

2019 FLORIDA HEALTH CARE PLAN
QUALITY IMPROVEMENT PROGRAM
ANNUAL EVALUATION

TABLE OF CONTENTS

EXECUTIVE SUMMARY	2
2018 PHM POPULATION ASSESSMENT	7
2018 PHM STRATEGY	49
2018 PHM EFFECTIVENESS ANALYSIS	57
2019 CONTINUITY & COORDINATION BETWEEN MEDICAL CARE AND BEHAVIORAL HEALTH	79
2018 CONTINUITY AND COORDINATION OF MEDICAL CARE.....	93
2018 FHCP BH MEMBER EXPERIENCE ANALYSIS	111
2018 FHCP MEMBER EXPERIENCE ANALYSIS	127
2018 CREDENTIALING SUMMARY	149
2018 PHARMACY SERVICES TELEPHONE QUALITY AND ACCURACY REVIEW	150
2018 PHARMACY SERVICES WEBSITE QUALITY AND ACCURACY REVIEW	156
2018 PRACTITIONER ACCESS ANALYSIS	159
2018 PRACTITIONER AVAILABILITY ANALYSIS.....	191
2018 PROVIDER QUALITY MONITORING	229
2018 QUALITY & ACCURACY OF CUSTOMER SERVICE EMAIL PROCESS.....	235
2018 QUALITY & ACCURACY OF CUSTOMER SERVICE PROCESS	238
2019 SUMMARY INTERRATOR RELIABILITY TESTING MCG	246
2019 UM TIMELINESS REPORT	254
2019 UM PROGRAM EVALUATION	259
2019 QUALITY IMPROVEMENT WORK PLAN.....	273
2019 COMMERCIAL CAHPS RESULTS	283
2019 QHP CAHPS RESULTS	355
2019 NCQA HEDIS SCORESHEET COMMERCIAL.....	430

Executive Summary

Florida Health Care Plan, Inc. (FHCP), licensed by the State of Florida in 1974 as a staff model managed care organization, is dedicated to providing high quality, affordable healthcare and services to our members. The FHCP Quality Improvement Program Annual Evaluation (AE) is the mechanism for assessing the overall effectiveness of the 2019 Quality Improvement Program (QIP).

PLAN OVERVIEW

FHCP provides healthcare services and related functions in Volusia, Flagler, Brevard, Seminole, and St. Johns counties .

FHCP's products and enrollees include*:

Product Name	Product Type	Enrollees	Initial date of operation
Commercial	HMO	34,763	June 1974
Marketplace	Individual	35,676	January 2014
Total Membership		70,439	

FHCP's provider network is comprised of a total of 7,580 providers. This number includes 1,057 primary care physicians (PCP), 44 of which are directly employed and 6,523 specialists, of which 57 are directly employed. Behavioral health services are integrated into the staff model with 6 employed physicians. The plan also contracts with behavioral health providers in the coverage area. Other contracted providers include 31 acute care facilities, 21 home health care agencies, 26 skilled nursing facilities and one national laboratory. FHCP owns and operates dispensing retail and mail order pharmacies throughout the coverage area.

The most recent race/ethnicity information taken from the FHCP 2019 Commercial Consumer Assessment of Healthcare Providers and Systems (CAHPS®) data indicates that 86.8% of the reporting population is Caucasian, 8.9% is African American, 7.4% is Hispanic/Latino, 0.9% is American Indian, 3.2% is Asian, 0.3% is Hawaiian and 4.3% is "Other". 72.6% of the population is female and 27.4% is male.

SCOPE

The QIP encompasses the quality of care and service provided to our members in both the inpatient and outpatient setting. The scope includes, but is not limited to service and care provided in clinics, hospitals and behavioral health facilities. The service and care are provided by staff and contracted physicians as well as other ancillary providers.

This evaluation provides a discussion of the quality improvement activities and accomplishments for 2019 in the areas of clinical care, service, access, patient safety, and member satisfaction and establishes the basis for the 2020 Quality Improvement (QI) Work Plan.

FHCP currently holds a “Commendable” accreditation status by the National Commission for Quality Assurance (NCQA) for the Commercial product line.

Each reporting year HEDIS® scores are recalculated along with CAHPS® scores.

Accreditation Summary Report

8/30/2019

Org Name:	Florida Health Care Plan, Inc.
Accred Code:	1233H-18
Last HEDIS® Review Based on HEDIS® 2019	

Product Line: Combined	Commercial HMO/POS	Accreditation Status : Commendable
Last Survey Date:	5/8/2018	Effective Date: 6/11/2018

	Points	Number of Stars
Access & Service	92.3	4
Getting Better	73.2	2
Living with Illness	62.6	1
Quality Providers	93	4
Staying Healthy	77.9	2

* Standard Scores: 49.3158
 * EOC Score: 23.5390
 * CAHPS Score: 9.3600
 * Total HEDIS® Score: 32.8990
 Total Score: 82.2148

Next HEDIS® Review Based on HEDIS® 2010

Standards Score Expiration: 11/28/2020

HEDIS®/CAHPS® Results

- Overall increase in EOC score: 0.5638 (22.9752 to 23.5390)
- Overall decrease in CAHPS® score: 2.0222 (11.3822 to 9.3600)

HEDIS® (NCQA Accreditation sensitive measures):

- 32 total EOC measures (counting individual measures, leaving out the ‘averaged rate’ measures)
- Maintained or improved to 75% in the following area: Adult BMI Assessment, Breast Cancer Screening, Cervical Cancer Screening, Diabetes (HbA1c Control), Diabetes (Blood Pressure Control), Follow-up After Hospitalization for Mental Illness (7day follow-up), and Plan All-Cause Readmissions
- Maintained or improved to 90% in the following areas: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, and Weight Assessment and Counseling (BMI)
- Moved up at least one percentile level in the following areas:
 - Antidepressant Medication Management (Continuation Phase)
 - Asthma Medication Ratio - Total
 - Breast Cancer Screening
 - Cervical Cancer Screening
 - CDC (Blood Pressure Control)
 - Follow-up After Hospitalization for Mental Illness (7-day follow-up)
 - Plan All-Cause Readmissions
 - Statin Therapy for Patients with Diabetes (Statin Adherence 80%)
 - Weight Assessment and Counseling (BMI)

Areas for improvement:

- Decreased one percentile level in five (5) measures: Diabetes (Eye Exam), Colorectal Cancer Screening, Pharmacotherapy Management of COPD Exacerbation (Bronchodilator Within 30 Days of Event), Statin Therapy for Patients with Cardiovascular Disease (Statin Adherence 80%), and Metabolic Monitoring for Children and Adolescents on Antipsychotics (Total)
- Decreased at least two percentile levels in two (2) measures: Appropriate Testing for Children with Pharyngitis, and Pharmacotherapy Management of COPD Exacerbation (Systemic Corticosteroid Within 14 days of Event)

CAHPS®:

- 9 total CAHPS® composites: Claims Processing, Customer Service, Getting Care Quickly, Getting Needed Care, Coordination of Care, Rating of All Health Care, Rating of Health Plan, Rating of Personal Doctor, Rating of Specialist
- Rating of Personal Doctor scored at the 90th percentile
- Coordination of Care, and Rating of Health Plan scored at the 75th percentile

Areas for improvement:

- Getting Care Quickly decreased from 90th to the 25th percentile
 - The composite summary rate score decreased from 89.9% in 2018 to 83.7% in 2019
 - Key questions include:
 - “In the last 12 months, when you needed care right away, how often did you get care as soon as you needed?” decreased from 92.3% in 2018 to 85.0% in 2019. This is significantly lower when compared to the trend or benchmark score.
 - “In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor’s office or clinic as soon as you needed?” decreased from 87.5% in 2018 to 82.4% in 2019.
- Getting Needed Care decreased from 50th to the 25th percentile
- Rating of All Health Care decreased from 75th to the 50th percentile

MEMBER SAFETY

FHCP ensured the safety and quality of health care to our members by:

Providing education to our members

- Members received information on member and physician communication, rights and responsibilities, quality and safety resources, and electronic medical records.

Monitoring adverse events

- All quality of care issues identified during health plan activities were investigated, reviewed, and when necessary, sent to peer review.

Monitoring complaints

- Member complaints were reviewed for possible quality of care, services, and access and availability issues. Aggregate results were reviewed for trends and opportunities for improvement.

Pharmacy Management

- FHCP pharmacies ensured that processes were followed to oversee overutilization, polypharmacy issues, and appropriateness of prescribing, narcotic abuse, and medication management.

Continuity and Coordination

- Continuity and coordination are important elements of care and are monitored as part of FHCP's commitment to quality. Patient safety and transition of care is evaluated for improvement opportunities. FHCP's Utilization Management, Case Management, Community Resource and Behavioral Health teams meet weekly to improve coordination and quality of the care FHCP offers to our members.

Clinical Practice Guidelines

- Because evidenced-based research provides the basis for clinical practice guidelines, all FHCP guidelines are based on the most current scientific evidence.

Ambulatory Surgical Center (ASC) Patient Safety Committee

- This committee's purpose is to reduce and prevent medical errors and adverse events in the ASC setting.

RESOURCES

Throughout 2019, staff and analytical resources were appropriate for much of the year. The active level of participation in the QI program from physicians and leadership continue to be important aspects of the quality program that contribute to its success.

QI OVERSIGHT COMMITTEE

FHCP's Performance Improvement Council (PIC) acts to plan and coordinate organization-wide improvement in quality and safety of clinical care and service to members. The PIC is charged with responsibility for oversight of all quality related activities and processes in the following functional areas, including but not limited to: Utilization Management, Case Management, Population Health Management, Behavioral Health, Wellness, Pharmacy, Member Services, and Network Relations. The committee was evaluated to ensure that the existing members function in a manner that support the program. Therefore membership is unchanged for 2020.

WORK PLAN

Each year FHCP develops an annual plan comprised of initiatives to improve clinical and service quality. The results of the QI Work Plan can be found in the attached document library.

Initiatives for 2019 included:

- Integration of the Population Health Management standards into QI activities
- Development and distribution of a member report card, "Healthy Me"
- Quarterly staff provider office visits to review gap and peer comparative data
- Gap report corrections/returns from physician offices reviewed to update the Supplemental Data Source
- Hired a full time Behavioral Health Quality Improvement Coordinator dedicated to work BH measures
- PCE: Increased collaboration between Quality Management and pharmacy to contact providers and members, assist with new scripts and refills, and provide cost assistance
- BCS: Member outreach in the form of a birthday postcard which includes a reminder to get a mammogram
- CIS: Gift card incentive program for parents whose child is combo 10 compliant by the age of 2
- IMA: Incentive program in the form of a drawing for an iPad to parents whose child is combo 2 compliant by the age of 13
- CBP: Individualized letters to staff PCPs with rates in the bottom 1/3rd along with a list of non-compliant members. Additionally, status letters were sent to all PCPs twice during the year

- Member and physician outreach for chronic conditions such as asthma, diabetes, heart disease, chronic obstructive pulmonary disease as well as HEDIS® effective of care measures, coordination of care, strategies to reduce inappropriate utilization and serving members with complex health needs via identification, outreach and complex care management programs
- Wellness and health promotions that addressed worksite health and wellness and initiatives to assist with lifestyle management
- Programs addressing medication adherence and reduction in medical errors particularly those related to drug prescribing and monitoring
- Physician incentive programs to promote clinical quality in the physician network
- Oversight of delegated relationships
- Evaluation of member complaints, appeals, and surveys to improve member communications, enhance programs and improve health literacy
- Rotated Welch Allyn's RetinaVue 100 Imager (hand-held imaging device) through higher volume PCP offices to help increase retinal eye exam rates in diabetics

2019 GOALS

As part of FHCP's commitment to quality improvement, the 2020 QI Work Plan will include 2019 activities that require ongoing monitoring. Other goals for 2020:

- Continue monthly HEDIS Quality Initiative Meetings to analyze effectiveness of interventions, identify barriers and develop new strategies to improve care
- Expand "Healthy Me" to our pediatric population
- Expand provider office visits to include top network providers with the highest number of gaps
- Integrate Behavioral Health in provider office visits
- Use quality and performance improvement methodologies to achieve population health management program goals such improved clinical outcomes and member experiences
- Increase the use of clinical reporting and technologies to enable quality improvement efforts
- Increase the review and management of gap reports through use of provider portal and expand face to face discussions with network providers
- Continue to partner with other functional areas to assist in the identification of opportunities to improve all gaps in care.
- Offer HEDIS® training to relevant staff to improve understanding of clinical measures, data collection, medical record review and reporting methodology.
- Continue to use web-based technologies to support communication, education and access to self-service functions
- Continue QI efforts with Florida Blue for the Medicare Advantage population
- Continue ongoing periodic file audits of denials, appeals and grievances
- Revise physician incentive programs to make them more meaningful and transparent
- Promote member engagement in wellness and preventive care using the health risk assessments (HRA) that includes self-management tools and health coaching
- Continue the focus on service improvements to increase member experience and satisfaction survey rates

The remainder of this document provides detailed results, analysis, and actions to improve performance for the clinical and service activities monitored in 2019.

