element ranging at least 80 percentage points between the lowest and highest observed rates.

The most common reasons for medical record omission rates included the following: provider refusal (75.9 percent), record could not be located (17.0 percent), poor documentation in the record (5.9 percent), or the record submitted was incorrect (1.2 percent). A total of 66 records could not be matched with AHCA encounter data due to different dates of service. Other reasons included the provider not performing the service(s) documented in the AHCA encounter; and system restrictions

on the number of diagnosis codes, procedure codes, or procedure code modifiers processed and stored by AHCA that may differ from the encounter data elements submitted by the plans.

Assessment of encounter data omission rates revealed that not all services documented in enrollees' medical records were submitted to or processed and stored by AHCA. Though encounter data omission rates for key data elements were generally lower than medical record omission rates, 35.9 percent of diagnosis codes, 28.5 percent of procedure codes, and 45.2 percent of procedure code modifiers found in enrollees' medical records were missing from the respective AHCA encounters. Medical records with date of service discrepancies did not completely account for the omission of other key data elements. *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* omission rates varied considerably for plans as well. Common reasons for encounter data omissions included coding errors made by a provider's billing office, deficiencies in plans' data submission or resubmission processes (for denied or rejected encounters), and submission of nonstandard procedure codes and procedure code modifiers.

Encounter Data Element Accuracy

Overall, encounter data element accuracy was high, with 95.4 percent of diagnosis codes, 82.3 percent of procedure codes, and 99.3 percent of procedure code modifiers validated and supported by clinical documentation in enrollees' medical records. However, while accuracy for key data elements was high, only 31.9 percent of the validated dates of service were accurately represented in all three data elements (*Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) when compared to enrollees' medical record documentation. This finding suggests that submission of encounter data elements is frequently incomplete, leading to overall inaccuracy of the clinical record contained in the State's encounter data.

Recommendations

Based on HSAG's review of the encounters submitted by AHCA and the plans, HSAG noted several opportunities for continued improvement in the overall quality of Florida's encounter data. While some of the discrepancies noted are related to processing problems associated with the preparation of data, high rates of omissions, surpluses, and errors, coupled with variation between plans and encounter types, suggest systemic issues with the transmission of data between the plans and FMMIS. To ensure the success of future encounter data validation activities and the quality of encounter data submissions from contracted health plans, the following recommendations have been identified as potential opportunities for improvement.

- **AHCA should work with the plans to investigate and reconcile identified differences in the monthly encounter data volume.** Although professional and dental encounter data volumes were similar between AHCA- and plan-submitted encounter data, variation among plans and encounter types, along with differences in overall volume, suggest potential deficiencies in the data. Ideally, AHCA's encounter system should accurately capture all encounters—both paid and denied—to account for all encounter information transmitted between the plans and the State.

- **AHCA should continue to work with its MMIS and DSS teams to implement quality controls to ensure the accurate production of standard data extracts and reports.** Through the development of standard data extraction procedures and quality controls, the number of errors associated with extracted data could be reduced. Moreover, stored procedures can be reused with minimal changes for future studies. Sufficient processes and training should be put in place to ensure the data are thoroughly validated for accuracy and completeness prior to submission and delivery. As of April 2015, AHCA began exploring how encounter data are pulled from its DSS to determine how to proceed with standardizing encounter data extraction procedures.
- **AHCA should investigate the quality of the *Admission Date* and *Discharge Date* encounter data elements for outpatient institutional encounters.** As noted in this study, both fields were poorly populated and led to omissions in the encounter data submitted by AHCA. As a result, confidence in the analysis and trending of encounter data volumes between AHCA and the plans was limited. AHCA could implement a time-limited workgroup to evaluate the factors contributing to the lack of values in these fields and work with affected stakeholders to implement solutions.
- **AHCA should review its encounter data submission standards and automated edits to ensure they meet agency needs and expectations.** As with most Medicaid programs, it is critical that agencies continually evaluate their data needs and uses. As federal and State reporting of plan and program performance have become increasingly important, expectations need to be modified to ensure all data suppliers are submitting the necessary data to ensure complete and accurate reporting. Additionally, the high number of missing or inaccurate provider-related encounter data elements (e.g., *Billing Provider NPI*) indicates that ongoing review of plan processes for tracking and submitting provider information is critical to overall encounter data quality accuracy. As the basis for calculation of numerous State and federal performance measures, accurate and complete submission of rendering, billing, and attending physician information is becoming increasingly important.
- **AHCA should also continue its efforts to work with the plans to explore reasons and resolutions for incomplete encounter data submission rates.** As of April 2015, AHCA reported that since September 2014, Medicaid Fiscal Agent Operations and Hewlett-Packard (HP) Provider Support have worked together to develop an encounter data support process. This effort created an HP Operational Support Unit that specifically works with the plans to improve encounter data submission issues including both timeliness and accuracy. This unit works with the plans through a dedicated email account, on-site plan visits, webinars, and conference calls. An issues log process was implemented to track and resolve technical and policy-related issues. AHCA hired a dedicated staff person in the Medicaid Fiscal Agent Operations Unit to support these efforts and to also be a contact for the plans for encounter data submissions.
- **AHCA should review, and modify as needed, existing plan contracts and encounter submission guidelines to include language outlining specific requirements for submitting complete data to AHCA.** Modifications to the contract or supplemental guidelines should include explicit definitions of the types of encounters to be submitted—e.g., paid, denied, other, etc. As the ultimate payer, AHCA's encounter data system should comprise a complete record of all transactions processed and maintained by the plans and downstream contractors. At the time of this study, considerable variation was noted in the types of encounters submitted by the plans to AHCA leading to differences in overall encounter data volume. If all types of

encounters (e.g., paid, denied, etc.) are not submitted to and accepted by AHCA, claims paid at the plan level but denied during AHCA's processing of the encounter will not be available to AHCA for use in monitoring and reporting activities. In addition, to ensure complete data, contracts should specify every critical element (e.g., provider data, etc.) needed for contract and program monitoring.

- **AHCA should consider developing a monitoring strategy to routinely examine encounter volume on a regular basis.** As part of a larger encounter data quality strategy or program, these metrics would help ensure timely identification of potential problems and establish expectations of contracted plans. Additionally, implementation of a performance monitoring system could lead to the development of performance standards which can be used to monitor plan performance as well as a means to monitor contract compliance. AHCA can monitor encounter volume by provider type, place of service, type of service (e.g., vision, lab), etc.
- **AHCA should work with the plans to develop a monitoring program that requires the plans to audit provider encounter submissions for completeness and accuracy.** AHCA may also want to require the plans to develop periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with the plans. In addition, HSAG recommends that AHCA consider requiring the plans to perform periodic reviews of submitted claims to verify appropriate coding and completeness to ensure encounter data quality.

Focused Study—Cultural Competency

Overview of Focused Study

To comply with a request from CMS to include additional information in future external quality review reports related to cultural considerations, AHCA requested that HSAG perform a statewide focused study related to cultural competencies, with the goal of assisting AHCA and its SMMC plans in identifying areas and strategies for improvement. HSAG completed a review and analysis of each plan's most recent cultural competency plan (CCP) and the plan's evaluation of its CCP from the previous year. The primary objective of this review was to provide meaningful information to AHCA regarding the SMMC plans' contract and regulatory compliance (State and federal) and consistency with National CLAS Standards in the area of cultural competency.

HSAG developed a data collection tool (study tool) to use in the review of each plan to assess contract and regulatory compliance and consistency with "best practices" to evaluate the cultural competency performance of each SMMC plan. The study tool was divided into two sections: Federal and State Contract Requirements (five State contract standards that related to the requirements of a plan's CCP) and National CLAS Standards (15 standards). HSAG obtained information from the MMA Model Contract—Core Contract Provisions, federal managed care regulations, National CLAS Standards, and cultural competency best practice literature to develop the study tool.

The study was conducted on all SMMC plans: MMA Standard, MMA Specialty, and LTC plans. One cultural competency plan was submitted by the plan for all lines of business/contract types;

therefore, for comprehensive plans, HSAG reviewed one cultural competency plan. This equated to 19 cultural competency plans in total.

Literature Review

As part of the study, HSAG conducted a literature review of cultural competency best practices, which included several websites and resources. The results of this research clearly indicated that adoption of the National CLAS Standards is considered a best practice. Other common themes (many of which are integrated into these standards) regarding implementation of cultural competency within healthcare organizations also emerged and include:

- Leadership involvement.
- Ongoing training for new employees, with specialized training for job functions such as member and provider services.
- Organizational self-assessment.
- Demographic data to understand the unique needs of their membership.

Many organizations, including Georgetown University's National Center for Cultural Competence (NCCC), cited the work of Cross et al, 1989,[15] when defining and addressing the core principles of cultural competence. On its website, NCCC included a selection of cultural competence definitions, including its own from 1998[16], which were modified from Cross et al:

Cultural competence requires that organizations:

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally.
- Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of communities they serve.
- Incorporate the above in all aspects of policymaking, administration, practice, and service delivery; and systematically involve consumers, families, and communities.

An important component of the literature review involved the CLAS standards that the Office of Minority Health (OMH) developed in 2000. From 2010–2012 OMH conducted the National CLAS Standards Enhancement Initiative to establish a new benchmark for culturally and linguistically appropriate services. The initiative led to the creation of the Enhanced National CLAS Standards (referred to as CLAS Standards from this point forward in the report). The OMH publication, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice* (also known as *The Blueprint*), contained extensive information regarding the development of the CLAS Standards and strategies

[15] Cross, T, et al. *Towards A Culturally Competent System of Care, Volume I.* Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center. 1989.
[16] National Center for Cultural Competence. "Definitions of Cultural Competence" Curricula Enhancement Module Series; Georgetown University. Available at: http://nccccurricula.info/culturalcompetence.html. Accessed on: January 28, 2016.

for implementation of each. The 15 CLAS Standards are organized into one Principal Standard and three themes as listed below. As noted in *The Blueprint,* if all other standards are met, Standard 1 is also achieved. Although each standard is important, the goal is for organizations to implement all 15 standards, in order to "…advance health equity, improve quality, and help eliminate health care disparities."[17]

- Principal Standard (Standard 1)
- Governance, Leadership, and Workforce (Standards 2–4)
- Communication and Language Assistance (Standards 5–8)
- Engagement, Continuous Improvement, and Accountability (Standards 9–15)

Research conducted by *The New England Journal of Medicine* and documented in the article, "Culturally and Linguistically Appropriate Services—Advancing Health with CLAS"[18] provided examples of how healthcare organizations are implementing CLAS Standards specific to the three themes. A selection of those examples is noted below.

- Governance, Leadership, and Workforce: National Quality Forum identified leadership as one of seven primary domains for measuring and reporting cultural competence. Other organizations promote CLAS and health equity policies through their mission, vision, or values statements.
- Communications and Language Assistance: California's Alameda Alliance for Health included a multifaceted approach to language assistance, including, but not limited to, remote interpreting systems and "I speak . . ." cards with which clients indicate their language needs, and verbal contact with the Member Services Department.
- Engagement, Continuous Improvement, and Accountability: In its resource manual for stakeholders, *Making CLAS Happen*, the Massachusetts Department of Public Health recommended using "cultural brokers," such as community health workers or *promotores de salud,* as bridges to people of various cultural backgrounds.

Summary of Study Results

State and Federal Requirements

HSAG reviewed each plan's CCP and evaluation document and scored each element as *Met, Partially Met,* or *Not Met.* (For additional information regarding scoring, please see the Methodology Section in Appendix A.) All CCPs included at least some of the components of each standard; therefore, the lowest score for any of these standards was *Partially Met*. (For plan-specific scores by contract standard, in addition to the plan's overall score, and the statewide score for each standard, please see the summary of the results in Table F-1 of Appendix F).

[17] U.S. Department of Health and Human Services, Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services in Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice*. Available at: http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf. Accessed on: Apr 26, 2016.

[18] Koh H, Gracia N, Alvarez M. Culturally and Linguistically Appropriate Services—Advancing Health with CLAS. *New England Journal of Medicine*. Available at: http://www.nejm.org/stoken/default+domain/Permissions-HHS/full. Accessed on: Mar 30, 2015.

Standard 1: The managed care plan (MCP) shall have a comprehensive written cultural competency plan (CCP) describing the MCP's program to ensure that services are provided in a culturally competent manner to all enrollees (including those with limited English proficiency), for all services and within all service settings.

Due to the broad scope of this standard, HSAG developed a minimum set of required elements (to use in conjunction with the contract language) to score this standard. Required elements included: (1) demographic analysis, (2) goals and/or objectives, (3) employee training, (4) provider training, and (5) translation services. Although this did not imply that HSAG believed this list represented a comprehensive number of required elements, it was used to evaluate each plan consistently.

The statewide score for this standard was 63 percent, with only five plans receiving a *Met* score. For the 14 plans that received a *Partially Met* score, the prevalent reason was that the CCP did not include a demographic description of the plan's membership. For LTC and MMA Specialty plans, in some cases the CCP referenced neither the special populations served nor the membership's unique cultural needs. Three plans also did not specifically address the needs of members with limited English proficiency.

Standard 2: The CCP must describe how providers, MCP employees, and systems will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms, and respects the worth of the individual enrollees and protects and preserves the dignity of each.

The statewide score for this standard was 87 percent, with 14 plans receiving a *Met* score and five plans receiving a *Partially Met* score. For those that received a *Partially Met* score, the prevalent reason was that the CCP did not address religion in its vision, mission, or any other statements that alluded to the standard. In some cases religion was referred to in anti-discrimination hiring practices but was not included in regard to cultural competency.

Standard 3: The MCP shall complete an annual evaluation of the effectiveness of its CCP.

The statewide score for this standard was 100 percent. All plans submitted an evaluation and therefore received a *Met* score for this standard. Specific deficiencies, if any, with the evaluation were noted in the comments sections for Standard 4 and Standard 5 on the plan-specific study tools.

Standard 4: The MCP's evaluation of its CCP may include results from CAHPS or other comparative member satisfaction surveys, outcomes for certain cultural groups, member grievances, member appeals, provider feedback, and MCP employee surveys.

The statewide score for this standard was 87 percent, with 14 plans receiving a *Met* score and five plans receiving a *Partially Met* score. For those plans that received a *Partially Met* score, the prevalent reason was that the evaluation did not include results from any of the suggested data sources in the standard or included data from other sources, but did not describe how this information was used to evaluate the effectiveness of the CCP.

Standard 5: A description of the MCP's evaluation of its CCP, its results, the analysis of the results, and interventions to be implemented shall be described in the CCP submitted to the Agency annually by June 1 of each contract year.

The statewide score for this standard was 79 percent, with 11 plans receiving a *Met* score and eight plans receiving a *Partially Met* score. For those plans that received a *Partially Met* score, the prevalent reasons were (1) the evaluation did not include an analysis of results, (2) the evaluation did not include interventions to be implemented, and (3) there was not a direct link between the CCP and the evaluation.

National CLAS Standards

One of the primary objectives of this review was to provide meaningful information to AHCA regarding the SMMC plans' consistency with CLAS Standards in the area of cultural competency. Since it is not mandated that the plans adhere to these standards, in place of traditional scoring, HSAG indicated whether the plan demonstrated adherence to the CLAS Standards in its CCP by marking each standard *Yes* (Y) or *No* (N). (For plan-specific *Yes* or *No* (Y/N) scores by standard, in addition to the plan's overall score and the statewide score for each standard, please see the summary of results, broken out by the four main CLAS Standard headers in Table F-2 of Appendix F.)

Standard 1: Principal Standard

As noted in the CLAS Standards Overview section above, standards 2 through 14 generally must be met to denote adherence to the Principal Standard (Standard 1). Amerigroup was the only plan whose CCP demonstrated adherence to all CLAS Standards with the exception of Standard 7. Amerigroup met part of this standard and therefore received a Yes score for the Principal Standard.

Standards 2–4: Governance, Leadership, and Workforce

For this group of standards that focus on leadership, training, and recruitment, the majority of plans did well, with a statewide average of 80 percent. Two plans received a *No* score for Standard 2 and one plan received a *No* score for Standard 4. For Standard 3, the statewide average was 58 percent, with eight plans receiving a *No* score. One of the key components of Standard 3 is to make efforts to recruit a workforce that is representative of the population the plan serves. Those plans whose CCP did not adhere to this standard did not describe efforts to recruit an employee workforce that is representative of the population in the plans' service area. In some cases the CCP referenced having bilingual staff but did not describe the workforce beyond that statement, nor did it discuss recruitment efforts in general.

Standards 5–8: Communication and Language Assistance

These four standards focus on providing language assistance, both verbally and in writing, in a variety of formats. All plans received a *No* for Standard 7 because they did not include information that the use of untrained individuals and/or minors as interpreters should be avoided. Three plans received a *No* score for Standard 5, due to not specifically addressing the needs of members with limited English proficiency. The statewide average for this grouping of standards, without Standard 7, is 82 percent; with Standard 7 it is 62 percent.

Standards 9–15: Engagement, Continuous Improvement, and Accountability

This is the largest group of standards, and it is also the group for which the largest number of CCPs did not demonstrate adherence to the standards. The statewide score for this group of standards was 53 percent, with statewide scores for each standard ranging from 11 to 89 percent. The majority of plans' CCPs did not demonstrate adherence to standards 12, 13, and 15.

Standards 12, 13, and 15 pertain to conducting assessments of community needs, partnering with the community to inform and evaluate plan practices and policies, and communicating the plan's progress regarding its CLAS activities.

The prevalent reasons the plans received a *No* score for these standards based on their CCPs was either the lack of discussion of community involvement or inclusion of a broad statement of community involvement without a description of specific activities that would demonstrate adherence to these three CLAS Standards. (For further illustration of plan comparisons, please see Table F-3 in Appendix F, which includes select highlights for each plan: (1) overall score for federal and State contract requirements, (2) examples of areas for improvement, and (3) examples of strengths and/or best practices).

Recommendations

Plans

The majority of the plans met the minimum federal and State contract requirements, as evidenced by 14 plans receiving a score of 80 percent or higher. However, common areas for improvement that are applicable to many, if not all plans, emerged from analysis of the review findings.

Demographic Description of Membership/Scope of Cultural Competence

Many plans took a narrow approach to describing their membership and the unique needs of the various communities served in that much of the information was limited to race and/or ethnicity and language preference. In many cases, plans did not specify which counties they served or if they were a Specialty or LTC plan. In addition, the cultural needs of specific populations were not discussed.

Recommendations:

- The CCP should indicate if the plan is an MMA Standard, MMA Specialty, LTC, or comprehensive plan and provide a demographic description of membership accordingly.
- MMA Specialty plans should recognize the unique cultural needs of the communities and groups of members they serve.
- All CCPs should indicate which counties the plan serves and the unique cultural needs of those counties. For example, the demographics of Miami-Dade County versus a northern county may have distinct cultural and linguistic needs that should be recognized in the CCP.
- Demographic information and analysis should be expanded beyond race, ethnicity, and language preference.

- Cultural needs of the aged, disabled, homeless, and Gay-Bisexual-Lesbian-Transgender (GBLT) communities should be addressed.
- All CCPs should recognize religion as part of cultural competency.

Language Assistance/Translation Services

Some plans described language assistance and translation services in broad terms instead of specifically addressing how services are provided in a culturally competent manner to those members with various communication needs.

Recommendation:

- All CCPs should specifically address the communication needs of members with limited English proficiency, limited reading proficiency, hearing impairment, and visual impairment. The availability of sign language interpreters, large print materials, audio tapes, and access to TTY/TDD should also specifically be addressed.

Plan Evaluation of Previous Year's CCP

All plans approached the CCP and evaluation of the prior year's CCP as two distinct functions and documents. In many instances, this led to the evaluation document including much of the same information that was in the CCP (which in most cases was redundant). In some cases, information that should have been in the CCP was contained in the evaluation document. Due to the distinction between the two documents, there was no connection between the evaluation of the CCP leading to improvements or interventions for next year's CCP. Many plans included analysis of language preference and race and/or ethnicity in the evaluation document but did not demonstrate how this analysis led to revising the next year's CCP.

Recommendations:

- There should be a direct link between the evaluation and the CCP. The evaluation should include an analysis of the successes and challenges in meeting the prior year's CCP goals and/or objectives. The results of that analysis should be applied to updating the annual CCP, as necessary.
- A link between analysis of demographic information and objectives of the CCP should be made.

AHCA

As noted previously, there was wide variation and depth to the CCPs and evaluation documents, with some limited to two pages and others more extensive and comprehensive. This may be the result of broad contract language that does not provide enough specificity for the plans, which may indicate a need for more direction from AHCA.

Recommendations:

- Develop a detailed cultural competency policy that includes the minimum required elements of a CCP. Consider developing a "Checklist of Required Elements" as an attachment to the policy.
- Update the core contract language to refer to a CCP policy, if a policy is developed.

- Require that the findings from the evaluation be applied to updating the annual CCP, as necessary.
- Provide specificity to the evaluation portion of the CCP, noting that an analysis of the success in meeting goals and objectives must be included.
- Consider requiring plan adherence to some, if not all, of the CLAS Standards. If so, develop clear guidance on the minimum requirements to meet each standard.

Child Health Check-Up Participation Rates

States are responsible for providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services to all Medicaid-eligible children younger than 21 years of age. Florida's CHCUP program includes comprehensive and preventive health services provided according to the State's Child Health Check-Up Coverage and Limitations Handbook. Florida plans are contractually required to submit an annual report that includes basic data elements specified by the State. An independent auditor must certify the data. The State requires plans to screen at least 80 percent of those enrolled in the program for at least eight months. The State also requires the health plans to meet a participation goal of 80 percent. Plans that do not achieve the 80 percent screening and participation goals must submit a corrective action plan to the State and are subject to liquidated damages. The most recent (October 1, 2013, to September 30, 2014) CHCUP statewide screening rate was 95 percent, and the participation rate was 53 percent.

Medicaid Health Plan Report Card

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

The first Medicaid Health Plan Report Card was based on HEDIS 2014 data (i.e., CY 2013 data reported in 2014). Individual performance measures are used to compare plans and are rolled up into six performance measure categories:

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

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

Medicaid benchmarks published by NCQA, using a 5-star rating scale. The third annual report card, to be published in 2017 and subsequent report cards will include enrollees and services under the MMA plan contracts. Only those who have been enrolled in plans for a specified amount of time are included in measure calculations.

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

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

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

Plan Accreditation Results

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

Validation of Performance Improvement Projects

Objectives

As part of the State's quality strategy, each plan was required by AHCA to conduct PIPs in accordance with 42 CFR §438.240. The purpose of these PIPs was to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical care as well as services in nonclinical areas. For the projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, the PIPs must be designed, conducted, and reported using sound methodology and must be completed in a reasonable time. This structured method of assessing and improving plan processes is expected to have a favorable effect on health outcomes and member satisfaction. As one of the mandatory EQR activities required under the BBA, HSAG validated the PIPs through an independent review process that followed CMS' *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012[19]. The primary objective of the PIP validation was to determine compliance with requirements set forth in 42 CFR §438.240, including:

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

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

Description of Data Obtained

Data obtained for the validation of PIPs was taken from the HSAG PIP Summary Forms completed by the plans and submitted to HSAG between July and October 2014. The plans did not submit study indicator results during this validation cycle because none of the PIPs had progressed beyond the Design stage.

[19] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2013.

Technical Methods of Data Collection/Analysis

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

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

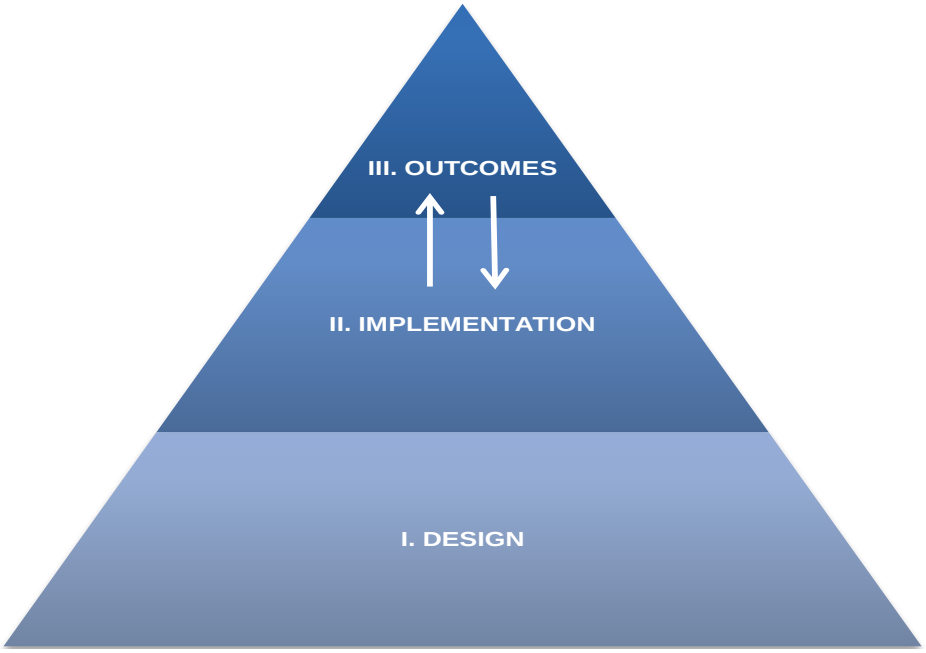
HSAG obtained the data needed to conduct the PIP validation from the plans' PIP Summary Forms. These forms provided detailed information about each plan's PIPs related to the activities completed by the plan and evaluated by HSAG for the SFY 2014–2015 validation cycle.

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

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

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

Figure A-1—PIP Stages



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

Validation of Performance Measures

Objectives

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

For MMA Standard and Specialty plans (collectively referred to as "plans" in this section), AHCA required that the plans undergo an NCQA HEDIS Compliance Audit on the performance measures selected for reporting. To avoid any redundancy in the auditing process, HSAG evaluated the NCQA HEDIS Compliance Audit process in light of the steps described in the CMS protocol. AHCA required the LTC plans to undergo a PMV process conducted by an external audit firm, according to the CMS protocol. However, since some of the measures required to be reported are HEDIS measures, AHCA intended that an NCQA HEDIS Compliance Audit be conducted to the extent possible. Due to slightly different validation processes, while the information obtained from the plans is similar, the technical methods used for the PMV are different from those used for the NCQA HEDIS Compliance Audit.

Description of Data Obtained

Since the plan audits were performed by NCQA-licensed organizations (LOs) during SFY 2014–2015, HSAG's role was to determine the extent to which the measures reported to AHCA were calculated according to AHCA's specifications. HSAG conducted its PMV activity for these plans during SFY 2015–2016. In general, three primary data sources were used to conduct the PMV audits: the Roadmap, final audit results, and the FAR.

For these audits, data were obtained from the customized Information Systems Capabilities Assessment Tool (ISCAT), requested documents, and performance measure rates provided by the plans.

Technical Methods of Data Collection/Analysis

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

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

Table A-1—Key PMV Steps Performed by HSAG
Pre-On-Site Visit Call/Meeting—HSAG verified that the LOs addressed key HEDIS topics, such as timelines and on-site review dates.
HEDIS Roadmap Review—HSAG examined the completeness of the Roadmap and looked for evidence in the FARs that the LOs completed a thorough review of all components of the Roadmap.
Software Vendor—HSAG assessed whether a vendor was contracted to calculate and produce the rates for the required measures, and if this software vendor achieved full measure certification status by NCQA for the reported HEDIS measure. Where applicable, the NCQA Measure Certification letter was reviewed to ensure that each measure was under the scope of certification. Otherwise, HSAG examined whether source code review was conducted by the LOs (see next step below).

Table A-1—Key PMV Steps Performed by HSAG
Source Code Review— HSAG ensured that if a software vendor with certified measures was not used, the LOs reviewed the plans' programming language for HEDIS measures. Source code review was used to determine compliance with the performance measure definitions, including accurate numerator and denominator identification, sampling, and algorithmic compliance (ensuring that rate calculations were performed correctly, medical record and administrative data were combined appropriately, and numerator events were counted accurately).
Primary Source Verification—HSAG verified that the LOs conducted appropriate checks to ensure that records used for HEDIS reporting matched primary data source records. This step is to determine the validity of the source data used to generate the HEDIS rates.
Supplemental Data Validation—If the plan used any supplemental data for reporting, the LO was to validate the supplemental data according to NCQA's guideline. HSAG verified whether 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 (MRR) validation process, the LOs identified whether a convenience sample was required, and if not, whether specific reasons were documented.
MRR—HSAG examined whether the LOs performed a re-review of a random sample of medical records based on the NCQA medical record review (MRR) validation protocol to ensure the reliability and validity of the data collected.
MCO Quality Indicator Data File Review—HSAG evaluated whether there was any documentation in the FAR to show that the LOs performed a review of the plan quality indicator data file. The plans are required to submit a health plan quality indicator data file for the submission of audited rates to AHCA. The file should comply with the AHCA-specified reporting format and contain the denominator, numerator, and reported rate for each performance measure.

To evaluate a plan's capabilities for accurate rate reporting, HSAG reviewed each FAR submitted by the plans to confirm/evaluate the LO's assessment of IS capabilities,[20] specifically focusing on aspects of the plan's system that could affect the AHCA measure reporting set.

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

For each HEDIS measure, the range of plan performance is shown in the figures using vertical grey lines, with green horizontal bars representing the AHCA performance targets, generally established

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

based on the HEDIS national Medicaid 75th percentiles. This provides a picture of the range of plan performance relative to the AHCA-established performance targets. The figures also include the statewide weighted averages when the AHCA performance targets are available.

Encounter Validation Study

During SFY 2014–2015, AHCA contracted with HSAG to conduct an EDV study. The goal of the study was to examine the extent to which encounters submitted to AHCA by its contracted MCOs and PIHPs (collectively referred to as "plans" in this section) were complete and accurate.

Objectives

The SFY 2014–2015 EDV study included two evaluation components: (1) a comparative data analysis of encounter data, and (2) a medical record review. Combined, these approaches addressed the following study objectives:

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

Encounter Data File Review and Comparative Analysis

Description of Data Obtained

Based on activities defined in CMS's protocol for encounter data validation[21] (i.e., analyses of plan electronic encounter data for accuracy and completeness), the comparative data analysis evaluates the extent to which encounters submitted by the plans and maintained in FMMIS (and the data subsequently extracted and submitted by AHCA to HSAG) are accurate and complete when compared to data submitted by the plans to HSAG. The comparative analysis examined professional, institutional, and dental encounters with dates of service between January 1, 2013, and March 31, 2014. The professional encounters include services such as physician visits, nursing visits, laboratory tests, radiology services, durable medical equipment (DME), etc. Institutional encounters, on the other hand, include services such as inpatient or outpatient services, dialysis centers, birthing centers, and other institutional services.

The comparative analysis involved three key steps:

[21] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 4 Validation of Encounter Data Reported by the MCO*. Protocol 4. Version 2.0. September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2013.

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

HSAG prepared and submitted data submission requirement documents to AHCA and the plans in October and December 2014, respectively. These documents included a brief description of the SFY 2014–2015 EDV study, a description of the review period, requested encounter data types, required data elements, and the procedures for submitting the requested files. The encounter data fields requested by HSAG included key data elements to be evaluated in the EDV study. AHCA and the plans were requested to submit all encounter data records with dates of service between January 1, 2013, and March 31, 2014, and submitted to AHCA before October 1, 2014, to HSAG for processing. The requested data were limited to encounters in their final status and excluded encounters associated with interim adjustment history.

HSAG conducted multiple technical assistance sessions with AHCA and the plans to facilitate accurate and timely submission of data. For the plans, HSAG held two technical assistance sessions after distributing the data submission requirements documents, allowing the plans time to review and prepare any questions in advance of the sessions. During these technical assistance sessions, HSAG's EDV team introduced the SFY 2014–2015 EDV study and reviewed the data submission requirements to ensure that all questions related to data preparation and extraction were addressed. Following the completion of the technical assistance sessions, HSAG provided a question and answer (Q&A) document to the plans that addressed plan-specific questions during the sessions as well as questions sent via email. The plans were given approximately one month to extract and prepare the requested files for submission to HSAG. Similarly, HSAG met regularly with AHCA staff to review the data request documents to address any questions related to the submission of data to HSAG.

Technical Methods of Data Collection/Analysis

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

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

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

Preliminary File Review

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

- **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 ICD-9 codes in the diagnosis field.*

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

Comparative Analysis

The comparative analysis evaluated the extent to which the values populated for key encounter data elements in AHCA's data matched those in the encounter data submitted by the plans. The 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 but not in the files submitted by the plans.*

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

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

Medical Record Review

Description of Data Obtained

Medical 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 plans' encounter data through medical record review. A maximum of 50 records per plan were reviewed.

Table A-2 displays the data elements evaluated in the medical record review by encounter type. Pharmacy encounters and certain ancillary outpatient services (i.e., laboratory, radiology, and transportation) were excluded from the medical record component of the study.

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

Key Data Fields	Professional	Dental	Institutional
Date of Service	√	√	√
Diagnosis Code	√		√
CPT/CDT/HCPCS Code/Surgical Procedure Code	√	√	√
Procedure Code Modifier	√	√	√

To be eligible for the medical record review component of the EDV study, an enrollee must have been enrolled in a plan as of March 31, 2014, and must have had at least one visit during the study period (i.e., April 1, 2013—March 31, 2014). For enrollees not enrolled in a LTC plan, the enrollee must have been continuously enrolled in the same plan between April 1, 2013, and March 31, 2014, with no gaps. However, due to changes in plan operations, the continuous enrollment criteria were modified for three plans:

- Clear Health Alliance: October 2013–March 2014 (i.e., six months continuous enrollment)
- First Coast Advantage Central, LLC: April 2013–February 2014 (i.e., 11 months continuous enrollment)
- Magellan Complete Care: October 2013–March 2014 (i.e., six months continuous enrollment)

Continuous enrollment criteria were not applied for enrollees enrolled in LTC plans due to the plans' implementation dates. As a result, a second date of service was not evaluated as part of the medical record review for LTC plans.

Technical Methods of Data Collection/Analysis

AHCA encounter data from the comparative analyses, plan-based enrollment data, and provider data were used in the selection of medical record review samples. HSAG employed a two-stage stratified sampling design to ensure that (1) an enrollee's record was selected once, and (2) the number of encounters included in the final sample accounted for all available encounter types in approximate proportion to the total distribution of encounters. First, HSAG identified all enrollees

by encounter type and by plan, and determined the required sample size of each encounter type based on the total distribution of enrollees. HSAG then randomly selected the enrollees from each encounter type based on the required sample size. Once sample enrollees were selected, HSAG identified all encounters associated with an enrollee and randomly selected one date of service to represent the final sampled case. The final sample consisted of a maximum of 50 cases across the three encounter types per plan.

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

When the sample was finalized, the associated dates of service and service providers were identified for each sampled enrollee. The plans were responsible for coordinating the medical record procurement process with their contracted providers. HSAG worked with the plans to monitor the record submissions from their targeted providers.

Concurrent with the record procurement activities, HSAG trained the EDV review staff on the specific study protocols and conducted interrater reliability and rater-to-standard testing. All reviewers had to achieve a 95 percent accuracy rate before they were allowed to review medical records and to continue collecting data for the study.

During the medical record review, trained reviewers first verified whether the sampled date of service could be found in the enrollee's medical record. If the date of service did not match the State's encounter data, the reviewers identified the date of service as a *medical record omission*. 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 date elements (see Table A-2). All findings were entered into an electronic medical record abstraction tool to ensure data integrity.

After evaluating the selected date of service, the reviewers determined whether a second date of service during the study period was available for review in the submitted medical record. If the documentation for a second date of service was available, a review of the services rendered on the second date of service was conducted that validated its key encounter data elements. If the second date of service was missing from AHCA's encounter data, it was listed as an *encounter data omission*. The missing values associated with this date were listed as an omission for each key data element, respectively.

Medical Record Review Indicators

Once the medical record abstraction was completed, HSAG's analysts exported the abstraction data from the electronic tool, reviewed the data, and conducted the analysis. HSAG developed four study indicators to report the medical review results:

- **Medical Record Omission**—the percentage of dates of service identified in the electronic encounter data that were not found in the enrollees' medical records. HSAG also calculated this rate for the other key data elements in Table A-2.

- **Encounter Data Omission**—the percentage of dates of service from enrollees' medical records that were not found in the electronic encounter data. HSAG also calculated this rate for the other key data elements in Table A-2.
- **Coding Accuracy**—the percentage of diagnosis codes, procedure codes, and procedure code modifiers associated with validated dates of service from the electronic encounter data that were correctly coded based on the enrollees' medical records.
- **Overall Accuracy**—the percentage of dates of service with all data elements coded correctly among all the validated dates of service from the electronic encounter data.

Focused Study—Cultural Competency

Objectives

The primary objective of HSAG's contract year 2014–2015 focused study was to provide meaningful information to AHCA regarding the SMMC plans' contract and regulatory compliance (State and federal) and consistency with National CLAS Standards in the area of cultural competency. Specifically, the study addressed the following questions:

- To what extent did each plan's CCP comply with the requirements of its contract with AHCA and the applicable standards in the BBA?
- To what extent did each plan's CCP meet the CLAS Standards?
- To what extent was each plan's prior year evaluation of the effectiveness of its CCP adequate in assessing the outcomes of its CCP goals and initiatives?