***Enrollees as of 12/31/2019**

Florida Health Care Plans

Population Identification

PHM2 Element B

Population Assessment



2018

Table of Contents

Emergency Room Utilization and Resources Analysis	22
Summary and Trends	23
Children and Adolescent population (2-19 years of age) by Product Line	24
Table D: Children and Adolescent Membership by Product Line	24
Table E: Children and Adolescent Membership by Product Line	24
Methodology	25
Table 13: Commercial Inpatient (age 2-19) Diagnoses by Unique Count:	25
Table 14: Commercial ED Diagnoses by Unique Count:	26
Table 15: Marketplace (Children and Adolescent age 2-19) IP Diagnoses by Unique Count:	26
Table 16: Marketplace ER (Children and Adolescent age 2-19) Diagnoses by Unique Count:	27
Inpatient Admissions Analysis.....	28
Emergency Room Utilization Analysis.....	28
Summary and Trends	28
Behavioral Health Children and Adolescent population (2-19 years of age) by Product Line	30
Commercial.....	30
Table 17: Behavioral Health: Commercial Inpatient Diagnoses by Unique Count (age 2-19)	30
Table 18: Behavioral Health: Commercial ER Diagnoses by Unique Count (age 2-19)	30
Marketplace	31
Table 19: Behavioral Health: Marketplace Inpatient Diagnoses by Unique Count (2-19)	31
Table 25: Behavioral Health: Marketplace ER Diagnoses by Unique Count (age 2-19)	32
Inpatient Admissions Analysis.....	32
Summary and Trends	33
Disabled Children and Adolescents (Age 2-19).....	33
Comparative Analysis Across all Product Lines and Age Groups.....	33
Inpatient by Encounter	33
Table 20: Inpatient Top 3 Admission Related Diagnosis	33
Members age 20 and Older	34
Members age 2-19	35
Table 21: Emergency Room: Top 3 Visit Related Diagnosis	35
Members age 20 and Older	36
Members age 2-19	36

2018 Population Analysis

Conclusion:	36
Inpatient Utilization	36
Emergency Room Utilization	36
Population Health Management Processes and Resources	38
Reporting.....	40
This QI activity was reported to the following QI committees:.....	40

Introduction

FHCP completes an annual analysis of the needs of our member population to identify key health risks. Assessment of the total enrolled population's needs is based on the top 25 diagnoses in the inpatient and emergency department setting. The population is stratified by product (Commercial, and Marketplace). *The Medicare membership is not included in the analysis; FHCP will no longer be accredited for this product line effective January 1, 2019. The population and needs analysis examined the following subpopulations using data from the period of 1/1/2018 – 12/31/2018.

FHCP assesses the characteristics and needs of identified subpopulations, including social determinants of health across all product lines. Social determinants of health [1] are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks. The organization defines the determinants assessed as difficulty accessing health care related to transportation options and linguistic barriers.

A needs assessment of individuals with disabilities was conducted across all product lines. Disability was defined as individuals with long-term impairments in activities of daily living. This population was identified through use of the following Durable Medical Equipment (DME): Enteral Feeding Supply Kit, Feeding pump, Gastro/Jejuno Tube, Hospital Bed, POV, PT Lift, Hydraulic and C GRP2 STD Chair. Once we identified these individuals, we examined their key health issues through review of the top 25 diagnoses in the inpatient and emergency department setting.

A needs assessment of individuals with serious and persistent mental illness (SPMI) was conducted, by product lines (Commercial, and Marketplace), based on ICD-10 diagnoses codes for Schizophrenia and Bipolar disorder. Once we identified these individuals, we examined their key issues through review of the top 25 diagnoses in the inpatient and emergency department setting.

Assessment of the children and adolescent population's needs (2-19 years of age) for the Commercial and Marketplace product lines are based on the top 25 diagnoses in the inpatient and emergency department setting. Due to small numbers of members, the data was combined for the two products lines.

Methodology

The analysis, as listed below, included the highest volume by members who had an admission and what the key health risks are for those members. Data was analyzed by individual diagnosis and by systematic grouping, i.e. Diseases of circulator system, diseases of digestive system, etc. Additionally, a comparison analysis was performed between product lines to determine if there were any similarities or difference with respect to their health needs, in relationship to total admissions for the reporting period.

2018 Population Analysis

The general population's data was then compared to the populations currently identified by the Complex Case Management Program to determine if the current Case Management (CM) identification process and interventions are in-line with the needs of the high-risk populations enrolled in the plan. If gaps are identified, modifications to the current Case Management identification process and interventions are made.

Analysis by Membership Methodology

During this reporting period of 1/1/2018-12/31/2018, FHCP's total plan membership consisted of 105,104 total member enrollment.

- 11,226 members between the age 2-19 (20.1%) and
- 93,878 members were $\geq$ than age 20 (89.6%).

The analysis was completed based on total members enrolled within the 365 days reporting period.

Table A: Membership by Product Line

MEMBERSHIP BY PRODUCT LINE			
Product Line	Commercial	Marketplace	Total
# members	44,627	44,919	89,546
% of enrollment	49.8%	50.2%	100.0%

Social Determinants of Health Impact Analysis

FHCP analyzes data about member cultural needs and preferences annually to determine the current needs related to cultural or linguistic barriers, and Transportation Disadvantages

Methodology

Member cultural needs and preferences are assessed through:

- US census data on proportion of residents that speak a language other than English, as available
- Member complaints regarding language needs and cultural needs and preferences

The proportion of households in the service area that speak a language other than English was obtained from US 2010 census data.

- 13.2% of the Volusia County population speaks a language other than English, with 68.2% able to speak English “very well”.
- For Flagler County, 14.9% of the total population speaks a language other than English, with 56.4% able to speak English “very well”.
- For Seminole County 20.2% of the population speaks a language other than English, with 71.2% able to speak English “very well”.
- For Brevard County 10.4% of the population speaks a language other than English, with 67.2% able to speak English “very well”.

Spanish is typically the language most frequently spoken other than English within the FHCP Service Area. However, in Flagler County, Indo-European languages are spoken slightly more often at 6.6% compared to 6.5% Spanish. Since FHCP’s Hispanic population is significantly less than that of its service area, higher populations of FHCP members speak English in comparison to the population of the FHCP service area.

FHCP Member services provides an option to choose a Spanish speaking Customer Service Representative (CSR) For the reporting year, (2017) there were 21,028 requests through the member services option for Spanish CSRs (see Table A). Of those 21,028 requests, 6,631 calls were from the Marketplace membership. In addition to the Member Services phone option, FHCP partners with a Vendor to provide interpreter services for many other languages (see Tables 1B and 2B).

Table 1A: Spanish Customer Services Representative Requests Through Member Services

CSQ Name	CSQ ID	Skills	Calls Presented
ACA-Spanish	1	(ACA-Spanish)	6631
MS-Spanish	2	(MS-Spanish)	14397
Total Members Served			21028

Table 1B: 2018 Interpreter Service Requests (1/1/2018 - 12/31/2018)

2018 Interpreter Line Requests													
Language	January	February	March	April	May	June	July	August	September	October	November	December	Total Calls
French			2	5	5	5					2		19
Spanish	8	14	18	12	12	4		12	14	7		29	130
Mandarin	4	6	8	8	4	2	6	1				4	43
Polish			1									1	2
Vietnamese	1	3	7	8	3		3	3		2		2	32
Russian	1	2	2		1	2	2	2				2	14
Korean							3						3
Gujarati													
Taglog	1	3	5	3	4								16
Cantonese		2	3	4	6								15
Turkish								1					1
Portuguese	14	1	1			1		3					20
Portuguese Br.	1												1
Haitian Creole		2											2
Farsi				1						4			5
Sorani		2	2										4
Greek		1						1					2
Arabic										2			2
Cambodian					2								2
Total	30	38	52	41	37	9	14	23	14	17	0	38	313

**Table 1C: 2018 Interpreter Service Requests for the Deaf
(American Sign Language Interpreter (ASL))**

Members Requiring Services	Total Encounters	Total Hours
11	30	60

Member provided cultural and linguistic data From CAHPs survey:

- 6.4% of the FHCP Commercial,
- 12.26% of Marketplace and
- 2.9% of Medicare members indicated they were of Hispanic/Latino origin.
- 6.6% of the population in Flagler County speaks an Indo-European language.

FHCP employs multilingual Case Managers to address, assist and coordinate care of members whose primary language is not English. In addition, interpreter services are available for members at appointments, and telephonically. TTY services and Sign Language interpreters are also available to members.

Social Determinants of Health: Transportation Gaps

“Chapter 427, Florida Statutes defines “transportation disadvantaged” as “those persons who because of physical or mental disability, income status, or age are unable to transport themselves or purchase transportation and are, therefore, dependent on others to obtain access to health care, employment, education, shopping, social activities, or other life-sustaining activities or children who are handicapped or high-risk or at-risk as defined in s. 411.202, Florida Statutes⁴. (USF Center for Urban Transportation Research)

” Volusia County’s main transportation service is Votran. Votran released its “Transportation Disadvantaged Service Plan (TDSP)” in January of 2017. The TDSP considers current statistics and predictive modeling for 2018 through 2022 to anticipate future needs of the community. Transportation to and from locations, for members without transportation, or support systems can be a challenge that hinders access to appropriate health services, follow up and efforts to coordinate care. FHCP assesses the needs of members who express an inability to obtain transportation and provides Votran Gold passes to members in the 16 municipalities within Volusia Counties Votran service area. Members in the areas where public transportation is readily available within the ¼ mile of their residence are assisted with access to County transportation vouchers. Gaps in other expansion counties are handled on a case by case basis. Requests in expansion counties have been statistically insignificant during this reporting period.

Table 2 A: Transportation Disadvantaged Populations Volusia County and Surrounding areas⁵

General Transportation Disadvantaged Population Forecast	2018	2019	2020	2021	2022
Estimate non-elderly/disabled/low income	12,243	12,364	12,487	12,610	,12,735
Estimate non-elderly/disabled/not low income	4,151	4,192	4,233	4,275	4,318

2018 Population Analysis

Estimate elderly/disabled/low income	35,239	35,588	35,941	36,297	36,657
Estimate elderly/non-disabled/low income	5,894	5,952	6,012	6,071	6,131
Estimate elderly/non-disabled/not low income	74,596	75,336	76,083	76,837	77,599
Estimate low income/not elderly/not disabled	68,764	69,445	70,134	70,829	71,532
TOTAL GENERAL TD POPULATION	228,542	230,808	233,096	235,407	237,741
TOTAL POPULATION	517,143	522,270	527,448	532,677	537,959

Data is based on 37 percent of the Volusia County population having access within ¼-mile of the existing fixed-route system and the paratransit service operating service 362 days. (TDSP, 2107)

According to the Florida DOH, the average female user of public transportation is white, under the age of 24 with an annual income under \$10,000, while the average male user is white, age 25-44, with an annual income under \$10,000.

FHCP services 36,932 Marketplace members with potential transportation issues or barriers to healthcare. There are 2,064 members who are enrolled in subsidized plan with a zero premium; indicating they are at risk of being transportation disadvantaged, based on annual income.

Analysis by Product Line and Special Populations

During the reporting period there were 7,367 hospital admissions (age 20 and older). The Marketplace was slightly higher than the Commercial product line at 2.1 vs. 1.8%.

Table B: Hospital Admissions by Product Line

HOSPITAL ADMISSIONS BY PRODUCT LINE		
Product Line	Commercial	Marketplace
TOTAL MEMBERS	44,627	44,919
# admissions	1892	2177
Admissions/1000	42/1000	49/1000
% of admissions	4.2%	4.9%

Utilizing the number of members enrolled per product line in comparison to the number admissions per product line, followed by the Marketplace population, and the Commercial, separated by 3/10 of one percentage point (Table C).

Analysis by Product Line:

Methodology:

Claims data was utilized to determine, up to, the top 25 inpatient admission diagnoses by member count and resource expenditure for Inpatient and Emergency Room utilization for all three product lines. Re-admissions account for the variable in “total member count”. The top three Medical Diagnosis Codes (MDC), were utilized for an in-depth analysis of our “at risk” populations. Members may overlap in multiple categories due to primary and secondary CPT coding on claims for admissions and ER visits.

Diagnosis/Membership

Numerator: Total Member Count

Denominator: Total Admissions per Product Line

Commercial

In 2018, FHCP Commercial population accounted for 49.8% of the total plan membership. Tables 1-4 include data for the entire enrolled Commercial population.

Table 1: Commercial Inpatient Diagnoses by Unique Count

COMMERCIAL IP TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MD C	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage/
14	Maternity and Childbirth	1	333	15.1%
05	Circulatory System	2	279	12.7%
23	Factors Influencing Health Status	3	228	10.4%
04	Respiratory System	4	208	
06	Digestive System	5	204	
08	Musculoskeletal/Connective Tissue Diseases	6	183	
10	Endocrine/Metabolic/Immunity Disorders	7	116	
11	Kidney and Urinary Tract	8	92	
18	Infectious/Parasitic Diseases	9	91	
01	Nervous System	10	88	
13	Female Genitourinary System	11	73	
09	Skin/Subcutaneous Tissue and Breast Diseases	12	69	
16	Blood Related Diseases	13	57	

2018 Population Analysis

07	Hepatobiliary System and Pancreas Disorders	14	52	
21	Injuries and Poisoning	15	49	
03	Ear, Nose, Mouth and Throat Diseases	16	28	
17	Myeloproliferative Diseases and Disorders	17	22	
20	Chemical Dependency	18	14	
02	Eye Diseases and Disorders	19	6	
15	Perinatal Conditions	20	4	
19	Mental Diseases and Disorders	21	4	
22	Burns	22	2	
25	HIV Infections	23	1	
			2203	

Analysis:

The top 3 medical diagnosis codes were identified by utilizing the unique member counts in comparison to the total number of enrolled members during this reporting period. Maternity/childbirth, was the leading Medical Diagnosis Category (MDC) for the adult commercial product line, followed by circulatory disorders and Factors Influencing Health Status (FIHS). The top three MDC account for 38.2% of the admissions for the Commercial membership.

Factors influencing health status¹ are a broad collection of related procedure codes, encompassing health services for high body mass index, examination and investigation, health hazards related to communicable diseases, health hazards related to socioeconomic and psychosocial circumstances, health hazards related to family and personal history and certain conditions influencing health status, and Social Determinates of Health (SDOH). These factors have a great impact on our commercial populations according to the data.

Table 2: Commercial ED Diagnoses by Encounter Volume

COMMERCIAL ER TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
08	Musculoskeletal/Connective Tissue Diseases	1	797	13.9%
05	Circulatory System	2	780	13.6%
06	Digestive System	3	740	12.9%
09	Skin/Subcutaneous Tissue and Breast Diseases	4	489	
04	Respiratory System	5	475	
03	Ear, Nose, Mouth and Throat Diseases	6	398	
21	Injuries and Poisoning	7	339	
01	Nervous System	8	324	
11	Kidney and Urinary Tract	9	302	
23	Factors Influencing Health Status	10	265	

2018 Population Analysis

14	Maternity and Childbirth	11	195	
13	Female Genitourinary System	12	148	
18	Infectious/Parasitic Diseases	13	136	
10	Endocrine/Metabolic/Immunity Disorders	14	112	
07	Hepatobiliary System and Pancreas Disorders	15	82	
02	Eye Diseases and Disorders	16	79	
16	Blood Related Diseases	17	36	
20	Chemical Dependency	18	20	
22	Burns	19	12	
17	Myeloproliferative Diseases and Disorders	20	9	
19	Mental Diseases and Disorders	21	1	
			5,739	

The top 21 Medical Diagnosis Codes (MDC) generated 5,739 Emergency Room visits; of the top 21 MDC diagnoses, data identifies musculoskeletal/connective tissue disorders circulatory, digestive/gastrointestinal disorders and as the leading diagnoses for Emergency Room utilization. Together, these three-diagnosis account for 40.4% percentage of Emergency Room utilization in the Commercial membership.

Marketplace

During this reporting period, FHCP Marketplace population accounts for 50.2% of the total plan membership. Tables 9-12 include data for the entire enrolled Marketplace population. The top 3 medical diagnosis codes were identified by utilizing the unique member counts in comparison to the total number of admissions for Marketplace membership during this reporting period.

Table 3: Marketplace Inpatient Diagnoses by Unique Count:

MARKETPLACE IP TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
05	Circulatory System	1	373	13.8%
23	Factors Influencing Health Status	2	307	11.34%
04	Respiratory System	3	306	11.3%
06	Digestive System	4	280	
08	Musculoskeletal/Connective Tissue Diseases	5	244	
14	Maternity and Childbirth	6	151	
10	Endocrine/Metabolic/Immunity Disorders	7	142	
11	Kidney and Urinary Tract	8	136	
18	Infectious/Parasitic Diseases	9	131	
01	Nervous System	10	127	

2018 Population Analysis

07	Hepatobiliary System and Pancreas Disorders	11	114	
09	Skin/Subcutaneous Tissue and Breast Diseases	12	98	
16	Blood Related Diseases	13	77	
13	Female Genitourinary System	14	61	
21	Injuries and Poisoning	15	55	
03	Ear, Nose, Mouth and Throat Diseases	16	39	
20	Chemical Dependency	17	34	
17	Myeloproliferative Diseases and Disorders	18	27	
02	Eye Diseases and Disorders	19	6	
19	Mental Diseases and Disorders	20	4	
15	Perinatal Conditions	21	3	
25	HIV Infections	22	2	
22	Burns	23	1	
			2,718	

Of the 20 inpatient admission diagnoses by Medical Diagnosis Code (2,718), the top three diagnosis codes, circulatory, FIHS, and respiratory, accounted for 36.44% of the total hospitalizations in this population.

Table 4: Marketplace ED Diagnoses by Unique Count:

MARKETPLACE ER TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
05	Circulatory System	1	880	13.3%
06	Digestive System	2	877	13.2%
08	Musculoskeletal/Connective Tissue Diseases	3	853	12.9%
04	Respiratory System	4	602	
09	Skin/Subcutaneous Tissue and Breast Diseases	5	537	
03	Ear, Nose, Mouth and Throat Diseases	6	451	
01	Nervous System	7	393	
21	Injuries and Poisoning	8	384	
23	Factors Influencing Health Status	9	337	
11	Kidney and Urinary Tract	10	330	
13	Female Genitourinary System	11	145	
10	Endocrine/Metabolic/Immunity Disorders	12	135	
18	Infectious/Parasitic Diseases	13	112	
14	Maternity and Childbirth	14	112	
07	Hepatobiliary System and Pancreas Disorders	15	103	
02	Eye Diseases and Disorders	16	76	
16	Blood Related Diseases	17	46	
20	Chemical Dependency	18	29	
22	Burns	19	9	

2018 Population Analysis

17	Myeloproliferative Diseases and Disorders	20	5	
19	Mental Diseases and Disorders	21	3	
			6,419	

For this report, only 21 Medical Diagnosis Codes were present for this population. The top 21 MDC generated 6,419 Emergency Room visits for the Marketplace population. The top three diagnoses by enrolled members were diseases of the circulatory, digestive systems, and musculoskeletal/connective tissue accounting for 39.4% of all diagnoses.

Inpatient Admissions Analysis

For this report, total member admissions in each product line were used to determine the members at highest risk by disease.

The analysis of the top three inpatient diagnoses categories across both product lines identified maternity and childbirth as the leading cause of admission for the commercial membership and circulatory disorders as the leading admission diagnosis category for the Marketplace membership. Circulatory disorders ranked second for the Commercial membership, with FHIS (SDOH) in second for the Marketplace membership. FIHS and respiratory ranked third for the Marketplace and Commercial lines, respectively.

Emergency Room Utilization Analysis

The analysis of the top three Emergency Room diagnoses categories across both product lines identified musculoskeletal/connective tissue disorders as the leading cause of Commercial ER visits. Circulatory disorders ranked as the leading diagnosis category for the Marketplace membership. Circulatory disorders ranked second for the Commercial membership, with digestive system disorders in second for the Marketplace membership. musculoskeletal/connective tissue disorders and digestive system disorders ranked third for the Marketplace and Commercial lines, respectively.

Summary and Trends

Respiratory (Marketplace) and Maternity/child birth (Commercial) MDC were exclusive to each product line in the top three MDC for admissions. Both shared FIHS and circulatory in the top three, in different rank for inpatient stay. Emergency room visits are driven by the same diagnosis categories, with the exclusion of Maternity and Childbirth, as these are commonly not seen in the emergency room setting.

Disabled Members by Product Line

Individuals with disabilities across both product lines (Commercial, Marketplace) had acute needs and intense resource use. Members were identified by age group (Children and Adolescents 2-19 years and the Adult Population age 20 and greater) using codes for durable medical equipment (DME) to assess limitations in functional status related to activities of daily living, i.e. eating and mobility. There were 643 members identified in total across all three product lines; nine (9) in the Children and Adolescents 2-19 age group and 634 in the Adult Population age 20 and greater. DME used to define disabilities were enteral feeding supply kit, pump feed, gastro/jejuno tube, hospital bed, POV, PT lift, hydraulic, and C GRP 2 STD Chair.

Table C: Disabled Members by Product Line and Age

Disabled Members by Product Lines and Age Group			
Product Line	Commercial	Marketplace	Total Membership All Product Lines
TOTAL MEMBERS	44,627	44,919	89,546
# members	59	91	150
# Adults	58 1.3/1000	91 2/1000	150 1.7/1000
# Children & Adolescents	1 0.02/1000	0	1 0.01/1000

Data indicates that 1.7/1000 of all members enrolled across all ages and product lines have a disability. There are no children or adolescents in the Marketplace Product lines with disabilities. The Commercial product line data contains 0.13% and Marketplace contains 0.2% of the adult population with a disability. Once these members were identified, key health issues were examined through review of the top 25 diagnoses in the inpatient and ED setting by product line.

Commercial Members

Table 5: Disabled Commercial IP Diagnoses by Unique Count:

COMMERCIAL IP TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
04	Respiratory System	1	17	15.2%
05	Circulatory System	2	16	14.3%
08	Musculoskeletal/Connective Tissue Diseases	3	14	12.5%
23	Factors Influencing Health Status	4	13	
06	Digestive System	5	9	
10	Endocrine/Metabolic/Immunity Disorders	6	9	
01	Nervous System	7	7	
21	Injuries and Poisoning	8	5	
18	Infectious/Parasitic Diseases	9	5	
16	Blood Related Diseases	10	4	
11	Kidney and Urinary Tract	11	4	
03	Ear, Nose, Mouth and Throat Diseases	12	4	
09	Skin/Subcutaneous Tissue and Breast Diseases	13	2	
17	Myeloproliferative Diseases and Disorders	14	1	
07	Hepatobiliary System and Pancreas Disorders	15	1	
13	Female Genitourinary System	16	1	
			112	

For this report there were 112 total member related admissions in 16 diagnosis categories identified for members over 20 years of age with disabilities in the Commercial population. Respiratory, circulatory, musculoskeletal/connective tissue diseases account for 42.0% in the Disabled Commercial membership.

Table 6: Disabled Commercial ER Diagnoses by Unique Count:

COMMERCIAL ER TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
06	Digestive System	1	9	15.0%
04	Respiratory System	2	8	13.6%
08	Musculoskeletal/Connective Tissue Diseases	3	8	13.6%
01	Nervous System	4	5	
10	Endocrine/Metabolic/Immunity Disorders	5	5	
23	Factors Influencing Health Status	6	5	
05	Circulatory System	7	4	
11	Kidney and Urinary Tract	8	3	
09	Skin/Subcutaneous Tissue and Breast Diseases	9	3	
21	Injuries and Poisoning	10	2	
13	Female Genitourinary System	11	2	

2018 Population Analysis

03	Ear, Nose, Mouth and Throat Diseases	12	2	
17	Myeloproliferative Diseases and Disorders	13	1	
07	Hepatobiliary System and Pancreas Disorders	14	1	
16	Blood Related Diseases	15	1	
			59	

There were 59-member visits to the Emergency Room for this population during the reporting period. Of the top three diagnosis categories, digestive system, respiratory and musculoskeletal/connective tissue diseases accounted for 42,2% of all ER encounters,

Marketplace Members

Table 7: Disabled Marketplace IP Diagnoses by Unique Member Count:

MARKETPLACE IP TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
04	Respiratory System	1	19	11.8%
06	Digestive System	2	19	11.8%
05	Circulatory System	3	16	10.0%
23	Factors Influencing Health Status	4	15	
08	Musculoskeletal/Connective Tissue Diseases	5	15	
11	Kidney and Urinary Tract	6	11	
10	Endocrine/Metabolic/Immunity Disorders	7	10	
01	Nervous System	8	8	
18	Infectious/Parasitic Diseases	9	8	
16	Blood Related Diseases	10	7	
09	Skin/Subcutaneous Tissue and Breast Diseases	11	7	
17	Myeloproliferative Diseases and Disorders	12	4	
07	Hepatobiliary System and Pancreas Disorders	13	4	
02	Eye Diseases and Disorders	14	4	
03	Ear, Nose, Mouth and Throat Diseases	15	4	
13	Female Genitourinary System	16	3	
21	Injuries and Poisoning	17	3	
19	Mental Diseases and Disorders	18	3	
20	Chemical Dependency	19	1	
			161	

2018 Population Analysis

For this report there were 19 diagnosis categories identified members with disabilities in the Marketplace population. Diseases of the respiratory system and digestive system and circulatory system accounted for 33.6 % of all inpatient admissions.