Description of Data Obtained

HSAG obtained information from the following documents:

- MMA Model Contract—Core Contract Provisions
- Federal Managed Care Regulations
- National CLAS Standards

To assess each plan's compliance with the study tool, HSAG reviewed each plan's CCP and evaluation document submitted by AHCA.

Technical Methods of Data Collection/Analysis

Prior to beginning the focused study, HSAG, in collaboration with AHCA, developed a customized data collection tool (study tool) to use in the review of each plan. The content of the study tool was based on applicable federal and State contract regulations regarding cultural competency (and as referenced in the State's CQS), and the Enhanced National CLAS Standards. The questions/standards included in the study tool elicited information from the desk review of plan

documents and corresponded to each study question. One standardized study tool was developed for all plan types. AHCA submitted each plan's most recent CCP and evaluation document to HSAG.

HSAG conducted the reviews in accordance with the CMS protocol, *EQR Protocol 8: Conducting Focused Studies of Health Care Quality: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[22]

Scoring Federal and State Contract Requirements

Each standard was assigned one of the following scores:

- *Met*—indicates full compliance with the standard
- *Partially Met*—indicates partial compliance with the standard
- *Not Met*—indicates noncompliance with the standard

HSAG used the scores assigned for each of the standards to calculate an overall score for this section of the tool. Scores were calculated by assigning 1 point to *Met* items, 0.5 points to *Partially Met* items, and 0 points to *Not Met* items, then dividing the total points by the number of applicable items.

Scoring National CLAS Standards

Each standard was assigned one of the following scores:

- *Yes*—indicated that the plan provided at least a minimum description in the CCP demonstrating how the plan adheres to the standard.
- *No*—indicated that the plan did not provide at least a minimum description in the CCP demonstrating how the plan adheres to the standard.

HSAG used the scores assigned for each of the standards to calculate an overall score for this section of the tool. Scores were calculated by assigning 1 point to *Yes* items, 0 points to *No* items, and then dividing the total points by the number of applicable items.

[22] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 8: Conducting Focused Studies of Health Care Quality: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2013.

Appendix B. Listing of Plan PIP Validation Results for SFY 2014–2015

Table B-1 includes the following information for each MMA Standard 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 Standard Plans

Plan Name	PIP Topic	Validation Scores and Status
Amerigroup Community Care	*Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits*	*92% / 100% / Met*
	Preventive Dental Services for Children	*100% / 100% / Met*
	Improving Overall Member Satisfaction	*100% / 100% / Met*
	Improving Use of Appropriate Medications for People with Asthma	*75% / 60% / Partially Met*
Better Health	*Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits*	*100% / 100% / Met*
	Preventive Dental Services for Children	*100% / 100% / Met*
	Reduce All-Cause Hospital Readmissions Within 30 Days	*100% / 100% / Met*
	Improve Member Satisfaction	*100% / 100% / Met*
Coventry Health Care of Florida, Inc.	*Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits*	*94% / 88% / Partially Met*
	Preventive Dental Services for Children	*63% / 60% / Partially Met*
	Improving Member Satisfaction	*91% / 83% / Partially Met*
	Improving Member Management of Diabetes	*100% / 100% / Met*
First Coast Advantage	*Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits*	*100% / 100% / Met*
	Preventive Dental Services for Children	*100% / 100% / Met*
	Call Answer Timeliness	*100% / 100% / Met*
	Reducing Preventable Readmissions	*89% / 100% / Met*

Table B-1—MMA Standard Plans		
Plan Name	**PIP Topic**	**Validation Scores and Status**
Humana Medical Plan, Inc.	*Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits*	*88% / 75% / Partially Met*
	Preventive Dental Services for Children	*86% / 80% / Partially Met*
	Electronic Health Record with Meaningful Use	*100% / 100% / Met*
	Integrating Primary Care and Behavioral Health in Antidepressant Medication Management	*100% / 100% / Met*
Integral Quality Care	*Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits*	*100% / 100% / Met*
	Preventive Dental Services for Children	*100% / 100% / Met*
	Cervical Cancer Screening	*100% / 100% / Met*
	Improving Enrollee Satisfaction (Child) with Health Plan Services—Access to Care	*100% / 100% / Met*
Molina Healthcare of Florida, Inc.	*Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits*	*73% / 50% / Partially Met*
	Preventive Dental Services for Children	*88% / 80% / Partially Met*
	Improving the Rate of Asthmatic Children Using Controller Medications	*88% / 80% / Partially Met*
	Practitioner Satisfaction	*93% / 100% / Met*
Preferred Medical Plan, Inc.	*Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits*	*100% / 100% / Met*
	Preventive Dental Services for Children	*100% / 100% / Met*
	Continuity and Coordination of Care for High-Risk Members with Co-Existing Medical and Mental Health Disorders	*44% / 20% / Not Met*
	Use of Appropriate Medications for People With Asthma	*88% / 80% / Partially Met*
Prestige Health Choice	*Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits*	*93% / 100% / Met*
	Preventive Dental Services for Children	*100% / 100% / Met*
	Cultural Competency/Disparities in Overall Satisfaction with the Health Plan	*79% / 57% / Partially Met*
	Disparities in Access to HbA1c Testing and Compliance Among Diabetics	*100% / 100% / Met*

Table B-1—MMA Standard Plans		
Plan Name	**PIP Topic**	**Validation Scores and Status**
South Florida Community Care Network	*Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits*	*33% / 17% / Not Met*
	Preventive Dental Services for Children	*29% / 20% / Not Met*
	Improving the Number of Health Risk Assessments	*31% / 17% / Not Met*
	Reducing Preventable Readmissions for Enrollees with Diabetes	*38% / 17% / Not Met*
Simply Healthcare Plans, Inc.	*Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits*	*100% / 100% / Met*
	Preventive Dental Services for Children	*100% / 100% / Met*
	Reduce All-Cause Hospital Readmissions Within 30 Days	*100% / 100% / Met*
	Improve Member Satisfaction	*100% / 100% / Met*
Sunshine State Health Plan, Inc.	*Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits*	*100% / 100% / Met*
	Preventive Dental Services for Children	*100% / 100% / Met*
	Member Satisfaction	*100% / 100% / Met*
	Comprehensive Diabetic Care—Duval County	*100% / 100% / Met*
United Healthcare of Florida, Inc.	*Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits*	*100% / 100% / Met*
	Preventive Dental Services for Children	*100% / 100% / Met*
	Annual Diabetic Retinal Eye Exam	*100% / 100% / Met*
	Call Answer Timeliness and Call Abandonment (CAT-CAB)	*100% / 100% / Met*
Wellcare d/b/a Staywell Health Plan of Florida, Inc.	*Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits*	*42% / 40% / Not Met*
	Preventive Dental Services for Children	*75% / 80% / Partially Met*
	Call Answer Timeliness	*100% / 100% / Met*
	Pine Hills Community Health Worker	*33% / 0% / Not Met*

Table B-2 includes the following information for each MMA Specialty 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—MMA Specialty 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*	*75% / 60% / Partially Met*
	Improving Rates of CD4 and Viral Load Testing	*89% / 80% / Partially Met*
	Improving Satisfaction with Cultural and Language Services for People Living with HIV/AIDS	*100% / 100% / Met*
	Reducing Avoidable Emergency Department Visits	*100% / 100% / Met*
Children's Medical Services Network	*Decreasing Behavioral Health Readmissions Rates*	*100% / 100% / Met*
	Improving Call Center Timeliness	*100% / 100% / Met*
	Preventive Dental Services for Children	*29% / 20% / Not Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*100% / 100% / Met*
Clear Health Alliance	*Behavioral Health Screening of CHA Members by a PCP*	*100% / 100% / Met*
	Improve Member Satisfaction	*75% / 71% / Partially Met*
	Preventive Dental Services	*100% / 100% / Met*
Freedom Health, Inc.	*Care for Older Adults (COA)—Advance Care Planning*	*100% / 100% / Met*
	Comprehensive Diabetes Care (CDC)—HbA1c Poor Control >9%	*100% / 100% / Met*
	Comprehensive Diabetes Care (CDC)—HbA1c Testing	*100% / 100% / Met*
	Plan All-Cause Readmissions (PCR)	*100% / 100% / Met*
Magellan Complete Care	*Improving Diabetes Screening Rates for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	*100% / 100% / Met*
	Increase the Rate of Adult Member's Overall Satisfaction (CAHPS)	*100% / 100% / Met*
	Preventive Dental Services for Children	*100% / 100% / Met*

Table B-3 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-3—LTC Plans		
Plan Name	**PIP Topic**	**Validation Scores and Status**
American Eldercare, Inc.	*Person-Centered Care Plan*	*75% / 75% / Partially Met*
	Medication Review	*50% / 50% / Not Met*
Amerigroup Community Care	*Improving the Number of Members with Advance Directives*	*89% / 83% / Not Met*
	Medication Review	*93% / 88% / Partially Met*
Coventry Health Care of Florida, Inc.	*Timeliness of Services for the Long Term Care Program*	*100% / 100% / Met*
	Medication Review	*100% / 100% / Met*
Humana Medical Plan, Inc.	*Advance Directives*	*100% / 100% / Met*
	Medication Review	*100% / 100% / Met*
Molina Healthcare of Florida, Inc.	*Reduction of Home and Community-Based Service Recipients Transferred to Nursing Homes*	*75% / 60% / Partially Met*
	Medication Review	*88% / 80% / Partially Met*
Sunshine State Health Plan, Inc.	*Influenza Immunization*	*100% / 100% / Met*
	Medication Review	*100% / 100% / Met*
United Healthcare of Florida, Inc.	*Documentation of an Advance Directive*	*100% / 100% / Met*
	Medication Review	*100% / 100% / Met*

Appendix C. Plan Performance Measure Results

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

MMA Standard/Specialty Plans

This section represents the Florida Medicaid HEDIS 2015 (CY 2014) results by domain of care compared to the AHCA-developed combined percentiles (where applicable). With the exception of the Ambulatory Care measures where the values represent the number of outpatient or emergency department (ED) visits per 1,000 MM, all values are shown as percentages. Results in this report are rounded to the second decimal place.

For each HEDIS measure, the range of plan performance is shown in the figures using vertical grey lines, with green horizontal bars representing the AHCA performance targets, generally established based on the HEDIS national Medicaid 75th percentiles. This provides a picture of the range of plan performance relative to the AHCA-established performance targets. The figures also include the statewide weighted averages; however, the AHCA performance targets are not always available.

For all tables presented in this section, the following legend applies to the Performance Level Analysis and 2015 Rate columns:

Symbols in the Performance Level Analysis Column		
★	=	Below-average performance relative to national Medicaid results
★★	=	Average performance relative to national Medicaid results
★★★	=	Above-average performance relative to national Medicaid results
- -	=	Indicates national Medicaid result is not available to compare or plan rate reported as *NA* or *NB.* Please note, for *Ambulatory Care* and *Mental Health Utilization* measures, performance level analysis is not applicable.
Symbols in the 2015 Rate Column		
NR	=	Indicates *Not Reportable* for the following reasons: ◆ The calculated rate was materially biased, or ◆ The MMA plan chose not to report the measure, or ◆ The MMA plan was not required to report the measure.
NA	=	Indicates *Small Denominator* (i.e., the MMA plan followed the specifications, but the denominator was too small [< 30] to report a valid rate.)
NB	=	Indicates *No Benefit* (i.e., the MMA plan did not offer the health benefits required by the measure)

Table C-1 contains the HEDIS 2015 (CY 2014) rates and performance level analysis results for Amerigroup MMA Standard plan.

Table C-1—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Amerigroup			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★★	0.46%
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	0.69%
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	3.47%
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	3.94%
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	8.56%
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	18.29%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★★	64.58%
	Well-Child Visits in the 3rd–6th Years of Life	★★	77.55%
	Lead Screening in Children	★★	65.74%
	Adolescent Well-Care Visits	★★	56.16%
	Annual Dental Visit—2–3 years	- -	NA
	Annual Dental Visit—4–6 years	- -	NA
	Annual Dental Visit—7–10 years	- -	NA
	Annual Dental Visit—11–14 years	- -	NA
	Annual Dental Visit—15–18 years	- -	NA
	Annual Dental Visit—19–21 years	- -	NA
	Annual Dental Visit—Total	- -	NA
	Childhood Immunization Status—Combination 2	★★	79.17%
	Childhood Immunization Status—Combination 3	★★	74.77%
	Immunizations for Adolescents—Combination 1	★★	66.92%
	Immunizations for Adolescents—Meningococcal	★★	67.69%
	Immunizations for Adolescents—Tdap/Td	- -	86.92%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★★	53.99%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	★★★	71.13%
	Preventive Dental Services	- -	6.82%
	Dental Treatment Services	- -	2.92%
	Sealants	- -	2.02%
Women's Care	*Cervical Cancer Screening*	- -	61.31%
	Chlamydia Screening in Women—16–20 Years	★★	57.13%
	Chlamydia Screening in Women—21–24 Years	★★★	74.88%

Table C-1—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Amerigroup			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
	Chlamydia Screening in Women—Total	★★	61.42%
	Breast Cancer Screening	★★	62.24%
	Timeliness of Prenatal Care	★★	84.51%
	Postpartum Care	★★	60.09%
	Prenatal Care Frequency	★★★	83.57%
	Antenatal Steroids	- -	0.00%
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	87.04%
	Diabetes Care—HbA1c Poor Control	★★	40.51%
	Diabetes Care—HbA1c Control (<8%)	★★	49.77%
	Diabetes Care—LDL-C Screening	- -	84.72%
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	37.73%
	Diabetes Care—Eye Exam (Retinal) Performed	★★	47.69%
	Diabetes Care—Medical Attention for Nephropathy	★★	85.42%
	Controlling High Blood Pressure	★★	60.49%
	Adult BMI Assessment	★★	87.96%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	89.00%
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	85.37%
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	67.00%
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	71.95%
	Use of Appropriate Medications for People with Asthma—Total	★★	84.86%
	HIV-Related Medical Visits—0 Visits	- -	8.60%
	HIV-Related Medical Visits—1 Visit	- -	23.66%
	HIV-Related Medical Visits—>=2 Visits	- -	67.74%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	50.54%
	Highly Active Anti-Retroviral Treatment	- -	75.95%
	Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★	92.61%
	Annual Monitoring for Members on Digoxin	★	62.79%
	Annual Monitoring for Members on Diuretics	★★★	92.55%
	Annual Monitoring for Patients on Persistent Medications—Total Rate	★★★	92.23%
	HIV Viral Load Suppression—18-64 Years	- -	27.14%
	HIV Viral Load Suppression—65+ Years	- -	NA
	Plan All-Cause Readmissions—18-64 Years	- -	16.82%
	Plan All-Cause Readmissions—65+ Years	- -	18.28%

Table C-1—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Amerigroup			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	- -	312.15
	Ambulatory Care—ED Visits per 1,000 MM	- -	68.43
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★★	97.42%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★	91.06%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★★	90.18%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★★	88.41%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	70.40%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★★	87.71%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★★	90.86%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	76.52%
	Call Abandonment	- -	1.00%
	Call Answer Timeliness	★★	85.00%
	Transportation Availability	- -	100.00%
	Transportation Timeliness	- -	87.94%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	★★	37.72%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	★★	57.34%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★	58.17%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★	40.79%
	Mental Health Readmission Rate	- -	42.22%
	Initiation of Alcohol and Other Drug Dependence Treatment—13-17 Years	★★★	60.93%
	Initiation of Alcohol and Other Drug Dependence Treatment—18+ Years	★★★	61.97%
	Initiation of Alcohol and Other Drug Dependence Treatment—Total	★★★	61.80%
	Engagement of Alcohol and Other Drug Dependence Treatment—13-17 Years	★★	10.60%
	Engagement of Alcohol and Other Drug Dependence Treatment—18+ Years	★★	12.81%
	Engagement of Alcohol and Other Drug Dependence Treatment—Total	★★	12.45%

Amerigroup performed above average on 10 measures and below average on three measures relative to national Medicaid results.

Table C-2 contains the HEDIS 2015 (CY 2014) rates and performance level analysis results for Better Health MMA Standard plan.

Table C-2—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Better Health			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★★	1.95%
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	0.97%
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	3.41%
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	5.84%
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	13.14%
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	11.68%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★★	63.02%
	Well-Child Visits in the 3rd–6th Years of Life	★★	76.40%
	Lead Screening in Children	★★	71.29%
	Adolescent Well-Care Visits	★★	50.36%
	Annual Dental Visit—2–3 years	- -	24.61%
	Annual Dental Visit—4–6 years	- -	44.94%
	Annual Dental Visit—7–10 years	- -	47.43%
	Annual Dental Visit—11–14 years	- -	36.41%
	Annual Dental Visit—15–18 years	- -	49.30%
	Annual Dental Visit—19–21 years	- -	25.22%
	Annual Dental Visit—Total	★	40.65%
	Childhood Immunization Status—Combination 2	★★	76.64%
	Childhood Immunization Status—Combination 3	★★	73.48%
	Immunizations for Adolescents—Combination 1	★★	70.80%
	Immunizations for Adolescents—Meningococcal	★★	72.02%
	Immunizations for Adolescents—Tdap/Td	- -	84.91%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★★	59.30%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	NA
	Preventive Dental Services	- -	20.13%
	Dental Treatment Services	- -	8.29%
	Sealants	- -	7.45%
Women's Care	*Cervical Cancer Screening*	- -	55.23%
	Chlamydia Screening in Women—16–20 Years	★★	59.30%
	Chlamydia Screening in Women—21–24 Years	★★★	73.65%

Table C-2—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Better Health			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
	Chlamydia Screening in Women—Total	★★	63.76%
	Breast Cancer Screening	★★	58.13%
	Timeliness of Prenatal Care	★★	77.86%
	Postpartum Care	★★	59.12%
	Prenatal Care Frequency	★★	66.91%
	Antenatal Steroids	- -	0.00%
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	87.10%
	Diabetes Care—HbA1c Poor Control	★★	39.66%
	Diabetes Care—HbA1c Control (<8%)	★★	46.72%
	Diabetes Care—LDL-C Screening	- -	84.43%
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	30.41%
	Diabetes Care—Eye Exam (Retinal) Performed	★	40.39%
	Diabetes Care—Medical Attention for Nephropathy	★★★	93.67%
	Controlling High Blood Pressure	★★	58.15%
	Adult BMI Assessment	★★	79.08%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	78.92%
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	81.08%
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	74.42%
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	NA
	Use of Appropriate Medications for People with Asthma—Total	★	76.60%
	HIV-Related Medical Visits—0 Visits	- -	20.51%
	HIV-Related Medical Visits—1 Visit	- -	16.67%
	HIV-Related Medical Visits—>=2 Visits	- -	64.10%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	0.00%
	Highly Active Anti-Retroviral Treatment	- -	76.06%
	Annual Monitoring for Members on ACE Inhibitors or ARBs	★★	91.15%
	Annual Monitoring for Members on Digoxin	★	74.19%
	Annual Monitoring for Members on Diuretics	★★★	92.62%
	Annual Monitoring for Patients on Persistent Medications—Total Rate	★★★	91.38%
	HIV Viral Load Suppression—18-64 Years	- -	0.00%
	HIV Viral Load Suppression—65+ Years	- -	NA
	Plan All-Cause Readmissions—18-64 Years	- -	23.06%
	Plan All-Cause Readmissions—65+ Years	- -	6.94%

Table C-2—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Better Health			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	- -	300.05
	Ambulatory Care—ED Visits per 1,000 MM	- -	76.76
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★★	97.02%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★	90.66%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★★	88.55%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	84.07%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	64.89%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★★	85.89%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★★	86.66%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	73.72%
	Call Abandonment	- -	2.47%
	Call Answer Timeliness	★★	89.87%
	Transportation Availability	- -	100.00%
	Transportation Timeliness	- -	84.15%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	★	14.24%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	★	25.12%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★★	64.56%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★★	50.00%
	Mental Health Readmission Rate	- -	50.00%
	Initiation of Alcohol and Other Drug Dependence Treatment—13-17 Years	★★★	66.20%
	Initiation of Alcohol and Other Drug Dependence Treatment—18+ Years	★★★	51.42%
	Initiation of Alcohol and Other Drug Dependence Treatment—Total	★★★	52.99%
	Engagement of Alcohol and Other Drug Dependence Treatment—13-17 Years	★★	11.27%
	Engagement of Alcohol and Other Drug Dependence Treatment—18+ Years	★★	7.85%
	Engagement of Alcohol and Other Drug Dependence Treatment—Total	★★	8.21%

Better Health performed above average on 10 measures and below average on nine measures relative to national Medicaid results.

Table C-3 contains the HEDIS 2015 (CY 2014) rates and performance level analysis results for Children's Medical Services-S MMA Specialty plan.

Table C-3—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Children's Medical Services-S

Dimension of Care	2015 Measures	Performance Level Analysis	2015
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★★	2.20%
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	2.20%
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	3.30%
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	7.69%
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	12.09%
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	25.27%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★	47.25%
	Well-Child Visits in the 3rd–6th Years of Life	★★	75.69%
	Lead Screening in Children	★★	72.19%
	Adolescent Well-Care Visits	★★	57.49%
	Annual Dental Visit—2–3 years	- -	28.52%
	Annual Dental Visit—4–6 years	- -	49.04%
	Annual Dental Visit—7–10 years	- -	59.37%
	Annual Dental Visit—11–14 years	- -	53.84%
	Annual Dental Visit—15–18 years	- -	47.78%
	Annual Dental Visit—19–21 years	- -	36.61%
	Annual Dental Visit—Total	★★	50.20%
	Childhood Immunization Status—Combination 2	★★	74.00%
	Childhood Immunization Status—Combination 3	★★	68.67%
	Immunizations for Adolescents—Combination 1	★★	76.29%
	Immunizations for Adolescents—Meningococcal	★★	77.58%
	Immunizations for Adolescents—Tdap/Td	- -	89.18%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★	50.66%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	★★★	65.96%
	Preventive Dental Services	- -	28.93%
	Dental Treatment Services	- -	12.57%
	Sealants	- -	4.20%
	HPV Vaccine for Female Adolescents	- -	18.32%
Women's Care	*Chlamydia Screening in Women—16–20 Years*	★★	45.51%
	Chlamydia Screening in Women—21–24 Years	- -	NA

Table C-3—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Children's Medical Services-S			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
	Chlamydia Screening in Women—Total	★	45.51%
	Timeliness of Prenatal Care	- -	NA
	Postpartum Care	- -	NA
	Prenatal Care Frequency	- -	NA
	Antenatal Steroids	- -	NA
Living With Illness	*Use of Appropriate Medications for People with Asthma—5–11 years*	- -	92.16%
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	89.23%
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	NA
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	NA
	Use of Appropriate Medications for People with Asthma—Total	★★	90.64%
	HIV-Related Medical Visits—0 Visits	- -	5.41%
	HIV-Related Medical Visits—1 Visit	- -	8.11%
	HIV-Related Medical Visits—>=2 Visits	- -	86.49%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	40.54%
	Highly Active Anti-Retroviral Treatment	- -	NA
	Medication Management for People With Asthma—5-11 Years—Medication Compliance 50%	- -	72.87%
	Medication Management for People With Asthma—12-18 Years—Medication Compliance 50%	- -	71.55%
	Medication Management for People With Asthma—19-50 Years—Medication Compliance 50%	- -	NA
	Medication Management for People With Asthma—Total—Medication Compliance 50%	- -	72.26%
	Medication Management for People With Asthma—5-11 Years—Medication Compliance 75%	- -	49.47%
	Medication Management for People With Asthma—12-18 Years—Medication Compliance 75%	- -	48.28%
	Medication Management for People With Asthma—19-50 Years—Medication Compliance 75%	- -	NA
	Medication Management for People With Asthma—Total—Medication Compliance 75%	- -	48.71%
	HIV Viral Load Suppression—18-64 Years	- -	NA
	HIV Viral Load Suppression—65+ Years	- -	NA
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	- -	513.90
	Ambulatory Care—ED Visits per 1,000 MM	- -	78.13
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★★★	98.53%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★★	95.55%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★★★	97.08%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★★★	95.64%

Table C-3—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Children's Medical Services-S			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
	Call Abandonment	- -	8.35%
	Call Answer Timeliness	★	53.98%
	Transportation Availability	- -	99.98%
	Transportation Timeliness	- -	43.69%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	★★	46.48%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	★★	60.95%
	Mental Health Readmission Rate	- -	18.05%
	Initiation of Alcohol and Other Drug Dependence Treatment—13-17 Years	- -	NA
	Initiation of Alcohol and Other Drug Dependence Treatment—18+ Years	- -	NA
	Initiation of Alcohol and Other Drug Dependence Treatment—Total	★★	44.90%
	Engagement of Alcohol and Other Drug Dependence Treatment—13-17 Years	- -	NA
	Engagement of Alcohol and Other Drug Dependence Treatment—18+ Years	- -	NA
	Engagement of Alcohol and Other Drug Dependence Treatment—Total	★★	10.20%

Children's Medical Services-S performed above average on five measures and below average on three measures relative to national Medicaid results.

Table C-4 contains the HEDIS 2015 (CY 2014) rates and performance level analysis results for Clear Health-S MMA Specialty plan.

Table C-4—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Clear Health-S			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	- -	NA
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	NA
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	NA
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	NA
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	NA
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	NA
	Well-Child Visits in the First 15 Months of Life—6+ Visits	- -	NA
	Well-Child Visits in the 3rd–6th Years of Life	- -	NA
	Lead Screening in Children	- -	NA
	Adolescent Well-Care Visits	- -	NA
	Annual Dental Visit—2–3 years	- -	NA
	Annual Dental Visit—4–6 years	- -	NA
	Annual Dental Visit—7–10 years	- -	NA
	Annual Dental Visit—11–14 years	- -	NA
	Annual Dental Visit—15–18 years	- -	NA
	Annual Dental Visit—19–21 years	- -	NA
	Annual Dental Visit—Total	- -	NA
	Childhood Immunization Status—Combination 2	- -	NA
	Childhood Immunization Status—Combination 3	- -	NA
	Immunizations for Adolescents—Combination 1	- -	NA
	Immunizations for Adolescents—Meningococcal	- -	NA
	Immunizations for Adolescents—Tdap/Td	- -	NA
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	- -	NA
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	NA
	Preventive Dental Services	- -	5.60%
	Dental Treatment Services	- -	1.60%
	Sealants	- -	4.65%
Women's Care	*Cervical Cancer Screening*	- -	62.29%
	Chlamydia Screening in Women—16–20 Years	- -	NA
	Chlamydia Screening in Women—21–24 Years	- -	NA

Table C-4—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Clear Health-S			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
	Chlamydia Screening in Women—Total	- -	NA
	Breast Cancer Screening	★★	60.00%
	Timeliness of Prenatal Care	- -	NA
	Postpartum Care	- -	NA
	Prenatal Care Frequency	- -	NA
	Antenatal Steroids	- -	NA
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	82.18%
	Diabetes Care—HbA1c Poor Control	★★	51.15%
	Diabetes Care—HbA1c Control (<8%)	★★	38.51%
	Diabetes Care—LDL-C Screening	- -	87.36%
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	28.16%
	Diabetes Care—Eye Exam (Retinal) Performed	★	33.91%
	Diabetes Care—Medical Attention for Nephropathy	★★★	91.38%
	Controlling High Blood Pressure	★★	56.64%
	Adult BMI Assessment	★★	87.14%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	NA
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	NA
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	NA
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	NA
	Use of Appropriate Medications for People with Asthma—Total	- -	NA
	HIV-Related Medical Visits—0 Visits	- -	21.22%
	HIV-Related Medical Visits—1 Visit	- -	15.48%
	HIV-Related Medical Visits—>=2 Visits	- -	64.43%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	0.00%
	Highly Active Anti-Retroviral Treatment	- -	88.58%
	Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★	97.81%
	Annual Monitoring for Members on Digoxin	- -	NA
	Annual Monitoring for Members on Diuretics	★★★	98.26%
	Annual Monitoring for Patients on Persistent Medications—Total Rate	★★★	97.34%
	HIV Viral Load Suppression—18-64 Years	- -	0.00%
	HIV Viral Load Suppression—65+ Years	- -	NA
	Plan All-Cause Readmissions—18-64 Years	- -	26.70%
	Plan All-Cause Readmissions—65+ Years	- -	NA

Table C-4—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Clear Health-S			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	- -	367.50
	Ambulatory Care—ED Visits per 1,000 MM	- -	135.13
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	- -	NA
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	- -	NA
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	- -	NA
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	- -	NA
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★★★	90.10%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★★★	93.77%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★★	90.91%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★★★	92.55%
	Call Abandonment	- -	1.38%
	Call Answer Timeliness	★★	93.52%
	Transportation Availability	- -	100.00%
	Transportation Timeliness	- -	89.36%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	★	9.02%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	★	16.43%
	Antidepressant Medication Management—Effective Acute Phase Treatment	- -	NA
	Antidepressant Medication Management—Effective Continuation Phase Treatment	- -	NA
	Mental Health Readmission Rate	- -	31.38%
	Initiation of Alcohol and Other Drug Dependence Treatment—13-17 Years	- -	NA
	Initiation of Alcohol and Other Drug Dependence Treatment—18+ Years	★★★	55.24%
	Initiation of Alcohol and Other Drug Dependence Treatment—Total	★★★	55.24%
	Engagement of Alcohol and Other Drug Dependence Treatment—13-17 Years	- -	NA
	Engagement of Alcohol and Other Drug Dependence Treatment—18+ Years	★	2.02%
	Engagement of Alcohol and Other Drug Dependence Treatment—Total	★	2.02%

Clear Health-S performed above average on nine measures and below average on five measures relative to national Medicaid results.

Table C-5 contains the HEDIS 2015 (CY 2014) rates and performance level analysis results for Coventry MMA Standard plan.

Table C-5—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Coventry			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★	3.89%
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	2.19%
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	4.62%
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	8.03%
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	15.82%
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	25.55%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★	39.90%
	Well-Child Visits in the 3rd–6th Years of Life	★★	76.72%
	Lead Screening in Children	★★	62.77%
	Adolescent Well-Care Visits	★★	55.47%
	Annual Dental Visit—2–3 years	- -	NA
	Annual Dental Visit—4–6 years	- -	NA
	Annual Dental Visit—7–10 years	- -	NA
	Annual Dental Visit—11–14 years	- -	NA
	Annual Dental Visit—15–18 years	- -	NA
	Annual Dental Visit—19–21 years	- -	NA
	Annual Dental Visit—Total	- -	NA
	Childhood Immunization Status—Combination 2	★	69.59%
	Childhood Immunization Status—Combination 3	★	65.45%
	Immunizations for Adolescents—Combination 1	★★	74.70%
	Immunizations for Adolescents—Meningococcal	★★	75.91%
	Immunizations for Adolescents—Tdap/Td	- -	88.81%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★	25.14%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	NA
	Preventive Dental Services	- -	10.72%
	Dental Treatment Services	- -	4.01%
	Sealants	- -	6.20%
Women's Care	*Cervical Cancer Screening*	- -	61.31%
	Chlamydia Screening in Women—16–20 Years	★★★	67.69%
	Chlamydia Screening in Women—21–24 Years	★★	65.57%

Table C-5—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Coventry			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
	Chlamydia Screening in Women—Total	★★★	67.24%
	Breast Cancer Screening	★★	66.27%
	Timeliness of Prenatal Care	★★	87.10%
	Postpartum Care	★★	58.15%
	Prenatal Care Frequency	★★	75.43%
	Antenatal Steroids	- -	NA
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	89.39%
	Diabetes Care—HbA1c Poor Control	★★	40.91%
	Diabetes Care—HbA1c Control (<8%)	★★	49.24%
	Diabetes Care—LDL-C Screening	- -	87.88%
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	35.35%
	Diabetes Care—Eye Exam (Retinal) Performed	★★	51.77%
	Diabetes Care—Medical Attention for Nephropathy	★★★	88.89%
	Controlling High Blood Pressure	★★	61.80%
	Adult BMI Assessment	★★	90.73%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	84.09%
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	73.53%
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	NA
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	NA
	Use of Appropriate Medications for People with Asthma—Total	★	80.69%
	HIV-Related Medical Visits—0 Visits	- -	9.30%
	HIV-Related Medical Visits—1 Visit	- -	39.53%
	HIV-Related Medical Visits—>=2 Visits	- -	51.16%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	41.86%
	Highly Active Anti-Retroviral Treatment	- -	58.97%
	Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★	93.46%
	Annual Monitoring for Members on Digoxin	- -	NA
	Annual Monitoring for Members on Diuretics	★★★	93.32%
	Annual Monitoring for Patients on Persistent Medications—Total Rate	★★★	93.17%
	HIV Viral Load Suppression—18-64 Years	- -	49.26%
	HIV Viral Load Suppression—65+ Years	- -	NA
	Plan All-Cause Readmissions—18-64 Years	- -	18.06%
	Plan All-Cause Readmissions—65+ Years	- -	12.28%

Table C-5—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Coventry			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	- -	278.45
	Ambulatory Care—ED Visits per 1,000 MM	- -	66.42
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★★	96.12%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★	92.16%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★★	91.99%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★★	88.65%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	67.08%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	82.89%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★	71.05%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	72.16%
	Call Abandonment	- -	2.02%
	Call Answer Timeliness	★	80.10%
	Transportation Availability	- -	100.00%
	Transportation Timeliness	- -	89.35%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	★	10.23%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	★	22.79%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★	46.72%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★	27.05%
	Mental Health Readmission Rate	- -	22.28%
	Initiation of Alcohol and Other Drug Dependence Treatment—13-17 Years	★★★	57.14%
	Initiation of Alcohol and Other Drug Dependence Treatment—18+ Years	★	32.70%
	Initiation of Alcohol and Other Drug Dependence Treatment—Total	★★	35.57%
	Engagement of Alcohol and Other Drug Dependence Treatment—13-17 Years	★★	22.86%
	Engagement of Alcohol and Other Drug Dependence Treatment—18+ Years	★	3.42%
	Engagement of Alcohol and Other Drug Dependence Treatment—Total	★★	5.70%

Coventry performed above average on seven measures and below average on 16 measures relative to national Medicaid results.

Table C-6 contains the HEDIS 2015 (CY 2014) rates and performance level analysis results for Humana MMA Standard plan.

Table C-6—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Humana			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★★	1.22%
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	2.43%
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	1.95%
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	5.11%
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	11.68%
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	17.76%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★★	59.85%
	Well-Child Visits in the 3rd–6th Years of Life	★★	82.43%
	Lead Screening in Children	★★	76.40%
	Adolescent Well-Care Visits	★★	60.93%
	Annual Dental Visit—2–3 years	- -	18.92%
	Annual Dental Visit—4–6 years	- -	38.45%
	Annual Dental Visit—7–10 years	- -	40.98%
	Annual Dental Visit—11–14 years	- -	37.00%
	Annual Dental Visit—15–18 years	- -	33.12%
	Annual Dental Visit—19–21 years	- -	19.56%
	Annual Dental Visit—Total	★	33.41%
	Childhood Immunization Status—Combination 2	★★	75.91%
	Childhood Immunization Status—Combination 3	★★	72.02%
	Immunizations for Adolescents—Combination 1	★★	72.26%
	Immunizations for Adolescents—Meningococcal	★★	73.24%
	Immunizations for Adolescents—Tdap/Td	- -	86.37%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★	8.95%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	★	24.24%
	Preventive Dental Services	- -	15.48%
	Dental Treatment Services	- -	6.48%
	Sealants	- -	4.93%
Women's Care	*Cervical Cancer Screening*	- -	55.96%
	Chlamydia Screening in Women—16–20 Years	★★	60.51%
	Chlamydia Screening in Women—21–24 Years	★★	72.35%

Table C-6—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Humana			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
	Chlamydia Screening in Women—Total	★★	63.99%
	Breast Cancer Screening	★★★	71.46%
	Timeliness of Prenatal Care	★★	87.35%
	Postpartum Care	★★	62.29%
	Prenatal Care Frequency	★★	69.10%
	Antenatal Steroids	- -	NR
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	84.91%
	Diabetes Care—HbA1c Poor Control	★★★	33.82%
	Diabetes Care—HbA1c Control (<8%)	★★	53.28%
	Diabetes Care—LDL-C Screening	- -	79.08%
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	36.98%
	Diabetes Care—Eye Exam (Retinal) Performed	★★	59.12%
	Diabetes Care—Medical Attention for Nephropathy	★★★	90.02%
	Controlling High Blood Pressure	★★	67.64%
	Adult BMI Assessment	★★★	93.08%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	83.91%
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	79.22%
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	70.00%
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	61.76%
	Use of Appropriate Medications for People with Asthma—Total	★	78.77%
	HIV-Related Medical Visits—0 Visits	- -	22.15%
	HIV-Related Medical Visits—1 Visit	- -	16.11%
	HIV-Related Medical Visits—>=2 Visits	- -	61.74%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	0.00%
	Highly Active Anti-Retroviral Treatment	- -	100.00%
	Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★	94.75%
	Annual Monitoring for Members on Digoxin	★	59.49%
	Annual Monitoring for Members on Diuretics	★★★	94.28%
	Annual Monitoring for Patients on Persistent Medications—Total Rate	★★★	93.79%
	HIV Viral Load Suppression—18-64 Years	- -	0.00%
	HIV Viral Load Suppression—65+ Years	- -	0.00%
	Plan All-Cause Readmissions—18-64 Years	- -	21.55%
	Plan All-Cause Readmissions—65+ Years	- -	13.33%

Table C-6—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Humana			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	- -	308.10
	Ambulatory Care—ED Visits per 1,000 MM	- -	67.78
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★	95.04%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★	91.29%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★★	92.13%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★★	87.25%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	70.65%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★★	87.21%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★★	82.45%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	79.61%
	Call Abandonment	- -	2.11%
	Call Answer Timeliness	★★★	97.89%
	Transportation Availability	- -	100.00%
	Transportation Timeliness	- -	96.72%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	★	8.90%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	★	19.16%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★	52.85%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★	37.54%
	Mental Health Readmission Rate	- -	12.65%
	Initiation of Alcohol and Other Drug Dependence Treatment—13-17 Years	★★	42.86%
	Initiation of Alcohol and Other Drug Dependence Treatment—18+ Years	★	33.74%
	Initiation of Alcohol and Other Drug Dependence Treatment—Total	★★	34.39%
	Engagement of Alcohol and Other Drug Dependence Treatment—13-17 Years	★★	18.80%
	Engagement of Alcohol and Other Drug Dependence Treatment—18+ Years	★	3.07%
	Engagement of Alcohol and Other Drug Dependence Treatment—Total	★	4.20%

Humana performed above average on eight measures and below average on 13 measures relative to national Medicaid results.