Table 8: Disabled Marketplace ER Diagnoses by Unique Member Count:

MARKETPLACE ER TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
04	Respiratory System	1	7	16.7%
08	Musculoskeletal/Connective Tissue Diseases	2	6	14.3%
09	Skin/Subcutaneous Tissue and Breast Diseases	3	6	14.3%
21	Injuries and Poisoning	4	4	
05	Circulatory System	5	4	
06	Digestive System	6	4	
01	Nervous System	7	2	
23	Factors Influencing Health Status	8	2	
16	Blood Related Diseases	9	2	
10	Endocrine/Metabolic/Immunity Disorders	10	2	
17	Myeloproliferative Diseases and Disorders	11	1	
11	Kidney and Urinary Tract	12	1	
02	Eye Diseases and Disorders	13	1	
			42	

There were 42 Emergency room encounters for this population during the reporting period. Of the top three (3) diagnosis categories, diseases of the respiratory system, musculoskeletal/connective tissue and skin/subcutaneous tissue accounted for 45.3% of all ER visits for the disabled Marketplace members.

Inpatient Admissions Analysis

For this report, the total number of admissions in the top three MDC categories were divided by the total member count for all admissions of members with a disability, in each product line to determine the total percentage of admissions.

The analysis of the top three inpatient diagnosis categories across product lines identified disorders of the respiratory system as the top-ranking MDC for both the commercial and Marketplace membership. Circulatory and musculoskeletal/connective tissue disorders ranked second and third for the commercial membership. Digestive system and circulatory disorders ranked second and third for the Marketplace membership.

Emergency Room Utilization Analysis

For this report, the total number of ER visits in the top three MDC categories were divided by the total count for all ER visits in each product line to determine the total percentage of.

The analysis of the top three diagnose codes that drive members to utilize the Emergency Room identified digestive system, respiratory and musculoskeletal/connective tissue disorders, in respective order for the commercial ER utilization. The Marketplace membership top three MDC in rank order were respiratory, digestive and circulatory disorders.

Summary and Trends

Members with disabilities share the same common diagnosis categories with the general population. The key health issues driving the admission volume and cost of ER visits for these members overlapped. Digestive system disorders were exclusive to the Marketplace while, musculoskeletal/connective tissue disorders were exclusive to the Commercial membership for ED utilization.

Behavioral Health

Severe and Persistent Mental Illness by Product Line

Individuals with Severe and Persistent Mental Illness (SPMI), across all product lines (Commercial, and Marketplace), had acute needs for care coordination and intense resource use. Members were identified by age group (Children and Adolescents 2-19 years and the Adult population age 20 and greater), using diagnosis codes for Schizophrenia and Bipolar Disorder to identify the members at high risk. A total of 10,115 members were identified across all three product lines: 9,511 in the Adult population, 604 were identified in the children and adolescent (age 2-19) Table E provides a breakdown across products lines.

Table E: Unique SPMI Members by Product Lines and Age Group

Unique SPMI Members by Product Lines and Age Group		
Product Line	Commercial	Marketplace
# members	44,627	44,919
TOTAL SPMI MEMBERS	5,110 114/1000	5,005 111/1000
# ADULTS	4,684 104/1000	4,827 107/1000

2018 Population Analysis

# CHILDREN & ADOLESCENTS	426 9.5/1000	178 3.9/1000

Data identified 11.5% of the Commercial product line of which 10.5% are adults and 0.9% of the child and adolescent Commercial product line have a SPMI diagnosis. For the Marketplace product line, 11.1% of which 10.7% are adults and 0.04% of the child and adolescent population have a SPMI diagnosis.

Table 9: Behavioral Health: Commercial Inpatient Diagnoses by Unique Count

COMMERCIAL IP TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
23	Factors Influencing Health Status	1	134	11.2%
05	Circulatory System	2	132	11%
04	Respiratory System	3	127	10.6%
06	Digestive System	4	113	
08	Musculoskeletal/Connective Tissue Diseases	5	105	
14	Maternity and Childbirth	6	76	
10	Endocrine/Metabolic/Immunity Disorders	7	68	
19	Mental Diseases and Disorders	8	67	
01	Nervous System	9	62	
18	Infectious/Parasitic Diseases	10	48	
07	Hepatobiliary System and Pancreas Disorders	11	42	
11	Kidney and Urinary Tract	12	41	
20	Chemical Dependency	13	36	
09	Skin/Subcutaneous Tissue and Breast Diseases	14	35	
21	Injuries and Poisoning	15	31	
13	Female Genitourinary System	16	28	
16	Blood Related Diseases	17	24	
03	Ear, Nose, Mouth and Throat Diseases	18	20	
17	Myeloproliferative Diseases and Disorders	19	8	
02	Eye Diseases and Disorders	20	4	
			1,201	

For this report there were 1,201 associated admission encounters in 20 diagnosis categories identified for members with SPMI in the Commercial population, the top three MDC codes accounted for 32.8% of all inpatient admissions.

Table 10: Behavioral Health: Commercial ER Diagnoses by Unique Count:

COMMERCIAL ER TOP 25 DIAGNOSES BY TOTAL MEMBERS

2018 Population Analysis

MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
05	Circulatory System	1	406	15%
06	Digestive System	2	394	14.5%
08	Musculoskeletal/Connective Tissue Diseases	3	301	11.1%
04	Respiratory System	4	248	
09	Skin/Subcutaneous Tissue and Breast Diseases	5	200	
01	Nervous System	6	170	
03	Ear, Nose, Mouth and Throat Diseases	7	159	
21	Injuries and Poisoning	8	152	
23	Factors Influencing Health Status	9	133	
11	Kidney and Urinary Tract	10	121	
19	Mental Diseases and Disorders	11	104	
13	Female Genitourinary System	12	68	
10	Endocrine/Metabolic/Immunity Disorders	13	64	
14	Maternity and Childbirth	14	47	
18	Infectious/Parasitic Diseases	15	41	
07	Hepatobiliary System and Pancreas Disorders	16	36	
20	Chemical Dependency	17	25	
16	Blood Related Diseases	18	19	
02	Eye Diseases and Disorders	19	18	
22	Burns	20	4	
17	Myeloproliferative Diseases and Disorders	21	3	
25	HIV Infections	22	1	
			2,714	

There were 2,714 Emergency Room encounters for this population during the reporting period. Of the top three diagnosis categories, circulatory system disorders, digestive disorders and by musculoskeletal/connective tissue diseases accounted for 40.6% of all commercial Emergency Room visits for members with Severe and Persistent Mental Illness.

Table 11: Behavioral Health: Marketplace Inpatient Diagnoses by Unique Count

MARKETPLACE IP TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
05	Circulatory System	1	182	11.0%
04	Respiratory System	2	164	9.9%
23	Factors Influencing Health Status	3	159	9.6%
06	Digestive System	4	157	

2018 Population Analysis

MARKETPLACE IP TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
19	Mental Diseases and Disorders	5	141	
08	Musculoskeletal/Connective Tissue Diseases	6	138	
01	Nervous System	7	93	
10	Endocrine/Metabolic/Immunity Disorders	8	87	
11	Kidney and Urinary Tract	9	78	
20	Chemical Dependency	10	77	
18	Infectious/Parasitic Diseases	11	71	
21	Injuries and Poisoning	12	58	
09	Skin/Subcutaneous Tissue and Breast Diseases	13	51	
07	Hepatobiliary System and Pancreas Disorders	14	45	
16	Blood Related Diseases	15	42	
13	Female Genitourinary System	16	38	
14	Maternity and Childbirth	17	29	
03	Ear, Nose, Mouth and Throat Diseases	18	25	
17	Myeloproliferative Diseases and Disorders	19	8	
02	Eye Diseases and Disorders	20	8	
15	Perinatal Conditions	21	3	
			1,654	

For this report there were 1,654 admission in 21 diagnosis categories identified for members with SPMI in the Marketplace population. Diseases of the circulatory system, respiratory system and FIHS account for 30.5% of emergency room utilization in this population.

Table 12: Behavioral Health: Marketplace ER Diagnoses by Unique Count

MARKETPLACE ER TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
05	Circulatory System	1	449	13.5%
06	Digestive System	2	441	13.2%
08	Musculoskeletal/Connective Tissue Diseases	3	370	11.1%
04	Respiratory System	4	313	
01	Nervous System	5	244	
09	Skin/Subcutaneous Tissue and Breast Diseases	6	221	
23	Factors Influencing Health Status	7	213	
21	Injuries and Poisoning	8	184	
03	Ear, Nose, Mouth and Throat Diseases	9	180	
19	Mental Diseases and Disorders	10	163	
11	Kidney and Urinary Tract	11	156	

2018 Population Analysis

MARKETPLACE ER TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
10	Endocrine/Metabolic/Immunity Disorders	12	86	
18	Infectious/Parasitic Diseases	13	70	
20	Chemical Dependency	14	61	
13	Female Genitourinary System	15	61	
07	Hepatobiliary System and Pancreas Disorders	16	46	
14	Maternity and Childbirth	17	28	
02	Eye Diseases and Disorders	18	21	
16	Blood Related Diseases	19	18	
17	Myeloproliferative Diseases and Disorders	20	4	
22	Burns	21	4	
			3,333	

There were 3,333 Emergency room visits for this population during the reporting period. Of the top three diagnosis categories, circulatory system disorders, digestive system disorders and musculoskeletal/connective tissue diseases accounted for 47.8% of all Marketplace Emergency Room visits for members with SPMI.

Inpatient Admissions Analysis

For this report, the total members with SPMI enrolled in each product line were used to determine the members at highest risk by disease category.

The analysis of the top three inpatient diagnosis categories, across product lines, identified, in rank order, FIHS (SDOH), disorders of the circulatory and respiratory systems at the leading MDC codes for the Commercial Membership. Circulatory, respiratory and FIHS (SDOH) in rank order, were the top three MDC for the marketplace membership.

Emergency Room Utilization and Resources Analysis

For this report, total number of ER visits in each product line was used to determine members at high risk by disease category. Factors influencing health care status at high risk by disease.

The top three diagnoses that drive members to utilize the Emergency Room for members with SPMI were identical across both product lines. Circulatory diseases were the leading cause of ER utilization followed by Digestive system disorders with musculoskeletal/Connective Tissue Diseases in third place for all three product lines. Respiratory disorders were in third place for Medicare with digestive disorders in second for both the Marketplace and Commercial membership.

Summary and Trends

Members with SPMI closely mirror other populations in many disease categories. Circulatory system, musculoskeletal system/connective tissue, respiratory and digestive system disorder are common drivers of utilization in the inpatient and Emergency settings.

Children and Adolescent population (2-19 years of age) by Product Line

In this reporting period, FHCP children and adolescent population accounts for 11% of the total plan membership. Children and adolescents may need support because they are still growing physically, mentally, and emotionally, and may have special needs when they face medical or behavioral challenges. During this measurement period, despite the small population, the age groups for the Commercial and Marketplace product lines were delineated to identify at risk populations.

Table D: Children and Adolescent Membership by Product Line

CHILDREN AND ADOLESCENT (age 2-19) MEMBERSHIP BY PRODUCT LINE		
Product Line	Commercial	Marketplace
Total Members per Product Line	44,627	44,919
# members	7061	4,165
% of enrollment (Product Line)	15.8%	9.3%
% of enrollment Total Membership	6.7%	4%

Children and adolescents in the Commercial product line account for 7% of our total enrolled members. The Marketplace enrollment accounts for 4% of our total membership.

Table E: Children and Adolescent Membership by Product Line

CHILDREN AND ADOLESCENT (age 2-19) HOSPITALIZATIONS BY MEMBERSHIP		
Product Line	Commercial	Marketplace
# members (2-19)	6,571	3,338
# of admissions	64	25
% of Total Admissions	0.97%	0.075%

Utilizing the number of children and adolescents enrolled per product line in comparison to the number members admitted per product line, the Commercial population had the highest overall admission rate per membership.

Methodology

Claims data was utilized to determine up to the top 25 inpatient admission diagnoses by member count for inpatient and Emergency Room utilization by product line. The top three Medical Diagnosis Codes (MDC) were utilized for an in-depth analysis of the “at risk” populations among children and adolescents age 2- 19.

Table 13: Commercial Inpatient (age 2-19) Diagnoses by Unique Count:

COMMERCIAL IP TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
04	Respiratory System	1	16	21.6%
08	Musculoskeletal/Connective Tissue Diseases	2	9	12.2%
05	Circulatory System	3	6	8.1%
01	Nervous System	4	5	
03	Ear, Nose, Mouth and Throat Diseases	5	5	
06	Digestive System	6	4	
23	Factors Influencing Health Status	7	4	
21	Injuries and Poisoning	8	4	
18	Infectious/Parasitic Diseases	9	4	
16	Blood Related Diseases	10	3	
09	Skin/Subcutaneous Tissue and Breast Diseases	11	3	
10	Endocrine/Metabolic/Immunity Disorders	12	3	
19	Mental Diseases and Disorders	13	3	
17	Myeloproliferative Diseases and Disorders	14	2	
07	Hepatobiliary System and Pancreas Disorders	15	2	
14	Maternity and Childbirth	16	1	
			74	

Of the top 16 inpatient admission diagnoses by unique member count for members aged 2-19, 74 admissions were identified. Of those admissions, diseases of the respiratory system, musculoskeletal/connective tissue, and circulatory system accounted for 41.9% of all inpatient admission among this population.

Table 14: Commercial ED Diagnoses by Unique Count:

COMMERCIAL ER TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
08	Musculoskeletal/Connective Tissue Diseases	1	179	18%
03	Ear, Nose, Mouth and Throat Diseases	2	138	13.9%
09	Skin/Subcutaneous Tissue and Breast Diseases	3	132	13.3%
06	Digestive System	4	110	
21	Injuries and Poisoning	5	107	
04	Respiratory System	6	80	
18	Infectious/Parasitic Diseases	7	65	
05	Circulatory System	8	45	
01	Nervous System	9	37	
11	Kidney and Urinary Tract	10	26	
23	Factors Influencing Health Status	11	22	
13	Female Genitourinary System	12	14	
02	Eye Diseases and Disorders	13	11	
10	Endocrine/Metabolic/Immunity Disorders	14	9	
16	Blood Related Diseases	15	5	
20	Chemical Dependency	16	4	
14	Maternity and Childbirth	17	3	
07	Hepatobiliary System and Pancreas Disorders	18	2	
19	Mental Diseases and Disorders	19	1	
22	Burns	20	1	
			991	

Of the top 20 ER diagnoses by member count, 991 Emergency room visits occurred during this reporting period. Diseases of the musculoskeletal/connective tissue, Ear, Nose, Mouth and Throat (ENT) and skin/subcutaneous tissue and breast accounted for 47.2% of all Emergency Room visits.

Table 15: Marketplace (Children and Adolescent age 2-19) IP Diagnoses by Unique Count:

MARKETPLACE IP TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
01	Nervous System	1	6	19.4%
23	Factors Influencing Health Status	2	3	9.7%
09	Skin/Subcutaneous Tissue and Breast Diseases	3	2	6.5%
21	Injuries and Poisoning	4	2	

2018 Population Analysis

MARKETPLACE IP TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
14	Maternity and Childbirth	5	2	
13	Female Genitourinary System	6	2	
08	Musculoskeletal/Connective Tissue Diseases	7	2	
06	Digestive System	8	2	
04	Respiratory System	9	2	
03	Ear, Nose, Mouth and Throat Diseases	10	2	
07	Hepatobiliary System and Pancreas Disorders	11	1	
05	Circulatory System	12	1	
02	Eye Diseases and Disorders	13	1	
16	Blood Related Diseases	14	1	
18	Infectious/Parasitic Diseases	15	1	
10	Endocrine/Metabolic/Immunity Disorders	16	1	
			31	

Of the top 16 inpatient admission diagnoses by unique member count for the Marketplace children and adolescent population, 31 admissions were identified. Of those admissions, diseases of the nervous system, FIHS, and skin/subcutaneous tissue and breast diseases accounted for 35.6% of all inpatient admissions.

Table 16: Marketplace ER (Children and Adolescent age 2-19) Diagnoses by Unique Count:

MARKETPLACE ER TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
08	Musculoskeletal/Connective Tissue Diseases	1	69	14.3%
09	Skin/Subcutaneous Tissue and Breast Diseases	2	63	13.0%
03	Ear, Nose, Mouth and Throat Diseases	3	62	12.8%
06	Digestive System	4	57	
04	Respiratory System	5	50	
21	Injuries and Poisoning	6	42	
18	Infectious/Parasitic Diseases	7	32	
05	Circulatory System	8	22	
23	Factors Influencing Health Status	9	16	
13	Female Genitourinary System	10	15	
01	Nervous System	11	15	
11	Kidney and Urinary Tract	12	15	
02	Eye Diseases and Disorders	13	9	
16	Blood Related Diseases	14	6	
07	Hepatobiliary System and Pancreas Disorders	15	3	
20	Chemical Dependency	16	3	

MARKETPLACE ER TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
14	Maternity and Childbirth	17	2	
19	Mental Diseases and Disorders	18	1	
10	Endocrine/Metabolic/Immunity Disorders	19	1	
			483	

Of the top 19 ER diagnoses by unique member count, 483 Emergency Room encounters occurred during this reporting period. Musculoskeletal/connective tissue diseases, skin/subcutaneous tissue and breast diseases and ENT disorders accounted for 40.1% of emergency room utilization by Marketplace child and adolescent members.

Inpatient Admissions Analysis

For this report, the number of total member admissions in each product line for Children and Adolescents age 2-19 was used to determine the members at highest risk by disease category. The analysis of the top three inpatient diagnoses across both product lines identified respiratory, musculoskeletal system/connective tissue and circulatory disorders, in rank order, as the leading inpatient diagnosis categories for FHCP children and adolescents. In rank order, nervous system disorders, FIHS (SDOH), and skin/subcutaneous tissue and breast disorders as the leading inpatient diagnosis for the Marketplace membership.

Emergency Room Utilization Analysis

For this report total number of ER visits in each product line was used to determine members at high risk by disease.

The analysis of the top three diagnoses that drive members to utilize the Emergency Room identified musculoskeletal system/connective tissue, ENT and skin/subcutaneous tissue as the highest for both lines of business, in varying order.

Summary and Trends

Each product line has its unique disease categories that seem to drive admissions.

For the Commercial and Marketplace product lines, the key health issues driving the increased admission volume and cost of ER visits for children and adolescents between the ages of 2-19 overlapped. The disorders included the diseases of the digestive system, nervous system disorders and musculoskeletal system/connective tissue. Inpatient MDC for Commercial and Marketplace, did not share any common MDC.

2018 Population Analysis

Common themes among both product lines for Emergency Room utilization identify these disease categories as the primary focus for prevention and education in this population.

Behavioral Health Children and Adolescent population (2-19 years of age) by Product Line

Commercial

Table 17: Behavioral Health: Commercial Inpatient Diagnoses by Unique Count (age 2-19)

COMMERCIAL IP TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
19	Mental Diseases and Disorders	1	23	46.9%
05	Circulatory System	2	5	10.0%
01	Nervous System	3	4	8.2%
21	Injuries and Poisoning	4	4	
20	Chemical Dependency	5	3	
14	Maternity and Childbirth	6	2	
06	Digestive System	7	2	
23	Factors Influencing Health Status	8	2	
15	Perinatal Conditions	9	1	
10	Endocrine/Metabolic/Immunity Disorders	10	1	
09	Skin/Subcutaneous Tissue and Breast Diseases	11	1	
03	Ear, Nose, Mouth and Throat Diseases	12	1	
			49	

There were 49-member admissions in 1 diagnosis categories for members with severe and persistent mental health illness (SPMI) in the Commercial child and adolescent population. Mental diseases and disorders, diseases of the circulatory system and nervous system diseases accounted for 65.1% of all inpatient admissions in this population.

Table 18: Behavioral Health: Commercial ER Diagnoses by Unique Count (age 2-19)

COMMERCIAL ER TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
06	Digestive System	1	36	15.3%
08	Musculoskeletal/Connective Tissue Diseases	2	35	14.8%
21	Injuries and Poisoning	3	27	11.4%
09	Skin/Subcutaneous Tissue and Breast Diseases	4	27	
05	Circulatory System	5	18	
03	Ear, Nose, Mouth and Throat Diseases	6	15	

2018 Population Analysis

COMMERCIAL ER TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
11	Kidney and Urinary Tract	7	13	
01	Nervous System	8	12	
04	Respiratory System	9	10	
19	Mental Diseases and Disorders	10	10	
23	Factors Influencing Health Status	11	8	
18	Infectious/Parasitic Diseases	12	6	
13	Female Genitourinary System	13	6	
14	Maternity and Childbirth	14	4	
10	Endocrine/Metabolic/Immunity Disorders	15	3	
16	Blood Related Diseases	16	2	
20	Chemical Dependency	17	2	
02	Eye Diseases and Disorders	18	1	
22	Burns	19	1	
			236	

There were 236 Emergency Room visits for this population, during the reporting period. Of the top three (3) diagnosis categories, Digestive System ranked the highest musculoskeletal/connective tissue disorders ranked second followed by injuries and poisoning, accounting for 41.5% of all emergency room utilization in this population.

Marketplace

Table 19: Behavioral Health: Marketplace Inpatient Diagnoses by Unique Count (2-19)

MARKETPLACE IP TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
19	Mental Diseases and Disorders	1	14	58.0%
05	Circulatory System	2	3	12.5%
13	Female Genitourinary System	3	2	8.3%
21	Injuries and Poisoning	4	2	
06	Digestive System	5	1	
23	Factors Influencing Health Status	6	1	
04	Respiratory System	7	1	
			24	

For this report there were 24-member admissions in 7 diagnosis categories identified for child and adolescent members with SPMI in the Marketplace population. Mental diseases and disorders, diseases of the circulatory

system ranked second followed by female genitourinary systems. The top three diagnosis groups accounted for 78.8% of inpatient utilization for children in the Marketplace product line.

Table 25: Behavioral Health: Marketplace ER Diagnoses by Unique Count (age 2-19)

MARKETPLACE ER TOP 25 DIAGNOSES BY TOTAL MEMBERS				
MDC	MDC DESC	TOTAL MEMBERS RANK	TOTAL MEMBER COUNT	Top Three Diagnosis Percentage
09	Skin/Subcutaneous Tissue and Breast Diseases	1	14	14.3%
21	Injuries and Poisoning	2	13	13.3%
08	Musculoskeletal/Connective Tissue Diseases	3	13	13.3%
06	Digestive System	4	11	
19	Mental Diseases and Disorders	5	9	
01	Nervous System	6	6	
03	Ear, Nose, Mouth and Throat Diseases	7	6	
05	Circulatory System	8	6	
18	Infectious/Parasitic Diseases	9	6	
23	Factors Influencing Health Status	10	4	
04	Respiratory System	11	3	
10	Endocrine/Metabolic/Immunity Disorders	12	2	
11	Kidney and Urinary Tract	13	2	
13	Female Genitourinary System	14	2	
14	Maternity and Childbirth	15	1	
			98	

There were 98 Emergency room visits for this population during the reporting period. Of the top three (3) diagnosis categories, Skin/Subcutaneous Tissue and Breast Diseases, Injuries and Poisoning Musculoskeletal/connective tissue disorders. All three account for 40.9% of the resource utilization for this population.

Inpatient Admissions Analysis

For this report, the total member admissions for members age 2-9, with SPMI in each product line was used to determine the members at highest risk by disease category.

Mental diseases and disorders and circulatory system disorders ranked first and second among both Commercial and Marketplace membership. Nervous system disorders were third for the commercial membership and female genitourinary system disorders was third for the Marketplace membership.

Emergency Room Utilization Analysis

Digestive system disorders ranked as the leading cause of ER utilization in the Commercial membership, while skin/subcutaneous tissue and breast disorders ranked first for the Marketplace membership. Skin/subcutaneous tissue and breast disorders and injuries and poisonings ranked second and third for the Commercial membership, and third and second for the Marketplace membership.