Table C-7 contains the HEDIS 2015 (CY 2014) rates and performance level analysis results for Integral MMA Standard plan.

Table C-7—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Integral			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★	5.09%
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	2.31%
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	6.48%
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	9.72%
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	18.06%
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	25.46%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★	32.87%
	Well-Child Visits in the 3rd–6th Years of Life	★★	75.23%
	Lead Screening in Children	★	53.40%
	Adolescent Well-Care Visits	★★	49.07%
	Annual Dental Visit—2–3 years	- -	25.35%
	Annual Dental Visit—4–6 years	- -	46.69%
	Annual Dental Visit—7–10 years	- -	53.80%
	Annual Dental Visit—11–14 years	- -	44.70%
	Annual Dental Visit—15–18 years	- -	37.71%
	Annual Dental Visit—19–21 years	- -	17.98%
	Annual Dental Visit—Total	★	42.42%
	Childhood Immunization Status—Combination 2	★	70.37%
	Childhood Immunization Status—Combination 3	★★	67.59%
	Immunizations for Adolescents—Combination 1	★	58.14%
	Immunizations for Adolescents—Meningococcal	★	60.63%
	Immunizations for Adolescents—Tdap/Td	- -	83.55%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★	52.46%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	NA
	Preventive Dental Services	- -	20.65%
	Dental Treatment Services	- -	10.60%
	Sealants	- -	12.80%
Women's Care	*Cervical Cancer Screening*	- -	36.34%
	Chlamydia Screening in Women—16–20 Years	★★	48.84%
	Chlamydia Screening in Women—21–24 Years	★★	63.44%

Table C-7—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Integral			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
	Chlamydia Screening in Women—Total	★★	53.96%
	Breast Cancer Screening	★	48.91%
	Timeliness of Prenatal Care	★★	80.24%
	Postpartum Care	★★	60.00%
	Prenatal Care Frequency	★★	66.75%
	Antenatal Steroids	- -	NA
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	83.10%
	Diabetes Care—HbA1c Poor Control	★★	48.15%
	Diabetes Care—HbA1c Control (<8%)	★★	42.82%
	Diabetes Care—LDL-C Screening	- -	75.93%
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	32.18%
	Diabetes Care—Eye Exam (Retinal) Performed	★	39.58%
	Diabetes Care—Medical Attention for Nephropathy	★★	79.63%
	Controlling High Blood Pressure	★	37.69%
	Adult BMI Assessment	★	68.06%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	82.98%
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	NA
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	NA
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	NA
	Use of Appropriate Medications for People with Asthma—Total	★	75.76%
	HIV-Related Medical Visits—0 Visits	- -	NA
	HIV-Related Medical Visits—1 Visit	- -	NA
	HIV-Related Medical Visits—>=2 Visits	- -	NA
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	NA
	Highly Active Anti-Retroviral Treatment	- -	NA
	Annual Monitoring for Members on ACE Inhibitors or ARBs	★★	87.86%
	Annual Monitoring for Members on Digoxin	- -	NA
	Annual Monitoring for Members on Diuretics	★★	87.47%
	Annual Monitoring for Patients on Persistent Medications—Total Rate	★★	87.31%
	HIV Viral Load Suppression—18-64 Years	- -	0.00%
	HIV Viral Load Suppression—65+ Years	- -	NA

Table C-7—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Integral			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	- -	224.80
	Ambulatory Care—ED Visits per 1,000 MM	- -	71.05
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★	93.61%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★	84.65%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★	83.11%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	79.28%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	61.88%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	79.57%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★	74.20%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	68.47%
	Call Abandonment	- -	4.17%
	Call Answer Timeliness	★★	86.70%
	Transportation Availability	- -	91.18%
	Transportation Timeliness	- -	76.08%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	★	31.20%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	★	46.51%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★	46.79%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★	30.77%
	Mental Health Readmission Rate	- -	13.03%
	Initiation of Alcohol and Other Drug Dependence Treatment—13-17 Years	- -	NA
	Initiation of Alcohol and Other Drug Dependence Treatment—18+ Years	- -	NA
	Initiation of Alcohol and Other Drug Dependence Treatment—Total	- -	NA
	Engagement of Alcohol and Other Drug Dependence Treatment—13-17 Years	- -	NA
	Engagement of Alcohol and Other Drug Dependence Treatment—18+ Years	- -	NA
	Engagement of Alcohol and Other Drug Dependence Treatment—Total	- -	NA

Integral had no above average measures and performed below average on 22 measures relative to national Medicaid results.

Table C-8 contains the HEDIS 2015 (CY 2014) rates and performance level analysis results for Magellan-S MMA Specialty plan.

Table C-8—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Magellan-S			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	- -	NA
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	NA
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	NA
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	NA
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	NA
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	NA
	Well-Child Visits in the First 15 Months of Life—6+ Visits	- -	NA
	Well-Child Visits in the 3rd–6th Years of Life	- -	NA
	Lead Screening in Children	- -	NA
	Adolescent Well-Care Visits	- -	NA
	Annual Dental Visit—2–3 years	- -	NA
	Annual Dental Visit—4–6 years	- -	NA
	Annual Dental Visit—7–10 years	- -	NA
	Annual Dental Visit—11–14 years	- -	NA
	Annual Dental Visit—15–18 years	- -	NA
	Annual Dental Visit—19–21 years	- -	NA
	Annual Dental Visit—Total	- -	NA
	Childhood Immunization Status—Combination 2	- -	NA
	Childhood Immunization Status—Combination 3	- -	NA
	Immunizations for Adolescents—Combination 1	- -	NA
	Immunizations for Adolescents—Meningococcal	- -	NA
	Immunizations for Adolescents—Tdap/Td	- -	NA
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	- -	NA
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	NA
	Preventive Dental Services	- -	9.22%
	Dental Treatment Services	- -	5.06%
	Sealants	- -	NA
Women's Care	*Cervical Cancer Screening*	- -	NA
	Chlamydia Screening in Women—16–20 Years	- -	NA
	Chlamydia Screening in Women—21–24 Years	- -	NA

Table C-8—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Magellan-S			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
	Chlamydia Screening in Women—Total	- -	NA
	Breast Cancer Screening	- -	NA
	Timeliness of Prenatal Care	★	55.26%
	Postpartum Care	★	35.53%
	Prenatal Care Frequency	★	0.00%
	Antenatal Steroids	- -	NR
Living With Illness	*Diabetes Care—HbA1c Testing*	- -	NA
	Diabetes Care—HbA1c Poor Control	- -	NA
	Diabetes Care—HbA1c Control (<8%)	- -	NA
	Diabetes Care—LDL-C Screening	- -	NA
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	NA
	Diabetes Care—Eye Exam (Retinal) Performed	- -	NA
	Diabetes Care—Medical Attention for Nephropathy	- -	NA
	Controlling High Blood Pressure	- -	NA
	Adult BMI Assessment	- -	NA
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	NA
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	NA
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	NA
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	NA
	Use of Appropriate Medications for People with Asthma—Total	- -	NA
	HIV-Related Medical Visits—0 Visits	- -	NA
	HIV-Related Medical Visits—1 Visit	- -	NA
	HIV-Related Medical Visits—>=2 Visits	- -	NA
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	NA
	Highly Active Anti-Retroviral Treatment	- -	NA
	Annual Monitoring for Members on ACE Inhibitors or ARBs	- -	NA
	Annual Monitoring for Members on Digoxin	- -	NA
	Annual Monitoring for Members on Diuretics	- -	NA
	Annual Monitoring for Patients on Persistent Medications—Total Rate	- -	NA
	HIV Viral Load Suppression—18-64 Years	- -	NA
	HIV Viral Load Suppression—65+ Years	- -	NA

Table C-8—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Magellan-S			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	- -	231.84
	Ambulatory Care—ED Visits per 1,000 MM	- -	149.64
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	- -	NA
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	- -	NA
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	- -	NA
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	- -	NA
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	- -	NA
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	- -	NA
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	- -	NA
	Adults' Access to Preventive/Ambulatory Health Services—Total	- -	NA
	Call Abandonment	- -	0.79%
	Call Answer Timeliness	★★	90.94%
	Transportation Availability	- -	100.00%
	Transportation Timeliness	- -	88.00%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	★	15.94%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	★	30.39%
	Antidepressant Medication Management—Effective Acute Phase Treatment	- -	NA
	Antidepressant Medication Management—Effective Continuation Phase Treatment	- -	NA
	Mental Health Readmission Rate	- -	30.80%
	Initiation of Alcohol and Other Drug Dependence Treatment—13-17 Years	★★★	62.86%
	Initiation of Alcohol and Other Drug Dependence Treatment—18+ Years	★★★	58.53%
	Initiation of Alcohol and Other Drug Dependence Treatment—Total	★★★	58.84%
	Engagement of Alcohol and Other Drug Dependence Treatment—13-17 Years	★★	8.57%
	Engagement of Alcohol and Other Drug Dependence Treatment—18+ Years	★★	6.91%
	Engagement of Alcohol and Other Drug Dependence Treatment—Total	★★	7.03%

Magellan-S performed above average on three measures and below average on five measures relative to national Medicaid results.

Table C-9 contains the HEDIS 2015 (CY 2014) rates and performance level analysis results for Molina MMA Standard plan.

Table C-9—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Molina			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★	3.09%
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	3.75%
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	3.53%
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	8.17%
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	16.56%
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	26.49%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★	38.41%
	Well-Child Visits in the 3rd–6th Years of Life	★★	76.60%
	Lead Screening in Children	★★	65.78%
	Adolescent Well-Care Visits	★★	49.23%
	Annual Dental Visit—2–3 years	- -	25.02%
	Annual Dental Visit—4–6 years	- -	46.12%
	Annual Dental Visit—7–10 years	- -	49.09%
	Annual Dental Visit—11–14 years	- -	42.74%
	Annual Dental Visit—15–18 years	- -	36.26%
	Annual Dental Visit—19–21 years	- -	24.05%
	Annual Dental Visit—Total	★	40.24%
	Childhood Immunization Status—Combination 2	★	67.55%
	Childhood Immunization Status—Combination 3	★	61.37%
	Immunizations for Adolescents—Combination 1	★★	63.58%
	Immunizations for Adolescents—Meningococcal	★★	66.89%
	Immunizations for Adolescents—Tdap/Td	- -	79.47%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★	42.18%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	NA
	Preventive Dental Services	- -	18.24%
	Dental Treatment Services	- -	7.25%
	Sealants	- -	5.59%
Women's Care	*Cervical Cancer Screening*	- -	54.65%
	Chlamydia Screening in Women—16–20 Years	★★	62.54%
	Chlamydia Screening in Women—21–24 Years	★★	67.41%

Table C-9—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Molina			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
	Chlamydia Screening in Women—Total	★★	63.90%
	Breast Cancer Screening	★	50.42%
	Timeliness of Prenatal Care	★	77.13%
	Postpartum Care	★★	56.28%
	Prenatal Care Frequency	★★	65.70%
	Antenatal Steroids	- -	0.38%
Living With Illness	*Diabetes Care—HbA1c Testing*	★	78.30%
	Diabetes Care—HbA1c Poor Control	★★	50.00%
	Diabetes Care—HbA1c Control (<8%)	★	37.50%
	Diabetes Care—LDL-C Screening	- -	74.06%
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	33.96%
	Diabetes Care—Eye Exam (Retinal) Performed	★	45.52%
	Diabetes Care—Medical Attention for Nephropathy	★★	77.83%
	Controlling High Blood Pressure	★★	48.67%
	Adult BMI Assessment	★★	79.25%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	86.67%
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	NA
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	NA
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	NA
	Use of Appropriate Medications for People with Asthma—Total	★	74.63%
	HIV-Related Medical Visits—0 Visits	- -	NA
	HIV-Related Medical Visits—1 Visit	- -	NA
	HIV-Related Medical Visits—>=2 Visits	- -	NA
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	NA
	Highly Active Anti-Retroviral Treatment	- -	NA
	Annual Monitoring for Members on ACE Inhibitors or ARBs	★★	91.71%
	Annual Monitoring for Members on Digoxin	- -	NA
	Annual Monitoring for Members on Diuretics	★★	91.27%
	Annual Monitoring for Patients on Persistent Medications—Total Rate	★★★	90.92%
	HIV Viral Load Suppression—18-64 Years	- -	0.00%
	HIV Viral Load Suppression—65+ Years	- -	NA
	Plan All-Cause Readmissions—18-64 Years	- -	17.49%
	Plan All-Cause Readmissions—65+ Years	- -	9.29%

Table C-9—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Molina			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	- -	304.11
	Ambulatory Care—ED Visits per 1,000 MM	- -	66.48
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★	93.59%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★	89.62%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★★	90.21%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	82.60%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	62.84%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	72.89%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★	57.63%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	63.51%
	Call Abandonment	- -	2.36%
	Call Answer Timeliness	★★	88.47%
	Transportation Availability	- -	100.00%
	Transportation Timeliness	- -	85.09%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	★	19.44%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	★	33.25%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★	55.73%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★	33.84%
	Mental Health Readmission Rate	- -	25.97%
	Initiation of Alcohol and Other Drug Dependence Treatment—13-17 Years	★★	42.19%
	Initiation of Alcohol and Other Drug Dependence Treatment—18+ Years	★★	34.88%
	Initiation of Alcohol and Other Drug Dependence Treatment—Total	★★	35.47%
	Engagement of Alcohol and Other Drug Dependence Treatment—13-17 Years	★	6.25%
	Engagement of Alcohol and Other Drug Dependence Treatment—18+ Years	★	1.64%
	Engagement of Alcohol and Other Drug Dependence Treatment—Total	★	2.01%

Molina performed above average on one measure and below average on 22 measures relative to national Medicaid results.

Table C-10 contains the HEDIS 2015 (CY 2014) rates and performance level analysis results for Positive-S MMA Specialty plan.

Table C-10—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Positive-S			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	- -	NA
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	NA
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	NA
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	NA
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	NA
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	NA
	Well-Child Visits in the First 15 Months of Life—6+ Visits	- -	NA
	Well-Child Visits in the 3rd–6th Years of Life	- -	NA
	Lead Screening in Children	- -	NA
	Adolescent Well-Care Visits	- -	NA
	Annual Dental Visit—2–3 years	- -	NA
	Annual Dental Visit—4–6 years	- -	NA
	Annual Dental Visit—7–10 years	- -	NA
	Annual Dental Visit—11–14 years	- -	NA
	Annual Dental Visit—15–18 years	- -	NA
	Annual Dental Visit—19–21 years	- -	NA
	Annual Dental Visit—Total	- -	NA
	Childhood Immunization Status—Combination 2	- -	NA
	Childhood Immunization Status—Combination 3	- -	NA
	Immunizations for Adolescents—Combination 1	- -	NA
	Immunizations for Adolescents—Meningococcal	- -	NA
	Immunizations for Adolescents—Tdap/Td	- -	NA
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	- -	NA
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	NA
	Preventive Dental Services	- -	0.00%
	Dental Treatment Services	- -	0.00%
	Sealants	- -	NA
Women's Care	*Cervical Cancer Screening*	- -	54.55%
	Chlamydia Screening in Women—16–20 Years	- -	NA
	Chlamydia Screening in Women—21–24 Years	- -	NA

Table C-10—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Positive-S			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
	Chlamydia Screening in Women—Total	- -	NA
	Breast Cancer Screening	- -	NA
	Timeliness of Prenatal Care	- -	NA
	Postpartum Care	- -	NA
	Prenatal Care Frequency	- -	NA
	Antenatal Steroids	- -	NA
Living With Illness	*Diabetes Care—HbA1c Testing*	★★★	92.98%
	Diabetes Care—HbA1c Poor Control	★★	38.60%
	Diabetes Care—HbA1c Control (<8%)	★★	38.60%
	Diabetes Care—LDL-C Screening	- -	89.83%
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	15.25%
	Diabetes Care—Eye Exam (Retinal) Performed	★	28.07%
	Diabetes Care—Medical Attention for Nephropathy	★★	78.95%
	Controlling High Blood Pressure	★★	55.12%
	Adult BMI Assessment	★★	84.62%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	NA
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	NA
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	NA
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	NA
	Use of Appropriate Medications for People with Asthma—Total	- -	NA
	HIV-Related Medical Visits—0 Visits	- -	4.74%
	HIV-Related Medical Visits—1 Visit	- -	8.42%
	HIV-Related Medical Visits—>=2 Visits	- -	86.84%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	68.16%
	Highly Active Anti-Retroviral Treatment	- -	67.84%
	Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★	98.85%
	Annual Monitoring for Members on Digoxin	- -	NA
	Annual Monitoring for Members on Diuretics	★★★	96.77%
	Annual Monitoring for Patients on Persistent Medications—Total Rate	★★★	98.00%
	HIV Viral Load Suppression—18-64 Years	- -	27.19%
	HIV Viral Load Suppression—65+ Years	- -	7.46%
	Plan All-Cause Readmissions—18-64 Years	- -	25.97%
	Plan All-Cause Readmissions—65+ Years	- -	NA

Table C-10—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Positive-S			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	- -	485.25
	Ambulatory Care—ED Visits per 1,000 MM	- -	114.28
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	- -	NA
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	- -	NA
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	- -	NA
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	- -	NA
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★★★	89.01%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★★★	97.15%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	- -	NA
	Adults' Access to Preventive/Ambulatory Health Services—Total	★★★	95.41%
	Call Abandonment	- -	3.39%
	Call Answer Timeliness	★★	84.24%
	Transportation Availability	- -	99.27%
	Transportation Timeliness	- -	81.05%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	★	1.46%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	★	3.16%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★★	71.88%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★★	59.38%
	Mental Health Readmission Rate	- -	48.87%
	Initiation of Alcohol and Other Drug Dependence Treatment—13-17 Years	- -	NA
	Initiation of Alcohol and Other Drug Dependence Treatment—18+ Years	★★	38.24%
	Initiation of Alcohol and Other Drug Dependence Treatment—Total	★★	38.24%
	Engagement of Alcohol and Other Drug Dependence Treatment—13-17 Years	- -	NA
	Engagement of Alcohol and Other Drug Dependence Treatment—18+ Years	★★	5.88%
	Engagement of Alcohol and Other Drug Dependence Treatment—Total	★★	5.88%

Positive-S performed above average on nine measures and below average on three measures relative to national Medicaid results.

Table C-11 contains the HEDIS 2015 (CY 2014) rates and performance level analysis results for Preferred MMA Standard plan.

Table C-11—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Preferred			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★	9.52%
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	5.36%
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	4.17%
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	5.95%
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	4.76%
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	8.93%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★★	61.31%
	Well-Child Visits in the 3rd–6th Years of Life	★★	73.24%
	Lead Screening in Children	★	50.61%
	Adolescent Well-Care Visits	★★	57.18%
	Annual Dental Visit—2–3 years	- -	NA
	Annual Dental Visit—4–6 years	- -	NA
	Annual Dental Visit—7–10 years	- -	NA
	Annual Dental Visit—11–14 years	- -	NA
	Annual Dental Visit—15–18 years	- -	NA
	Annual Dental Visit—19–21 years	- -	NA
	Annual Dental Visit—Total	- -	NA
	Childhood Immunization Status—Combination 2	★	61.16%
	Childhood Immunization Status—Combination 3	★	53.21%
	Immunizations for Adolescents—Combination 1	★	41.52%
	Immunizations for Adolescents—Meningococcal	★	41.88%
	Immunizations for Adolescents—Tdap/Td	- -	79.42%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★	11.32%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	NA
	Preventive Dental Services	- -	9.91%
	Dental Treatment Services	- -	5.73%
	Sealants	- -	1.56%
Women's Care	*Cervical Cancer Screening*	- -	47.13%
	Chlamydia Screening in Women—16–20 Years	★★	55.09%
	Chlamydia Screening in Women—21–24 Years	★★	60.29%

Table C-11—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Preferred			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
	Chlamydia Screening in Women—Total	★★	56.60%
	Breast Cancer Screening	★	48.78%
	Timeliness of Prenatal Care	★★	78.04%
	Postpartum Care	★	47.84%
	Prenatal Care Frequency	★★	45.88%
	Antenatal Steroids	- -	0.00%
Living With Illness	*Diabetes Care—HbA1c Testing*	★	74.33%
	Diabetes Care—HbA1c Poor Control	★★	43.85%
	Diabetes Care—HbA1c Control (<8%)	★	32.62%
	Diabetes Care—LDL-C Screening	- -	62.03%
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	19.25%
	Diabetes Care—Eye Exam (Retinal) Performed	★★	50.80%
	Diabetes Care—Medical Attention for Nephropathy	★★	77.01%
	Controlling High Blood Pressure	★★★	82.79%
	Adult BMI Assessment	★★	83.45%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	NA
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	NA
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	NA
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	NA
	Use of Appropriate Medications for People with Asthma—Total	- -	NA
	HIV-Related Medical Visits—0 Visits	- -	NA
	HIV-Related Medical Visits—1 Visit	- -	NA
	HIV-Related Medical Visits—>=2 Visits	- -	NA
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	NA
	Highly Active Anti-Retroviral Treatment	- -	NA
	Annual Monitoring for Members on ACE Inhibitors or ARBs	- -	NA
	Annual Monitoring for Members on Digoxin	- -	NA
	Annual Monitoring for Members on Diuretics	- -	NA
	Annual Monitoring for Patients on Persistent Medications—Total Rate	- -	NA
	HIV Viral Load Suppression—18-64 Years	- -	0.00%
	HIV Viral Load Suppression—65+ Years	- -	NA
	Plan All-Cause Readmissions—18-64 Years	- -	21.26%
	Plan All-Cause Readmissions—65+ Years	- -	28.00%

Table C-11—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Preferred			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	- -	189.84
	Ambulatory Care—ED Visits per 1,000 MM	- -	51.74
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★	83.06%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★	80.26%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★	82.25%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	78.21%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	56.45%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	73.91%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★	68.55%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	63.70%
	Call Abandonment	- -	3.31%
	Call Answer Timeliness	★★	84.05%
	Transportation Availability	- -	100.00%
	Transportation Timeliness	- -	80.38%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	★	8.88%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	★	20.82%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★	44.44%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★	17.28%
	Mental Health Readmission Rate	- -	24.44%
	Initiation of Alcohol and Other Drug Dependence Treatment—13-17 Years	- -	NA
	Initiation of Alcohol and Other Drug Dependence Treatment—18+ Years	★★	43.75%
	Initiation of Alcohol and Other Drug Dependence Treatment—Total	★★	45.76%
	Engagement of Alcohol and Other Drug Dependence Treatment—13-17 Years	- -	NA
	Engagement of Alcohol and Other Drug Dependence Treatment—18+ Years	★★	7.29%
	Engagement of Alcohol and Other Drug Dependence Treatment—Total	★★	7.63%

Preferred performed above average on one measure and below average on 23 measures relative to national Medicaid results.

Table C-12 contains the HEDIS 2015 (CY 2014) rates and performance level analysis results for Prestige MMA Standard plan.

Table C-12—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Prestige			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★	6.71%
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	4.17%
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	6.02%
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	11.81%
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	14.35%
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	14.81%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★	42.13%
	Well-Child Visits in the 3rd–6th Years of Life	★★	71.32%
	Lead Screening in Children	★★	58.70%
	Adolescent Well-Care Visits	★★	45.37%
	Annual Dental Visit—2–3 years	- -	17.67%
	Annual Dental Visit—4–6 years	- -	33.23%
	Annual Dental Visit—7–10 years	- -	34.84%
	Annual Dental Visit—11–14 years	- -	31.16%
	Annual Dental Visit—15–18 years	- -	25.16%
	Annual Dental Visit—19–21 years	- -	15.07%
	Annual Dental Visit—Total	★	28.81%
	Childhood Immunization Status—Combination 2	★★	72.46%
	Childhood Immunization Status—Combination 3	★	65.70%
	Immunizations for Adolescents—Combination 1	★	61.27%
	Immunizations for Adolescents—Meningococcal	★	62.50%
	Immunizations for Adolescents—Tdap/Td	- -	82.35%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★	37.46%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	★★	40.32%
	Preventive Dental Services	- -	14.72%
	Dental Treatment Services	- -	6.92%
	Sealants	- -	8.66%
Women's Care	*Cervical Cancer Screening*	- -	50.35%
	Chlamydia Screening in Women—16–20 Years	★★	53.47%
	Chlamydia Screening in Women—21–24 Years	★★	67.43%

Table C-12—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Prestige			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
	Chlamydia Screening in Women—Total	★★	59.20%
	Breast Cancer Screening	★	40.12%
	Timeliness of Prenatal Care	★★	87.04%
	Postpartum Care	★★	62.27%
	Prenatal Care Frequency	★★	55.32%
	Antenatal Steroids	- -	NA
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	80.56%
	Diabetes Care—HbA1c Poor Control	★★	48.96%
	Diabetes Care—HbA1c Control (<8%)	★★	41.67%
	Diabetes Care—LDL-C Screening	- -	72.22%
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	30.03%
	Diabetes Care—Eye Exam (Retinal) Performed	★	33.33%
	Diabetes Care—Medical Attention for Nephropathy	★★	83.16%
	Controlling High Blood Pressure	★	42.86%
	Adult BMI Assessment	★★	84.95%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	93.33%
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	89.36%
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	76.92%
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	72.22%
	Use of Appropriate Medications for People with Asthma—Total	★★	87.85%
	HIV-Related Medical Visits—0 Visits	- -	15.63%
	HIV-Related Medical Visits—1 Visit	- -	15.63%
	HIV-Related Medical Visits—>=2 Visits	- -	68.75%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	53.13%
	Highly Active Anti-Retroviral Treatment	- -	NA
	Annual Monitoring for Members on ACE Inhibitors or ARBs	★★	88.54%
	Annual Monitoring for Members on Digoxin	- -	NA
	Annual Monitoring for Members on Diuretics	★★	87.76%
	Annual Monitoring for Patients on Persistent Medications—Total Rate	★★	87.71%
	HIV Viral Load Suppression—18-64 Years	- -	2.91%
	HIV Viral Load Suppression—65+ Years	- -	NA
	Plan All-Cause Readmissions—18-64 Years	- -	16.10%
	Plan All-Cause Readmissions—65+ Years	- -	11.76%

Table C-12—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Prestige			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	- -	265.59
	Ambulatory Care—ED Visits per 1,000 MM	- -	72.13
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★	91.70%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★	81.54%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★	81.86%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	78.37%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	61.18%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	79.40%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★	74.90%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	67.64%
	Call Abandonment	- -	1.33%
	Call Answer Timeliness	★★	91.31%
	Transportation Availability	- -	100.00%
	Transportation Timeliness	- -	80.97%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	★	14.85%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	★	35.80%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★	56.60%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★	44.68%
	Mental Health Readmission Rate	- -	12.67%
	Initiation of Alcohol and Other Drug Dependence Treatment—13-17 Years	★	7.94%
	Initiation of Alcohol and Other Drug Dependence Treatment—18+ Years	★★	36.14%
	Initiation of Alcohol and Other Drug Dependence Treatment—Total	★★	35.02%
	Engagement of Alcohol and Other Drug Dependence Treatment—13-17 Years	★	0.00%
	Engagement of Alcohol and Other Drug Dependence Treatment—18+ Years	★	4.20%
	Engagement of Alcohol and Other Drug Dependence Treatment—Total	★	4.04%

Prestige had no above average measures and performed below average on 23 measures relative to national Medicaid results.

Table C-13 contains the HEDIS 2015 (CY 2014) rates and performance level analysis results for SFCCN MMA Standard plan.

Table C-13—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: SFCCN			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★	3.31%
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	1.77%
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	2.65%
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	8.61%
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	18.76%
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	27.15%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★	37.75%
	Well-Child Visits in the 3rd–6th Years of Life	★★	82.34%
	Lead Screening in Children	★★	75.30%
	Adolescent Well-Care Visits	★★	61.15%
	Annual Dental Visit—2–3 years	- -	27.38%
	Annual Dental Visit—4–6 years	- -	45.38%
	Annual Dental Visit—7–10 years	- -	51.85%
	Annual Dental Visit—11–14 years	- -	47.11%
	Annual Dental Visit—15–18 years	- -	39.45%
	Annual Dental Visit—19–21 years	- -	21.79%
	Annual Dental Visit—Total	★	43.12%
	Childhood Immunization Status—Combination 2	★	67.36%
	Childhood Immunization Status—Combination 3	★	63.89%
	Immunizations for Adolescents—Combination 1	★★	73.29%
	Immunizations for Adolescents—Meningococcal	★★	74.91%
	Immunizations for Adolescents—Tdap/Td	- -	82.48%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★	28.96%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	★	34.00%
	Preventive Dental Services	- -	26.17%
	Dental Treatment Services	- -	10.80%
	Sealants	- -	13.54%
Women's Care	*Cervical Cancer Screening*	- -	47.35%
	Chlamydia Screening in Women—16–20 Years	★★	59.65%
	Chlamydia Screening in Women—21–24 Years	★★	60.78%

Table C-13—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: SFCCN			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
	Chlamydia Screening in Women—Total	★★	59.91%
	Breast Cancer Screening	★★	69.25%
	Timeliness of Prenatal Care	★	71.88%
	Postpartum Care	★	55.36%
	Prenatal Care Frequency	★★	57.68%
	Antenatal Steroids	- -	NA
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	87.27%
	Diabetes Care—HbA1c Poor Control	★★	41.04%
	Diabetes Care—HbA1c Control (<8%)	★★	48.57%
	Diabetes Care—LDL-C Screening	- -	84.94%
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	41.56%
	Diabetes Care—Eye Exam (Retinal) Performed	★	43.12%
	Diabetes Care—Medical Attention for Nephropathy	★★	85.71%
	Controlling High Blood Pressure	★★	50.33%
	Adult BMI Assessment	★	46.27%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	79.44%
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	84.06%
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	NA
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	NA
	Use of Appropriate Medications for People with Asthma—Total	★	78.82%
	HIV-Related Medical Visits—0 Visits	- -	0.72%
	HIV-Related Medical Visits—1 Visit	- -	7.91%
	HIV-Related Medical Visits—>=2 Visits	- -	91.37%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	72.66%
	Highly Active Anti-Retroviral Treatment	- -	90.27%
	Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★	92.90%
	Annual Monitoring for Members on Digoxin	- -	NA
	Annual Monitoring for Members on Diuretics	★★	91.28%
	Annual Monitoring for Patients on Persistent Medications—Total Rate	★★★	91.21%
	HIV Viral Load Suppression—18-64 Years	- -	NR
	HIV Viral Load Suppression—65+ Years	- -	NR
	Plan All-Cause Readmissions—18-64 Years	- -	20.48%
	Plan All-Cause Readmissions—65+ Years	- -	13.45%

Table C-13—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: SFCCN			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	- -	287.63
	Ambulatory Care—ED Visits per 1,000 MM	- -	67.17
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★★	95.86%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★	92.34%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★★	92.43%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★★	88.73%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	58.50%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	82.59%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★★	86.20%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	70.92%
	Call Abandonment	- -	4.41%
	Call Answer Timeliness	★	68.18%
	Transportation Availability	- -	100.00%
	Transportation Timeliness	- -	82.86%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	★	22.15%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	★	41.46%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★★	85.66%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★★	78.87%
	Mental Health Readmission Rate	- -	24.91%
	Initiation of Alcohol and Other Drug Dependence Treatment—13-17 Years	★	28.13%
	Initiation of Alcohol and Other Drug Dependence Treatment—18+ Years	★★	46.54%
	Initiation of Alcohol and Other Drug Dependence Treatment—Total	★★	44.18%
	Engagement of Alcohol and Other Drug Dependence Treatment—13-17 Years	★★	9.38%
	Engagement of Alcohol and Other Drug Dependence Treatment—18+ Years	★★	7.83%
	Engagement of Alcohol and Other Drug Dependence Treatment—Total	★★	8.03%

SFCCN performed above average on four measures and below average on 19 measures relative to national Medicaid results.

Table C-14 contains the HEDIS 2015 (CY 2014) rates and performance level analysis results for Simply MMA Standard plan.

Table C-14—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Simply			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★★	2.43%
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	2.92%
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	4.14%
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	8.27%
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	12.17%
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	19.46%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★	50.61%
	Well-Child Visits in the 3rd–6th Years of Life	★★	75.18%
	Lead Screening in Children	★★	61.80%
	Adolescent Well-Care Visits	★★	48.42%
	Annual Dental Visit—2–3 years	- -	NA
	Annual Dental Visit—4–6 years	- -	NA
	Annual Dental Visit—7–10 years	- -	NA
	Annual Dental Visit—11–14 years	- -	NA
	Annual Dental Visit—15–18 years	- -	NA
	Annual Dental Visit—19–21 years	- -	NA
	Annual Dental Visit—Total	- -	NA
	Childhood Immunization Status—Combination 2	★★	71.29%
	Childhood Immunization Status—Combination 3	★★	67.40%
	Immunizations for Adolescents—Combination 1	★★	64.72%
	Immunizations for Adolescents—Meningococcal	★★	66.42%
	Immunizations for Adolescents—Tdap/Td	- -	82.97%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★	45.15%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	NA
	Preventive Dental Services	- -	7.42%
	Dental Treatment Services	- -	3.55%
	Sealants	- -	3.39%
Women's Care	*Cervical Cancer Screening*	- -	58.15%
	Chlamydia Screening in Women—16–20 Years	★★★	66.10%
	Chlamydia Screening in Women—21–24 Years	★★	69.33%

Table C-14—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Simply			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
	Chlamydia Screening in Women—Total	★★	66.76%
	Breast Cancer Screening	★★	62.68%
	Timeliness of Prenatal Care	★	72.91%
	Postpartum Care	★	49.44%
	Prenatal Care Frequency	★★	60.61%
	Antenatal Steroids	- -	0.00%
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	90.78%
	Diabetes Care—HbA1c Poor Control	★★★	31.01%
	Diabetes Care—HbA1c Control (<8%)	★★★	59.78%
	Diabetes Care—LDL-C Screening	- -	90.22%
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	40.50%
	Diabetes Care—Eye Exam (Retinal) Performed	★	45.53%
	Diabetes Care—Medical Attention for Nephropathy	★★★	95.81%
	Controlling High Blood Pressure	★★	58.15%
	Adult BMI Assessment	★★	88.32%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	NA
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	NA
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	NA
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	NA
	Use of Appropriate Medications for People with Asthma—Total	★	75.41%
	HIV-Related Medical Visits—0 Visits	- -	NA
	HIV-Related Medical Visits—1 Visit	- -	NA
	HIV-Related Medical Visits—>=2 Visits	- -	NA
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	NA
	Highly Active Anti-Retroviral Treatment	- -	NA
	Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★	93.87%
	Annual Monitoring for Members on Digoxin	- -	NA
	Annual Monitoring for Members on Diuretics	★★★	94.24%
	Annual Monitoring for Patients on Persistent Medications—Total Rate	★★★	93.71%
	HIV Viral Load Suppression—18-64 Years	- -	NA
	HIV Viral Load Suppression—65+ Years	- -	NA
	Plan All-Cause Readmissions—18-64 Years	- -	20.64%
	Plan All-Cause Readmissions—65+ Years	- -	10.53%

Table C-14—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Simply			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	- -	365.36
	Ambulatory Care—ED Visits per 1,000 MM	- -	62.77
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★	94.02%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★	88.68%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★★	88.13%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	83.13%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	66.31%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	82.07%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★★	90.49%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	76.94%
	Call Abandonment	- -	2.58%
	Call Answer Timeliness	★★	90.11%
	Transportation Availability	- -	100.00%
	Transportation Timeliness	- -	86.88%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	★	12.98%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	★	22.65%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★	49.08%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★	42.49%
	Mental Health Readmission Rate	- -	30.17%
	Initiation of Alcohol and Other Drug Dependence Treatment—13-17 Years	★★	50.00%
	Initiation of Alcohol and Other Drug Dependence Treatment—18+ Years	★★	42.54%
	Initiation of Alcohol and Other Drug Dependence Treatment—Total	★★	42.96%
	Engagement of Alcohol and Other Drug Dependence Treatment—13-17 Years	★	0.00%
	Engagement of Alcohol and Other Drug Dependence Treatment—18+ Years	★	1.79%
	Engagement of Alcohol and Other Drug Dependence Treatment—Total	★	1.69%

Simply performed above average on seven measures and below average on 15 measures relative to national Medicaid results.

Table C-15 contains the HEDIS 2015 (CY 2014) rates and performance level analysis results for Staywell MMA Standard plan.

Table C-15—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Staywell			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★★	2.68%
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	2.43%
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	5.11%
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	6.08%
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	9.49%
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	18.73%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★★	55.47%
	Well-Child Visits in the 3rd–6th Years of Life	★★	73.72%
	Lead Screening in Children	★★	58.39%
	Adolescent Well-Care Visits	★★	55.47%
	Annual Dental Visit—2–3 years	- -	16.91%
	Annual Dental Visit—4–6 years	- -	35.38%
	Annual Dental Visit—7–10 years	- -	47.67%
	Annual Dental Visit—11–14 years	- -	41.27%
	Annual Dental Visit—15–18 years	- -	33.28%
	Annual Dental Visit—19–21 years	- -	18.60%
	Annual Dental Visit—Total	★	35.03%
	Childhood Immunization Status—Combination 2	★★	78.83%
	Childhood Immunization Status—Combination 3	★★	74.21%
	Immunizations for Adolescents—Combination 1	★★	65.21%
	Immunizations for Adolescents—Meningococcal	★★	67.40%
	Immunizations for Adolescents—Tdap/Td	- -	83.94%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★★	54.91%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	★★★	70.41%
	Preventive Dental Services	- -	13.26%
	Dental Treatment Services	- -	5.96%
	Sealants	- -	4.90%
Women's Care	*Cervical Cancer Screening*	- -	56.93%
	Chlamydia Screening in Women—16–20 Years	★★	56.02%
	Chlamydia Screening in Women—21–24 Years	★★	70.03%

Table C-15—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Staywell			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
	Chlamydia Screening in Women—Total	★★	60.04%
	Breast Cancer Screening	★★	63.31%
	Timeliness of Prenatal Care	★★	84.91%
	Postpartum Care	★★	59.61%
	Prenatal Care Frequency	★★	74.21%
	Antenatal Steroids	- -	1.57%
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	85.89%
	Diabetes Care—HbA1c Poor Control	★★	40.88%
	Diabetes Care—HbA1c Control (<8%)	★★	49.39%
	Diabetes Care—LDL-C Screening	- -	84.18%
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	33.09%
	Diabetes Care—Eye Exam (Retinal) Performed	★★	54.99%
	Diabetes Care—Medical Attention for Nephropathy	★★	82.24%
	Controlling High Blood Pressure	★★	56.20%
	Adult BMI Assessment	★★	88.81%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	89.63%
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	87.84%
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	73.63%
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	65.00%
	Use of Appropriate Medications for People with Asthma—Total	★★	86.37%
	HIV-Related Medical Visits—0 Visits	- -	12.37%
	HIV-Related Medical Visits—1 Visit	- -	12.04%
	HIV-Related Medical Visits—>=2 Visits	- -	75.59%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	51.51%
	Highly Active Anti-Retroviral Treatment	- -	64.15%
	Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★	92.18%
	Annual Monitoring for Members on Digoxin	★	56.41%
	Annual Monitoring for Members on Diuretics	★★★	92.60%
	Annual Monitoring for Patients on Persistent Medications—Total Rate	★★★	91.83%
	HIV Viral Load Suppression—18-64 Years	- -	0.00%
	HIV Viral Load Suppression—65+ Years	- -	NA
	Plan All-Cause Readmissions—18-64 Years	- -	17.30%
	Plan All-Cause Readmissions—65+ Years	- -	10.30%

Table C-15—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Staywell			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	- -	305.35
	Ambulatory Care—ED Visits per 1,000 MM	- -	74.08
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★★	96.76%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★	89.33%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★★	88.94%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★★	86.83%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	70.96%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★★	86.51%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★★	90.42%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	76.18%
	Call Abandonment	- -	2.31%
	Call Answer Timeliness	★★	89.04%
	Transportation Availability	- -	98.74%
	Transportation Timeliness	- -	61.37%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	★★	33.53%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	★★	52.17%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★	45.98%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★	29.33%
	Mental Health Readmission Rate	- -	21.19%
	Initiation of Alcohol and Other Drug Dependence Treatment—13-17 Years	★★	46.47%
	Initiation of Alcohol and Other Drug Dependence Treatment—18+ Years	★★	42.73%
	Initiation of Alcohol and Other Drug Dependence Treatment—Total	★★	43.18%
	Engagement of Alcohol and Other Drug Dependence Treatment—13-17 Years	★★	13.24%
	Engagement of Alcohol and Other Drug Dependence Treatment—18+ Years	★★	7.43%
	Engagement of Alcohol and Other Drug Dependence Treatment—Total	★★	8.13%

Staywell performed above average on five measures and below average on five measures relative to national Medicaid results.

Table C-16 contains the HEDIS 2015 (CY 2014) rates and performance level analysis results for Sunshine MMA Standard plan.

Table C-16—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Sunshine			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★	3.33%
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	2.38%
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	3.33%
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	5.95%
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	10.48%
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	15.24%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★★	59.29%
	Well-Child Visits in the 3rd–6th Years of Life	★★	75.00%
	Lead Screening in Children	★★	59.52%
	Adolescent Well-Care Visits	★★	47.92%
	Annual Dental Visit—2–3 years	- -	11.60%
	Annual Dental Visit—4–6 years	- -	24.50%
	Annual Dental Visit—7–10 years	- -	29.82%
	Annual Dental Visit—11–14 years	- -	25.67%
	Annual Dental Visit—15–18 years	- -	21.92%
	Annual Dental Visit—19–21 years	- -	12.25%
	Annual Dental Visit—Total	★	23.40%
	Childhood Immunization Status—Combination 2	★★	74.05%
	Childhood Immunization Status—Combination 3	★★	70.24%
	Immunizations for Adolescents—Combination 1	★★	63.57%
	Immunizations for Adolescents—Meningococcal	★★	64.76%
	Immunizations for Adolescents—Tdap/Td	- -	80.71%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★	52.52%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	★★★	65.33%
	Preventive Dental Services	- -	8.44%
	Dental Treatment Services	- -	3.29%
	Sealants	- -	3.98%
Women's Care	*Cervical Cancer Screening*	- -	52.76%
	Chlamydia Screening in Women—16–20 Years	★★	57.64%
	Chlamydia Screening in Women—21–24 Years	★★	70.98%

Table C-16—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Sunshine			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
	Chlamydia Screening in Women—Total	★★	61.98%
	Breast Cancer Screening	★	50.97%
	Timeliness of Prenatal Care	★★	81.21%
	Postpartum Care	★	55.92%
	Prenatal Care Frequency	★★	54.08%
	Antenatal Steroids	- -	NA
Living With Illness	*Diabetes Care—HbA1c Testing*	★	79.87%
	Diabetes Care—HbA1c Poor Control	★★	42.48%
	Diabetes Care—HbA1c Control (<8%)	★★	48.23%
	Diabetes Care—LDL-C Screening	- -	79.65%
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	37.61%
	Diabetes Care—Eye Exam (Retinal) Performed	★★	62.39%
	Diabetes Care—Medical Attention for Nephropathy	★★	79.42%
	Controlling High Blood Pressure	★★	57.53%
	Adult BMI Assessment	★★	86.90%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	85.75%
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	83.12%
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	72.16%
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	65.66%
	Use of Appropriate Medications for People with Asthma—Total	★★	81.86%
	HIV-Related Medical Visits—0 Visits	- -	9.90%
	HIV-Related Medical Visits—1 Visit	- -	15.35%
	HIV-Related Medical Visits—>=2 Visits	- -	74.75%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	52.48%
	Highly Active Anti-Retroviral Treatment	- -	73.33%
	Annual Monitoring for Members on ACE Inhibitors or ARBs	★★★	92.50%
	Annual Monitoring for Members on Digoxin	★	52.63%
	Annual Monitoring for Members on Diuretics	★★	91.78%
	Annual Monitoring for Patients on Persistent Medications—Total Rate	★★★	91.66%
	HIV Viral Load Suppression—18-64 Years	- -	15.07%
	HIV Viral Load Suppression—65+ Years	- -	NA
	Plan All-Cause Readmissions—18-64 Years	- -	15.57%
	Plan All-Cause Readmissions—65+ Years	- -	4.48%

Table C-16—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Sunshine			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	- -	277.38
	Ambulatory Care—ED Visits per 1,000 MM	- -	68.62
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★★	96.27%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★	88.65%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★	86.22%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★	82.22%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	65.12%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★	82.00%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★	77.16%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	70.72%
	Call Abandonment	- -	1.66%
	Call Answer Timeliness	★★	84.33%
	Transportation Availability	- -	86.65%
	Transportation Timeliness	- -	74.26%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	★★	43.90%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	★★	56.76%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★	46.62%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★	31.39%
	Mental Health Readmission Rate	- -	29.64%
	Initiation of Alcohol and Other Drug Dependence Treatment—13-17 Years	- -	NA
	Initiation of Alcohol and Other Drug Dependence Treatment—18+ Years	- -	NA
	Initiation of Alcohol and Other Drug Dependence Treatment—Total	- -	NA
	Engagement of Alcohol and Other Drug Dependence Treatment—13-17 Years	- -	NA
	Engagement of Alcohol and Other Drug Dependence Treatment—18+ Years	- -	NA
	Engagement of Alcohol and Other Drug Dependence Treatment—Total	- -	NA

Sunshine performed above average on three measures and below average on 12 measures relative to national Medicaid results.

Table C-17 contains the HEDIS 2015 (CY 2014) rates and performance level analysis results for Sunshine MMA Specialty plan.

Table C-17—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Sunshine-S			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★★★	0.00%
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	0.00%
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	0.00%
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	12.50%
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	34.38%
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	21.88%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★	31.25%
	Well-Child Visits in the 3rd–6th Years of Life	★★★	84.71%
	Lead Screening in Children	★	52.63%
	Adolescent Well-Care Visits	★★★	69.14%
	Annual Dental Visit—2–3 years	- -	12.75%
	Annual Dental Visit—4–6 years	- -	25.50%
	Annual Dental Visit—7–10 years	- -	37.78%
	Annual Dental Visit—11–14 years	- -	37.04%
	Annual Dental Visit—15–18 years	- -	48.57%
	Annual Dental Visit—19–21 years	- -	NA
	Annual Dental Visit—Total	★	31.59%
	Childhood Immunization Status—Combination 2	★	53.95%
	Childhood Immunization Status—Combination 3	★	46.05%
	Immunizations for Adolescents—Combination 1	- -	NA
	Immunizations for Adolescents—Meningococcal	- -	NA
	Immunizations for Adolescents—Tdap/Td	- -	NA
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	- -	NA
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	- -	NA
	Preventive Dental Services	- -	21.92%
	Dental Treatment Services	- -	1.49%
	Sealants	- -	8.57%
	HPV Vaccine for Female Adolescents	- -	NA
Women's Care	*Chlamydia Screening in Women—16–20 Years*	★★★	73.53%
	Chlamydia Screening in Women—21–24 Years	- -	NA

Table C-17—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Sunshine-S			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
	Chlamydia Screening in Women—Total	★★★	73.53%
	Timeliness of Prenatal Care	- -	NA
	Postpartum Care	- -	NA
	Prenatal Care Frequency	- -	NA
	Antenatal Steroids	- -	NA
Living With Illness	*Use of Appropriate Medications for People with Asthma—5–11 years*	- -	NA
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	NA
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	NA
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	NA
	Use of Appropriate Medications for People with Asthma—Total	- -	NA
	HIV-Related Medical Visits—0 Visits	- -	NA
	HIV-Related Medical Visits—1 Visit	- -	NA
	HIV-Related Medical Visits—>=2 Visits	- -	NA
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	NA
	Highly Active Anti-Retroviral Treatment	- -	NA
	Medication Management for People With Asthma—5-11 Years—Medication Compliance 50%	- -	NA
	Medication Management for People With Asthma—12-18 Years—Medication Compliance 50%	- -	NA
	Medication Management for People With Asthma—19-50 Years—Medication Compliance 50%	- -	NA
	Medication Management for People With Asthma—Total—Medication Compliance 50%	- -	NA
	Medication Management for People With Asthma—5-11 Years—Medication Compliance 75%	- -	NA
	Medication Management for People With Asthma—12-18 Years—Medication Compliance 75%	- -	NA
	Medication Management for People With Asthma—19-50 Years—Medication Compliance 75%	- -	NA
	Medication Management for People With Asthma—Total—Medication Compliance 75%	- -	NA
	HIV Viral Load Suppression—18-64 Years	- -	NA
	HIV Viral Load Suppression—65+ Years	- -	NA
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★★★	99.21%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★★	94.38%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★★	92.26%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★★	92.39%
	Call Abandonment	- -	1.66%
	Call Answer Timeliness	★★	84.33%

Table C-17—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Sunshine-S			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
	Transportation Availability	- -	93.22%
	Transportation Timeliness	- -	55.25%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	★★	51.08%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	★★	61.02%
	Antidepressant Medication Management—Effective Acute Phase Treatment	- -	59.80%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	- -	NA
	Mental Health Readmission Rate	- -	NA
	Initiation of Alcohol and Other Drug Dependence Treatment—13-17 Years	- -	NA
	Initiation of Alcohol and Other Drug Dependence Treatment—18+ Years	- -	NA
	Initiation of Alcohol and Other Drug Dependence Treatment—Total	- -	NA
	Engagement of Alcohol and Other Drug Dependence Treatment—13-17 Years	- -	NA
	Engagement of Alcohol and Other Drug Dependence Treatment—18+ Years	- -	NA
	Engagement of Alcohol and Other Drug Dependence Treatment—Total	- -	NA

Sunshine-S performed above average on seven measures and below average on five measures relative to national Medicaid results.

Table C-18 contains the HEDIS 2015 (CY 2014) rates and performance level analysis results for United MMA Standard plan.

Table C-18—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: United			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Pediatric Care	*Well-Child Visits in the First 15 Months of Life—Zero Visits*	★★	1.95%
	Well-Child Visits in the First 15 Months of Life—1 Visit	- -	1.70%
	Well-Child Visits in the First 15 Months of Life—2 Visits	- -	2.92%
	Well-Child Visits in the First 15 Months of Life—3 Visits	- -	5.35%
	Well-Child Visits in the First 15 Months of Life—4 Visits	- -	10.22%
	Well-Child Visits in the First 15 Months of Life—5 Visits	- -	15.82%
	Well-Child Visits in the First 15 Months of Life—6+ Visits	★★	62.04%
	Well-Child Visits in the 3rd–6th Years of Life	★★	71.28%
	Lead Screening in Children	★	56.93%
	Adolescent Well-Care Visits	★★	48.42%
	Annual Dental Visit—2–3 years	- -	19.59%
	Annual Dental Visit—4–6 years	- -	42.58%
	Annual Dental Visit—7–10 years	- -	51.96%
	Annual Dental Visit—11–14 years	- -	48.96%
	Annual Dental Visit—15–18 years	- -	40.37%
	Annual Dental Visit—19–21 years	- -	25.21%
	Annual Dental Visit—Total	★★	43.61%
	Childhood Immunization Status—Combination 2	★	69.83%
	Childhood Immunization Status—Combination 3	★	63.99%
	Immunizations for Adolescents—Combination 1	★	57.25%
	Immunizations for Adolescents—Meningococcal	★	57.99%
	Immunizations for Adolescents—Tdap/Td	- -	82.06%
	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	★★	47.36%
	Follow-up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	★★★	63.70%
	Preventive Dental Services	- -	7.63%
	Dental Treatment Services	- -	3.25%
	Sealants	- -	3.14%
Women's Care	*Cervical Cancer Screening*	- -	53.28%
	Chlamydia Screening in Women—16–20 Years	★★	49.03%
	Chlamydia Screening in Women—21–24 Years	★★	64.36%

Table C-18—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: United			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
	Chlamydia Screening in Women—Total	★★	52.88%
	Breast Cancer Screening	★★	59.12%
	Timeliness of Prenatal Care	★★	87.83%
	Postpartum Care	★★	65.45%
	Prenatal Care Frequency	★★	53.34%
	Antenatal Steroids	- -	NR
Living With Illness	*Diabetes Care—HbA1c Testing*	★★	85.89%
	Diabetes Care—HbA1c Poor Control	★★	51.09%
	Diabetes Care—HbA1c Control (<8%)	★★	40.88%
	Diabetes Care—LDL-C Screening	- -	81.27%
	Diabetes Care—LDL-C Control (<100 mg/dL)	- -	28.22%
	Diabetes Care—Eye Exam (Retinal) Performed	★	42.58%
	Diabetes Care—Medical Attention for Nephropathy	★★	83.45%
	Controlling High Blood Pressure	★★	54.26%
	Adult BMI Assessment	★★	78.35%
	Use of Appropriate Medications for People with Asthma—5–11 years	- -	89.39%
	Use of Appropriate Medications for People with Asthma—12–18 years	- -	80.42%
	Use of Appropriate Medications for People with Asthma—19–50 years	- -	62.71%
	Use of Appropriate Medications for People with Asthma—51–64 years	- -	62.86%
	Use of Appropriate Medications for People with Asthma—Total	★★	81.84%
	HIV-Related Medical Visits—0 Visits	- -	22.64%
	HIV-Related Medical Visits—1 Visit	- -	12.26%
	HIV-Related Medical Visits—>=2 Visits	- -	65.09%
	HIV-Related Medical Visits—>= 2 Visits (182)	- -	41.51%
	Highly Active Anti-Retroviral Treatment	- -	22.50%
	Annual Monitoring for Members on ACE Inhibitors or ARBs	★★	91.58%
	Annual Monitoring for Members on Digoxin	★	62.00%
	Annual Monitoring for Members on Diuretics	★★	91.60%
	Annual Monitoring for Patients on Persistent Medications—Total Rate	★★★	91.00%
	HIV Viral Load Suppression—18-64 Years	- -	9.83%
	HIV Viral Load Suppression—65+ Years	- -	NA
	Plan All-Cause Readmissions—18-64 Years	- -	16.85%
	Plan All-Cause Readmissions—65+ Years	- -	12.50%

Table C-18—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: United			
Dimension of Care	**2015 Measures**	**Performance Level Analysis**	**2015**
Use of Services	*Ambulatory Care—Outpatient Visits per 1,000 MM*	- -	333.50
	Ambulatory Care—ED Visits per 1,000 MM	- -	75.03
Access/Availability of Care	*Children and Adolescents' Access to Primary Care Practitioners—12–24 months*	★★	96.91%
	Children and Adolescents' Access to Primary Care Practitioners—25 months–6 years	★★	89.75%
	Children and Adolescents' Access to Primary Care Practitioners—7–11 years	★★	88.99%
	Children and Adolescents' Access to Primary Care Practitioners—12–19 years	★★	86.90%
	Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	★	70.16%
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	★★	87.94%
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	★★	88.76%
	Adults' Access to Preventive/Ambulatory Health Services—Total	★	77.28%
	Call Abandonment	- -	6.07%
	Call Answer Timeliness	★	75.43%
	Transportation Availability	- -	100.00%
	Transportation Timeliness	- -	84.69%
Mental Health	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	★★	35.29%
	Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	★★	52.33%
	Antidepressant Medication Management—Effective Acute Phase Treatment	★★	60.98%
	Antidepressant Medication Management—Effective Continuation Phase Treatment	★★	44.31%
	Mental Health Readmission Rate	- -	26.06%
	Initiation of Alcohol and Other Drug Dependence Treatment—13-17 Years	★★★	56.06%
	Initiation of Alcohol and Other Drug Dependence Treatment—18+ Years	★★	46.93%
	Initiation of Alcohol and Other Drug Dependence Treatment—Total	★★★	47.73%
	Engagement of Alcohol and Other Drug Dependence Treatment—13-17 Years	★★	23.23%
	Engagement of Alcohol and Other Drug Dependence Treatment—18+ Years	★★	8.21%
	Engagement of Alcohol and Other Drug Dependence Treatment—Total	★★	9.52%

United performed above average on four measures and below average on 10 measures relative to national Medicaid results.

LTC Plans

This section presents the Florida Medicaid HEDIS 2015 (CY 2014) results compared to the AHCA-developed, combined percentiles (only *Call Answer Timeliness* was assigned a performance target by AHCA). Measures for which the LTC plan's eligible population (<30) was too small to calculate a valid rate received an audit designation of *NA*.

For all tables presented in this appendix, the following legend applies to the Performance Level Analysis and 2015 Rate columns:

Symbols in the Performance Level Analysis Column		
★	=	Below-average performance relative to national Medicaid results
★★	=	Average performance relative to national Medicaid results
★★★	=	Above-average performance relative to national Medicaid results
- -	=	Indicates AHCA-developed, combined percentiles were not available to compare, or plan rate reported as *NA* or *NB*
Symbols in the 2015 Rate Column		
NR	=	Indicates *Not Reportable* for the following reasons: ◆ The calculated rate was materially biased, or ◆ The LTC plan chose not to report the measure, or ◆ The LTC plan was not required to report the measure.
NA	=	Indicates *Small Denominator* (i.e., the LTC plan followed the specifications, but the denominator was too small (< 30) to report a valid rate.)
NB	=	Indicates *No Benefit* (i.e., the LTC plan did not offer the health benefits required by the measure)

Table C-19 displays American Eldercare's performance rates and performance level analysis results.

Table C-19—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: American Eldercare-LTC		
2015 Measures	Performance Level Analysis	2015
Care for Older Adults—Advance Care Planning—18–60 Years	- -	85.06%
Care for Older Adults—Advance Care Planning—61–65 Years	- -	87.29%
Care for Older Adults—Advance Care Planning—66+ Years	- -	87.24%
Care for Older Adults—Advance Care Planning—Total	- -	87.08%
Care for Older Adults—Medication Review—18–60 Years	- -	92.65%
Care for Older Adults—Medication Review—61–65 Years	- -	94.90%
Care for Older Adults—Medication Review—66+ Years	- -	96.66%
Care for Older Adults—Medication Review—Total	- -	96.36%
Care for Older Adults—Functional Status Assessment—18–60 Years	- -	88.98%
Care for Older Adults—Functional Status Assessment—61–65 Years	- -	90.82%
Care for Older Adults—Functional Status Assessment—66+ Years	- -	93.32%
Care for Older Adults—Functional Status Assessment—Total	- -	92.96%
Call Abandonment	- -	5.60%
Call Answer Timeliness	★★	88.31%
Required Record Documentation—701B Assessment	- -	91.18%
Required Record Documentation—Enrollee Participation	- -	95.98%
Required Record Documentation—Primary Care Physician Notification	- -	61.93%
Face-to-Face Encounters	- -	74.76%
Case Manager Training	- -	100.00%
Timeliness of Services	- -	87.43%

American Eldercare's performance results showed that for the *Care for Older Adults* measure, at least eight out of 10 enrollees had an advance care plan, at least nine out of 10 enrollees received a medication review, and at least nine out of 10 enrollees had a functional status assessment.

For the *Call Abandonment* measure, one out of 20 calls were abandoned by the caller before being answered by a live voice, while nearly nine out of 10 calls from enrollees were answered by a live voice within 30 seconds.

During the measurement year, at least nine out of 10 American Eldercare enrollees had a 701B Assessment Form and had a signed plan of care in their record, while only six out of 10 enrollees had their plans of care sent to their primary care physicians within the required time frame.

The results also showed that at least seven out of 10 enrollees had a face-to-face encounter with a case manager every three months, while for the *Timeliness of Services* measure, at least eight out of 10 enrollees received services within three days of enrollment. All case managers with at least three months of employment received training on the mandate to report abuse, neglect, and exploitation.

Table C-20 displays Amerigroup's performance rates and performance level analysis results.

Table C-20—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Amerigroup-LTC		
2015 Measures	Performance Level Analysis	2015
Care for Older Adults—Advance Care Planning—18–60 Years	- -	74.19%
Care for Older Adults—Advance Care Planning—61–65 Years	- -	NA
Care for Older Adults—Advance Care Planning—66+ Years	- -	72.80%
Care for Older Adults—Advance Care Planning—Total	- -	73.13%
Care for Older Adults—Medication Review—18–60 Years	- -	NA
Care for Older Adults—Medication Review—61–65 Years	- -	NA
Care for Older Adults—Medication Review—66+ Years	- -	14.72%
Care for Older Adults—Medication Review—Total	- -	15.05%
Care for Older Adults—Functional Status Assessment—18–60 Years	- -	NA
Care for Older Adults—Functional Status Assessment—61–65 Years	- -	NA
Care for Older Adults—Functional Status Assessment—66+ Years	- -	61.68%
Care for Older Adults—Functional Status Assessment—Total	- -	61.57%
Call Abandonment	- -	9.95%
Call Answer Timeliness	★	67.40%
Required Record Documentation—701B Assessment	- -	33.10%
Required Record Documentation—Enrollee Participation	- -	79.17%
Required Record Documentation—Primary Care Physician Notification	- -	53.47%
Face-to-Face Encounters	- -	69.27%
Case Manager Training	- -	95.18%
Timeliness of Services	- -	58.84%

Amerigroup's performance results showed that for the *Care for Older Adults* measure, at least seven out of 10 enrollees had an advance care plan, less than two out of 10 enrollees received a medication review, and at least six out of 10 enrollees had a functional status assessment.

For the *Call Abandonment* measure, nearly one out of 10 calls were abandoned by the caller before being answered by a live voice, while at least six out of 10 calls from enrollees were answered by a live voice within 30 seconds, where the rate was below the national Medicaid average.

During the measurement year, less than four out of 10 Amerigroup enrollees had a 701B Assessment Form, while nearly eight out of 10 enrollees had a signed plan of care in their record. Only five out of 10 enrollees had their plans of care sent to their primary care physicians within the required time frame.

The results also showed that nearly seven out of 10 enrollees had a face-to-face encounter with a case manager every three months, while for the *Timeliness of Services* measure, less than six out of 10 enrollees received services within three days of enrollment. In addition, at least nine out of 10 case managers with at least three months of employment received training on the mandate to report abuse, neglect, and exploitation.

Table C-21 displays Coventry's performance rates and performance level analysis results.

Table C-21—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Coventry-LTC		
2015 Measures	Performance Level Analysis	2015
Care for Older Adults—Advance Care Planning—18–60 Years	- -	83.33%
Care for Older Adults—Advance Care Planning—61–65 Years	- -	84.38%
Care for Older Adults—Advance Care Planning—66+ Years	- -	75.37%
Care for Older Adults—Advance Care Planning—Total	- -	76.89%
Care for Older Adults—Medication Review—18–60 Years	- -	85.71%
Care for Older Adults—Medication Review—61–65 Years	- -	90.63%
Care for Older Adults—Medication Review—66+ Years	- -	83.98%
Care for Older Adults—Medication Review—Total	- -	84.67%
Care for Older Adults—Functional Status Assessment—18–60 Years	- -	100.00%
Care for Older Adults—Functional Status Assessment—61–65 Years	- -	96.88%
Care for Older Adults—Functional Status Assessment—66+ Years	- -	94.96%
Care for Older Adults—Functional Status Assessment—Total	- -	95.62%
Call Abandonment	- -	6.81%
Call Answer Timeliness	★★	93.19%
Required Record Documentation—701B Assessment	- -	33.67%
Required Record Documentation—Enrollee Participation	- -	81.02%
Required Record Documentation—Primary Care Physician Notification	- -	49.39%
Face-to-Face Encounters	- -	58.79%
Case Manager Training	- -	98.85%
Timeliness of Services	- -	96.89%

Coventry's performance results showed that for the *Care for Older Adults* measure, at least seven out of 10 enrollees had an advance care plan, at least eight out of 10 enrollees received a medication review, and nine out of 10 enrollees had a functional status assessment.

For the *Call Abandonment* measure, at least one out of 20 calls were abandoned by the caller before being answered by a live voice, while at least nine out of 10 calls from enrollees were answered by a live voice within 30 seconds.

During the measurement year, less than four out of 10 Coventry enrollees had a 701B Assessment Form, while at least eight out of 10 enrollees had a signed plan of care in their record. Additionally, nearly five out of 10 enrollees had their plans of care sent to their primary care physicians within the required time frame.

The results also showed that less than six out of 10 enrollees had a face-to-face encounter with a case manager every three months, while for the *Timeliness of Services* measure, at least nine out of 10 enrollees received services within three days of enrollment. In addition, at least nine out of 10 case managers with at least three months of employment received training on the mandate to report abuse, neglect, and exploitation.

Table C-22 displays Humana's performance rates and performance level analysis results.

Table C-22—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Humana-LTC		
2015 Measures	Performance Level Analysis	2015
Care for Older Adults—Advance Care Planning—18–60 Years	- -	58.93%
Care for Older Adults—Advance Care Planning—61–65 Years	- -	64.71%
Care for Older Adults—Advance Care Planning—66+ Years	- -	84.35%
Care for Older Adults—Advance Care Planning—Total	- -	81.38%
Care for Older Adults—Medication Review—18–60 Years	- -	17.74%
Care for Older Adults—Medication Review—61–65 Years	- -	11.11%
Care for Older Adults—Medication Review—66+ Years	- -	13.62%
Care for Older Adults—Medication Review—Total	- -	13.74%
Care for Older Adults—Functional Status Assessment—18–60 Years	- -	100.00%
Care for Older Adults—Functional Status Assessment—61–65 Years	- -	100.00%
Care for Older Adults—Functional Status Assessment—66+ Years	- -	100.00%
Care for Older Adults—Functional Status Assessment—Total	- -	100.00%
Call Abandonment	- -	3.57%
Call Answer Timeliness	★★★	96.42%
Required Record Documentation—701B Assessment	- -	84.47%
Required Record Documentation—Enrollee Participation	- -	85.02%
Required Record Documentation—Primary Care Physician Notification	- -	31.52%
Face-to-Face Encounters	- -	81.58%
Case Manager Training	- -	92.77%
Timeliness of Services	- -	68.38%

Humana's performance results showed that for the *Care for Older Adults* measure, at least eight out of 10 enrollees had an advance care plan, only one out of 10 enrollees received a medication review, and all enrollees had a functional status assessment.

For the *Call Abandonment* measure, nearly two out of 50 calls were abandoned by the caller before being answered by a live voice, while at least nine out of 10 calls from enrollees were answered by a live voice within 30 seconds, where the rate was above the national Medicaid average.

During the measurement year, at least eight out of 10 Humana enrollees had a 701B Assessment Form and signed plan of care in their record, while only three out of 10 enrollees had their plans of care sent to their primary care physicians within the required time frame.

The results also showed that at least eight out of 10 enrollees had a face-to-face encounter with a case manager every three months, while for the *Timeliness of Services* measure, at least seven out of 10 enrollees received services within three days of enrollment. In addition, at least nine out of 10 case managers with at least three months of employment received training on the mandate to report abuse, neglect, and exploitation.

Table C-23 displays Molina's performance rates and performance level analysis results.

Table C-23—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Molina-LTC		
2015 Measures	Performance Level Analysis	2015
Care for Older Adults—Advance Care Planning—18–60 Years	- -	86.11%
Care for Older Adults—Advance Care Planning—61–65 Years	- -	NA
Care for Older Adults—Advance Care Planning—66+ Years	- -	92.98%
Care for Older Adults—Advance Care Planning—Total	- -	92.49%
Care for Older Adults—Medication Review—18–60 Years	- -	NA
Care for Older Adults—Medication Review—61–65 Years	- -	NA
Care for Older Adults—Medication Review—66+ Years	- -	13.63%
Care for Older Adults—Medication Review—Total	- -	13.02%
Care for Older Adults—Functional Status Assessment—18–60 Years	- -	NA
Care for Older Adults—Functional Status Assessment—61–65 Years	- -	NA
Care for Older Adults—Functional Status Assessment—66+ Years	- -	96.84%
Care for Older Adults—Functional Status Assessment—Total	- -	97.13%
Call Abandonment	- -	2.36%
Call Answer Timeliness	★★	88.47%
Required Record Documentation—701B Assessment	- -	85.71%
Required Record Documentation—Enrollee Participation	- -	96.21%
Required Record Documentation—Primary Care Physician Notification	- -	13.14%
Face-to-Face Encounters	- -	35.07%
Case Manager Training	- -	100.00%
Timeliness of Services	- -	9.57%

Molina's performance results showed that for the *Care for Older Adults* measure, at least nine out of 10 enrollees had an advance care plan, less than two out of 10 enrollees received a medication review, and at least nine out of 10 enrollees had a functional status assessment.

For the *Call Abandonment* measure, nearly one out of 40 calls were abandoned by the caller before being answered by a live voice, while at least eight out of 10 calls from enrollees were answered by a live voice within 30 seconds.

During the measurement year, at least eight out of 10 Molina enrollees had a 701B Assessment Form, while at least nine out of 10 enrollees had a signed plan of care in their record. Less than two out of 10 enrollees had their plans of care sent to their primary care physicians within the required time frame.

The results also showed that less than four out of 10 enrollees had a face-to-face encounter with a case manager every three months, while for the *Timeliness of Services* measure, one out of 10 enrollees received services within three days of enrollment. All case managers with at least three months of employment received training on the mandate to report abuse, neglect, and exploitation.

Table C-24 displays Sunshine's performance rates and performance level analysis results.

Table C-24—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: Sunshine-LTC		
2015 Measures	Performance Level Analysis	2015
Care for Older Adults—Advance Care Planning—18–60 Years	- -	36.28%
Care for Older Adults—Advance Care Planning—61–65 Years	- -	30.69%
Care for Older Adults—Advance Care Planning—66+ Years	- -	29.86%
Care for Older Adults—Advance Care Planning—Total	- -	30.62%
Care for Older Adults—Medication Review—18–60 Years	- -	0.00%
Care for Older Adults—Medication Review—61–65 Years	- -	0.00%
Care for Older Adults—Medication Review—66+ Years	- -	0.00%
Care for Older Adults—Medication Review—Total	- -	0.00%
Care for Older Adults—Functional Status Assessment—18–60 Years	- -	86.19%
Care for Older Adults—Functional Status Assessment—61–65 Years	- -	83.39%
Care for Older Adults—Functional Status Assessment—66+ Years	- -	78.16%
Care for Older Adults—Functional Status Assessment—Total	- -	79.34%
Call Abandonment	- -	13.03%
Call Answer Timeliness	★★★	96.02%
Required Record Documentation—701B Assessment	- -	16.06%
Required Record Documentation—Enrollee Participation	- -	36.25%
Required Record Documentation—Primary Care Physician Notification	- -	4.14%
Face-to-Face Encounters	- -	74.42%
Case Manager Training	- -	78.97%
Timeliness of Services	- -	37.18%

Sunshine's performance results showed that for the *Care for Older Adults* measure, three out of 10 enrollees had an advance care plan, no enrollees received a medication review, and nearly eight out of 10 enrollees had a functional status assessment.

For the *Call Abandonment* measure, approximately three out of 25 calls were abandoned by the caller before being answered by a live voice, while at least nine out of 10 calls from enrollees were answered by a live voice within 30 seconds, where the rate was above the national Medicaid average.

During the measurement year, less than two out of 10 Sunshine enrollees had a 701B Assessment Form, while less than four out of 10 enrollees had a signed plan of care in their record. Less than 5 percent of the enrollees had their plans of care sent to their primary care physicians within the required time frame.

The results also showed that at least seven out of 10 enrollees had a face-to-face encounter with a case manager every three months, while for the *Timeliness of Services* measure, less than four out of 10 enrollees received services within three days of enrollment. In addition, at least seven out of 10 case managers with at least three months of employment received training on the mandate to report abuse, neglect, and exploitation.

Table C-25 displays United's performance rates and performance level analysis results.

Table C-25—Florida Medicaid HEDIS 2015 (CY 2014) Result Summary Table: United-LTC		
2015 Measures	Performance Level Analysis	2015
Care for Older Adults—Advance Care Planning—18–60 Years	- -	0.00%
Care for Older Adults—Advance Care Planning—61–65 Years	- -	NA
Care for Older Adults—Advance Care Planning—66+ Years	- -	1.43%
Care for Older Adults—Advance Care Planning—Total	- -	1.22%
Care for Older Adults—Medication Review—18–60 Years	- -	6.38%
Care for Older Adults—Medication Review—61–65 Years	- -	NA
Care for Older Adults—Medication Review—66+ Years	- -	2.31%
Care for Older Adults—Medication Review—Total	- -	2.68%
Care for Older Adults—Functional Status Assessment—18–60 Years	- -	2.13%
Care for Older Adults—Functional Status Assessment—61–65 Years	- -	NA
Care for Older Adults—Functional Status Assessment—66+ Years	- -	6.94%
Care for Older Adults—Functional Status Assessment—Total	- -	6.33%
Call Abandonment	- -	1.47%
Call Answer Timeliness	★★	88.84%
Required Record Documentation—701B Assessment	- -	0.97%
Required Record Documentation—Enrollee Participation	- -	2.68%
Required Record Documentation—Primary Care Physician Notification	- -	1.22%
Face-to-Face Encounters	- -	82.06%
Case Manager Training	- -	95.40%
Timeliness of Services	- -	66.44%

United's performance results showed that for the *Care for Older Adults* measure, nearly three out of 200 enrollees had an advance care plan, less than three out of 100 enrollees received a medication review, and at least two out of 100 enrollees had a functional status assessment.

For the *Call Abandonment* measure, less than two out of 100 calls were abandoned by the caller before being answered by a live voice, while at least eight out of 10 calls from enrollees were answered by a live voice within 30 seconds.