Summary and Trends

Both the Commercial and Market place share similar drivers for ER utilization, except for Nervous system disorders for the commercial line and female and genitourinary disorders for Marketplace. The primary concern is the high percentage of admissions related to Mental Health diseases and disorders in this population. Leading the plan to identify this is the primary target of intervention and education for this at-risk sub-group.

Disabled Children and Adolescents (Age 2-19)

This category was not analyzed, as there was one child identified as eligible for this category in the Commercial membership. Data is clinically insufficient to evaluate and form a conclusion.

Comparative Analysis Across all Product Lines and Age Groups Inpatient by Encounter

Table 20: Inpatient Top 3 Admission Related Diagnosis

INPATIENT COMPARATIVE ANALYSIS TOP 3 ADMISSION RELATED DIAGNOSIS BY RANK												
	POPULATION	MEMBERS > Age 20						MEMBERS AGE 2 - 19 YEARS				
MDC	COMMERCIAL	MARKETPLACE			COMMERCIAL	MARKETPLACE						
	MDC DESC	All Members	Disabilities	SPMI	All Members	Disabilities	SPMI	All Members	Disabilities	SPMI	All Members	SPMI
23	Factors Influencing Health Status	3		1	2		3				2	
05	Circulatory System	2	2	2	1	3	1		3	1	2	2
14	Maternity and Childbirth	1										
04	Respiratory System		1	3	3	1	2		1			
01	Musculoskeletal/connective tissue disorders		3						2			
6	Digestive systems				2							
1	Nervous System Disorders										3	1
9	Skin/subcutaneous Tissue and Breast Disorders										3	
19	Mental Health Diseases and Disorders										1	1
13	Female Genitourinary System											3

The data analyzed identifies populations that were previously known to be high risk by Florida Health Care Plans; however, analysis is required to identify populations that may be overlooked. This analysis identifies Disease categories that are specific to certain subpopulations. The table above depicts a comparative analysis of all product lines, age groups and subpopulations within those product lines for inpatient related diagnosis categories across both product lines and age groups as applicable

Members age 20 and Older

Circulatory system disorders Factors Influencing Health Care (SDOH) and Respiratory disorders ranked in the top three for most of the population and subgroups, identifying these three diagnosis categories as the greatest driver of admissions among the FHCP membership for members over 20 and 65 or older. Maternity and childbirth

ranked first for the Commercial members overall, However, FHCP does not recognize this is a high-risk category, given the expectation of the commercial memberships childbearing age.

Members age 2-19

The Commercial line contained all subgroups; however, there was no available data for Marketplace members with disabilities. The Commercial membership only identified 1 member with an MDC eligible for this analysis. Mental Health disorders were the highest-ranking diagnosis category driving inpatient admissions in the majority for this population except for Commercial members with disabilities, age 2-19, where nervous system disorders were predominant. Second and third ranking diagnoses were scattered, with little identifiable pattern, for all three subgroups. Emergency Room by Encounter

Table 21: Emergency Room: Top 3 Visit Related Diagnosis

ER COMPARATIVE ANALYSIS TOP 3 VISIT RELATED DIAGNOSIS BY RANK													
POPULATION		MEMBERS > Age 20						MEMBERS AGE 2 - 19 YEARS					
MDC	COMMERCIAL	MARKETPLACE			COMMERCIAL			MARKETPLACE					
		All Members			Disabilities			SPMI					
		All Members			Disabilities			SPMI					
		All Members			Disabilities			SPMI					
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		All Members			Disabilities			SPMI					
		All Members			Disabilities								

Members age 20 and Older

Circulatory and digestive system disorders dominated Emergency room utilization in all lines of business and subgroups as the number one cause for ER utilization. Musculoskeletal/connective tissue dominated the third spot for both product lines and subgroups, except for Marketplace members with disabilities. The Commercial and Marketplace product lines consistently shared the same three diagnoses as the top reasons for Emergency Room utilization.

Members age 2-19

The Commercial and Marketplace lines were the only product lines available for analysis. The Commercial line contained all subgroups; however, there was no available data for Marketplace members with disabilities. The Commercial membership only identified 1 member with an MDC eligible for this analysis. The data here was somewhat scattered and without any identifiable pattern. Each product line and subgroups had its own unique combination of diagnosis category driving its three top spots.

Conclusion:

Florida Health Care Plan's total membership was 101,105 across all lines of business. 11,226 members were between the age 2-19 (20.1%), and 93,878 members were > than age 20 (89.6%). The analysis was completed based on total members enrolled during the 365-day reporting period

Inpatient Utilization

For the combined adult membership (age 20 and greater) in the "Top 25 Admissions by Unique Member Count" both product lines and all subgroups have MDCs in common including: circulatory, musculoskeletal/connective tissue disorders, digestive and respiratory disorders in various order. Nervous systems are noted to affect the subpopulation for Marketplace children; these MDC category codes are the top reasons for inpatient stays.

Emergency Room Utilization

Data identifies a more consistent trend, for utilization of Emergency services in both product lines of business.

For the combined adult membership (age 20 and greater), total Emergency Room related encounters were. Circulatory respiratory, musculoskeletal and digestive system disorders dominate Emergency Room visits as the chief complaint on arrival for adults over the age of 20. Children predominately present with Injuries, poisonings, nervous system disorders and musculoskeletal complaints.

Identifying Diagnosis Categories that tend to drive utilization allows the plan to identify, targeted populations for services and further evaluation of needs.

Evaluation of Extent to which PHM Activities Meet Member Needs

FHCP Case management managed 4,910 members of which 322 members required and enrolled in Complex Case Management services after being identified as high risk. accounting for <1% of the general population during this reporting period. The remaining members had a onetime intervention, were referred for other services, (Short term Case Management, Interactive Health at Home, (Remote Patient Management) or Community Resource Coordination. Complex care participants were identified through claims data for members with high resource utilization, admission and re-admission data, and Emergency Room utilization. In addition, members known to be at high risk were identified through reports identifying members with high ER utilization, Beta Blocker Prescriptions, COPD and elevated Hemoglobin A1C, high admission rates and re-admissions rates.

Identified in this analysis were members that were previously noted to be at high risk but were being addressed individually, not as a population. Factors influencing health care status was a predominant theme. While it did not consume the highest utilization of resources, this diagnosis category affected many members. FHCP currently reviews data associated with this diagnosis category. BMI surveillance is conducted regularly to ensure members with an elevated BMI and co-morbidities are addressed and referred to the appropriate resources. Members identified with socioeconomic issues are referred to our Community Resource Coordinators.

Social determinants of health related to language barriers and members' linguistic needs were evaluated and it was determined that our mix of bilingual and multilingual Physicians, Case Managers and access to interpretation services for language and for the Deaf are consistent with the population. FHCP has the resources to address and intervene to prevent the possibility of this barrier interfering with the health care needs of our members.

Members at risk or Transportation disadvantaged, are identified through several resources, including, Case Management, self-referral, chart audits, interview, utilization management, discharge planning and PCP referral. These members are referred to Community Resource Coordination for evaluation of community services, funding and support systems address barriers and identify options.

Case Management will develop strategies to identify members in these high-risk areas to offer and provide services that will assist members in accessing appropriate health care and navigate their FHCP benefits.

Population Health Management Processes and Resources

The population health management structure and processes were reviewed to identify barriers, to facilitate linking members with internal or external services to meet the needs of Florida Health Care Plan members.

Identified High Risk Populations in need of Population Health Management and Proposed Program Adjustments		
Existing and Newly Identified High Risk Populations & Diagnosis	Gaps addressed	Actions Implemented
Factors Influencing Health Care Status (FIHS)/ Social Determinants of Health (SDOH)	These factors encompass a vast number of MDC's related to psychosocial, socioeconomic, communicable diseases, reproductive issues, access to health care and persons with potential health hazards related to family and personal history and certain conditions influencing health status. Because of the wide array of diagnosis codes that fall into his category, high risk members may be unaware of how to access their benefits; hence be overlooked.	Review of claims data associated with this ICD grouper code to identify members who need Case Management services based on high risk needs.
Members with SPMI (existing)	Members diagnosed with a SPMI with co-morbid conditions opting not to participate in Case Management (i.e. Diabetes, COPD, Heart Disease, Non-compliance with medical treatment plan, etc.).	Case Managers and Community Resource Coordinators partner with FHCP Behavioral Health LCSW to provide in home mental health services and assist with care coordination and health coaching. In 2018, additional LCSWs have been added to meet member growth and needs. Staff added that are dedicated to medication adherence and follow up adherence and monitoring.

Identified High Risk Populations in need of Population Health Management and Proposed Program Adjustments		
Existing and Newly Identified High Risk Populations & Diagnosis	Gaps addressed	Actions Implemented
Members with Disabilities and SPMI in Commercial Product line within Maternity and Childbirth Diagnosis Category	Many members work during FHCP business hours Monday-Friday and are unable to accept non-work-related telephone calls.	Flexible scheduling promoted to provide care coordination and health coaching to the working population. Additional resources in practice management are being added throughout the services areas to meet member growth.
Access to and utilization of Case management	Members discharged from hospital or skilled nursing facility without FHCP contact information to access resources or care, combined with lack of knowledge of their benefits.	Utilization Management identifies members enrolled in or meeting criteria for Case Management Services. Once identified, they communicate through Electronic Medical Record Task system. Complex Case Managers and Community Resource Coordinators initiate contact with members as described in the Case Management Policy CM007. When appropriate, onsite visits in the inpatient setting to connect with member and identify psychosocial and socioeconomic barriers, are conducted. Collaboration with facility case managers to improve discharge planning and needs, quarterly meetings with Advent Health Leadership and Case Management to collaborate efforts to improve patient outcomes.

Identified High Risk Populations in need of Population Health Management and Proposed Program Adjustments

Existing and Newly Identified High Risk Populations & Diagnosis	Gaps addressed	Actions Implemented
Staffing Ratio, and Physician Consultant Resources.	Case Management consists of 9 Coordination of Care Case Managers. Enrolled members at the end of this reporting period were approximately 68,000 members. Creating a Staffing ratio of 1: 7,555 members. The population contains a mixture of short-term acute needs as well as members with complex health issues. High patient ratios impact the ability to identify and service members in need.	Restructure Case Management Coordination into two tiers: Case Management Telehealth - focus on members that require monitoring and utilizing telehealth innovation on a short-term basis. Traditional case management to treat acute needs. Case Management Complex Care - focus on members with multiple co-morbidities and assistance with self-management of health conditions. In 2017 Case Management added new positions to meet the needs of members. 2018, addition of Physician Consultants imbedded in case Management Department for review and recommendations on high risk members, and collaboration (communication) with PCP and specialists) when needed.

Reporting

This QI activity was reported to the following QI committees:

Committee Name	Meeting Date	Committee Actions or Recommendations
Health Outcomes and Patient Engagement Committee	May 15, 2019	Approved to send to PIC
Performance Improvement Council	July 17, 2019	Approved

References:

1. ICD.Codes, (2017) Factors influencing health care status and contact with health services. Chapter 21, retrieved from: <https://icd.codes/icd10cm/chapter21>
2. Network Availability Analysis, 2017
3. Generated on March 7, 2019 4:48:19 PM EST by CCX\Siciliano (2 records).
Filter Interval [Ending At]: 12/31/2017 19:59:59; CSQ Names: ACA-Spanish, MS-Spanish; Interval[Starting At]: 01/01/2017 08:00:00

4. University of South Florida Center for Urban Transportation Research (2017)
<http://apdcares.org/publications/legal/docs/APD%20Final%2012-14-2017.pdf>
5. Source: University of South Florida's Center for Urban Transportation Research (CUTR), Paratransit Service Demand Estimation Tool, 2013.
http://www.votran.org/core/fileparse.php/6120/urlt/Volusia_TDSP_Draft_1.10.17.pdf

Population Health Management Strategy Description

Florida Health Care Plan, Inc.

Effective 7/1/2018

This document describes Florida Health Care Plan's, Inc. (FHCP) strategy for managing the health of its enrolled population. It provides an overview of how the needs of the population are identified and stratified for intervention, summarizes the population health management (PHM) programs used to address the needs of the population across the entire health and illness continuum and explains enabling strategies used by the health plan to promote the transition to value-based care in its contracted network.

Population Assessment

Annually the health plan evaluates the needs of its enrolled population and uses that information to assess whether current programs need modification to better address the needs of its membership.