During the measurement year, less than two out of 200 United enrollees had a 701B Assessment Form, while only six out of 200 enrollees had a signed plan of care in their record. Less than 2 percent of the enrollees had their plans of care sent to their primary care physicians within the required time frame.

The results also showed that at least eight out of 10 enrollees had a face-to-face encounter with a case manager every three months, while for the *Timeliness of Services* measure, at least six out of 10 enrollees received services within three days of enrollment. In addition, at least nine out of 10 case managers with at least three months of employment received training on the mandate to report abuse, neglect, and exploitation.

Appendix D. Compliance Review Results—Deeming Study

Table D-1 below includes the federal requirements that were given a *Met* equivalency by HSAG. Rows shaded in yellow indicate that AHCA contract provisions exceeded federal requirements.

Table D-1—*Met* Federal Requirements			
Row No. on Crosswalks	**Federal Medicaid Managed Care Regulation**	**NCQA *Met***	**AAAHC *Met***
Access Standards			
2.	§438.206 (b) (1)		X
3.	§438.206 (b) (2)	X	X
5.	§438.206 (b) (4)	X	
6.	§438.206 (b) (5)	X	X
9.	§438.206 (c) (1) (i)(ii)(iii)		X
10.	§438.206 (c) (1) (iv)(v)(vi)		X
11.	§438.206 (c) (2)	X	X
13.	§438.207 (b) (1)(2)	X	
22.	§438.208 (b)(4)		X
30.	§438.210 (b) (3)	X	
31.	§438.210 (c)	X	
32.	§438.210 (d) (1)(2)		X
33.	§438.210 (e)		X
Structure & Operations Standards			
42.	§438.214 (b) (1) (2)	X	
43.	§438.214(c)	X	X
44.	§438.214 (d)		X
52.	§438.230 (b)(1)		X
53.	§438.230 (b)(2)(i)(ii)		X
54.	§438.230 (b)(3)		X
55.	§438.230 (b)(4)		X
Measurement & Improvement Standards			
57.	§438.236 (b) (1)(2)(3)(4)		X
59.	§438.236 (d)		X
60.	§438.240 (a) (1)	X	
71.	§438.242 (b) (1)(2)(3)		X
Grievance System			
84.	§438.406(b)(3)	X	
90.	§438.408 (c)(1)(i)(ii)	X	
92.	§438.408 (d)(1)	X	
94.	§438.408 (e)(1)	X	
98.	§438.410(a)	X	

Table D-1—*Met* Federal Requirements			
Row No. on Crosswalks	**Federal Medicaid Managed Care Regulation**	**NCQA *Met***	**AAAHC *Met***
104.	§438.424 (a)	X	
Information Requirements			
107.	§438.10(b) (1)	X	
109.	§438.10(b) (3)	X	
120.	§438.10(f)(2)	X	
123.	§438.10(f) (5)	X	
125.	§438.10(f) (6)(ii)	X	
128.	§438.10(f) (6)(v)	X	
129.	§438.10(f) (6)(vi)	X	
133.	§438.10(f) (6)(x)	X	
134.	§438.10(f) (6)(xi)	X	

Encounter Volume Completeness and Reasonableness

Table E-1 provides a general overview of the average utilization per enrollee by plan from the beginning of CY 2013 through the first quarter of CY 2014 (January 1, 2013—March 31, 2014) for professional, dental, and institutional encounters.

Table E-1—Encounter Data Overview

Plan	Average Number of Enrollees per Month[1]	Professional		Dental		Institutional	
		Total Number of Encounters[2]	Total Encounters PMPM[3]	Total Number of Encounters	Total Encounters PMPM	Total Number of Encounters	Total Encounters PMPM
AMG-L[4]	1,399	292,955	13.96	2	0.00	6,309	0.30
AMG-M[4]	181,436	1,385,944	0.51	8	0.00	14,782	0.01
BET-M	40,371	207,244	0.34	24,953	0.04	3	0.00
CHA-S	1,270	25,387	1.33	44	0.00	444	0.02
COV-L[4]	1,608	85,782	3.56	6	0.00	13,023	0.54
COV-M[4]	29,601	330,159	0.74			3,557	0.01
FRE-S	32,666	305,424	0.62	4,109	0.01	46,720	0.10
HEA-M	143,805	1,523,311	0.71	11	0.00	16,558	0.01
HUM-L[4]	953	92,635	6.48			6,358	0.44
HUM-M	53,898	754,211	0.93	7,293	0.01	7,374	0.01
IHP-M	36,172	334,407	0.62	8,274	0.02	3,417	0.01
MCC-S	241	2,182	0.60	56	0.02	167	0.05
MOL-L	1,100	138,205	8.38	18	0.00	4,243	0.26
MOL-M	80,814	956,829	0.79	53,269	0.04	9,550	0.01
PHC-S[4]	479	17,918	2.49	4	0.00	422	0.06
PRE-M	15,743	133,710	0.57	636	0.00	17,634	0.07
PRS-M	94,044	859,429	0.61	4,704	0.00	10,502	0.01
SHP-M	41,256	367,310	0.59	835	0.00	2,824	0.00
STW-M	239,618	3,000,473	0.83	6,325	0.00	30,788	0.01
SUN-L	7,105	607,466	5.70	375	0.00	67,847	0.64
SUN-M	207,603	2,470,508	0.79	66,384	0.02	28,026	0.01
UFS-M	70,516	82,663	0.08	2	0.00	124	0.00
URA-L	5,414	302,590	3.73	645	0.01	41,699	0.51
URA-M	119,402	1,154,039	0.64	2,522	0.00	7,213	0.00
VIS-M[4]	24,286	239,330	0.66			2,020	0.01
All Plans	**1,430,531**	**15,670,111**	**0.73**	**180,475**	**0.01**	**341,604**	**0.02**

[1] The average number of enrollees was calculated by dividing the total number of member months by 15, in order to align with the number of months in the encounter data for the review period of January 1, 2013, through March 31, 2014.

[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.

These plans did not provide dental services during the study period. While they did not provide dental services during the study period, a small number of encounters were reported in AHCA's encounter submission; therefore, rates should be interpreted with caution.

Gray shading indicates that no encounters were submitted.

Encounter Data Volume by Encounter Status

Table E-2 shows the number and percentage of professional encounter records by encounter status for AHCA's and the plans' submitted encounters.

Table E-2—Distribution of Volume for Professional Encounters by Claim Status (January 1, 2013–March 31, 2014)

Plan	Status	AHCA Submitted Data[1]		Plan Submitted Data[2]		Volume Difference
		N	%	N	%	
AMG-L	Denied	126,393	25.7%	39,411	9.0%	86,982
	Paid	365,590	74.3%	397,261	91.0%	-31,671
	Total	**491,983**	**100.0%**	**436,672**	**100.0%**	**55,311**
AMG-M	Denied	1,020,718	30.0%	1,040,711	19.9%	-19,993
	Paid	2,378,182	70.0%	4,180,669	80.1%	-1,802,487
	Total	**3,398,900**	**100.0%**	**5,221,380**	**100.0%**	**-1,822,480**
BET-M	Denied	271,307	42.0%	0	0.0%	271,307
	Paid	374,795	58.0%	104,798	100.0%	269,997
	Total	**646,102**	**100.0%**	**104,798**	**100.0%**	**541,304**
CHA-S	Denied	24,090	26.8%	0	0.0%	24,090
	Paid	65,880	73.2%	39,036	100.0%	26,844
	Total	**89,970**	**100.0%**	**39,036**	**100.0%**	**50,934**
COV-L	Denied	115,831	50.6%	0	0.0%	115,831
	Paid	112,921	49.4%	129,083	92.0%	-16,162
	Reversed	0	0.0%	11,280	8.0%	-11,280
	Total	**228,752**	**100.0%**	**140,363**	**100.0%**	**88,389**
COV-M	Denied	100,323	13.0%	0	0.0%	100,323
	Other	0	0.0%	154,424	25.4%	-154,424
	Paid	673,289	87.0%	454,280	74.6%	219,009
	Total	**773,612**	**100.0%**	**608,704**	**100.0%**	**164,908**
FRE-S	Denied	233,569	28.7%	0	0.0%	233,569
	Other	0	0.0%	767,116	100.0%	-767,116
	Paid	579,083	71.3%	0	0.0%	579,083
	Total	**812,652**	**100.0%**	**767,116**	**100.0%**	**45,536**
HEA-M	Denied	1,108,686	29.2%	0	0.0%	1,108,686
	Other	0	0.0%	403,093	15.5%	-403,093
	Paid	2,684,267	70.8%	2,196,940	84.5%	487,327
	Total	**3,792,953**	**100.0%**	**2,600,033**	**100.0%**	**1,192,920**
HUM-L	Denied	251,529	65.9%	0	0.0%	251,529
	Paid	130,370	34.1%	142,712	95.3%	-12,342
	Reversed	0	0.0%	7,098	4.7%	-7,098
	Total	**381,899**	**100.0%**	**149,810**	**100.0%**	**232,089**

Table E-2—Distribution of Volume for Professional Encounters by Claim Status (January 1, 2013–March 31, 2014)						
Plan	Status	AHCA Submitted Data[1]		Plan Submitted Data[2]		Volume Difference
		N	%	N	%	
HUM-M	Denied	1,511,965	56.3%	0	0.0%	1,511,965
	Other	0	0.0%	1,785,052	99.6%	-1,785,052
	Paid	1,174,713	43.7%	7,950	0.4%	1,166,763
	Total	**2,686,678**	**100.0%**	**1,793,002**	**100.0%**	**893,676**
IHP-M	Denied	135,076	19.3%	0	0.0%	135,076
	Other	0	0.0%	525,193	84.4%	-525,193
	Paid	564,346	80.7%	97,298	15.6%	467,048
	Total	**699,422**	**100.0%**	**622,491**	**100.0%**	**76,931**
MCC-S	Denied	757	15.5%	0	0.0%	757
	Other	0	0.0%	93	2.5%	-93
	Paid	4,118	84.5%	3,644	97.5%	474
	Total	**4,875**	**100.0%**	**3,737**	**100.0%**	**1,138**
MOL-L	Denied	80,993	34.4%	0	0.0%	80,993
	Other	0	0.0%	291	0.2%	-291
	Paid	154,753	65.6%	165,009	99.8%	-10,256
	Total	**235,746**	**100.0%**	**165,300**	**100.0%**	**70,446**
MOL-M	Denied	649,733	29.5%	0	0.0%	649,733
	Other	0	0.0%	97,922	5.1%	-97,922
	Paid	1,554,764	70.5%	1,832,839	94.9%	-278,075
	Total	**2,204,497**	**100.0%**	**1,930,761**	**100.0%**	**273,736**
PHC-S	Denied	5,652	11.7%	0	0.0%	5,652
	Paid	42,536	88.3%	42,260	100.0%	276
	Total	**48,188**	**100.0%**	**42,260**	**100.0%**	**5,928**
PRE-M	Denied	69,274	21.9%	0	0.0%	69,274
	Paid	246,669	78.1%	291,393	100.0%	-44,724
	Total	**315,943**	**100.0%**	**291,393**	**100.0%**	**24,550**
PRS-M	Denied	620,554	36.2%	91,576	5.7%	528,978
	Paid	1,091,839	63.8%	1,506,235	94.3%	-414,396
	Total	**1,712,393**	**100.0%**	**1,597,811**	**100.0%**	**114,582**
SHP-M	Denied	402,705	36.0%	0	0.0%	402,705
	Paid	714,762	64.0%	543,497	100.0%	171,265
	Total	**1,117,467**	**100.0%**	**543,497**	**100.0%**	**573,970**
STW-M	Denied	1,965,038	26.0%	0	0.0%	1,965,038
	Other	0	0.0%	4,565,194	82.3%	-4,565,194
	Paid	5,594,582	74.0%	981,976	17.7%	4,612,606
	Total	**7,559,620**	**100.0%**	**5,547,170**	**100.0%**	**2,012,450**
SUN-L	Denied	1,074,721	53.4%	243,410	17.9%	831,311
	Other	0	0.0%	5,405	0.4%	-5,405
	Paid	936,121	46.6%	1,108,321	81.7%	-172,200
	Total	**2,010,842**	**100.0%**	**1,357,136**	**100.0%**	**653,706**
SUN-M	Denied	1,335,935	24.5%	1,267,734	21.6%	68,201
	Other	0	0.0%	248,759	4.2%	-248,759
	Paid	4,124,311	75.5%	4,356,676	74.2%	-232,365
	Total	**5,460,246**	**100.0%**	**5,873,169**	**100.0%**	**-412,923**

Table E-2—Distribution of Volume for Professional Encounters by Claim Status (January 1, 2013–March 31, 2014)						
Plan	Status	AHCA Submitted Data[1]		Plan Submitted Data[2]		Volume Difference
		N	%	N	%	
UFS-M	Denied	5,122	3.5%	47,618	20.6%	-42,496
	Other	0	0.0%	9,353	4.0%	-9,353
	Paid	139,699	96.5%	174,017	75.3%	-34,318
	Total	**144,821**	**100.0%**	**230,988**	**100.0%**	**-86,167**
URA-L	Denied	156,621	29.3%	169,258	22.9%	-12,637
	Other	0	0.0%	80,897	10.9%	-80,897
	Paid	377,690	70.7%	489,859	66.2%	-112,169
	Total	**534,311**	**100.0%**	**740,014**	**100.0%**	**-205,703**
URA-M	Denied	994,318	39.6%	763,835	21.0%	230,483
	Other	0	0.0%	120,162	3.3%	-120,162
	Paid	1,513,970	60.4%	2,751,424	75.7%	-1,237,454
	Total	**2,508,288**	**100.0%**	**3,635,421**	**100.0%**	**-1,127,133**
VIS-M	Denied	78,881	11.3%	0	0.0%	78,881
	Other	0	0.0%	314,160	52.1%	-314,160
	Paid	617,314	88.7%	289,304	47.9%	328,010
	Total	**696,195**	**100.0%**	**603,464**	**100.0%**	**92,731**

[1] Final status of the encounter claim line (either paid or denied)

[2] Plans submitted these values in either the *EncClaimStat-Process* or *EncClaimStat-Plan* fields. According to the data requirement, the *EncClaimStat-Process* represents the Status of the claim/encounter as a result of the plan's internal processing of the claim/encounter and the *EncClaimStat-Plan* represents the status of the claim based on payment to the provider for services performed.

Table E-3 shows the number and percentage of dental encounter records by claim status for AHCA's and plans' submitted encounters.

Table E-3—Distribution of Volume for Dental Encounters by Claim Status (January 1, 2013–March 31, 2014)						
Plan	Status	AHCA Submitted Data[1]		Plan Submitted Data[2]		Volume Difference
		N	%	N	%	
AMG-L	Denied	9	75.0%	17	53.1%	-8
	Paid	3	25.0%	15	46.9%	-12
	Total	**12**	**100.0%**	**32**	**100.0%**	**-20**
AMG-M	Denied	0	0.0%	12	2.0%	-12
	Paid	31	100.0%	587	98.0%	-556
	Total	**31**	**100.0%**	**599**	**100.0%**	**-568**
BET-M	Denied	612,642	96.6%	0	0.0%	612,642
	Paid	21,594	3.4%	347,335	100.0%	-325,741
	Total	**634,236**	**100.0%**	**347,335**	**100.0%**	**286,901**
CHA-S	Denied	169	88.0%	0	0.0%	169
	Paid	23	12.0%	24	100.0%	-1
	Total	**192**	**100.0%**	**24**	**100.0%**	**168**
COV-L	Other	0	0.0%	10	100.0%	-10
	Paid	10	100.0%	0	0.0%	10
	Total	**10**	**100.0%**	**10**	**100.0%**	**0**
FRE-S	Denied	3,554	23.9%	0	0.0%	3,554
	Other	0	0.0%	16,996	100.0%	-16,996

Table E-3—Distribution of Volume for Dental Encounters by Claim Status (January 1, 2013–March 31, 2014)						
Plan	Status	AHCA Submitted Data[1]		Plan Submitted Data[2]		Volume Difference
		N	%	N	%	
	Paid	11,308	76.1%	0	0.0%	11,308
	Total	**14,862**	**100.0%**	**16,996**	**100.0%**	**-2,134**
HEA-M	Denied	12	30.0%	0	0.0%	12
	Paid	28	70.0%	5	100.0%	23
	Total	**40**	**100.0%**	**5**	**100.0%**	**35**
HUM-M	Accepted	0	0.0%	34,847	99.7%	-34,847
	Cross-over	0	0.0%	1	0.0%	-1
	Denied	25,065	60.6%	0	0.0%	25,065
	Other	0	0.0%	109	0.3%	-109
	Paid	16,329	39.4%	0	0.0%	16,329
	Total	**41,394**	**100.0%**	**34,957**	**100.0%**	**6,437**
IHP-M	Denied	11,581	30.4%	0	0.0%	11,581
	Other	0	0.0%	34,943	100.0%	-34,943
	Paid	26,569	69.6%	0	0.0%	26,569
	Total	**38,150**	**100.0%**	**34,943**	**100.0%**	**3,207**
MCC-S	Accepted	0	0.0%	155	100.0%	-155
	Denied	251	56.3%	0	0.0%	251
	Paid	195	43.7%	0	0.0%	195
	Total	**446**	**100.0%**	**155**	**100.0%**	**291**
MOL-L	Denied	26	52.0%	0	0.0%	26
	Paid	24	48.0%	50	100.0%	-26
	Total	**50**	**100.0%**	**50**	**100.0%**	**0**
MOL-M	Denied	141,343	51.9%	0	0.0%	141,343
	Paid	131,050	48.1%	240,066	100.0%	-109,016
	Total	**272,393**	**100.0%**	**240,066**	**100.0%**	**32,327**
PHC-S	Denied	12	100.0%	0	NA	12
	Total	**12**	**100.0%**	**0**	**NA**	**12**
PRE-M	Denied	1,141	39.5%	0	0.0%	1,141
	Paid	1,744	60.5%	4,193	100.0%	-2,449
	Total	**2,885**	**100.0%**	**4,193**	**100.0%**	**-1,308**
PRS-M	Denied	1,526	16.4%	0	0.0%	1,526
	Paid	7,762	83.6%	9,214	100.0%	-1,452
	Total	**9,288**	**100.0%**	**9,214**	**100.0%**	**74**
SHP-M	Denied	2,087	72.9%	0	0.0%	2,087
	Paid	777	27.1%	414	100.0%	363
	Total	**2,864**	**100.0%**	**414**	**100.0%**	**2,450**
STW-M	Denied	14,002	38.4%	0	0.0%	14,002
	Paid	22,506	61.6%	32,022	100.0%	-9,516
	Total	**36,508**	**100.0%**	**32,022**	**100.0%**	**4,486**
SUN-L	Denied	128	15.0%	0	0.0%	128
	Paid	724	85.0%	1,998	100.0%	-1,274
	Total	**852**	**100.0%**	**1,998**	**100.0%**	**-1,146**
SUN-M	Denied	68,156	19.5%	3	0.0%	68,153
	Paid	281,227	80.5%	340,000	100.0%	-58,773

Table E-3—Distribution of Volume for Dental Encounters by Claim Status (January 1, 2013–March 31, 2014)						
Plan	Status	AHCA Submitted Data[1]		Plan Submitted Data[2]		Volume Difference
		N	%	N	%	
	Total	**349,383**	**100.0%**	**340,003**	**100.0%**	**9,380**
UFS-M	Denied	2	100.0%	5,718	61.8%	-5,716
	Other	0	0.0%	88	1.0%	-88
	Paid	0	0.0%	3,443	37.2%	-3,443
	Total	**2**	**100.0%**	**9,249**	**100.0%**	**-9,247**
URA-L	Denied	2,698	69.5%	0	0.0%	2,698
	Other	0	0.0%	8,899	100.0%	-8,899
	Paid	1,184	30.5%	0	0.0%	1,184
	Total	**3,882**	**100.0%**	**8,899**	**100.0%**	**-5,017**
URA-M	Denied	3,422	26.9%	0	0.0%	3,422
	Other	0	0.0%	47,372	100.0%	-47,372
	Paid	9,308	73.1%	0	0.0%	9,308
	Total	**12,730**	**100.0%**	**47,372**	**100.0%**	**-34,642**

[1] Final status of the encounter claim line (either paid or denied)

[2] Plans submitted encounter statuses in either the *EncClaimStat-Process* or *EncClaimStat-Plan* fields. According to the data requirement, the *EncClaimStat-Process* represents the "Status of the claim/encounter as a result of the plan's internal processing of the claim/encounter and the *EncClaimStat-Plan* represents the status of the claim based on payment to the provider for services performed.

Table E-4 shows the number and percentage of institutional encounter records by encounter status for AHCA's and plans' submitted encounters.

Table E-4—Distribution of Volume for Institutional Encounters by Claim Status (January 1, 2013–March 31, 2014)						
Plan	Status	AHCA Submitted Data[1]		Plan Submitted Data[2]		Volume Difference
		N	%	N	%	
AMG-L	Denied	25,605	58.4%	14,594	66.4%	11,011
	Paid	18,262	41.6%	7,399	33.6%	10,863
	Total	**43,867**	**100.0%**	**21,993**	**100.0%**	**21,874**
AMG-M	Denied	81,942	38.1%	760,420	42.7%	-678,478
	Paid	133,286	61.9%	1,020,793	57.3%	-887,507
	Total	**215,228**	**100.0%**	**1,781,213**	**100.0%**	**-1,565,985**
BET-M	Denied	4	100.0%	0	NA	4
	Total	**4**	**100.0%**	**0**	**NA**	**4**
CHA-S	Denied	6,890	70.2%	0	0.0%	6,890
	Paid	2,920	29.8%	13,251	100.0%	-10,331
	Total	**9,810**	**100.0%**	**13,251**	**100.0%**	**-3,441**
COV-L	Denied	73,545	82.0%	0	0.0%	73,545
	Paid	16,150	18.0%	51,140	92.8%	-34,990
	Reversed	0	0.0%	3,972	7.2%	-3,972
	Total	**89,695**	**100.0%**	**55,112**	**100.0%**	**34,583**
COV-M	Denied	16,794	30.8%	0	0.0%	16,794
	Other	0	0.0%	384	0.2%	-384
	Paid	37,697	69.2%	248,238	99.8%	-210,541
	Total	**54,491**	**100.0%**	**248,622**	**100.0%**	**-194,131**

Table E-4—Distribution of Volume for Institutional Encounters by Claim Status (January 1, 2013–March 31, 2014)

Plan	Status	AHCA Submitted Data[1]		Plan Submitted Data[2]		Volume Difference
		N	%	N	%	
FRE-S	Denied	211,279	61.9%	0	0.0%	211,279
	Other	0	0.0%	148,335	100.0%	-148,335
	Paid	130,145	38.1%	0	0.0%	130,145
	Total	**341,424**	**100.0%**	**148,335**	**100.0%**	**193,089**
HEA-M	Denied	50,985	22.6%	0	0.0%	50,985
	Other	0	0.0%	3,848	0.3%	-3,848
	Paid	174,455	77.4%	1,173,240	99.7%	-998,785
	Total	**225,440**	**100.0%**	**1,177,088**	**100.0%**	**-951,648**
HUM-L	Denied	24,917	76.2%	0	0.0%	24,917
	Paid	7,770	23.8%	18,163	95.4%	-10,393
	Reversed	0	0.0%	868	4.6%	-868
	Total	**32,687**	**100.0%**	**19,031**	**100.0%**	**13,656**
HUM-M	Denied	95,641	82.3%	0	0.0%	95,641
	Other	0	0.0%	505,513	100.0%	-505,513
	Paid	20,518	17.7%	69	0.0%	20,449
	Total	**116,159**	**100.0%**	**505,582**	**100.0%**	**-389,423**
IHP-M	Denied	16,337	28.3%	0	0.0%	16,337
	Other	0	0.0%	401,441	100.0%	-401,441
	Paid	41,471	71.7%	0	0.0%	41,471
	Total	**57,808**	**100.0%**	**401,441**	**100.0%**	**-343,633**
MCC-S	Denied	573	35.9%	0	0.0%	573
	Paid	1,025	64.1%	2,243	100.0%	-1,218
	Total	**1,598**	**100.0%**	**2,243**	**100.0%**	**-645**
MOL-L	Denied	17,826	100.0%	0	0.0%	17,826
	Paid	0	0.0%	20,399	100.0%	-20,399
	Total	**17,826**	**100.0%**	**20,399**	**100.0%**	**-2,573**
MOL-M	Denied	20,214	14.8%	0	0.0%	20,214
	Other	0	0.0%	765	0.1%	-765
	Paid	116,640	85.2%	697,189	99.9%	-580,549
	Total	**136,854**	**100.0%**	**697,954**	**100.0%**	**-561,100**
PHC-S	Denied	1,341	60.1%	0	0.0%	1,341
	Paid	890	39.9%	7,606	100.0%	-6,716
	Total	**2,231**	**100.0%**	**7,606**	**100.0%**	**-5,375**
PRE-M	Denied	21,594	17.0%	0	0.0%	21,594
	Paid	105,534	83.0%	90,467	100.0%	15,067
	Total	**127,128**	**100.0%**	**90,467**	**100.0%**	**36,661**
PRS-M	Denied	343,439	76.7%	11,822	1.3%	331,617
	Paid	104,557	23.3%	879,116	98.7%	-774,559
	Total	**447,996**	**100.0%**	**890,938**	**100.0%**	**-442,942**
SHP-M	Denied	35,262	66.4%	0	0.0%	35,262
	Paid	17,835	33.6%	137,065	100.0%	-119,230
	Total	**53,097**	**100.0%**	**137,065**	**100.0%**	**-83,968**
STW-M	Denied	100,618	23.1%	0	0.0%	100,618
	Other	0	0.0%	2,164,924	99.7%	-2,164,924

Table E-4—Distribution of Volume for Institutional Encounters by Claim Status (January 1, 2013–March 31, 2014)

Plan	Status	AHCA Submitted Data[1]		Plan Submitted Data[2]		Volume Difference
		N	%	N	%	
	Paid	334,898	76.9%	6,354	0.3%	328,544
	Total	**435,516**	**100.0%**	**2,171,278**	**100.0%**	**-1,735,762**
SUN-L	Denied	75,557	31.2%	155,699	40.6%	-80,142
	Paid	166,888	68.8%	227,602	59.4%	-60,714
	Total	**242,445**	**100.0%**	**383,301**	**100.0%**	**-140,856**
SUN-M	Denied	100,431	23.8%	302,632	14.3%	-202,201
	Paid	322,176	76.2%	1,814,730	85.7%	-1,492,554
	Total	**422,607**	**100.0%**	**2,117,362**	**100.0%**	**-1,694,755**
UFS-M	Denied	280	93.0%	27,617	18.5%	-27,337
	Other	0	0.0%	4,174	2.8%	-4,174
	Paid	21	7.0%	117,588	78.7%	-117,567
	Total	**301**	**100.0%**	**149,379**	**100.0%**	**-149,078**
URA-L	Denied	233,267	78.1%	0	0.0%	233,267
	Other	0	0.0%	464,018	100.0%	-464,018
	Paid	65,558	21.9%	0	0.0%	65,558
	Total	**298,825**	**100.0%**	**464,018**	**100.0%**	**-165,193**
URA-M	Denied	95,420	71.8%	0	0.0%	95,420
	Other	0	0.0%	1,961,651	100.0%	-1,961,651
	Paid	37,515	28.2%	0	0.0%	37,515
	Total	**132,935**	**100.0%**	**1,961,651**	**100.0%**	**-1,828,716**
VIS-M	Denied	7,126	24.8%	0	0.0%	7,126
	Other	0	0.0%	128	0.1%	-128
	Paid	21,623	75.2%	179,432	99.9%	-157,809
	Total	**28,749**	**100.0%**	**179,560**	**100.0%**	**-150,811**

[1] Final status of the encounter claim line (either paid or denied)

[2] Plans submitted these values in either the *EncClaimStat-Process* or *EncClaimStat-Plan* fields. According to the data requirement, the *EncClaimStat-Process* represents the "Status of the claim/encounter as a result of the plan's internal processing of the claim/encounter and the *EncClaimStat-Plan* represents the status of the claim based on payment to the provider for services performed.

Monthly Variations of Encounters for Dates of Service by Type

Figure E-1, Figure E-2, and Figure E-3 illustrate AHCA's and the plans' overall encounter data volume trends over time for professional, dental, and institutional encounters.

Figure E-1—Monthly Variations in Professional Encounters for Plans and AHCA

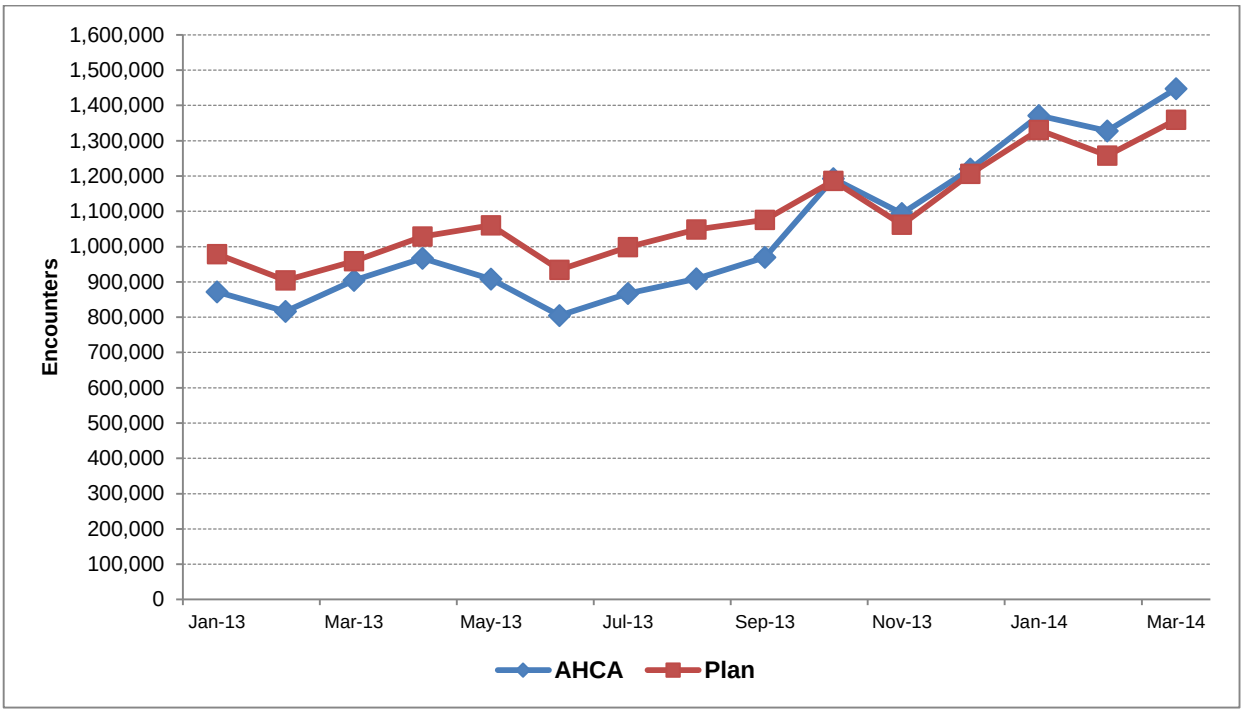


Figure E-2—Monthly Variations in Dental Encounters for Plans and AHCA

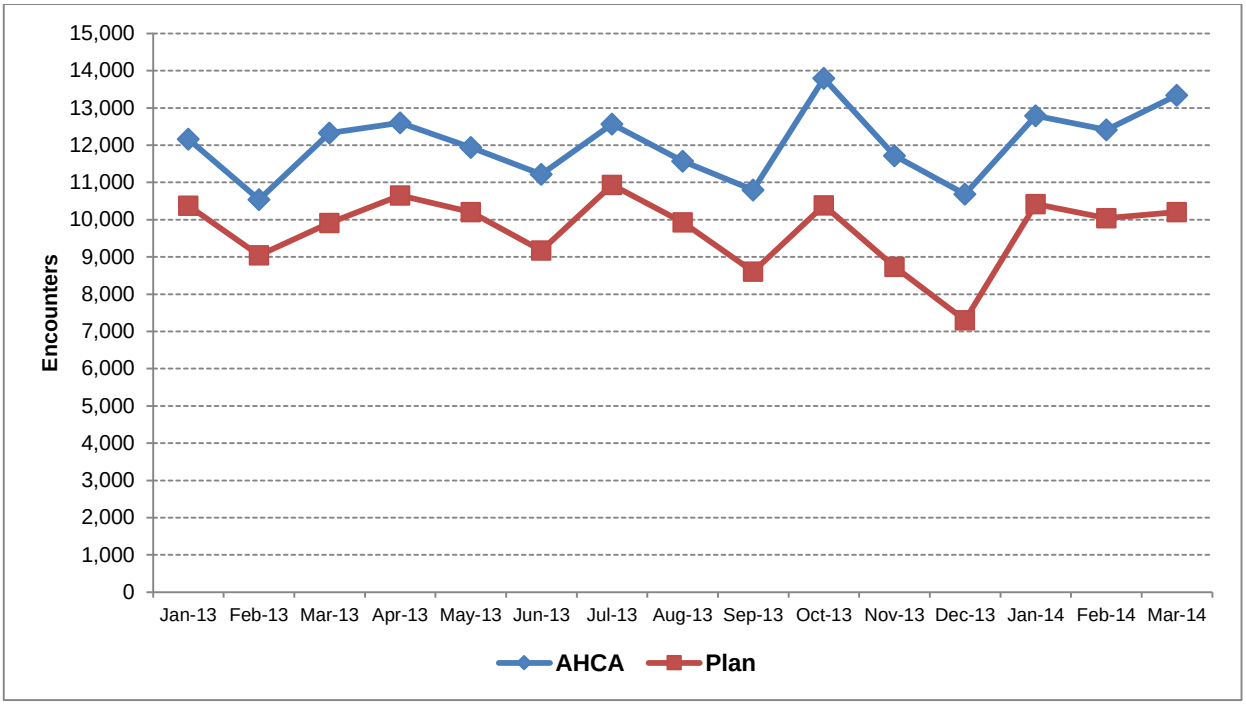
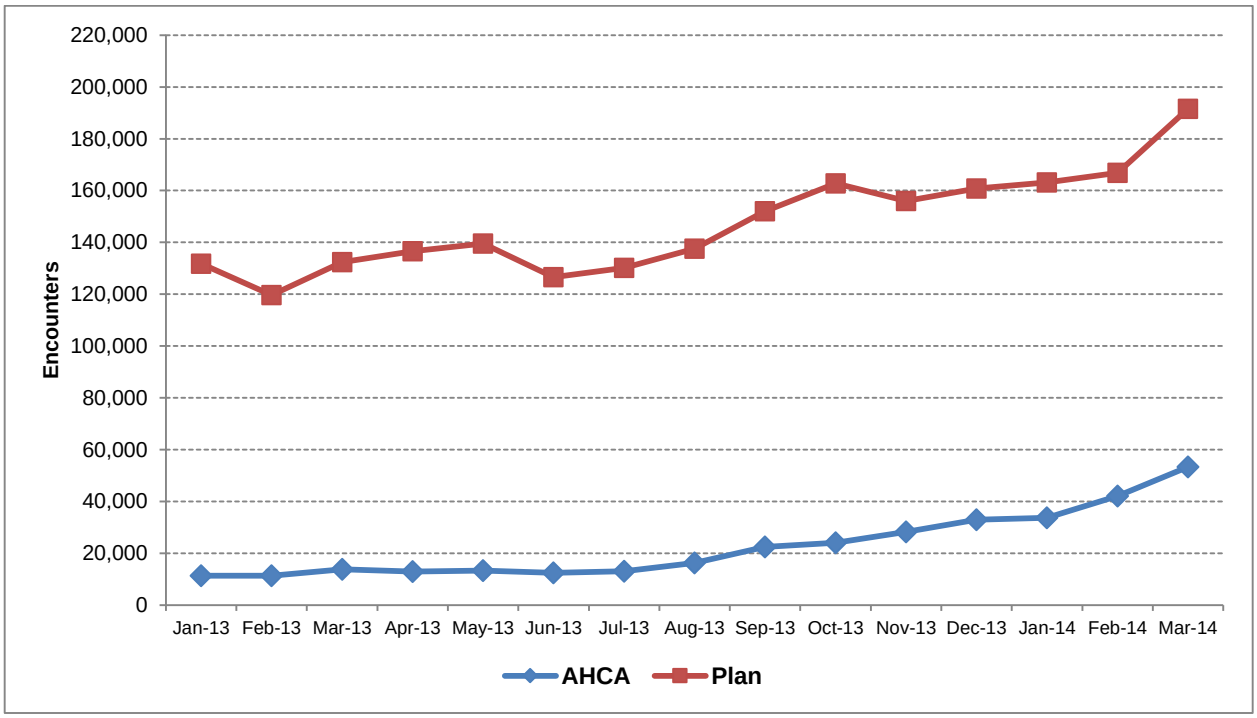


Figure E-3—Monthly Variations in Institutional Encounters for Plans and AHCA



Encounter Field Completeness and Reasonableness

Table E-5 shows the data fields and the associated acceptable ranges or values for each of the encounter types included in this study.

Table E-5—Valid Ranges or Values for the Data Field Completeness Analyses

Field	Format	Valid Ranges or Values	Analyses Applied		
			Professional Encounters	Institutional Encounters	Dental Encounters
Recipient ID	Character	State-supplied eligibility/enrollment file	√	√	√
Principal/ Primary Diagnosis	Character	ICD-9 Manual	√	√	
Additional Diagnoses (3)	Character	ICD-9 Manual	√	√	
Surgical Codes 1 – 4	Character	ICD-9 Manual		√	
Procedure Codes (4)	Character	CPT, HCPCS, and CDT Manual	√	√	√
NDC	Character	Medi-Span database	√	√	
Revenue Codes	Character	UB-04 Revenue Code Manual		√	
Billing Provider NPI	Character	State-supplied provider file	√	√	√
Rendering Provider NPI	Character	State-supplied provider file	√		√
Attending Provider NPI	Character	State-supplied provider file		√	
Referring Provider NPI	Character	State-supplied provider file	√	√	

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

Table E-6 and Table E-7 show the percent missing and valid rates for key data fields for professional encounter data extracted from the plans' and AHCA's encounter systems.

Table E-6—Completeness (Percent Missing) and Accuracy (Percent Valid) for Key Professional Encounter Data Elements (Recipient ID and Diagnosis Codes) by Plan and AHCA

	Recipient ID[A]		Primary Diagnosis Code[A]		Diagnosis Code 2[A,B]		Diagnosis Code 3[A,B]		Diagnosis Code 4[A,B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
Plan										
AMG-L	0.0%	99.9%	0.0%	> 99.9%	97.8%	100.0%	98.5%	100.0%	98.8%	100.0%
AMG-M	0.0%	95.0%	0.0%	> 99.9%	51.1%	> 99.9%	72.3%	> 99.9%	82.9%	> 99.9%
BET-M	0.0%	> 99.9%	0.0%	> 99.9%	58.0%	99.9%	75.0%	99.9%	84.3%	> 99.9%
CHA-S	0.0%	100.0%	0.0%	99.9%	45.9%	99.9%	64.9%	99.8%	73.5%	99.9%
COV-L	0.0%	99.6%	0.0%	99.9%	95.4%	99.8%	96.9%	99.7%	97.4%	99.8%
COV-M	0.0%	> 99.9%	0.0%	> 99.9%	49.8%	100.0%	68.9%	100.0%	79.5%	100.0%
FRE-S	0.0%	> 99.9%	0.0%	> 99.9%	44.3%	> 99.9%	67.1%	> 99.9%	78.5%	> 99.9%
HEA-M	0.0%	> 99.9%	0.0%	100.0%	52.5%	> 99.9%	73.4%	> 99.9%	83.9%	100.0%
HUM-L	0.0%	99.9%	< 0.1%	> 99.9%	93.9%	100.0%	94.4%	100.0%	94.6%	100.0%
HUM-M	0.1%	99.9%	0.0%	98.8%	43.8%	> 99.9%	64.1%	> 99.9%	76.6%	> 99.9%
IHP-M	0.0%	> 99.9%	0.0%	> 99.9%	58.7%	> 99.9%	76.6%	> 99.9%	89.6%	100.0%
MCC-S	0.0%	100.0%	0.0%	100.0%	76.6%	100.0%	87.6%	100.0%	93.3%	100.0%
MOL-L	0.0%	99.9%	0.0%	100.0%	98.1%	100.0%	98.4%	100.0%	98.6%	100.0%
MOL-M	0.0%	99.9%	0.0%	100.0%	48.9%	100.0%	70.3%	> 99.9%	81.1%	> 99.9%
PHC-S	0.0%	> 99.9%	0.0%	99.9%	> 99.9%	100.0%	> 99.9%	100.0%	> 99.9%	100.0%
PRE-M	< 0.1%	98.6%	< 0.1%	99.7%	76.8%	99.9%	87.9%	99.3%	93.0%	99.9%
PRS-M	< 0.1%	> 99.9%	< 0.1%	> 99.9%	52.6%	> 99.9%	72.6%	> 99.9%	83.1%	100.0%
SHP-M	0.0%	> 99.9%	< 0.1%	99.9%	42.8%	99.9%	63.1%	> 99.9%	74.2%	> 99.9%
STW-M	0.0%	> 99.9%	0.0%	100.0%	48.9%	> 99.9%	70.3%	> 99.9%	81.2%	> 99.9%
SUN-L	0.0%	99.9%	< 0.1%	99.9%	94.7%	99.8%	96.8%	99.9%	97.7%	> 99.9%
SUN-M	0.0%	> 99.9%	< 0.1%	> 99.9%	52.6%	> 99.9%	72.4%	> 99.9%	83.3%	> 99.9%
UFS-M	0.0%	100.0%	1.4%	97.9%	41.4%	97.8%	58.9%	98.1%	74.6%	99.1%
URA-L	0.0%	99.9%	0.0%	> 99.9%	86.7%	99.9%	89.4%	99.9%	91.6%	99.9%
URA-M	0.0%	99.7%	0.0%	99.9%	51.0%	> 99.9%	71.1%	99.9%	81.8%	99.9%
VIS-M	0.0%	100.0%	0.0%	100.0%	40.5%	100.0%	61.2%	> 99.9%	73.9%	100.0%
AHCA										
AMG-L	0.0%	100.0%	0.0%	> 99.9%	98.3%	100.0%	98.9%	100.0%	99.2%	100.0%
AMG-M	0.0%	100.0%	0.0%	> 99.9%	67.2%	> 99.9%	82.4%	100.0%	89.4%	100.0%
BET-M	0.0%	100.0%	0.0%	99.9%	65.0%	99.9%	80.8%	99.9%	88.0%	> 99.9%
CHA-S	0.0%	100.0%	0.0%	99.9%	59.3%	> 99.9%	72.6%	99.9%	79.6%	99.8%
COV-L	0.0%	100.0%	74.2%	99.9%	99.7%	100.0%	99.8%	100.0%	99.8%	99.5%
COV-M	0.0%	100.0%	0.0%	> 99.9%	> 99.9%	100.0%	> 99.9%	100.0%	100.0%	NA

Table E-6—Completeness (Percent Missing) and Accuracy (Percent Valid) for Key Professional Encounter Data Elements (Recipient ID and Diagnosis Codes) by Plan and AHCA										
	Recipient ID[A]		Primary Diagnosis Code[A]		Diagnosis Code 2[A,B]		Diagnosis Code 3[A,B]		Diagnosis Code 4[A,B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
FRE-S	0.0%	100.0%	0.0%	> 99.9%	62.3%	> 99.9%	79.5%	> 99.9%	86.9%	> 99.9%
HEA-M	0.0%	100.0%	0.0%	100.0%	70.9%	100.0%	85.7%	100.0%	92.4%	100.0%
HUM-L	0.0%	100.0%	61.9%	100.0%	99.5%	100.0%	99.5%	100.0%	99.5%	100.0%
HUM-M	0.0%	100.0%	< 0.1%	> 99.9%	98.8%	100.0%	99.3%	100.0%	99.5%	100.0%
IHP-M	0.0%	100.0%	0.0%	> 99.9%	65.7%	> 99.9%	79.3%	> 99.9%	90.6%	100.0%
MCC-S	0.0%	100.0%	0.0%	100.0%	81.2%	100.0%	89.9%	100.0%	94.8%	100.0%
MOL-L	0.0%	100.0%	0.0%	100.0%	98.9%	100.0%	99.1%	100.0%	99.2%	100.0%
MOL-M	0.0%	100.0%	0.0%	> 99.9%	61.9%	100.0%	78.5%	> 99.9%	86.2%	> 99.9%
PHC-S	0.0%	100.0%	0.0%	99.9%	> 99.9%	100.0%	> 99.9%	100.0%	> 99.9%	100.0%
PRE-M	0.0%	100.0%	0.0%	99.8%	77.1%	99.9%	87.9%	99.3%	93.1%	99.9%
PRS-M	0.0%	100.0%	< 0.1%	> 99.9%	89.4%	100.0%	89.6%	> 99.9%	89.7%	> 99.9%
SHP-M	0.0%	100.0%	0.0%	99.9%	62.1%	99.9%	77.3%	> 99.9%	84.9%	> 99.9%
STW-M	0.0%	100.0%	0.0%	100.0%	70.3%	100.0%	85.4%	100.0%	92.1%	100.0%
SUN-L	0.0%	100.0%	0.0%	> 99.9%	98.2%	> 99.9%	98.8%	> 99.9%	99.1%	100.0%
SUN-M	0.0%	100.0%	< 0.1%	> 99.9%	68.0%	> 99.9%	83.6%	> 99.9%	90.8%	> 99.9%
UFS-M	0.0%	100.0%	0.0%	> 99.9%	99.7%	100.0%	> 99.9%	100.0%	> 99.9%	100.0%
URA-L	0.0%	100.0%	0.0%	> 99.9%	92.8%	100.0%	93.3%	100.0%	94.5%	100.0%
URA-M	0.0%	100.0%	0.0%	> 99.9%	68.9%	> 99.9%	83.2%	> 99.9%	89.3%	> 99.9%
VIS-M	0.0%	100.0%	0.0%	> 99.9%	99.7%	100.0%	> 99.9%	100.0%	> 99.9%	100.0%

[A] *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.

[B] *Diagnosis Code 2*, *Diagnosis Code 3*, *Diagnosis Code 4*, *NDC*, *Rendering Provider NPI*, and *Referring Provider NPI* fields are situational (i.e., not required for every professional encounter transaction).

"NA" denotes all records had missing values for this data element; therefore, validity could not be assessed.

Table E-7—Completeness (Percent Missing) and Accuracy (Percent Valid) for Key Professional Encounter Data Elements (Procedure Code, NDC, and Provider NPI) by Plan and AHCA										
	Procedure Code[A]		NDC[A,B]		Billing Provider NPI		Rendering Provider NPI[A,B]		Referring Provider NPI[A,B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
Plan										
AMG-L	0.0%	> 99.9%	100.0%	NA	1.0%	88.7%	98.9%	96.5%	> 99.9%	95.6%
AMG-M	< 0.1%	> 99.9%	100.0%	NA	0.2%	93.7%	26.3%	94.9%	99.9%	96.7%
BET-M	0.0%	> 99.9%	99.3%	86.9%	1.1%	94.9%	6.4%	> 99.9%	34.6%	98.1%
CHA-S	0.0%	> 99.9%	99.0%	96.2%	0.7%	97.7%	0.1%	99.1%	40.2%	99.3%
COV-L	0.0%	> 99.9%	100.0%	NA	< 0.1%	96.2%	100.0%	NA	100.0%	NA

Table E-7—Completeness (Percent Missing) and Accuracy (Percent Valid) for Key Professional Encounter Data Elements (Procedure Code, NDC, and Provider NPI) by Plan and AHCA										
	Procedure Code[A]		NDC[A,B]		Billing Provider NPI		Rendering Provider NPI[A,B]		Referring Provider NPI[A,B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
COV-M	0.0%	> 99.9%	100.0%	NA	0.0%	98.0%	2.7%	99.6%	61.3%	96.0%
FRE-S	0.0%	> 99.9%	100.0%	NA	0.0%	97.3%	22.0%	99.2%	57.1%	95.4%
HEA-M	0.0%	100.0%	97.4%	94.0%	0.0%	97.6%	11.7%	98.0%	100.0%	NA
HUM-L	0.0%	99.9%	100.0%	NA	< 0.1%	92.3%	100.0%	NA	100.0%	NA
HUM-M	0.2%	98.3%	> 99.9%	95.9%	4.8%	97.6%	55.9%	96.5%	36.6%	97.7%
IHP-M	0.0%	> 99.9%	99.0%	98.1%	0.0%	97.9%	37.5%	99.2%	98.6%	98.0%
MCC-S	0.0%	99.9%	99.8%	100.0%	0.0%	94.1%	15.5%	96.0%	76.3%	98.9%
MOL-L	0.0%	> 99.9%	100.0%	NA	0.1%	96.2%	0.1%	96.2%	96.7%	87.8%
MOL-M	0.0%	100.0%	98.1%	94.5%	0.1%	96.6%	0.1%	99.0%	49.9%	98.0%
PHC-S	0.0%	> 99.9%	99.8%	100.0%	0.0%	97.1%	< 0.1%	97.6%	47.9%	96.1%
PRE-M	< 0.1%	> 99.9%	99.3%	0.0%	0.9%	94.8%	6.4%	99.1%	52.6%	96.8%
PRS-M	< 0.1%	97.7%	100.0%	NA	0.2%	97.6%	0.2%	98.4%	17.2%	99.7%
SHP-M	0.0%	> 99.9%	96.1%	93.4%	2.3%	95.1%	1.6%	99.4%	59.5%	98.2%
STW-M	0.0%	100.0%	96.4%	96.4%	0.0%	97.6%	14.1%	98.2%	100.0%	NA
SUN-L	< 0.1%	> 99.9%	> 99.9%	96.2%	3.9%	95.8%	61.8%	93.4%	73.9%	90.8%
SUN-M	< 0.1%	> 99.9%	97.3%	94.3%	< 0.1%	98.1%	27.0%	99.1%	50.3%	96.3%
UFS-M	0.0%	99.6%	97.3%	44.6%	99.5%	100.0%	100.0%	NA	100.0%	NA
URA-L	0.0%	> 99.9%	100.0%	NA	23.4%	96.2%	2.0%	96.9%	80.3%	83.5%
URA-M	< 0.1%	> 99.9%	100.0%	NA	4.6%	95.7%	0.7%	98.0%	50.6%	94.9%
VIS-M	0.0%	> 99.9%	100.0%	NA	0.0%	98.5%	0.4%	99.7%	72.2%	96.2%
AHCA										
AMG-L	< 0.1%	100.0%	> 99.9%	88.6%	17.3%	99.2%	18.2%	99.2%	59.6%	96.6%
AMG-M	1.6%	> 99.9%	99.2%	97.7%	3.8%	97.9%	9.0%	99.3%	73.7%	98.3%
BET-M	0.1%	> 99.9%	99.7%	96.3%	1.5%	99.3%	1.8%	99.8%	60.4%	99.6%
CHA-S	0.5%	> 99.9%	99.9%	100.0%	2.4%	99.6%	3.4%	99.8%	48.6%	99.0%
COV-L	0.3%	100.0%	100.0%	NA	20.1%	95.7%	21.7%	95.7%	99.9%	94.3%
COV-M	2.8%	> 99.9%	97.2%	95.3%	1.7%	99.1%	2.1%	99.0%	100.0%	NA
FRE-S	1.8%	> 99.9%	100.0%	NA	3.1%	99.2%	3.9%	99.7%	60.2%	98.8%
HEA-M	0.4%	100.0%	97.4%	92.3%	3.7%	98.6%	6.8%	99.4%	54.8%	98.9%
HUM-L	0.1%	> 99.9%	100.0%	NA	32.4%	86.1%	33.6%	85.8%	99.2%	98.7%
HUM-M	6.5%	99.5%	> 99.9%	93.8%	4.7%	94.1%	15.2%	95.1%	> 99.9%	94.5%
IHP-M	0.0%	> 99.9%	99.1%	98.0%	2.8%	98.8%	8.0%	99.2%	98.6%	96.8%
MCC-S	0.2%	100.0%	99.5%	100.0%	1.5%	97.8%	5.1%	98.8%	69.1%	97.7%
MOL-L	< 0.1%	100.0%	> 99.9%	100.0%	6.9%	97.0%	9.2%	97.0%	97.9%	97.3%
MOL-M	< 0.1%	100.0%	98.3%	94.7%	6.5%	97.8%	8.9%	99.6%	53.5%	99.3%
PHC-S	< 0.1%	> 99.9%	99.9%	97.3%	1.4%	98.2%	1.6%	99.4%	53.9%	99.8%
PRE-M	0.1%	> 99.9%	99.3%	92.2%	7.6%	99.1%	9.2%	99.7%	58.0%	99.3%

Table E-7—Completeness (Percent Missing) and Accuracy (Percent Valid) for Key Professional Encounter Data Elements (Procedure Code, NDC, and Provider NPI) by Plan and AHCA										
	Procedure Code[A]		NDC[A,B]		Billing Provider NPI		Rendering Provider NPI[A,B]		Referring Provider NPI[A,B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
PRS-M	< 0.1%	> 99.9%	99.6%	99.0%	1.4%	99.5%	3.0%	99.5%	100.0%	NA
SHP-M	4.4%	> 99.9%	99.9%	96.0%	6.4%	98.4%	9.5%	99.7%	61.1%	98.9%
STW-M	0.8%	100.0%	96.5%	96.3%	2.7%	98.6%	5.6%	99.5%	55.8%	99.0%
SUN-L	< 0.1%	99.7%	100.0%	NA	9.9%	96.1%	10.0%	96.0%	97.5%	93.0%
SUN-M	0.1%	> 99.9%	99.4%	98.5%	1.0%	99.2%	4.1%	99.5%	40.9%	98.9%
UFS-M	0.0%	100.0%	100.0%	NA	< 0.1%	100.0%	0.2%	100.0%	99.2%	100.0%
URA-L	0.0%	100.0%	> 99.9%	100.0%	8.6%	99.2%	9.6%	99.2%	96.1%	91.3%
URA-M	0.7%	> 99.9%	99.4%	95.0%	8.4%	99.4%	26.6%	99.4%	98.8%	90.0%
VIS-M	7.3%	> 99.9%	98.8%	93.2%	2.4%	99.7%	2.8%	99.7%	100.0%	NA

[A] *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.

[B] *Diagnosis Code 2*, *Diagnosis Code 3*, *Diagnosis Code 4*, *NDC*, *Rendering Provider NPI*, and *Referring Provider NPI* fields are situational (i.e., not required for every professional encounter transaction).

"NA" denotes all records had missing values for this data element; therefore, validity could not be assessed.

Table E-8 shows the percent missing and valid rates for key data fields for the dental encounter data extracted from the plans' and AHCA's encounter systems.

Table E-8—Completeness (Percent Missing) and Accuracy (Percent Valid) for Key Dental Encounter Data Elements (Recipient ID, Procedure Code, and Provider NPI) by Plan and AHCA								
	Recipient ID[A]		Procedure Code[A]		Billing Provider NPI[A]		Rendering Provider NPI[A,B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
Plan								
AMG-L	0.0%	0.0%	0.0%	100.0%	0.0%	68.8%	15.6%	100.0%
AMG-M	0.0%	0.0%	0.0%	100.0%	0.0%	96.7%	97.8%	100.0%
BET-M	0.0%	100.0%	0.0%	> 99.9%	0.0%	84.8%	100.0%	NA
CHA-S*	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	100.0%	NA
COV-L*	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	100.0%	NA
COV-M								
FRE-S	0.0%	87.4%	0.0%	100.0%	0.0%	95.3%	92.0%	96.1%
HEA-M*	0.0%	60.0%	0.0%	100.0%	0.0%	60.0%	0.0%	100.0%
HUM-L								
HUM-M	< 0.1%	99.5%	< 0.1%	> 99.9%	< 0.1%	83.0%	18.9%	99.9%
IHP-M	0.0%	99.5%	0.0%	98.6%	100.0%	NA	100.0%	NA
MCC-S	0.0%	100.0%	0.0%	100.0%	0.0%	81.9%	7.7%	100.0%
MOL-L	0.0%	100.0%	0.0%	100.0%	0.0%	78.0%	0.0%	100.0%
MOL-M	0.0%	> 99.9%	0.0%	100.0%	0.0%	76.2%	0.0%	99.2%

Table E-8—Completeness (Percent Missing) and Accuracy (Percent Valid) for Key Dental Encounter Data Elements (Recipient ID, Procedure Code, and Provider NPI) by Plan and AHCA								
	Recipient ID[A]		Procedure Code[A]		Billing Provider NPI[A]		Rendering Provider NPI[A,B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
PHC-S								
PRE-M	0.0%	57.8%	0.0%	99.5%	0.0%	96.7%	96.3%	90.3%
PRS-M	0.0%	100.0%	0.0%	100.0%	0.0%	95.4%	91.7%	100.0%
SHP-M	0.0%	100.0%	0.0%	100.0%	0.0%	81.2%	100.0%	NA
STW-M	0.0%	99.1%	0.0%	100.0%	0.0%	86.9%	0.0%	97.7%
SUN-L	0.0%	99.6%	0.0%	100.0%	0.0%	98.4%	0.0%	98.4%
SUN-M	0.0%	> 99.9%	0.0%	> 99.9%	0.0%	99.7%	0.0%	99.7%
UFS-M	0.0%	100.0%	0.0%	100.0%	100.0%	NA	100.0%	NA
URA-L	0.1%	99.3%	0.0%	99.9%	100.0%	NA	0.0%	99.5%
URA-M	0.0%	97.0%	0.0%	> 99.9%	100.0%	NA	< 0.1%	97.7%
VIS-M								
AHCA								
AMG-L*	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%
AMG-M	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%
BET-M	0.0%	100.0%	< 0.1%	100.0%	16.0%	97.7%	54.9%	98.5%
CHA-S	0.0%	100.0%	1.0%	100.0%	6.8%	92.7%	64.6%	100.0%
COV-L*	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%
COV-M								
FRE-S	0.0%	100.0%	0.0%	100.0%	1.8%	98.5%	4.7%	99.1%
HEA-M	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%
HUM-L								
HUM-M	0.0%	100.0%	< 0.1%	> 99.9%	21.5%	92.9%	2.2%	96.9%
IHP-M	0.0%	100.0%	0.0%	> 99.9%	1.9%	99.1%	0.1%	98.9%
MCC-S	0.0%	100.0%	0.0%	100.0%	26.9%	98.8%	0.0%	100.0%
MOL-L	0.0%	100.0%	0.0%	100.0%	52.0%	100.0%	10.0%	100.0%
MOL-M	0.0%	100.0%	0.0%	100.0%	27.4%	93.7%	3.6%	99.2%
PHC-S*	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%
PRE-M	0.0%	100.0%	0.2%	100.0%	14.2%	99.8%	14.4%	100.0%
PRS-M	0.0%	100.0%	0.0%	100.0%	7.7%	99.2%	1.2%	99.3%
SHP-M	0.0%	100.0%	0.1%	100.0%	25.3%	97.1%	28.7%	97.7%
STW-M	0.0%	100.0%	0.0%	100.0%	13.0%	99.9%	2.1%	100.0%
SUN-L	0.0%	100.0%	0.0%	100.0%	3.4%	100.0%	2.3%	100.0%
SUN-M	0.0%	100.0%	0.0%	> 99.9%	1.6%	99.4%	1.7%	99.9%
UFS-M*	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	100.0%	NA
URA-L	0.0%	100.0%	0.1%	> 99.9%	0.2%	100.0%	0.7%	100.0%
URA-M	0.0%	100.0%	< 0.1%	100.0%	1.0%	100.0%	1.6%	100.0%

Table E-8—Completeness (Percent Missing) and Accuracy (Percent Valid) for Key Dental Encounter Data Elements (Recipient ID, Procedure Code, and Provider NPI) by Plan and AHCA								
	Recipient ID[A]		Procedure Code[A]		Billing Provider NPI[A]		Rendering Provider NPI[A,B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
VIS-M								

[A] *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.

[B] *Rendering Provider NPI* field is situational (i.e., not required for every dental encounter transaction).

* Denotes that the plan had less than 30 records; therefore, results should be interpreted with caution.

"NA" denotes all records had missing values for this data element; therefore, validity could not be assessed.

Gray shading indicates there were no encounters to assess.

Table E-9, Table E-10 and Table E-11 show the percent missing and valid rates for key data fields for institutional encounter data extracted from the plans' and AHCA's encounter systems.

Table E-9—Completeness (Percent Missing) and Accuracy (Percent Valid) for Key Institutional Encounter Data Elements (Recipient ID and Diagnosis Codes) by Plan and AHCA										
	Recipient ID[A]		Primary Diagnosis Code[A]		Diagnosis Code 2[A,B]		Diagnosis Code 3[A,B]		Diagnosis Code 4[A,B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
Plan										
AMG-L	0.0%	99.8%	0.0%	100.0%	28.9%	100.0%	38.5%	100.0%	46.9%	99.9%
AMG-M	0.0%	99.5%	0.0%	100.0%	21.0%	> 99.9%	40.5%	> 99.9%	54.3%	> 99.9%
BET-M										
CHA-S	0.0%	100.0%	0.0%	100.0%	0.2%	100.0%	26.5%	100.0%	37.5%	100.0%
COV-L	0.0%	> 99.9%	0.0%	99.8%	9.2%	99.3%	27.5%	99.5%	39.4%	99.7%
COV-M	0.0%	100.0%	0.0%	> 99.9%	28.1%	100.0%	50.4%	100.0%	63.9%	100.0%
FRE-S	0.0%	100.0%	0.0%	100.0%	25.4%	99.9%	46.8%	> 99.9%	60.6%	> 99.9%
HEA-M	0.0%	> 99.9%	6.2%	100.0%	3.3%	100.0%	20.3%	100.0%	38.5%	100.0%
HUM-L	0.0%	> 99.9%	0.0%	99.7%	6.0%	99.1%	32.4%	98.4%	41.8%	99.5%
HUM-M	0.2%	99.9%	0.0%	98.6%	27.4%	> 99.9%	48.7%	> 99.9%	61.9%	> 99.9%
IHP-M	0.0%	> 99.9%	0.0%	100.0%	23.0%	100.0%	42.3%	100.0%	56.9%	100.0%
MCC-S	0.0%	100.0%	0.0%	100.0%	32.0%	100.0%	62.1%	100.0%	73.2%	100.0%
MOL-L	0.0%	99.9%	0.0%	> 99.9%	31.1%	100.0%	37.1%	99.7%	42.5%	> 99.9%
MOL-M	0.0%	> 99.9%	0.0%	100.0%	26.9%	> 99.9%	49.3%	100.0%	62.9%	100.0%
PHC-S	0.0%	98.8%	0.0%	70.7%	100.0%	NA	100.0%	NA	100.0%	NA
PRE-M	< 0.1%	99.2%	0.0%	> 99.9%	96.9%	100.0%	97.8%	99.9%	100.0%	NA
PRS-M	0.0%	> 99.9%	0.0%	> 99.9%	21.1%	> 99.9%	39.8%	> 99.9%	54.4%	100.0%
SHP-M	0.0%	100.0%	0.0%	> 99.9%	0.8%	99.9%	19.3%	> 99.9%	41.2%	99.8%
STW-M	0.0%	> 99.9%	5.5%	100.0%	2.5%	100.0%	19.0%	100.0%	37.2%	100.0%
SUN-L	0.0%	99.9%	< 0.1%	> 99.9%	25.8%	> 99.9%	34.1%	> 99.9%	43.0%	> 99.9%
SUN-M	0.0%	> 99.9%	< 0.1%	> 99.9%	25.0%	> 99.9%	45.8%	> 99.9%	59.3%	> 99.9%

Table E-9—Completeness (Percent Missing) and Accuracy (Percent Valid) for Key Institutional Encounter Data Elements (Recipient ID and Diagnosis Codes) by Plan and AHCA										
	Recipient ID[A]		Primary Diagnosis Code[A]		Diagnosis Code 2[A,B]		Diagnosis Code 3[A,B]		Diagnosis Code 4[A,B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
UFS-M	0.0%	100.0%	0.7%	98.0%	15.0%	97.7%	31.2%	98.1%	44.5%	98.1%
URA-L	0.0%	99.5%	0.0%	99.8%	27.9%	99.9%	35.6%	99.7%	43.5%	99.8%
URA-M	0.0%	99.8%	0.0%	> 99.9%	21.1%	> 99.9%	39.3%	> 99.9%	51.8%	> 99.9%
VIS-M	0.0%	> 99.9%	0.0%	> 99.9%	33.1%	100.0%	56.8%	100.0%	70.5%	100.0%
AHCA										
AMG-L	0.0%	100.0%	0.0%	100.0%	20.5%	100.0%	31.1%	100.0%	39.7%	100.0%
AMG-M	0.0%	100.0%	0.0%	100.0%	4.6%	100.0%	11.2%	100.0%	19.2%	100.0%
BET-M*	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%
CHA-S	0.0%	100.0%	0.0%	100.0%	0.1%	100.0%	0.9%	100.0%	4.0%	100.0%
COV-L	0.0%	100.0%	< 0.1%	99.8%	100.0%	NA	100.0%	NA	100.0%	NA
COV-M	0.0%	100.0%	0.0%	> 99.9%	5.6%	100.0%	14.5%	100.0%	23.3%	100.0%
FRE-S	0.0%	100.0%	0.0%	100.0%	22.1%	> 99.9%	42.6%	> 99.9%	56.5%	> 99.9%
HEA-M	0.0%	100.0%	0.0%	100.0%	6.1%	100.0%	15.0%	100.0%	24.0%	100.0%
HUM-L	0.0%	100.0%	0.0%	99.7%	100.0%	NA	100.0%	NA	100.0%	NA
HUM-M	0.0%	100.0%	0.0%	> 99.9%	3.8%	100.0%	36.8%	> 99.9%	43.7%	> 99.9%
IHP-M	0.0%	100.0%	0.0%	100.0%	3.5%	100.0%	11.6%	100.0%	19.4%	100.0%
MCC-S	0.0%	100.0%	0.0%	100.0%	22.8%	100.0%	43.7%	100.0%	54.3%	100.0%
MOL-L	0.0%	100.0%	0.0%	> 99.9%	28.9%	> 99.9%	33.7%	> 99.9%	37.3%	99.9%
MOL-M	0.0%	100.0%	0.0%	100.0%	4.6%	100.0%	13.5%	100.0%	22.2%	100.0%
PHC-S	0.0%	100.0%	0.0%	99.9%	8.2%	99.9%	9.8%	99.8%	11.2%	99.9%
PRE-M	0.0%	100.0%	0.0%	> 99.9%	27.1%	99.9%	47.0%	> 99.9%	62.6%	100.0%
PRS-M	0.0%	100.0%	0.0%	> 99.9%	3.6%	100.0%	11.0%	100.0%	17.7%	100.0%
SHP-M	0.0%	100.0%	0.0%	99.9%	3.8%	99.8%	11.4%	99.9%	21.9%	> 99.9%
STW-M	0.0%	100.0%	0.0%	100.0%	6.0%	100.0%	14.4%	100.0%	22.4%	100.0%
SUN-L	0.0%	100.0%	0.0%	> 99.9%	32.3%	100.0%	39.8%	100.0%	49.6%	100.0%
SUN-M	0.0%	100.0%	0.0%	100.0%	5.8%	100.0%	15.1%	> 99.9%	24.0%	100.0%
UFS-M	0.0%	100.0%	0.0%	100.0%	74.4%	100.0%	79.7%	100.0%	82.4%	100.0%
URA-L	0.0%	100.0%	0.0%	99.9%	23.2%	99.9%	33.3%	99.9%	42.9%	99.8%
URA-M	0.0%	100.0%	0.0%	> 99.9%	3.0%	99.9%	8.3%	100.0%	14.0%	> 99.9%
VIS-M	0.0%	100.0%	0.0%	99.9%	5.6%	100.0%	16.1%	100.0%	27.4%	100.0%

[A] *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.

[B] *Diagnosis Code 2*, *Diagnosis Code 3*, *Diagnosis Code 4*, *Primary Surgical Code*, *Surgical Code 2*, *Surgical Code 3*, *Surgical Code 4*, *Procedure Code*, *NDC*, *Attending Provider ID*, and *Referring Provider NPI* fields are situational (i.e., not required for every institutional encounter transaction).

* Denotes that the plan had less than 30 records; therefore, results should be interpreted with caution.

"NA" denotes all records had missing values for this data element; therefore, validity could not be assessed.

Gray shading indicates there were no encounters to assess.

Table E-10—Completeness (Percent Missing) and Accuracy (Percent Valid) for Key Institutional Encounter Data Elements (Surgical Procedure Codes and Procedure Code) by Plan and AHCA

	Primary Surgical Code[A,B]		Surgical Code 2[A,B]		Surgical Code 3[A,B]		Surgical Code 4[A,B]		Procedure Code[A,B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
Plan										
AMG-L	95.2%	100.0%	97.0%	100.0%	98.1%	100.0%	55.3%	95.8%	0.0%	100.0%
AMG-M	90.4%	100.0%	94.3%	100.0%	96.6%	100.0%	30.1%	> 99.9%	< 0.1%	> 99.9%
BET-M										
CHA-S	99.8%	100.0%	100.0%	NA	100.0%	NA	10.8%	100.0%	0.0%	100.0%
COV-L	100.0%	NA	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	> 99.9%
COV-M	89.0%	> 99.9%	93.8%	100.0%	96.4%	99.8%	32.3%	> 99.9%	< 0.1%	100.0%
FRE-S	100.0%	NA	100.0%	NA	100.0%	NA	29.6%	> 99.9%	0.0%	100.0%
HEA-M	100.0%	NA	100.0%	NA	100.0%	NA	29.4%	> 99.9%	0.0%	100.0%
HUM-L	100.0%	NA	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%
HUM-M	89.4%	100.0%	94.0%	100.0%	96.6%	100.0%	31.0%	97.6%	1.7%	100.0%
IHP-M	91.7%	19.8%	95.0%	18.5%	97.6%	0.0%	24.0%	> 99.9%	0.0%	100.0%
MCC-S	95.3%	100.0%	97.0%	100.0%	97.7%	100.0%	55.1%	100.0%	0.0%	100.0%
MOL-L	100.0%	NA	100.0%	NA	100.0%	NA	46.9%	94.9%	0.0%	100.0%
MOL-M	92.8%	> 99.9%	95.8%	100.0%	97.6%	100.0%	25.7%	> 99.9%	0.0%	100.0%
PHC-S	94.3%	40.9%	100.0%	NA	100.0%	NA	11.2%	> 99.9%	0.0%	> 99.9%
PRE-M	81.4%	100.0%	89.4%	100.0%	100.0%	NA	39.3%	> 99.9%	< 0.1%	> 99.9%
PRS-M	90.1%	100.0%	94.2%	100.0%	96.6%	100.0%	0.0%	75.4%	0.0%	98.9%
SHP-M	98.4%	100.0%	99.5%	100.0%	99.7%	100.0%	15.8%	> 99.9%	0.0%	100.0%
STW-M	100.0%	NA	100.0%	NA	100.0%	NA	29.3%	> 99.9%	0.0%	100.0%
SUN-L	94.2%	> 99.9%	96.9%	100.0%	98.2%	> 99.9%	45.5%	97.0%	0.1%	> 99.9%
SUN-M	88.0%	> 99.9%	93.1%	100.0%	96.0%	100.0%	35.6%	> 99.9%	0.1%	> 99.9%
UFS-M	100.0%	NA	100.0%	NA	100.0%	NA	46.4%	> 99.9%	0.0%	> 99.9%
URA-L	98.0%	100.0%	98.8%	100.0%	99.3%	100.0%	61.1%	95.8%	0.0%	100.0%
URA-M	90.6%	> 99.9%	94.2%	100.0%	96.5%	> 99.9%	40.1%	99.9%	0.0%	100.0%
VIS-M	91.4%	99.7%	95.0%	100.0%	96.8%	100.0%	26.3%	> 99.9%	< 0.1%	100.0%
AHCA										
AMG-L	95.6%	100.0%	97.2%	100.0%	98.0%	100.0%	48.3%	100.0%	0.0%	98.8%
AMG-M	42.6%	100.0%	64.7%	100.0%	79.0%	100.0%	98.6%	100.0%	0.0%	> 99.9%
BET-M*	100.0%	NA	100.0%	NA	100.0%	NA	100.0%	NA	0.0%	100.0%
CHA-S	44.7%	100.0%	73.8%	100.0%	85.1%	100.0%	99.9%	100.0%	0.0%	100.0%
COV-L	98.8%	100.0%	99.3%	100.0%	99.8%	100.0%	53.3%	100.0%	0.0%	99.9%
COV-M	40.6%	100.0%	66.3%	100.0%	81.0%	99.7%	97.0%	100.0%	0.0%	100.0%
FRE-S	94.7%	100.0%	96.9%	100.0%	98.3%	100.0%	30.4%	> 99.9%	0.0%	100.0%
HEA-M	40.5%	100.0%	64.5%	100.0%	79.7%	100.0%	98.0%	100.0%	0.0%	> 99.9%
HUM-L	100.0%	NA	100.0%	NA	100.0%	NA	45.0%	100.0%	0.0%	> 99.9%

Table E-10—Completeness (Percent Missing) and Accuracy (Percent Valid) for Key Institutional Encounter Data Elements (Surgical Procedure Codes and Procedure Code) by Plan and AHCA										
	Primary Surgical Code[A,B]		Surgical Code 2[A,B]		Surgical Code 3[A,B]		Surgical Code 4[A,B]		Procedure Code[A,B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
HUM-M	95.7%	100.0%	99.8%	100.0%	99.9%	100.0%	> 99.9%	100.0%	0.0%	100.0%
IHP-M	36.6%	100.0%	61.5%	100.0%	77.1%	100.0%	99.1%	100.0%	0.0%	100.0%
MCC-S	88.1%	100.0%	92.0%	100.0%	93.0%	100.0%	63.6%	100.0%	0.0%	80.4%
MOL-L	100.0%	NA	100.0%	NA	100.0%	NA	51.5%	100.0%	0.0%	98.7%
MOL-M	40.0%	> 99.9%	64.8%	> 99.9%	79.6%	100.0%	99.9%	100.0%	0.0%	100.0%
PHC-S	48.5%	99.9%	65.8%	100.0%	76.4%	100.0%	> 99.9%	100.0%	0.0%	100.0%
PRE-M	85.7%	100.0%	91.8%	100.0%	95.2%	100.0%	31.6%	> 99.9%	0.0%	> 99.9%
PRS-M	40.5%	100.0%	63.6%	100.0%	76.7%	100.0%	99.7%	99.9%	0.0%	> 99.9%
SHP-M	41.1%	100.0%	66.3%	100.0%	81.7%	100.0%	99.9%	100.0%	0.0%	100.0%
STW-M	43.1%	100.0%	67.4%	100.0%	81.1%	100.0%	98.1%	> 99.9%	0.0%	> 99.9%
SUN-L	99.7%	100.0%	99.8%	100.0%	99.9%	100.0%	46.1%	100.0%	0.0%	> 99.9%
SUN-M	44.5%	100.0%	69.4%	100.0%	82.7%	100.0%	99.1%	100.0%	0.0%	> 99.9%
UFS-M	100.0%	NA	100.0%	NA	100.0%	NA	85.0%	100.0%	0.0%	99.7%
URA-L	98.7%	100.0%	99.2%	100.0%	99.5%	100.0%	41.1%	100.0%	0.0%	99.5%
URA-M	43.6%	100.0%	63.9%	100.0%	78.1%	100.0%	96.6%	100.0%	0.0%	> 99.9%
VIS-M	38.3%	99.7%	64.6%	100.0%	77.3%	100.0%	98.3%	99.8%	0.0%	100.0%

[A] *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.