Each year the health plan examines data to evaluate the needs of member subpopulations:

- Evaluation of the characteristics and needs of the member population, including an analysis of the impact of relevant social determinants of health;
- Evaluation of health status and risks by using utilization data broken out into at least the following cohorts based on the enrolled product lines: birth to age 18, age 19 to 64 and ages 65 and over;
- Evaluation of the needs of members with disabilities; and
- Evaluation of the needs of members with severe and persistent mental illness (SPMI).

Data is reported separately by product line to facilitate an understanding of similarities and differences in health needs and status by product line.

When the data analysis is complete, it is used to determine if changes are required to population health management programs or resources. In addition, there is an evaluation of the extent to which PHM programs facilitate access and connection to community resources that address member needs outside the scope of the health benefit plan. Modifications to program design and resources are made based on these findings.

Population Stratification

FHCP combines data from multiple sources to use in its population stratification and program eligibility process. The following data are incorporated in a data warehouse from which the organization can generate reports: medical and behavioral claims/encounters, pharmacy claims, laboratory results, health appraisal results, electronic health records, data from health plan UM and/or CM programs and advanced data sources such as Florida State Health Online Tracking System (SHOTS), a statewide, centralized online immunization registry.

Annually, FHCP uses its system to segment and risk-stratify the entire enrolled population into meaningful subsets for targeted interventions.

A description of subsets and the types of interventions offered to members is described in the PHM Programs and Services portion of this document below.

Population Health Management Strategy Description
Florida Health Care Plan, Inc.
Effective 7/1/2018

PHM Programs and Services Overview

Florida Health Care Plans offers the following PHM programs and services to its enrolled members:

Program Name	Eligible Population	Applicable Product Lines
Annual Flu Shots	All members	Commercial, Medicare, Marketplace
Breast Cancer Screening	All female members ages 52-74	Commercial, Medicare, Marketplace
Diabetic Retinal Exams	All members ages 18-75 with a diagnosis of diabetes	Commercial, Medicare, Marketplace
Asthma Medication Management	All members ages 5-64 with persistent asthma	Commercial, Medicare, Marketplace
Readmission Prevention Initiative	All members in all product lines admitted through the emergency department for an inpatient stay	Commercial, Medicare, Marketplace
Health Services Navigation	All members with multiple chronic conditions with more than three (3) emergency room visits in a six (6) month period	Commercial, Medicare, Marketplace

Each program is described in greater detail below.

<i>Annual Flu Shots</i>	
Eligible population:	All members
Focus area:	Keeping members healthy
Program goal(s):	Improve annual flu shot rates by 5%
Program services:	- Open access to any FHCP facility during flu season - Marketing reminders in offices including emails from staff physicians through Follow My Health. - Educational materials: FHCP supplies offices with educational posters and fliers. Members age 65 and above are provided with information regarding the High Dose Flu vaccine. - Pre-season outreach: IVRs begin in late August and early September and provide the following information: date the flu clinics begin, locations, hours of operations and message that walk ins are welcome. . Results included on member report card (Healthy Me)
Methods and data sources used to identify the eligible population	Administrative claims data is used to determine flu vaccination rates. Included in this data are member reimbursement requests for immunizations done outside of FHCP e.g., Walgreens and CVS. Members are stratified into two categories; compliant and non-compliant. Members identified as non-compliant are targeted for education and outreach.

Population Health Management Strategy Description
Florida Health Care Plan, Inc.
Effective 7/1/2018

<i>Breast Cancer Screening</i>	
Eligible population:	All female members between the ages of 52-74 years of age
Focus area:	• Keeping members healthy
Program goal(s):	• Improve breast cancer screening rate by 5%
Program services:	• Reminder letters (co-branded with the American Cancer Society) are sent to non-compliant females (identified as not having a mammogram within the last two years) • IVR calls are made to non-compliant females (identified as not having a mammogram within the last two years) • Collaboration with radiology group – outreach to patients on behalf of plan and members’ physicians • Educational information on FHCP.com • Results included on member report card (Healthy Me) • On-staff and network Gap report
Methods and data sources used to identify the eligible population	Verscend software is used to identify the population of eligible members who are in need of a mammogram. After the eligible population is determined, the data is cross-referenced with claims data to identify women who have undergone a mammogram to screen for breast cancer.

<i>Diabetic Retinal Exams</i>	
Eligible population:	All diabetic members between 18- 75 years of age
Focus area:	• Managing members with emerging risk
Program goal(s):	• Improve diabetic retinal screening rates by 5%
Program services:	• Reminder letters to new and existing members • Targeted interventions with Endocrinology and Ophthalmology – If an endocrinologist determines a member needs a retinal exam during an office visit, before the member leaves the office the endocrinologist office staff will schedule an appointment with the FHCP ophthalmology office. • Collaboration with Pharmacy – Reminders stickers on prescription bags of members with diabetic medications - Will include FHCP ophthalmology department phone number • Researching the use of a mobile machine in doctor’s office • On staff and network GAP report • Results included on member report card (Healthy Me) • Educational information on FHCP.com • Diabetes Education program
Methods and data sources used to identify the eligible population	Members are identified monthly through administrative claims data, by diagnosis codes and test results/values for the condition of diabetes.

Population Health Management Strategy Description
Florida Health Care Plan, Inc.
Effective 7/1/2018

<i>Asthma Medication Management</i>	
Eligible population:	All members with persistent asthma between 5-64 years of age
Focus area:	Managing members with emerging risk
Program goal(s):	Improve medication adherence rates by 5%
Program services:	- Member communications and outreach - Members with persistent asthma on a controller medication receive an educational letter describing how controllers work and reminding them of the importance of taking the medication consistently. The member also receives a follow up phone call from a RN and offers assistance with a Community Resource Coordinator if finances are a barrier to purchasing medications. - Provider communications - Physicians with members having persistent asthma (on a controller medication) receive a memo specific to that member. The memo includes detailed information related to the prescribed medication. The intent is to ensure that the physician reminds the member to refill the controller medication consistently throughout the treatment period. - Educational information on FHCP.com
Methods and data sources used to identify the eligible population	Administrative claims and pharmacy databases are used to identify members 5 to 64 years of age identified as having persistent asthma (as defined by HEDIS® specifications), dispensed appropriate medications (asthma controllers) and remained on those controllers during the treatment period.

<i>Readmission Prevention Initiative</i>	
Eligible population:	All members in the Medicare Product line admitted through the emergency department for an inpatient stay.
Focus area:	Outcomes across settings
Program goal(s):	Reduce 30 day all-cause readmission rate by 0.5% below the 2017 baseline of 7.89%
Program services:	- Improve multiple transition processes, using Case Management, with tele-monitoring of discharged complex members - Complex Case management - Collaboration with network hospitals and agencies to improve discharge planning and needs assessment. - Identification of members at high risk for readmission utilizing the “LACE” risk assessment tool with automatic referral to Case Management. - Home Docs in-home visits with a mid-level practitioner - Mobile laboratory services - Mobile radiology services - Community resources coordination

Population Health Management Strategy Description
Florida Health Care Plan, Inc.
Effective 7/1/2018

Methods and data sources used to identify the eligible population	Administrative Claims Data, EHR data, and MCG Care web QI are used to identify admission and readmission rates on a monthly basis. Members are identified as “at risk for readmission” using the LACE risk assessment tool during the UM process. Emergency room data is reviewed to identify high utilization as a risk factor. Identified members are assigned a case manager, sent a letter and brochure outlining Case Management services, what to expect, and instructions for post-discharge follow-up.

<i>Readmission Prevention Initiative</i>	
Eligible population:	All members in the Commercial product line, admitted through the emergency department for an inpatient stay.
Focus area:	• Outcomes across settings
Program goal(s):	• Reduce 30 day all-cause readmission rate by 0.5% below the 2017 baseline of 8.12%
Program services:	• Improve multiple transition processes, using Case Management, with tele-monitoring of discharged complex members • Complex Case management • Collaboration with network hospitals and agencies to improve discharge planning and needs assessment. • Identification of members at high risk for readmission utilizing the “LACE” risk assessment tool with automatic referral to Case Management. • Home Docs in-home visits with a mid-level practitioner • Mobile laboratory services • Mobile radiology services • Community resources coordination
Methods and data sources used to identify the eligible population	Administrative Claims Data, EHR data, and MCG Care web QI are used to identify admission and readmission rates on a monthly basis. Members are identified as “at risk for readmission” using the LACE risk assessment tool during the UM process. Emergency room data is reviewed to identify high utilization as a risk factor. Identified members are assigned a case manager, sent a letter and brochure outlining Case Management services, what to expect, and instructions for post-discharge follow-up.

Population Health Management Strategy Description
Florida Health Care Plan, Inc.
Effective 7/1/2018

<i>Readmission Prevention Initiative</i>	
Eligible population:	All members in the Marketplace product line admitted through the emergency department for an inpatient stay.
Focus area:	• Outcomes across settings
Program goal(s):	• Reduce 30 day all-cause readmission rate by 0.5% below the 2017 baseline of 6.25%
Program services:	• Improve multiple transition processes, using Case Management, with tele-monitoring of discharged complex members • Complex Case management • Collaboration with network hospitals and agencies to improve discharge planning and needs assessment. • Automatic referral to Case Management for members at high risk for readmission identified utilizing the “LACE” risk assessment tool. • Home Docs in-home visits with a mid-level practitioner • Mobile laboratory and radiology services • Community resources coordination
Methods and data sources used to identify the eligible population	Administrative Claims Data, EHR data, and MCG Care web QI are used to identify admission and readmission rates on a monthly basis. Members are identified as “at risk for readmission” using the LACE risk assessment tool during the UM process. Emergency room data is reviewed to identify high utilization as a risk factor. Identified members are assigned a case manager, sent a letter and brochure outlining Case Management services, what to expect, and instructions for post-discharge follow-up.

<i>Health Services Navigation</i>	
Eligible population:	All members, in all product lines, who have had more than three (3) emergency department visits in a six (6) month period, presenting with dual conditions: • Heart Failure and Renal insufficiency • Diabetes and Hypertension
Focus area:	• Managing multiple chronic illnesses
Program goal(s):	• Reduce emergency department utilization 2% below the 2017 baseline of 203/1,000 members.
Program services:	• Member education resources sent to members who utilize the emergency department and are treated and released. • Connection with Case Management to assist with provider and services navigation, identify underlying drivers and make appropriate referrals. • Daily communication with providers to ensure follow up occurs. • FHCP Extended Hours Clinics throughout the coverage area • Doctor On Demand available 24 hours/day 7 days/week • Nurse On Call available 24 hours/day 7 days/week • Home Docs in-home visits with a mid-level practitioner

Population Health Management Strategy Description
Florida Health Care Plan, Inc.
Effective 7/1/2018

Methods and data sources used to identify the eligible population	Pharmacy data, emergency department claims data, daily census report, EHR review, utilization management data, elevated BMI data and laboratory data are used to identify members who may meet eligibility for case management services.

Activities Which Support PHM Programs and Services

In addition to the member programs outlined above, FHCP also conducts the following activities to support its PHM programs and services. These activities are targeted at supporting network practitioners and providers in the transition to value-based care and include the following:

- Data and information sharing with practitioners: Staff Providers receive daily Gap reports identifying key health care needs of the FHCP members within their practice. Contracted providers receive quarterly Gap reports.
- Value Based Payment Arrangements: The Physician Incentive Program is semi-annual bonus to compensate our contracted physicians for meeting or exceeding defined care standards in ED utilization and predetermined quality indicators.
- Integrating video technology: FHCP plans to expand its services to members with social determinants including, but not limited to, transportation and mobility issues by implementing virtual visits in the primary care practices. FHCP care delivery is coordinated through a member's primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand.

Coordination of Member Programs

FHCP uses the following tactics to coordinate across member programs and services, including programs members may receive through their provider care team:

- Case Management Coordination of Care; a patient- and family-centered, team-based activity designed to assess and meet the needs of patients, while helping them navigate effectively and efficiently through the health care system. Clinical coordination involves determining where to send the patient next (e.g., sequencing among specialists), what patient information is necessary to transfer among health care entities, and how accountability and responsibility is managed among all members of the care team. Members can rely on their case managers to collaborate between services. Case managers identify needs and refer members to resources they require, share information with providers and make recommendations regarding their health care needs. Additionally, they act as advocates and educators.
- Assignment of a single Care Coordinator: Case Managers collaborate closely with PCP and specialty offices through EHR documentation. Physicians with access to FHCP's EHR can view case management notes, glean valuable information regarding the patient's socioeconomic and psychosocial issues. Case Managers and providers can also improve communication through HER "tasking". Through use of a shared EHR, the entire care team has access to the most up to date medical information.