[B] *Diagnosis Code 2*, *Diagnosis Code 3*, *Diagnosis Code 4*, *Primary Surgical Code*, *Surgical Code 2*, *Surgical Code 3*, *Surgical Code 4*, *Procedure Code*, *NDC*, *Attending Provider ID*, and *Referring Provider NPI* fields are situational (i.e., not required for every institutional encounter transaction).

* Denotes that the plan had less than 30 records; therefore, results should be interpreted with caution.
"NA" denotes all records had missing values for this data element; therefore, validity could not be assessed.
Gray shading indicates there were no encounters to assess.

Table E-11—Completeness (Percent Missing) and Accuracy (Percent Valid) for Key Institutional Encounter Data Elements (Revenue Code, NDC, and Provider NPI) by Plan and AHCA										
	Revenue Code		NDC[A,B]		Billing Provider NPI[A]		Attending Provider ID/NPI[A,B]		Referring Provider NPI[A,B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
Plan										
AMG-L	0.0%	100.0%	99.9%	0.0%	0.0%	99.9%	100.0%	NA	100.0%	NA
AMG-M	< 0.1%	> 99.9%	93.8%	0.0%	< 0.1%	99.7%	100.0%	NA	100.0%	NA
BET-M										
CHA-S	0.0%	100.0%	82.5%	97.0%	0.2%	65.0%	68.1%	99.3%	100.0%	NA
COV-L	0.0%	> 99.9%	100.0%	NA	2.8%	98.9%	100.0%	NA	100.0%	NA
COV-M	< 0.1%	100.0%	100.0%	NA	0.0%	> 99.9%	55.8%	98.6%	99.7%	97.0%
FRE-S	0.0%	100.0%	100.0%	NA	0.0%	92.2%	0.0%	92.2%	100.0%	NA
HEA-M	0.0%	100.0%	90.7%	97.7%	0.0%	96.5%	1.7%	98.1%	100.0%	NA

Table E-11—Completeness (Percent Missing) and Accuracy (Percent Valid) for Key Institutional Encounter Data Elements (Revenue Code, NDC, and Provider NPI) by Plan and AHCA										
	Revenue Code		NDC[A,B]		Billing Provider NPI[A]		Attending Provider ID/NPI[A,B]		Referring Provider NPI[A,B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
HUM-L	0.0%	100.0%	100.0%	NA	1.7%	99.5%	100.0%	NA	100.0%	NA
HUM-M	1.7%	100.0%	99.9%	91.5%	5.0%	99.6%	6.3%	97.5%	99.9%	79.3%
IHP-M	0.0%	100.0%	91.3%	96.5%	0.0%	98.4%	12.1%	96.6%	100.0%	NA
MCC-S	0.0%	100.0%	99.1%	100.0%	0.0%	99.0%	0.1%	99.0%	100.0%	NA
MOL-L	0.0%	100.0%	100.0%	NA	0.0%	100.0%	1.3%	92.0%	99.9%	100.0%
MOL-M	0.0%	100.0%	92.6%	98.0%	0.0%	99.9%	0.3%	97.9%	99.9%	99.9%
PHC-S	0.0%	> 99.9%	79.9%	25.4%	0.0%	98.1%	18.2%	99.5%	> 99.9%	100.0%
PRE-M	< 0.1%	> 99.9%	95.8%	0.0%	0.0%	99.7%	1.1%	98.2%	100.0%	NA
PRS-M	0.0%	98.9%	100.0%	NA	0.2%	77.4%	5.3%	98.7%	15.9%	99.5%
SHP-M	0.0%	100.0%	72.9%	95.5%	0.5%	95.5%	44.2%	99.7%	99.9%	100.0%
STW-M	0.0%	100.0%	90.1%	97.0%	0.0%	99.8%	2.0%	98.2%	100.0%	NA
SUN-L	0.1%	> 99.9%	99.1%	96.3%	0.2%	99.4%	0.1%	91.6%	99.6%	92.3%
SUN-M	0.1%	> 99.9%	91.3%	98.0%	0.1%	99.7%	< 0.1%	98.0%	98.4%	96.7%
UFS-M	0.0%	> 99.9%	93.4%	32.0%	99.9%	100.0%	100.0%	NA	100.0%	NA
URA-L	0.0%	100.0%	> 99.9%	0.0%	0.1%	99.8%	0.7%	72.2%	96.2%	95.9%
URA-M	0.0%	100.0%	99.8%	0.0%	0.1%	99.6%	0.2%	15.0%	35.5%	97.0%
VIS-M	< 0.1%	100.0%	100.0%	NA	0.0%	99.9%	55.8%	98.2%	99.3%	99.8%
AHCA										
AMG-L	0.0%	98.8%	> 99.9%	100.0%	0.3%	100.0%	83.3%	0.0%	83.4%	89.7%
AMG-M	0.0%	> 99.9%	99.8%	98.2%	4.1%	99.9%	1.8%	0.0%	3.6%	97.8%
BET-M*	0.0%	100.0%	100.0%	NA	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%
CHA-S	0.0%	100.0%	100.0%	NA	18.3%	100.0%	< 0.1%	0.0%	0.3%	99.6%
COV-L	0.0%	99.9%	100.0%	NA	1.8%	99.5%	100.0%	NA	100.0%	NA
COV-M	0.0%	100.0%	100.0%	NA	0.8%	99.9%	0.1%	0.0%	0.7%	99.9%
FRE-S	0.0%	100.0%	100.0%	NA	0.1%	98.9%	0.0%	0.0%	0.1%	98.9%
HEA-M	0.0%	> 99.9%	99.3%	87.9%	0.5%	99.9%	1.4%	< 0.1%	2.6%	97.9%
HUM-L	0.0%	> 99.9%	100.0%	NA	5.2%	99.6%	100.0%	NA	100.0%	NA
HUM-M	0.0%	100.0%	> 99.9%	100.0%	1.2%	> 99.9%	22.3%	0.0%	25.9%	99.4%
IHP-M	0.0%	100.0%	98.9%	90.6%	0.3%	82.6%	0.0%	0.0%	0.4%	94.9%
MCC-S	0.0%	80.4%	98.7%	100.0%	0.0%	100.0%	0.8%	0.0%	1.2%	100.0%
MOL-L	0.0%	98.7%	100.0%	NA	0.0%	99.7%	1.6%	10.5%	4.0%	94.1%
MOL-M	0.0%	100.0%	99.7%	70.5%	0.4%	> 99.9%	0.1%	64.8%	2.5%	98.8%
PHC-S	0.0%	100.0%	100.0%	NA	14.7%	100.0%	33.5%	0.0%	34.0%	98.8%
PRE-M	0.0%	> 99.9%	96.8%	98.6%	0.3%	> 99.9%	0.2%	0.0%	1.5%	98.9%
PRS-M	0.0%	> 99.9%	100.0%	NA	0.4%	99.5%	< 0.1%	0.0%	2.7%	97.5%
SHP-M	0.0%	100.0%	100.0%	NA	5.1%	98.5%	0.4%	0.0%	2.0%	99.1%
STW-M	0.0%	> 99.9%	98.8%	86.7%	0.4%	99.8%	2.2%	0.0%	3.7%	98.3%

Table E-11—Completeness (Percent Missing) and Accuracy (Percent Valid) for Key Institutional Encounter Data Elements (Revenue Code, NDC, and Provider NPI) by Plan and AHCA										
	Revenue Code		NDC[A,B]		Billing Provider NPI[A]		Attending Provider ID/NPI[A,B]		Referring Provider NPI[A,B]	
	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid	Missing	Valid
SUN-L	0.0%	> 99.9%	> 99.9%	100.0%	0.1%	> 99.9%	< 0.1%	0.0%	3.6%	95.7%
SUN-M	0.0%	> 99.9%	> 99.9%	97.5%	0.5%	99.9%	0.0%	0.0%	1.8%	98.5%
UFS-M	0.0%	99.7%	100.0%	NA	0.0%	98.3%	0.3%	83.0%	0.3%	98.7%
URA-L	0.0%	99.5%	100.0%	NA	2.5%	98.8%	0.0%	0.0%	15.2%	94.8%
URA-M	0.0%	> 99.9%	> 99.9%	94.7%	3.6%	96.6%	0.0%	0.0%	7.4%	98.0%
VIS-M	0.0%	100.0%	100.0%	NA	0.6%	100.0%	0.0%	0.0%	0.5%	> 99.9%

[A] *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.

[B] *Diagnosis Code 2*, *Diagnosis Code 3*, *Diagnosis Code 4*, *Primary Surgical Code*, *Surgical Code 2*, *Surgical Code 3*, *Surgical Code 4*, *Procedure Code*, *NDC*, *Attending Provider ID*, and *Referring Provider NPI* fields are situational (i.e., not required for every institutional encounter transaction).

* Denotes that the plan had less than 30 records; therefore, results should be interpreted with caution.

"NA" denotes all records had missing values for this data element; therefore, validity could not be assessed.

Gray shading indicates there were no encounters to assess.

Data Element Completeness

Table E-12, Table E-13, and Table E-14 present the percentage of records with values present in the files submitted by the plans that were not present in AHCA's files (element omission), and the percentage of records with values present in AHCA's files that were not present in the files submitted by the plans (element surplus) for professional, dental, and institutional encounters, respectively.

Table E-12—Element Omission and Surplus: Professional Encounter						
Key Data Elements	Element Omission			Element Surplus		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Line First Date of Service	0.0%	0.0% — 0.0%	All pans reported 0.0%	0.0%	0.0% — 0.0%	All plans reported 0.0%
Primary Diagnosis Code	0.8%	0.0% — 88.5%	All plans except COV-L (86.2%) and HUM-L (88.5%) reported 0.0%	< 0.1%	0.0% — 98.5%	All plans except UFS-M (98.5%) reported 0.0%

Table E-12—Element Omission and Surplus: Professional Encounter						
Key Data Elements	Element Omission			Element Surplus		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Diagnosis Code 2	20.7%	0.0% — 59.5%	MCC-S (0.0%) PHC-S (0.0%) PRE-M (0.1%) COV-M (50.2%) HUM-M (53.5%) VIS-M (59.5%)	< 0.1%	0.0% — 0.1%	All plans except AMG-M (0.1%) reported 0.0%.
Diagnosis Code 3	13.4%	0.0% — 38.8%	MCC-S (0.0%) PHC-S (0.0%) SUN-L (0.2%) COV-M (31.1%) HUM-M (32.2%) VIS-M (38.8%)	< 0.1%	0.0% — 0.1%	All plans except AMG-M (0.1%) reported 0.0%.
Diagnosis Code 4	8.8%	0.0% — 26.1%	PHC-S (0.0%) SUN-L (0.1%) MOL-L (0.3%) HUM-M (19.7%) COV-M (20.5%) VIS-M (26.1%)	< 0.1%	0.0% — 0.1%	All plans reported 0.0% except AMG-M (0.1%).
Billing Provider NPI	2.4%	0.0% — 9.6%	UFS-M (0.0%) COV-M (0.7%) SUN-M (0.8%) PRE-M, SUN-L (6.4%) HUM-L (8.0%) AMG-L (9.6%)	0.6%	0.0% — 14.7%	9 plans (COV-M, FRE-S, HEA-M, IHP-M, MCC-S, PHC-S, PRS-M, STW-M, and VIS-M) reported 0.0%. HUM-M, SUN-L (2.0%) URA-M (2.3%) URA-L (14.7%)
Rendering Provider NPI	3.7%	0.0% — 12.9%	COV-L (0.0%) HUM-L (0.0%) UFS-M (0.0%) MOL-L (7.4%) SHP-M (8.6%) URA-M (12.9%)	18.8%	0.0% — 95.2%	PRS-M (0.0%) CHA-S (0.1%) MOL-L (0.1%) AMG-L (88.2%) HUM-L (91.6%) COV-L (95.2%)

Table E-12—Element Omission and Surplus: Professional Encounter						
Key Data Elements	Element Omission			Element Surplus		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Referring Provider NPI	14.3%	0.0% — 94.7%	5 plans (COV-L, HEA-M, HUM-L, STW-M, and UFS-M) reported 0.0% URA-M (50.7%) HUM-M (64.1%) PRS-M (94.7%)	19.9%	0.0% — 87.0%	12 plans (BET-M, CHA-S, COV-M, FRE-S, IHP-M, MOL-L, MOL-M, PHC-S, PRS-M, SHP-M, SUN-L, and VIS-M) reported 0.0% AMG-L (44.7%) HEA-M (45.5%) UFS-M 87.0%)
Procedure Code	1.0%	0.0% — 8.0%	4 plans (IHP-M, PHC-S, SUN-L, and URA-L) reported 0.0% COV-M (2.8%) SHP-M (6.7%) VIS-M (8.0%)	< 0.1%	0.0% — < 0.1%	All plans reported 0.0% except AMG-M (< 0.1%) and SUN-L (< 0.1%).
Procedure Code Modifier 1	1.1%	0.0% — 64.3%	9 plans (BET-M, CHA-S, COV-L, COV-M, FRE-S, HUM-L, IHP-M, SHP-M, and VIS-M) reported 0.0%. PRS-M (0.6%) HUM-M (17.0%) MCC-S (64.3%)	0.1%	0.0% — 1.4%	All plans reported 0.0% except PHC-S (0.1%), AMG-L (0.2%), AMG-M (0.4%), and PRS-M (1.4%).

Table E-12—Element Omission and Surplus: Professional Encounter						
Key Data Elements	Element Omission			Element Surplus		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans	Overall Rate	Plan Range	Top Three and Bottom Three Plans
NDC	0.5%	0.0% — 4.0%	All plans reported 0.0% except PHC-S (0.1%), BET-M (0.7%), CHA-S (1.0%), SUN-M (2.7%), and SHP-M (4.0%).	0.2%	0.0% — 3.4%	All plans reported 0.0% except MCC-S (0.1%), PRS-M (0.5%), AMG-M (0.7%), URA-M (0.8%), VIS-M (1.2%), and COV-M (3.4%).
Amount Paid	0.4%	0.0% — 5.3%	All plans reported 0.0% except HUM-M (0.1%), HEA-M (0.4%), STW-M (0.5%), and PRS-M (5.3%).	0.1%	0.0% — 0.4%	All plans reported 0.0% except HEA-M (0.1%) and STW-M (0.4%).

Table E-13—Element Omission and Surplus: Dental Encounter						
Key Data Elements	Element Omission			Element Surplus		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Line First Date of Service	0.0%	0.0% — 0.0%	All plans reported 0.0%	9.6%	0.0% — 98.7%	All plans reported 0.0% except STW-M (98.7%)
Billing Provider NPI	13.6%	0.0% — 52.0%	6 plans (CHA-S, COV-L, HEA-M, IHP-M, URA-L, and URA-M) reported 0.0%. MOL-M (24.0%) SHP-M (40.3%) MOL-L (52.0%)	2.8%	0.0% — 99.8%	All plans reported 0.0% except URA-M (99.3%), IHP-M (99.8%), and URA-L (99.8%)

Table E-13—Element Omission and Surplus: Dental Encounter						
Key Data Elements	Element Omission			Element Surplus		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Rendering Provider NPI	1.5%	0.0% — 10.0%	9 plans (BET-M, CHA-S, COV-L, FRE-S, HEA-M, IHP-M, MCC-S, PRS-M, and SHP-M) reported 0.0%. SUN-L (3.0%) MOL-M (3.6%) MOL-L (10.0%)	17.5%	0.0% — 100.0%	8 plans (HEA-M, MOL-L, MOL-M, STW-M, SUN-L, SUN-M, URA-L, and URA-M) reported 0.0%. PRS-M (90.3%) FRE-S (90.5%) COV-L (100.0%)
Dental Procedure Code (CDT)	< 0.1%	0.0% — 0.2%	All plans reported 0.0% except URA-L (0.1%) and PRE-M (0.2%)	0.0%	0.0% — 0.0%	All plans reported 0.0%.
Amount Paid	0.0%	0.0% — 0.0%	All plans reported 0.0%.	< 0.1%	0.0% — 14.0%	All plans reported 0.0% except PRE-M (14.0%)

Table E-14—Element Omission and Surplus: Institutional Encounter						
Key Data Elements	Element Omission			Element Surplus		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Admission Date	0.0%	0.0% — 0.0%	All plans reported 0.0%.	0.2%	0.0% — 100.0%	13 plans (AMG-L, AMG-M, FRE-S, HUM-L, HUM-M, IHP-M, MCC-S, MOL-L, MOL-M, PHC-S, PRE-M, PRS-M, and STW-M) reported 0.0%. SHP-M (52.3%) CHA-S (72.5%) UFS-M (100.0%)

Table E-14—Element Omission and Surplus: Institutional Encounter						
Key Data Elements	Element Omission			Element Surplus		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Discharge Date	0.0%	0.0% — 0.0%	All plans reported 0.0%	28.7%	0.0% — 100.0%	8 plans (AMG-L, AMG-M, MCC-S, MOL-L, MOL-M, PHC-S, PRE-M, and PRS-M) reported 0.0%. 6 plans (COV-L, FRE-S, HUM-L, UFS-M, URA-L, and URA-M) reported 100.0%.
Primary Diagnosis Code	< 0.1%	0.0% — < 0.1%	All plans reported 0.0% except COV-L (< 0.1%).	0.3%	0.0% — 1.3%	All plans reported 0.0% except STW-M (0.9%) and HEA-M (1.3%).
Diagnosis Code 2	2.7%	0.0% — 99.4%	10 plans (CHA-S, FRE-S, HUM-M, MCC-S, MOL-L, MOL-M, PHC-S, PRS-M, SUN-L, and URA-M) reported 0.0%, STW-M (3.7%) COV-L (98.1%) HUM-L (99.4%)	2.9%	0.0% — 85.7%	14 plans (AMG-L, AMG-M, COV-L, FRE-S, HUM-L, IHP-M, MCC-S, MOL-L, MOL-M, PRS-M, STW-M, SUN-L, SUN-M, and URA-M) reported 0.0%. UFS-M (34.4%) PRE-M (72.4%) PHC-S (85.7%)
Diagnosis Code 3	3.7%	0.0% — 81.4%	12 plans (AMG-L, AMG-M, CHA-S, FRE-S, IHP-M, MCC-S, MOL-L, MOL-M, PHC-S, PRS-M, UFS-M, and URA-M) reported 0.0%. HEA-M (8.5%) HUM-L (56.1%) COV-L (81.4%)	2.2%	0.0% — 85.7%	14 plans (AMG-L, AMG-M, COV-L, FRE-S, HUM-L, IHP-M, MCC-S, MOL-L, MOL-M, PRS-M, STW-M, SUN-L, SUN-M, and URA-M) reported 0.0%. UFS-M (26.4%) PRE-M (53.7%) PHC-S (85.7%)

Table E-14—Element Omission and Surplus: Institutional Encounter						
Key Data Elements	Element Omission			Element Surplus		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Diagnosis Code 4	3.6%	0.0% — 73.9%	11 plans (AMG-L, FRE-S, IHP-M, MCC-S, MOL-L, MOL-M, PHC-S, PRE-M, PRS-M, UFS-M, and URA-M) reported 0.0%. HEA-M (8.9%) HUM-L (50.5%) COV-L (73.9%0	1.6%	0.0% — 85.7%	14 plans (AMG-L, AMG-M, COV-L, FRE-S, HUM-L, IHP-M, MCC-S, MOL-L, MOL-M, PRS-M, STW-M, SUN-L, SUN-M, and URA-M) reported 0.0%. UFS-M (22.1%) PRE-M (39.1%) PHC-S (85.7%)
Primary Surgical Procedure	2.0%	0.0% — 50.7%	16 plans (AMG-M, COV-L, FRE-S, HEA-M, HUM-L, MCC-S, MOL-L, MOL-M, PHC-S, PRE-M, PRS-M, STW-M, SUN-M, UFS-M, URA-L, and URA-M) reported 0.0%. CHA-S (0.6%) SHP-M (2.1%) HUM-M (50.7%)	15.0%	0.0% — 60.1%	10 plans (AMG-L, AMG-M, HUM-L, MOL-L, MOL-M, PRE-M, SUN-L, UFS-M, URA-L, and URA-M) reported 0.0%. CHA-S (44.2%) STW-M (57.5%) HEA-M (60.1%)
Surgical Procedure Code 2	1.3%	0.0% — 31.2%	All plans reported 0.0% except SUN-M (0.4%), SHP-M (1.3%), and HUM-M (31.2%)	8.6%	0.0% — 57.1%	12 plans (AMG-L, AMG-M, HUM-L, IHP-M, MOL-L, MOL-M, PRE-M, PRS-M, SUN-L, UFS-M, URA-L, and URA-M) reported 0.0%. STW-M (32.6%) HEA-M (35.4%) PHC-S (57.1%)

Table E-14—Element Omission and Surplus: Institutional Encounter						
Key Data Elements	Element Omission			Element Surplus		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Surgical Procedure Code 3	0.8%	0.0% — 17.8%	All plans reported 0.0% except SUN-M (0.6%), SHP-M (0.8%), and HUM-M (17.8%)	5.3%	0.0% — 20.3%	11 plans (AMG-L, AMG-M, HUM-L, MOL-L, MOL-M, PHC-S, PRS-M, SUN-L, UFS-M, URA-L, and URA-M) reported 0.0% CHA-S (11.4%) STW-M (18.9%) HEA-M (20.3%)
Surgical Procedure Code 4	0.5%	0.0% — 10.7%	All plans reported 0.0% except SHP-M (0.2%), SUN-M (0.6%), and HUM-M (10.7%)	3.1%	0.0% — 11.8%	10 plans (AMG-L, AMG-M, HUM-L, MOL-L, MOL-M, PHC-S, PRS-M, SUN-L, UFS-M, and URA-M) reported 0.0%. CHA-S (7.6%) STW-M (10.9%) HEA-M (11.8%)
Billing Provider NPI	0.6%	0.0% — 14.3%	3 plans (MCC-S, MOL-L, and UFS-M) reported 0.0%. SHP-M (3.8%) CHA-S (10.5%) PHC-S (14.3%)	0.1%	0.0% — 5.5%	All plans reported less than 1% except HUM-M (2.3%) and UFS-M (5.5%)
Attending Provider ID	< 0.1%	0.0% — 0.1%	All plans reported 0.0% except PRE-M (0.1%)	77.6%	0.0% — 100.0%	4 plans (COV-L, FRE-S, HUM-L, and MCC-S) reported 0.0%. COV-M, PRS-M UFS-M, and VIS-M) reported 100.0%.
Referring Provider NPI	< 0.1%	0.0% — < 0.1%	All plans reported 0.0% except MOL-L (< 0.1%)	93.9%	0.0% — 100.0%	COV-L (0.0%) HUM-L (0.0%) AMG-L (10.2%) COV-M (99.8%) FRE-S (99.9%)

Table E-14—Element Omission and Surplus: Institutional Encounter						
Key Data Elements	Element Omission			Element Surplus		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans	Overall Rate	Plan Range	Top Three and Bottom Three Plans
						UFS-M (100.0%)
Procedure Code	6.8%	0.0% — 99.6%	5 plans (COV-L, HUM-L, IHP-M, MCC-S, and MOL-M) reported 0.0%. MOL-L (3.9%) PHC-S (90.5%0 PRS-M (99.6%)	0.8%	0.0% — 51.8%	All plans reported 0.0% except SUN-M (0.1%), HUM-L (22.6%), and COV-L (51.8%)
Procedure Code Modifier 1	0.6%	0.0% — 5.0%	10 plans (AMG-L, CHA-S, COV-L, HUM-L, IHP-M, MOL-M, PRS-M, SHP-M, SUN-L, and UFS-M) reported 0.0%. MCC-S (1.8%) PHC-S (4.8%) URA-L (5.0%)	< 0.1%	0.0% — < 0.1%	All plans reported 0.0% except HEA-M (< 0.1%), SUN-M (< 0.1%), and URA-L (< 0.1%).
Revenue Code	0.0%	0.0% — 0.0%	All plans reported 0.0%.	< 0.1%	0.0% — < 0.1%	All plans reported 0.0% except HUM-M (< 0.1%), SUN-L (< 0.1%), and SUN-M (< 0.1%)
NDC	0.1%	0.0% — 28.1%	All plans reported less than 1% except SHP-M (23.0%) and CHA-S (28.1%)	< 0.1%	0.0% — 0.1%	All plans reported 0.0% except AMG-M (0.1%) and URA-M (0.1%)
Amount Paid	0.8%	0.0% — 4.3%	All plans reported 0.0% except SUN-L (0.1%), MCC-S (2.2%), IHP-M (2.4%), and SUN-M (4.3%).	0.1%	0.0% — 30.8%	All plans reported 0.0% except CHA-S (0.9%), IHP-M (2.3%), and SHP-M (30.8%)

Table E-15, Table E-16, and Table E-17 present the overall agreement rates for each of the evaluated data elements for professional, dental, and institutional encounters, respectively. The minimum and maximum plan element agreement rates and the high and low plan performers were also provided.

Table E-15—Element Agreement: Professional Encounter			
Key Data Elements	Element Agreement		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Line First Date of Service	99.3%	91.5% — 100.0%	All plans reported 100% except PRS-M (91.5%), MCC-S (97.3%), AMG-L (99.4%), and PHC-S (99.9%).
Primary Diagnosis Code	92.0%	31.6% — > 99.9%	AMG-L, COV-L, HUM-M, and MCC-S reported > 99.9% UFS-M (31.6%) STW-M (87.1%) HEA-M (88.7%)
Diagnosis Code 2	94.7%	0.0% — 100.0%	COV-L, HUM-L, IHP-M, MCC-S, and PHC-S reported 100.0%. COV-M (0.0%) VIS-M (33.3%) UFS-M (72.2%)
Diagnosis Code 3	95.3%	0.0% — 100.0%	4 plans (COV-L, HUM-L, IHP-M, MCC-S, PHC-S, and PRE-M) reported 100%. UFS-M (0.0%) STW-M (91.4%0 HEA-M (91.5%)
Diagnosis Code 4	96.8%	91.9% — 100.0%	9 plans (COV-L, HUM-L, IHP-M, MCC-S, MOL-L, PHC-S, PRS-M, SUN-L, and URA-L) reported 100%. HUM-M (91.9%) AMG-M (92.9%) STW-M (94.5%)
Billing Provider NPI	87.5%	52.5% — 98.9%	PHC-S (98.9%) FRE-S (97.5%) STW-M (97.4%) PRS-M (52.5%) URA-M (55.3%) SUN-M (74.5%)

Table E-15—Element Agreement: Professional Encounter			
Key Data Elements	Element Agreement		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Rendering Provider NPI	85.7%	3.7% — > 99.9%	BET-M (> 99.9%) 3 plans (COV-M, IHP-M, and PRE-M) reported 98.8%. HUM-L (7.1%) AMG-M (5.9%) AMG-L (3.7%)
Referring Provider NPI	95.8%	29.8% — 98.8%	PRE-M (98.8%) CHA-S (98.5%) URA-M (98.2%) URA-L (90.3%) MOL-L (83.9%) HUM-M (29.8%)
Procedure Code	99.1%	87.5% — 100.0%	9 plans (BET-M, CHA-S, COV-M, FRE-S, IHP-M, MOL-L, SHP-M, URA-L, and VIS-M) reported 100%. MCC-S (94.1%) COV-L (91.2%) PRS-M (87.5%)
Procedure Code Modifier 1	81.1%	0.0% — 100.0%	10 plans (BET-M, CHA-S, COV-M, FRE-S, IHP-M, MOL-L, SHP-M, UFS-M, URA-L, and VIS-M) reported 100%. HUM-M (92.4%) SUN-L (0.0%) HUM-M (0.0%)
NDC	99.5%	0.0% — 100.0%	3 plans (BET-M, HUM-M, and IHP-M) reported 100%. SHP-M (43.2%) MCC-S (0.0%) PRE-M (0.0%)
Amount Paid	74.9%	9.6% — 89.5%	HUM-M (89.5%) AMG-L (84.8%) PRE-M (84.4%) COV-L (17.9%) URA-L (14.7%) MOL-L (9.6%)

Table E-16—Element Agreement: Dental Encounter			
Key Data Elements	Element Agreement		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Line First Date of Service	99.9%	99.8% — 100.0%	All plans reported 100% except PRS-M (99.8%) and SUN-M (99.9%)
Billing Provider NPI	95.2%	87.4% — 100.0%	4 plans (CHA-S, HEA-M, MCC-S, and MOL-L) reported 100%. SUN-M (89.9%) COV-L (88.9%) SHP-M (87.4%)
Rendering Provider NPI	98.7%	95.7% — 100.0%	6 plans (HEA-M, MCC-S, MOL-L, PRE-M, URA-L, and URA-M) reported 100%. MOL-M (97.3%) FRE-S (96.5%) HUM-M (95.7%)
Dental Procedure Code (CDT)	73.9%	30.2% — 100.0%	9 plans (COV-L, FRE-S, MCC-S, MOL-L, MOL-M, PRS-M, SHP-M, STW-M, and URA-L) reported 100%. IHP-M (46.8%) HEA-M (33.3%) BET-M (30.2%)
Amount Paid	98.8%	0.0% — 100.0%	9 plans (BET-M, CHA-S, COV-L, FRE-S, HEA-M, MOL-L, MOL-M, SHP-M, and STW-M) reported 100%. URA-L (84.0%) IHP-M (59.4%) PRE-M (0.0%)

Table E-17—Element Agreement: Institutional Encounter			
Key Data Elements	Element Agreement		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Admission Date	99.2%	4.3% — 100.0%	11 plans (FRE-S, IHP-M, MCC-S, MOL-L, MOL-M, PHC-S, PRE-M, PRS-M, SUN-L, SUN-M, and URA-M) reported 100.0% SHP-M (62.3%) HUM-L (54.2%) CHA-S (4.3%)
Discharge Date	91.3%	0.0% — 99.9%	IHP-M (99.9%) PRS-M (99.8%) SUN-M (99.6%) HUM-M (2.0%) CHA-S (0.0%) SHP-M (0.0%)
Primary Diagnosis Code	95.8%	9.9% — 100.0%	8 plans (AMG-L, FRE-S, MCC-S, MOL-L, MOL-M, PRS-M, SUN-L, and SUN-M) reported 100.0%. PHC-S (61.9%) UFS-M (55.2%) CHA-S (9.9%)
Diagnosis Code 2	75.7%	0.0% — 100.0%	6 plans (FRE-S, IHP-M, MCC-S, MOL-L, MOL-M, and PRS-M) reported 100.0%. SHP-M (12.1%) CHA-S (0.0%) PRE-M (0.0%0
Diagnosis Code 3	74.7%	0.0% — 100.0%	6 plans (FRE-S, IHP-M, MCC-S, MOL-L, MOL-M, and PRS-M) reported 100.0%. SHP-M (13.4%) CHA-S (3.0%) PRE-M (0.0%)

Table E-17—Element Agreement: Institutional Encounter			
Key Data Elements	Element Agreement		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Diagnosis Code 4	74.3%	2.5% — 100.0%	5 plans (CHA-S, HUM-M, IHP-M, MCC-S, MOL-L, and MOL-M) reported 100.0%. STW-M (14.2%) SHP-M (10.0%) CHA-S (2.5%)
Primary Surgical Procedure Code	95.4%	0.0% — 100.0%	10 plans (AMG-L, AMG-M, HUM-M, MCC-S, MOL-M, PRE-M, PRS-M, SUN-L, URA-M, and VIS-M) reported 100.0%. SHP-M (36.4%) IHP-M (20.4%) PHC-S (0.0%)
Surgical Procedure Code 2	94.7%	14.3% — 100.0%	9 plans (AMG-L, AMG-M, COV-M, MCC-S, PRE-M, PRS-M, SUN-L, URA-M, and VIS-M) reported 100.0%. URA-L (98.8%) IHP-M (19.1%) SHP-M (14.3%)
Surgical Procedure Code 3	93.6%	0.0% — 100.0%	8 plans (AMG-L, AMG-M, COV-M, MCC-S, PRS-M, SUN-L, URA-M, and VIS-M) reported 100.0%. SUN-M (96.5%) IHP-M (0.0%) SHP-M (0.0%)
Surgical Procedure Code 4	92.6%	0.0% — 100.0%	9 plans (AMG-L, AMG-M, COV-M, MCC-S, PRS-M, SUN-L, URA-L, URA-M, VIS-M) reported 100.0% MOL-M (99.8%) SUN-M (92.7%) IHP-M (0.0%)

Table E-17—Element Agreement: Institutional Encounter			
Key Data Elements	Element Agreement		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Billing Provider NPI	92.8%	32.5% — 99.9%	AMG-L (99.9%) HUM-M (98.9%) MOL-L (98.9%) SHP-M (73.5%) PRS-M (60.7%) CHA-S (32.5%)
Attending Provider ID	0.0%	0.0% — 0.0%	All plans reported 0.0%.
Referring Provider NPI	18.4%	0.0% — 21.3%	SUN-M (21.3%) COV-M (0.0%) MOL-L (0.0%) VIS-M (0.0%)
Procedure Code	97.6%	0.0% — 100.0%	8 plans (FRE-S, IHP-M, MCC-S, MOL-L, MOL-M, PRE-M, URA-M, and VIS-M) reported 100.0%. SUN-M (95.1%) SUN-L (88.3%) PRS-M (0.0%)
Procedure Code Modifier 1	> 99.9%	0.0% — 100.0%	All plans reported 100.0% except AMG-L (99.9%), MOL-L (99.6%), and SUN-M (0.0%)
Revenue Code	97.4%	4.8% — 100.0%	FRE-S (100%) MOL-M (100.0%) MOL-L (99.9%) PRS-M (99.9%) STW-M (99.9%) SHP-M (39.5%) CHA-S (9.9%) PHC-S (4.8%)
NDC	66.5%	0.0% — 100.0%	3 plans (HUM-M, MCC-S, and MOL-M) reported 100.0%. 4 plans (AMG-L, AMG-M, PRE-M, and SUN-L) reported 0.0%.

Table E-17—Element Agreement: Institutional Encounter			
Key Data Elements	Element Agreement		
	Overall Rate	Plan Range	Top Three and Bottom Three Plans
Amount Paid	87.1%	0.0% — 98.9%	AMG-L (98.9%) MOL-L (98.9%) COV-M (98.2%0 SHP-M (25.6%) UFS-M (22.7%) PHC-S (0.0%)

Medical Record Submission

Table E-18 highlights the percentage of medical records submitted by each plan.

Table E-18—Medical Record Submission									
Plan	Initial Sample Size	Valid Exclusions	Adjusted Sample Size	Medical Records Not Submitted		Medical Records Submitted			
				N	%	N	%	Number of Records With One Additional Date of Service	
								N	%
AMG-L	50	0	50	43	86.0%	7	14.0%	0	0.0%
AMG-M	50	0	50	13	26.0%	37	74.0%	19	38.0%
BET-M	50	0	50	12	24.0%	38	76.0%	17	34.0%
CHA-S	41	0	41	18	43.9%	23	56.1%	14	34.1%
COV-L	47	0	47	2	4.3%	45	95.7%	9	19.1%
COV-M	50	0	50	0	0.0%	50	100.0%	1	2.0%
FRE-S	50	0	50	11	22.0%	39	78.0%	14	28.0%
HEA-M	50	0	50	12	24.0%	38	76.0%	19	38.0%
HUM-L	50	0	50	11	22.0%	39	78.0%	0	0.0%
HUM-M	50	0	50	9	18.0%	41	82.0%	12	24.0%
IHP-M	50	0	50	10	20.0%	40	80.0%	12	24.0%
MCC-S	50	0	50	3	6.0%	47	94.0%	21	42.0%
MOL-L	49	0	49	1	2.0%	48	98.0%	0	0.0%
MOL-M	50	0	50	7	14.0%	43	86.0%	16	32.0%
PHC-S	50	0	50	9	18.0%	41	82.0%	19	38.0%
PRE-M	50	0	50	1	2.0%	49	98.0%	5	10.0%
PRS-M	50	0	50	0	0.0%	50	100.0%	22	44.0%
SHP-M	50	0	50	11	22.0%	39	78.0%	21	42.0%
STW-M	50	0	50	11	22.0%	39	78.0%	21	42.0%
SUN-L	50	0	50	4	8.0%	46	92.0%	1	2.0%
SUN-M	50	0	50	4	8.0%	46	92.0%	12	24.0%
UFS-M	47	0	47	0	0.0%	47	100.0%	23	48.9%
URA-L	50	0	50	36	72.0%	14	28.0%	1	2.0%
URA-M	50	0	50	25	50.0%	25	50.0%	1	2.0%
VIS-M	50	0	50	0	0.0%	50	100.0%	0	0.0%
All Plans	**1,234**	**0**	**1,234**	**253**	**20.5%**	**981**	**79.5%**	**280**	**22.7%**

Table E-19 highlights the major reasons medical records were not submitted by each plan.

Table E-19—Medical Records Not Submitted for Date of Service by Plan									
Plan	Medical Records Not Submitted	Provider Refused		Unable to Locate		No Documentation		Incorrect Record Submitted	
		N	%	N	%	N	%	N	%
AMG-L	43	40	93.0%	0	0.0%	3	7.0%	0	0.0%
AMG-M	13	11	84.6%	2	15.4%	0	0.0%	0	0.0%
BET-M	12	12	100.0%	0	0.0%	0	0.0%	0	0.0%
CHA-S	18	17	94.4%	0	0.0%	0	0.0%	1	5.6%
COV-L	2	0	0.0%	0	0.0%	2	100.0%	0	0.0%
COV-M									
FRE-S	11	11	100.0%	0	0.0%	0	0.0%	0	0.0%
HEA-M	12	10	83.3%	0	0.0%	2	16.7%	0	0.0%
HUM-L	11	7	63.6%	2	18.2%	2	18.2%	0	0.0%
HUM-M	9	2	22.2%	5	55.6%	2	22.2%	0	0.0%
IHP-M	10	1	10.0%	9	90.0%	0	0.0%	0	0.0%
MCC-S	3	3	100.0%	0	0.0%	0	0.0%	0	0.0%
MOL-L	1	0	0.0%	0	0.0%	0	0.0%	1	100.0%
MOL-M	7	7	100.0%	0	0.0%	0	0.0%	0	0.0%
PHC-S	9	9	100.0%	0	0.0%	0	0.0%	0	0.0%
PRE-M	1	0	0.0%	0	0.0%	1	100.0%	0	0.0%
PRS-M									
SHP-M	11	11	100.0%	0	0.0%	0	0.0%	0	0.0%
STW-M	11	10	90.9%	1	9.1%	0	0.0%	0	0.0%
SUN-L	4	4	100.0%	0	0.0%	0	0.0%	0	0.0%
SUN-M	4	2	50.0%	0	0.0%	1	25.0%	1	25.0%
UFS-M									
URA-L	36	35	97.2%	0	0.0%	1	2.8%	0	0.0%
URA-M	25	0	0.0%	24	96.0%	1	4.0%	0	0.0%
VIS-M									
All Plans	**253**	**192**	**75.9%**	**43**	**17.0%**	**15**	**5.9%**	**3**	**1.2%**

Gray shading indicates plan does not offer program options in the selected category.

Encounter Data Completeness

Table E-20 presents the percentage of dates of service identified in the encounter data that were not found in the enrollees' medical records for the *Date of Service* data element by population type (i.e., overall population, Reform program, and Non-Reform program).

Table E-20—Medical Record Omission for Date of Service by Plan					
Plan	Overall	Reform		Non-Reform	
	Rate	Date of Service Identified in Encounter Data	Rate	Date of Service Identified in Encounter Data	Rate
AMG-L	86.0%			50	86.0%
AMG-M	22.0%			59	22.0%
BET-M	25.0%	56	25.0%		
CHA-S	38.0%	21	23.8%	29	48.3%
COV-L	27.7%			47	27.7%
COV-M	7.8%			51	7.8%
FRE-S	18.6%	29	17.2%	30	20.0%
HEA-M	23.0%			61	23.0%
HUM-L	26.0%			50	26.0%
HUM-M	19.0%	31	19.4%	27	18.5%
IHP-M	22.8%			57	22.8%
MCC-S	8.1%	62	8.1%		
MOL-L	2.0%			49	2.0%
MOL-M	17.2%	30	10.0%	28	25.0%
PHC-S	16.9%	33	24.2%	32	9.4%
PRE-M	1.9%			53	1.9%
PRS-M	6.2%			65	6.2%
SHP-M	23.0%			61	23.0%
STW-M	19.7%	29	27.6%	37	13.5%
SUN-L	22.0%			50	22.0%
SUN-M	12.1%	30	10.0%	28	14.3%
UFS-M	0.0%			55	0.0%
URA-L	84.0%			50	84.0%
URA-M	58.0%	25	60.0%	25	56.0%
VIS-M	6.0%			50	6.0%
All Plans	**22.9%**	**346**	**20.8%**	**1,044**	**23.7%**

Gray shading indicates plan does not offer program options in the selected category.

Table E-21 presents the percentage of dates of service from enrollees' medical records that were not found in the encounter data.

Table E-21—Encounter Data Omission for Date of Service by Plan					
Plan	Overall	Reform		Non-Reform	
	Rate	Date of Service Identified in Medical Records	Rate	Date of Service Identified in Medical Records	Rate
AMG-L	0.0%			7	0.0%
AMG-M	17.9%			56	17.9%
BET-M	20.8%	53	20.8%		
CHA-S	13.9%	18	11.1%	18	16.7%
COV-L	20.9%			43	20.9%
COV-M	0.0%			47	0.0%
FRE-S	9.4%	25	4.0%	28	14.3%
HEA-M	14.5%			55	14.5%
HUM-L	0.0%			37	0.0%
HUM-M	7.8%	27	7.4%	24	8.3%
IHP-M	10.2%			49	10.2%
MCC-S	13.6%	66	13.6%		
MOL-L	0.0%	0	NA	48	0.0%
MOL-M	14.3%	32	15.6%	24	12.5%
PHC-S	6.9%	27	7.4%	31	6.5%
PRE-M	3.7%			54	3.7%
PRS-M	10.3%			68	10.3%
SHP-M	17.5%			57	17.5%
STW-M	8.6%	25	16.0%	33	3.0%
SUN-L	2.5%			40	2.5%
SUN-M	7.3%	29	6.9%	26	7.7%
UFS-M	21.4%			70	21.4%
URA-L	11.1%			9	11.1%
URA-M	4.5%	11	9.1%	11	0.0%
VIS-M	0.0%			47	0.0%
All Plans	**10.4%**	**313**	**12.5%**	**882**	**9.6%**

Gray shading indicates plan does not offer program options in the selected category.

"NA" indicates there were no records present; therefore, rates were not able to be reported.

Table E-22 presents the percentage of diagnosis codes identified in the encounter data that were not found in the enrollees' medical records.

Table E-22–Medical Record Omission for Diagnosis Code by Plan					
Plan	Overall	Reform		Non-Reform	
	Rate	Number of Diagnoses Identified in Encounter Data	Rate	Number of Diagnoses Identified in Encounter Data	Rate
AMG-L	89.3%			121	89.3%
AMG-M	37.4%			115	37.4%
BET-M	40.8%	71	40.8%		
CHA-S	44.3%	56	26.8%	66	59.1%
COV-L	39.3%			28	39.3%
COV-M	15.2%			66	15.2%
FRE-S	34.7%	51	37.3%	50	32.0%
HEA-M	36.0%			114	36.0%
HUM-L	60.0%			50	60.0%
HUM-M	31.5%	24	41.7%	30	23.3%
IHP-M	31.5%			92	31.5%
MCC-S	21.8%	87	21.8%		
MOL-L	2.4%			42	2.4%
MOL-M	44.9%	32	43.8%	37	45.9%
PHC-S	30.0%	45	40.0%	45	20.0%
PRE-M	21.4%			84	21.4%
PRS-M	20.2%			99	20.2%
SHP-M	37.7%			106	37.7%
STW-M	36.3%	38	47.4%	75	30.7%
SUN-L	71.1%			76	71.1%
SUN-M	30.8%	38	47.4%	53	18.9%
UFS-M	8.3%			60	8.3%
URA-L	85.4%			158	85.4%
URA-M	72.0%	32	75.0%	50	70.0%
VIS-M	19.4%			67	19.4%
All Plans	**41.6%**	**474**	**38.8%**	**1,684**	**42.4%**

Gray shading indicates plan does not offer program options in the selected category.

Table E-23 presents the percentage of diagnoses from enrollees' medical records that were not found in the encounter data.

Table E-23—Encounter Data Omission for Diagnosis Code by Plan					
Plan	Overall	Reform		Non-Reform	
	Rate	Number of Diagnoses Identified in Medical Records	Rate	Number of Diagnoses Identified in Medical Records	Rate
AMG-L	13.3%			15	13.3%
AMG-M	35.7%			112	35.7%
BET-M	36.4%	66	36.4%		
CHA-S	38.2%	51	19.6%	59	54.2%
COV-L	85.3%			116	85.3%
COV-M	27.3%			77	27.3%
FRE-S	16.5%	35	8.6%	44	22.7%
HEA-M	29.8%			104	29.8%
HUM-L	31.0%			29	31.0%
HUM-M	47.1%	23	39.1%	47	51.1%
IHP-M	30.0%			90	30.0%
MCC-S	46.5%	127	46.5%		
MOL-L	0.0%			41	0.0%
MOL-M	37.7%	33	45.5%	28	28.6%
PHC-S	40.6%	33	18.2%	73	50.7%
PRE-M	23.3%			86	23.3%
PRS-M	41.0%			134	41.0%
SHP-M	37.1%			105	37.1%
STW-M	27.3%	37	45.9%	62	16.1%
SUN-L	15.4%			26	15.4%
SUN-M	13.7%	22	9.1%	51	15.7%
UFS-M	45.5%			101	45.5%
URA-L	25.8%			31	25.8%
URA-M	28.1%	11	27.3%	21	28.6%
VIS-M	29.9%			77	29.9%
All Plans	**35.9%**	**438**	**33.8%**	**1,529**	**36.6%**

Gray shading indicates plan does not offer program options in the selected category.

Table E-24 presents the percentage of procedure codes identified in the encounter data that were not found in the enrollees' medical records.

Table E-24—Medical Record Omission for Procedure Code by Plan					
Plan	Overall	Reform		Non-Reform	
	Rate	Number of Procedures Identified in Encounter Data	Rate	Number of Procedures Identified in Encounter Data	Rate
AMG-L	90.5%			63	90.5%
AMG-M	46.2%			119	46.2%
BET-M	31.7%	164	31.7%		
CHA-S	64.9%	34	44.1%	77	74.0%
COV-L	20.8%			48	20.8%
COV-M	32.6%			92	32.6%
FRE-S	25.3%	73	17.8%	26	46.2%
HEA-M	32.7%			98	32.7%
HUM-L	NA			0	NA
HUM-M	29.8%	106	22.6%	62	41.9%
IHP-M	45.5%			110	45.5%
MCC-S	21.8%	119	21.8%		
MOL-L	13.6%			66	13.6%
MOL-M	19.0%	88	6.8%	80	32.5%
PHC-S	37.1%	36	22.2%	53	47.2%
PRE-M	39.7%			58	39.7%
PRS-M	19.8%			106	19.8%
SHP-M	25.7%			109	25.7%
STW-M	38.6%	93	54.8%	65	15.4%
SUN-L	32.1%			53	32.1%
SUN-M	23.2%	72	23.6%	40	22.5%
UFS-M	15.1%			53	15.1%
URA-L	95.2%			42	95.2%
URA-M	66.4%	55	61.8%	52	71.2%
VIS-M	46.2%			106	46.2%
All Plans	**36.3%**	**840**	**29.3%**	**1,578**	**40.0%**

Gray shading indicates plan does not offer program options in the selected category.

"NA" indicates there were no records present; therefore, rates were not able to be reported.

Table E-25 presents the percentage of procedure codes from enrollees' medical records that were not found in the encounter data.

Table E-25—Encounter Data Omission for Procedure Code by Plan					
Plan	Overall	Reform		Non-Reform	
	Rate	Number of Procedures Identified in Medical Records	Rate	Number of Diagnoses Identified in Medical Records	Rate
AMG-L	14.3%			7	14.3%
AMG-M	29.7%			91	29.7%
BET-M	28.7%	157	28.7%		
CHA-S	17.0%	23	17.4%	24	16.7%
COV-L	34.5%			58	34.5%
COV-M	13.9%			72	13.9%
FRE-S	42.2%	79	24.1%	49	71.4%
HEA-M	32.7%			98	32.7%
HUM-L	100.0%			7	100.0%
HUM-M	12.6%	87	5.7%	48	25.0%
IHP-M	42.9%			105	42.9%
MCC-S	31.6%	136	31.6%		
MOL-L	14.9%			67	14.9%
MOL-M	19.0%	99	17.2%	69	21.7%
PHC-S	13.8%	33	15.2%	32	12.5%
PRE-M	57.3%			82	57.3%
PRS-M	41.4%			145	41.4%
SHP-M	19.0%			100	19.0%
STW-M	21.1%	57	26.3%	66	16.7%
SUN-L	41.9%			62	41.9%
SUN-M	27.7%	72	23.6%	47	34.0%
UFS-M	36.6%			71	36.6%
URA-L	33.3%			3	33.3%
URA-M	10.0%	25	16.0%	15	0.0%
VIS-M	16.2%			68	16.2%
All Plans	**28.5%**	**768**	**22.7%**	**1,386**	**31.7%**

Gray shading indicates plan does not offer program options in the selected category.

Table E-26 presents the percentage of procedure code modifiers identified in the encounter data that were not found in the enrollees' medical records.

Table E-26—Medical Record Omission for Procedure Code Modifier by Plan					
Plan	Overall	Reform		Non-Reform	
	Rate	Number of Modifiers Identified in Encounter Data	Rate	Number of Modifiers Identified in Encounter Data	Rate
AMG-L	100.0%			10	100.0%
AMG-M	75.0%			48	75.0%
BET-M	80.0%	15	80.0%		
CHA-S	91.2%	6	50.0%	51	96.1%
COV-L	50.0%			4	50.0%
COV-M	47.1%			17	47.1%
FRE-S	100.0%	0	NA	2	100.0%
HEA-M	69.2%			13	69.2%
HUM-L	NA			0	NA
HUM-M	NA	0	NA	0	NA
IHP-M	71.4%			21	71.4%
MCC-S	70.6%	17	70.6%		
MOL-L	0.0%			15	0.0%
MOL-M	80.0%	3	66.7%	2	100.0%
PHC-S	82.4%	4	75.0%	13	84.6%
PRE-M	57.1%			7	57.1%
PRS-M	35.3%			17	35.3%
SHP-M	25.9%			27	25.9%
STW-M	50.0%	17	64.7%	9	22.2%
SUN-L	33.3%			3	33.3%
SUN-M	57.1%	8	50.0%	6	66.7%
UFS-M	24.0%			25	24.0%
URA-L	75.0%			4	75.0%
URA-M	83.3%	6	100.0%	18	77.8%
VIS-M	64.3%			14	64.3%
All Plans	**62.9%**	**76**	**69.7%**	**326**	**61.3%**

Gray shading indicates plan does not offer program options in the selected category.

"NA" indicates there were no records present; therefore, rates were not able to be reported.

Table E-27 presents the percentage of procedure code modifiers from enrollees' medical records that were not found in the encounter data.

Table E-27—Encounter Data Omission for Procedure Code Modifier by Plan					
Plan	Overall	Reform		Non-Reform	
	Rate	Number of Modifiers Identified in Medical Records	Rate	Number of Modifiers Identified in Medical Records	Rate
AMG-L	NA			0	NA
AMG-M	33.3%			18	33.3%
BET-M	62.5%	8	62.5%		
CHA-S	16.7%	3	0.0%	3	33.3%
COV-L	77.8%			9	77.8%
COV-M	35.7%			14	35.7%
FRE-S	100.0%	3	100.0%	9	100.0%
HEA-M	55.6%			9	55.6%
HUM-L	100.0%			1	100.0%
HUM-M	100.0%	4	100.0%	6	100.0%
IHP-M	45.5%			11	45.5%
MCC-S	58.3%	12	58.3%		
MOL-L	0.0%			15	0.0%
MOL-M	80.0%	2	50.0%	3	100.0%
PHC-S	25.0%	2	50.0%	2	0.0%
PRE-M	80.0%			15	80.0%
PRS-M	59.3%			27	59.3%
SHP-M	28.6%			28	28.6%
STW-M	27.8%	8	25.0%	10	30.0%
SUN-L	50.0%			4	50.0%
SUN-M	50.0%	4	0.0%	8	75.0%
UFS-M	13.6%			22	13.6%
URA-L	0.0%			1	0.0%
URA-M	0.0%	0	NA	4	0.0%
VIS-M	28.6%			7	28.6%
All Plans	**45.2%**	**46**	**50.0%**	**226**	**44.2%**

Gray shading indicates plan does not offer program options in the selected category.

"NA" indicates there were no records present; therefore, no rates were able to be reported.

Encounter Data Accuracy

Table E-28 presents the percentage of diagnosis codes associated with validated dates of service from the encounter data that were correctly coded based on enrollees' medical records.

Table E-28—Accuracy Results for Diagnosis Code by Plan					
Plan	Overall	Reform		Non-Reform	
	Rate	Number of Diagnoses Present in Both Sources	Rate	Number of Diagnoses Present in Both Sources	Rate
AMG-L	100.0%			13	100.0%
AMG-M	98.6%			72	98.6%
BET-M	90.5%	42	90.5%		
CHA-S	95.6%	41	95.1%	27	96.3%
COV-L	100.0%			17	100.0%
COV-M	96.4%			56	96.4%
FRE-S	98.5%	32	100.0%	34	97.1%
HEA-M	94.5%			73	94.5%
HUM-L	90.0%			20	90.0%
HUM-M	94.6%	14	100.0%	23	91.3%
IHP-M	92.1%			63	92.1%
MCC-S	95.6%	68	95.6%		
MOL-L	97.6%			41	97.6%
MOL-M	94.7%	18	94.4%	20	95.0%
PHC-S	96.8%	27	100.0%	36	94.4%
PRE-M	93.9%			66	93.9%
PRS-M	96.2%			79	96.2%
SHP-M	95.5%			66	95.5%
STW-M	100.0%	20	100.0%	52	100.0%
SUN-L	100.0%			22	100.0%
SUN-M	100.0%	20	100.0%	43	100.0%
UFS-M	89.1%			55	89.1%
URA-L	87.0%			23	87.0%
URA-M	87.0%	8	87.5%	15	86.7%
VIS-M	92.6%			54	92.6%
All Plans	**95.4%**	**290**	**96.2%**	**970**	**95.2%**

Gray shading indicates plan does not offer program options in the selected category.

Table E-29 displays the percentage of procedure codes associated with validated dates of service from the encounter data that were correctly coded based on enrollees' medical records.

Table E-29—Accuracy Results for Procedure Code by Plan					
Plan	Overall	Reform		Non-Reform	
	Rate	Number of Procedures Present in Both Sources	Rate	Number of Procedures Present in Both Sources	Rate
AMG-L	33.3%			6	33.3%
AMG-M	92.2%			64	92.2%
BET-M	84.8%	112	84.8%		
CHA-S	71.8%	19	68.4%	20	75.0%
COV-L	89.5%			38	89.5%
COV-M	83.9%			62	83.9%
FRE-S	87.8%	60	95.0%	14	57.1%
HEA-M	78.8%			66	78.8%
HUM-L	NA			0	NA
HUM-M	87.3%	82	90.2%	36	80.6%
IHP-M	70.0%			60	70.0%
MCC-S	72.0%	93	72.0%		
MOL-L	98.2%			57	98.2%
MOL-M	87.5%	82	96.3%	54	74.1%
PHC-S	66.1%	28	60.7%	28	71.4%
PRE-M	88.6%			35	88.6%
PRS-M	72.9%			85	72.9%
SHP-M	77.8%			81	77.8%
STW-M	77.3%	42	88.1%	55	69.1%
SUN-L	86.1%			36	86.1%
SUN-M	87.2%	55	90.9%	31	80.6%
UFS-M	100.0%			45	100.0%
URA-L	100.0%			2	100.0%
URA-M	88.9%	21	95.2%	15	80.0%
VIS-M	71.9%			57	71.9%
All Plans	**82.3%**	**594**	**85.7%**	**947**	**80.1%**

Gray shading indicates plan does not offer program options in the selected category.

"NA" indicates there were no records present; therefore, rates were not able to be reported.

Table E-30 presents the percentage of procedure code modifiers associated with validated dates of service from the encounter data that were correctly coded based on enrollees' medical records.

Table E-30—Accuracy Results for Procedure Code Modifier by Plan					
Plan	Overall	Reform		Non-Reform	
	Rate	Number of Procedure Code Modifiers Present in Both Sources	Rate	Number of Procedure Code Modifiers Present in Both Sources	Rate
AMG-L	NA			0	NA
AMG-M	100.0%			12	100.0%
BET-M	100.0%	3	100.0%		
CHA-S	100.0%	3	100.0%	2	100.0%
COV-L	100.0%			2	100.0%
COV-M	100.0%			9	100.0%
FRE-S	NA	0	NA	0	NA
HEA-M	75.0%			4	75.0%
HUM-L	NA			0	NA
HUM-M	NA	0	NA	0	NA
IHP-M	100.0%			6	100.0%
MCC-S	100.0%	5	100.0%		
MOL-L	100.0%			15	100.0%
MOL-M	100.0%	1	100.0%	0	NA
PHC-S	100.0%	1	100.0%	2	100.0%
PRE-M	100.0%			3	100.0%
PRS-M	100.0%			11	100.0%
SHP-M	100.0%			20	100.0%
STW-M	100.0%	6	100.0%	7	100.0%
SUN-L	100.0%			2	100.0%
SUN-M	100.0%	4	100.0%	2	100.0%
UFS-M	100.0%			19	100.0%
URA-L	100.0%			1	100.0%
URA-M	100.0%	0	NA	4	100.0%
VIS-M	100.0%			5	100.0%
All Plans	**99.3%**	**23**	**100.0%**	**126**	**99.2%**

Gray shading indicates plan does not offer program options in the selected category.

"NA" indicates there were no records present; therefore, rates were not able to be presented.

Table E-31 presents the percentage of dates of service present in both AHCA's encounter data and in the medical records with exactly the same values for all key data elements (*Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*). The denominator is the total number of dates of service that matched in both data sources. The numerator is the total number of dates of service with exactly the same values for all key data elements. Higher all-element accuracy rates indicated that the values populated in AHCA's encounter data are more complete and accurate for all key data elements when compared to medical records.

Table E-31—All-Element Accuracy by Plan

Plan	Overall	Reform		Non-Reform	
	Rate	Number of Dates of Service Present in Both Sources	Rate	Number of Dates of Service Present in Both Sources	Rate
AMG-L	0.0%			7	0.0%
AMG-M	39.1%			46	39.1%
BET-M	23.8%	42	23.8%		
CHA-S	22.6%	16	31.3%	15	13.3%
COV-L	8.8%			34	8.8%
COV-M	38.3%			47	38.3%
FRE-S	25.0%	24	41.7%	24	8.3%
HEA-M	36.2%			47	36.2%
HUM-L	43.2%			37	43.2%
HUM-M	27.7%	25	40.0%	22	13.6%
IHP-M	25.0%			44	25.0%
MCC-S	15.8%	57	15.8%		
MOL-L	79.2%			48	79.2%
MOL-M	33.3%	27	51.9%	21	9.5%
PHC-S	27.8%	25	40.0%	29	17.2%
PRE-M	15.4%			52	15.4%
PRS-M	18.0%			61	18.0%
SHP-M	36.2%			47	36.2%
STW-M	28.3%	21	28.6%	32	28.1%
SUN-L	30.8%			39	30.8%
SUN-M	47.1%	27	55.6%	24	37.5%
UFS-M	52.7%			55	52.7%
URA-L	37.5%			8	37.5%
URA-M	28.6%	10	30.0%	11	27.3%
VIS-M	29.8%			47	29.8%
All Plans	**31.9%**	**274**	**33.6%**	**797**	**31.4%**

Gray shading indicates plan does not offer program options in the selected category.

Plan-Specific Scores by Contract Standard

Table F-1—Federal and State Contract Requirements						
Plan Names	**Standard 1**	**Standard 2**	**Standard 3**	**Standard 4**	**Standard 5**	**Plan Scores**
Comprehensive and MMA Standard Plans						
Amerigroup	M	M	M	M	M	**100%**
Better Health	PM	M	M	M	M	**90%**
Coventry	PM	M	M	M	PM	**80%**
Humana	M	PM	M	PM	M	**80%**
Integral	PM	M	M	PM	PM	**70%**
Molina	PM	M	M	M	M	**90%**
Preferred	PM	M	M	M	M	**90%**
Prestige	M	M	M	M	M	**100%**
SFCCN	PM	M	M	M	PM	**80%**
Simply	PM	M	M	M	M	**90%**
Sunshine	PM	M	M	M	M	**90%**
United	PM	PM	M	M	PM	**70%**
Staywell	M	M	M	PM	PM	**80%**
MMA Specialty Plans						
Positive	PM	PM	M	M	M	**80%**
Children's Medical Services	PM	M	M	M	PM	**80%**
Clear Health	PM	M	M	M	M	**90%**
Freedom	PM	PM	M	PM	M	**70%**
Magellan	M	M	M	M	PM	**90%**
LTC Plan						
American Eldercare	PM	PM	M	PM	PM	**60%**
Total Statewide Score:	**63%**	**87%**	**100%**	**87%**	**79%**	**83%**

Scores were calculated by assigning 1 point to *Met* (M) items, 0.5 points to *Partially Met* (PM) items, and 0 points to *Not Met* (NM) items, then dividing the total points by the number of applicable items.

Plan-specific Yes or No (Y/N) Scores by CLAS Standard

Table F-2—National Culturally and Linguistically Appropriate Services (CLAS) Standards																
Plan Names	Standards															Plan Scores
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
Comprehensive and MMA Standard Plans																
Amerigroup	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	**93%**
Better Health	N	Y	Y	Y	N	Y	N	Y	Y	Y	Y	N	N	Y	N	**60%**
Coventry	N	N	Y	N	Y	Y	N	Y	Y	Y	Y	N	N	Y	N	**53%**
Humana	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	N	Y	**80%**
Integral	N	Y	N	Y	Y	Y	N	Y	Y	N	N	N	Y	Y	N	**53%**
Molina	N	Y	N	Y	Y	Y	N	N	N	Y	Y	N	N	Y	N	**47%**
Preferred	N	Y	N	Y	Y	Y	N	Y	Y	Y	N	N	N	Y	N	**53%**
Prestige	N	Y	Y	Y	Y	Y	N	Y	N	Y	Y	N	N	Y	N	**60%**
SFCCN	N	Y	N	Y	Y	Y	N	N	Y	Y	N	N	N	Y	N	**47%**
Simply	N	Y	Y	Y	N	Y	N	Y	Y	Y	Y	N	N	Y	N	**60%**
Sunshine	N	Y	N	Y	N	Y	N	Y	Y	Y	N	N	Y	Y	N	**53%**
United	N	Y	Y	Y	Y	Y	N	N	Y	Y	N	N	N	Y	N	**53%**
Staywell	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y	N	**73%**
MMA Specialty Plans																
Positive	N	Y	N	Y	Y	Y	N	Y	Y	Y	N	N	Y	Y	N	**60%**
Children's Medical Services	N	Y	N	Y	Y	Y	N	N	Y	Y	Y	N	N	Y	N	**53%**
Clear Health	N	Y	Y	Y	N	Y	N	Y	Y	Y	Y	N	N	Y	N	**60%**
Freedom	N	Y	Y	Y	Y	N	N	Y	N	Y	Y	N	N	N	N	**47%**
Magellan	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	N	Y	Y	N	**73%**
LTC Plan																
American Eldercare	N	N	N	Y	Y	Y	N	N	N	N	N	N	N	N	N	**20%**
Total Statewide Score:	**5%**	**89%**	**58%**	**94%**	**78%**	**95%**	**0%**	**74%**	**79%**	**89%**	**63%**	**16%**	**32%**	**84%**	**11%**	**58%**
Scores were calculated by assigning 1 point to *Yes* (Y) items, 0 points to *No* (N) items, and then dividing the total points by the number of applicable items.																

Plan Comparisons of Areas for Improvement, and Strengths and/or Best Practices

Table F-3—Areas for Improvement & Strengths/Best Practices by Plan			
Plan Name	**Overall Score Contract Requirements**	**Areas for Improvement**	**Strengths and/or Best Practices**
Amerigroup	100%	◆ In the evaluation, ensure that each objective from the CCP is evaluated; all objectives were evaluated with the exception of #8—Performance Improvement Project.	◆ Plan adopted CLAS Standards and linked them to objectives in the CCP. ◆ Evaluation correlates directly with the CCP objectives, with one exception: Objective #8. ◆ Holds quarterly Health Education Advisory Committee meeting. ◆ Strong recruitment efforts; strives to hire diverse workforce that is similar to demographic diversity of membership. ◆ Employee training tailored to the cultural diversity of the service area.
Prestige	100%	◆ Could strengthen CCP by stating goals of program more clearly.	◆ Extensive Learning Management System for employees that is used for cultural competency training. ◆ Designated April and August as provider cultural competency months; all site visits include cultural competency training and discussion. ◆ Providers surveyed monthly to determine adherence to CLAS Standards.
Better Health	90%	◆ Did not specifically address needs of members with limited English proficiency.	◆ Included a table with objectives, and related action plans and outcomes. ◆ Strong recruitment efforts; strives to hire diverse workforce that is representative of membership.
Clear Health	90%	◆ Did not discuss unique needs of specialty population it serves: HIV/AIDS community. ◆ Did not specifically address needs of members with limited English proficiency	◆ Included a table with objectives, and related action plans and outcomes. ◆ Strong recruitment efforts; strives to hire diverse workforce that is representative of membership.

Table F-3—Areas for Improvement & Strengths/Best Practices by Plan			
Plan Name	**Overall Score Contract Requirements**	**Areas for Improvement**	**Strengths and/or Best Practices**
Magellan	90%	◆ Demographic description of membership not in CCP, but this information was in the evaluation document. ◆ Evaluation did not include interventions to be implemented for the next year.	◆ Stated plan adopted CLAS Standards. ◆ Clear guiding principles and goals. ◆ Recognized behavioral health specialty population it serves and unique needs of this membership. ◆ Strong recruitment efforts; strives to hire diverse workforce that is representative of membership.
Molina	90%	◆ Information that should be in the CCP (e.g., employee training) was found in the evaluation document.	◆ Disease management culturally sensitive material. ◆ Strong emphasis on provider training; offers free online continuing medical education courses.
Preferred	90%	◆ Did not provide current demographic information (information from 2012). ◆ Did not include information on language preferences for membership.	◆ Top-down approach to infusing cultural competency within the organization. ◆ Recognized disabled community throughout CCP.
Simply	90%	◆ Did not specifically address needs of members with limited English proficiency.	◆ Included a table with objectives, and related action plans and outcomes. ◆ Strong recruitment efforts; strives to hire diverse workforce that is representative of membership.
Sunshine	90%	◆ Expand demographic description of membership; only reference was language preference.	◆ Stated plan adopted CLAS Standards. ◆ Has Member Advisory Committee.
Children's Medical Services	80%	◆ Did not address the specific population that it services. ◆ Interventions were not included in the evaluation.	◆ Stated plan adopted Enhanced National CLAS Standards but listed old CLAS Standards.
Coventry	80%	◆ Did not provide a demographic description of membership in CCP. Evaluation document included race/ethnicity data for the State but not for the counties the plan serves. ◆ Need to connect CCP and evaluation; evaluation included different goals and objectives. Interventions were not linked to all goals.	◆ Stated plan adopted CLAS Standards. ◆ Strong recruitment efforts; strives to hire diverse workforce.

Table F-3—Areas for Improvement & Strengths/Best Practices by Plan			
Plan Name	**Overall Score Contract Requirements**	**Areas for Improvement**	**Strengths and/or Best Practices**
Humana	80%	◆ CCP did not include demographic description of membership (information was in the evaluation). ◆ CCP did not address religion as part of cultural competency. ◆ There was no evidence of results from CAHPS or other surveys on grievances and appeals, provider feedback, or employee surveys.	◆ Stated plan adopted CLAS Standards. ◆ Has a Clinical Disparities and Cultural Diversity Committee. ◆ Top-down approach to infusing cultural competency within the organization. ◆ Strong emphasis on training. ◆ Included a section that addresses improving CLAS among network providers and members.
Positive	80%	◆ CCP did not include a demographic description of membership (some information in evaluation document). ◆ Religion only referenced with regard to antidiscrimination hiring practices.	◆ Stated plan adopted CLAS Standards. ◆ Client Advisory Committee; focused on specialty population it serves—HIV/AIDS community. ◆ Employee and provider training tailored to the population the plan serves.
SFCCN	80%	◆ Demographic information limited to language preference. ◆ Limited analysis of evaluation; no interventions noted except to say no changes needed.	◆ Provider application process captures diversity of provider network.
Staywell	80%	◆ Did not include demographic information in CCP (information in evaluation document). ◆ Not a direct link between CCP and evaluation document; the CCP listed six objectives, and the evaluation document listed four goals.	◆ Stated plan adopted CLAS Standards. ◆ Distinguish place of origin for Spanish-speaking staff to be sensitive to differences in cultural backgrounds. ◆ Recognized needs of disabled population and those who were functionally illiterate.
Freedom	70%	◆ Did not address religion as part of cultural competency.	◆ Interventions and strategies for next year clearly described and separated between providers, members, and employees. ◆ Tuition reimbursement program for employees; minority employee participation rate increased from 2012 to 2013.

Table F-3—Areas for Improvement & Strengths/Best Practices by Plan			
Plan Name	**Overall Score Contract Requirements**	**Areas for Improvement**	**Strengths and/or Best Practices**
Integral	70%	◆ Does not include a demographic description of membership in CCP (evaluation document included some information but not plan-specific). ◆ Evaluation information was limited.	◆ Cultural Competency Workgroup led by chief medical officer. ◆ Diversity potlucks to celebrate holidays and diversity. ◆ Quarterly enrollee meetings to obtain feedback.
United	70%	◆ Did not provide a demographic description of membership in the CCP. ◆ No reference to distinction between MMA versus LTC population. ◆ Religion only referenced with regard to antidiscrimination hiring practices. ◆ Evaluation did not include interventions.	◆ Has National Healthcare Disparities committee. ◆ Clear statement of goals/objectives.
American Eldercare	60%	◆ CCP was two pages long; included 13 action items but did not describe how any actions items would be implemented. ◆ Did not provide a demographic description of membership. ◆ Did not address provider training or education. ◆ Evaluation did not include analysis, results, or interventions.	◆ All employees receive cultural competency training.

Table G-1 includes the list of plans that were reviewed by HSAG for the EQR activities. From left to right, the table includes the plan type, the full plan name, the three-to-five letter plan code, and the plan shortened name.

Table G-1—SFY 2013–2014 Plan-Approved Naming Convention			
MCO Type	**Full Plan Name**	**4-Letter Code**	**Shortened Name**
MMA Standard Plans			
MMA	Amerigroup Community Care	AMG-M	Amerigroup
MMA	Better Health	BET-M	Better Health
MMA	Coventry Health Care of Florida, Inc.	COV-M	Coventry
MMA	First Coast Advantage (Acquired by Molina - membership transitioned 12/01/14)	UFS-M	First Coast
MMA	Humana Medical Plan, Inc.	HUM-M	Humana
MMA	Integral Quality Care	IHP-M	Integral
MMA	Molina Healthcare of Florida, Inc.	MOL-M	Molina
MMA	Preferred Medical Plan, Inc.	PRE-M	Preferred
MMA	Prestige Health Choice	PRS-M	Prestige
MMA	South Florida Community Care Network	NBD-M	SFCCN
MMA	Simply Healthcare Plans, Inc.	SHP-M	Simply
MMA	Sunshine State Health Plan, Inc.	SUN-M	Sunshine
MMA	United Healthcare of Florida, Inc.	URA-M	United
MMA	Wellcare d/b/a Staywell Health Plan of Florida, Inc.	STW-M	Staywell
MMA Specialty Plans			
Specialty	AHF MCO of Florida, Inc. dba Positive Healthcare, Inc.	PHC-S	Positive-S
Specialty	Children's Medical Services Network	CMS-S	Children's Medical Services-S
Specialty	Clear Health Alliance	CHA-S	Clear Health-S
Specialty	Freedom Health, Inc.	FRE-S	Freedom-S
Specialty	Magellan Complete Care	MCC-S	Magellan-S
Specialty	Sunshine State Health Plan, Inc.	SUN-S	Sunshine-S
LTC Plans			
LTC	American Eldercare, Inc.	AEC-L	American Eldercare-LTC
LTC	Amerigroup Community Care	AMG-L	Amerigroup-LTC
LTC	Coventry Health Care of Florida, Inc.	COV-L	Coventry-LTC
LTC	Humana Medical Plan, Inc.	HUM-L	Humana-LTC
LTC	Molina Healthcare of Florida, Inc.	MOL-L	Molina-LTC
LTC	Sunshine State Health Plan, Inc.	SUN-L	Sunshine-LTC
LTC	United Healthcare of Florida, Inc.	URA-L	United-LTC