Population Health Management Strategy Description
Florida Health Care Plan, Inc.
Effective 7/1/2018

Informing Members about Available PHM Programs

FHCP provides members with information about all available PHM programs and services through the following:

- Florida Health Care Plans website (www.fhcp.com)
- FHCP Member Portal, where members can also access an integrated health risk assessment, wellness tools, a health library and other population health management programs
- Member resource guide, published annually
- Quarterly Member newsletters.
- Brochures describing PHM programs, services, and community resources
- Informational videos displayed in member-accessible locations in FHCP facilities
- “On Hold” messages that describe PHM programs available to members
- Social media outlets such as Facebook, Twitter, YouTube, Instagram and Google+

Interactive Contact

Members who are eligible for programs that include interactive contact with Florida Health Care Plans staff receive information about how they became eligible to participate, how to use program services and how to opt in or out of the program by phone, in person, or by electronic means, such as secure email and messaging through Member Portal. Members eligible for PHM programs receive contact from Nurse Case Managers, Community Resource Coordinators, Utilization Management Specialists, Transition of Care Case Managers, and Interactive Voice Response (IVR) messaging.

Committee Reporting

Committee Name	Meeting Date	Committee Actions or Recommendations
Performance Improvement Committee	April 18, 2018	Approved

Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018

Executive Summary

This report is an annual summary of the impact of the Florida Health Care Plans (FHCP) population health management programs on care process or outcome, cost/utilization, and member experience.

Below is a summary of the measures which met goal by product line and program for 2018. Detailed results and analysis are in the body of the report which follows this executive summary.

Program Name	Measure	Goal Met for Commercial	Goal Met for Marketplace
Annual Flu Shots	Improve flu shot rates by 5%	Yes	No
Breast Cancer Screening	Improve breast cancer screening rates by 5%	No	No
Diabetic Retinal Exams	Improve diabetic retinal screening rates by 5%	No	No
Asthma Medication Management	Improved medication adherence rates by 5%	No	No
Readmission Prevention	Reduce 30 day all cause readmission rate by 0.5 percent below the 2017 baseline	Yes	No
Health Services Navigation	Reduce emergency department utilization 2% below the 2017 baseline	No	No
	Heart Failure/Renal Insufficiency Diabetes/Hypertension	Yes	No

Upon review of all the results discussed in this report, the following programs are achieving the desired impact on care process or outcome, cost/utilization and member experience for one or more product lines:

- Annual Flu Shots (Commercial)
- Readmission Prevention (Commercial)
- Health Services Navigation
 - o Diabetes and Hypertension (Commercial)

**Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018**

The following programs are not yet meeting the established goals to improve care process or outcome, cost/utilization and member experience for one or more product lines:

- Annual Flu Shots (Marketplace)
- Breast Cancer Screening (Commercial and Marketplace)
- Diabetic Retinal Exams (Commercial and Marketplace)
- Asthma Medication Management (Commercial and Marketplace)
- Readmission Prevention (Marketplace)
- Health Services Navigation
 - o Heart Failure and Renal Insufficiency (Commercial and Marketplace)
 - o Diabetes and Hypertension (Marketplace)

Analysis identified the following barriers negatively impacting our ability to meet our goals:

- Annual Flu Shots – Member resistance to obtaining vaccination due to misconceptions e.g., vaccine will make the member ill
- Breast Cancer Screening – Providers are overwhelmed with the number of screenings and tests they need to address with members
- Diabetic Retinal Exam – Members are declining screening because of the cost and benefit misunderstanding
- Readmission Prevention – Provider schedules do not have the flexibility to schedule follow up appointments within five business days after discharge from a hospital
- Health Services Navigations – Members may not have a good understanding of alternatives to seeking emergency room care

FHCP is taking the following actions to address identified barriers and reach established PHM program performance goals:

- Annual Flu Shots – Marketing reminders throughout facilities, reminders on prescription bottle caps and buttons for employees informing members that flu vaccines are available
- Breast Cancer Screening/Readmission Prevention – Revise work flows to improve efficiency and leverage other providers to balance responsibility
- Diabetic Retinal Exam – Increase communication that screening is covered as a medical benefit and a vision benefit is not required
- Health Services Navigation – Ongoing education regarding the services offered and increased access to care locations

Additional information on actions to improve performance is described in the body of this report.

Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018

1. Program Name: Annual Flu Shots

Measure Description and Relevance

Florida Health Care Plans uses the measure listed below to gauge the impact of this program on care process, care outcome or cost/utilization. We explain why the measure is a relevant method to assess the impact of this program.

Measure Name	Relevance
Annual Flu Shots	Influenza is a contagious respiratory illness that can cause mild to severe illness. Some cases may result in serious outcomes such as hospitalization or death. The best way to prevent the flu is getting vaccinated annually. Increasing vaccination rates helps FHCP ensure optimal health and wellness of our members.

Methodology

- Annual Flu Shots

The numerator specifications used for this measure are: Members who got flu shots between August 2018 and March 2019. The denominator specifications used for this measure are: Active membership as of March 2019. There were no exclusion criteria applied and the data sources were claims, the electronic health record and Florida SHOTS.

Annual Flu Shots

Product Line	Goal or Benchmark	8/1/18 – 3/31/19 Results	Goal Met?
Commercial	31.14%	30.16%	No
Marketplace HMO	26.38%	27.17%	Yes

Baseline Analysis

For the baseline measurement period, FHCP compared Annual Flu Shots to goal (Five-point rate increase) outlined in the strategy.

Results fell below the performance goal by 0.98 percentage points for the commercial population. Results fell above the performance goal by 0.79 percentage points for marketplace HMO. Because of these results, we concluded there was an opportunity to improve performance in our commercial line of business. Results of our barrier analysis are below.

Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018

A group of internal staff completed the initial opportunity and barrier analysis. Participants included representatives from quality management, infection control, VSI, practice management, and administration.

Barrier	Opportunity	Selected for Improvement?
Member resistance to getting vaccination due to misconceptions (i.e. belief that it doesn't work, will make them sick, or that it's not needed, lack of time).	Increase the importance of flu shot and educate on safety, efficacy, and herd immunity while attempting to debunk current myths.	Yes
Providers feel overwhelmed with the number of measures they need to address with a member.	Make work flows more efficient. Leverage other providers such as nurses to balance out responsibility.	Yes

Actions

FHCP implemented the following actions to address the identified barriers and improve Annual Flu Shot effectiveness:

Date Initiated	Action Implemented	Barriers Addressed
9/10/2018	Marketing reminders throughout facilities in the form of prescription bag stickers, prescription bottle caps, and buttons for employees informing members that the vaccine is available.	Member resistance to getting vaccination due to misconceptions (i.e. belief that it doesn't work, will make them sick, or that it's not needed, lack of time).
9/1/2018	Reimbursement (up to a certain amount) was offered to members that received their vaccination outside of FHCP (i.e. Walgreens, CVS).	Member resistance to getting vaccination due to misconceptions (i.e. belief that it doesn't work, will make them sick, or that it's not needed, lack of time).
9/1/2018	Open access at any FHCP facility. Mobile unit was used at Holly Hill facility for employees that are members.	Member resistance to getting vaccination due to misconceptions (i.e. belief that it doesn't work, will make them sick, or that it's not needed, lack of time). Providers feel overwhelmed with the number of measures they need to address with a member.

Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018

Date Initiated	Action Implemented	Barriers Addressed
9/10/2018	Educational materials: FHCP supplied offices with educational posters and fliers. Members age 65 and above are provided with information regarding the High Dose Flu vaccine.	Member resistance to getting vaccination due to misconceptions (i.e. belief that it doesn't work, will make them sick, or that it's not needed, lack of time).

2. Program Name: Breast Cancer Screening

Measure Description and Relevance

Florida Health Care Plans uses the measure listed below to gauge the impact of this program on care process, care outcome or cost/utilization. We explain why the measure is a relevant method to assess the impact of this program.

Measure Name	Relevance
Breast Cancer Screening Rate	Mammography is the best form of early detection. The earlier breast cancer is found, the better the outcome. Early detection allows for more treatment options and a better opportunity for long term survival. Increasing screening rates helps FHCP ensure optimal health and wellness of our members.

Methodology

- The following measure(s) used HEDIS specifications: **Breast Cancer Screening**

Product Line	Goal or Benchmark	1/1/18 – 12/31/18 Results	Goal Met?
Commercial	82.40	(4138/5187) 79.78	No
Marketplace HMO	76.17	(1322/1783) 74.14	No

Baseline Analysis

For the baseline measurement period, FHCP compared HEDIS Breast Cancer Screening rates to goal (Five-point rate increase) outlined in the strategy.

Results fell below the performance goal by 2.62 percentage points for the commercial population and 2.03 percentage points for marketplace HMO.

Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018

Therefore, we concluded there was an opportunity to improve performance. Results of our barrier analysis are below.

A group of internal staff completed the initial opportunity and barrier analysis. Participants included representatives from quality management, VSI, practice management, and administration.

Barrier	Opportunity	Selected for Improvement?
Member hesitance of getting screened (i.e. fear of unknown, past painful mammogram experience, lack of time).	Increase awareness and stress importance of screening through communication and education.	Yes
Providers feel overwhelmed with the number of measures they need to address with a member.	Make work flows more efficient. Leverage other providers (i.e. nurses) to balance out responsibility.	Yes
Provider office staff not pulling gap reports daily.	Improve work flows. Incorporate gap report run into daily routine.	Yes

Actions

FHCP implemented the following actions to address the identified barriers and improve Breast Cancer Screening effectiveness:

Date Initiated	Action Implemented	Barriers Addressed
10/2018	Increased awareness and education through the distribution of Healthy Me Checklist.	Member hesitance of getting screened (i.e. fear of unknown, past painful mammogram experience, lack of time).
03/2018	Education on process and importance of utilization via PM meeting and quarterly office visits.	Provider office staff not pulling gap reports daily.

3. Program Name: Diabetic Retinal Exams

Measure Description and Relevance

Florida Health Care Plans uses the measure listed below to gauge the impact of this program on care process, care outcome or cost/utilization. We explain why the measure is a relevant method to assess the impact of this program.

Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018

Measure Name	Relevance
Diabetic Retinal Exams	Eye exams can catch early signs of serious conditions such as glaucoma and diabetic retinopathy. If left untreated, these conditions may cause permanent damage. Increasing diabetic retinal eye screening rates helps FHCP ensure optimal health and wellness of our diabetic members.

Methodology

- The following measure(s) used HEDIS specifications: **Diabetic Retinal Exams**

Product Line	Goal or Benchmark	1/1/18 – 12/31/18 Results	Goal Met?
Commercial	58.06	(222/411) 54.01	No
Marketplace HMO	53.42	(203/411) 49.39	No

Baseline Analysis

For the baseline measurement period, FHCP compared HEDIS Diabetic Retinal Exam rates to goal (5-point rate increase) outlined in the strategy.

Results fell below the performance goal by 4.05 percentage points for the commercial population and 4.03 percentage points for marketplace. Therefore, we concluded there was an opportunity to improve performance. Results of our barrier analysis are below.

A group of internal staff completed the initial opportunity and barrier analysis. Participants included representatives from quality management, VSI, practice management, and administration.

Barrier	Opportunity	Selected for Improvement?
Member hesitance of getting screened (i.e. fear of unknown, lack of time).	Increase awareness and stress importance of screening through communication and education.	Yes
Member declining screening due to misconception of cost/coverage.	Increase communication that screening is covered as a medical benefit and vision benefit is not required.	Yes

Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018

Barrier	Opportunity	Selected for Improvement?
Providers feel overwhelmed with the number of measures they need to address with a member.	Make work flows more efficient. Leverage other providers (i.e. nurses) to balance out responsibility.	Yes
Provider office staff not pulling gap reports daily.	Improve work flows. Incorporate gap report run into daily routine.	Yes

Actions

FHCP implemented the following actions to address the identified barriers and improve Diabetic Retinal Exam effectiveness:

Date Initiated	Action Implemented	Barriers Addressed
10/2018	Increased awareness and education through the distribution of Healthy Me Checklist.	Member hesitance of getting screened (i.e. fear of unknown, lack of time).
4/13/2018	Streamlined scheduling process by designating a phone number for PCP office staff to use to schedule an exam with ophthalmology at the time of their visit.	Member hesitance of getting screened (i.e. fear of unknown, lack of time).
5/4/2018	Stickers created for diabetic medications with message regarding the importance of the exam, how to schedule, and that it is a covered medical benefit.	Member hesitance of getting screened (i.e. fear of unknown, lack of time). Member declining screening due to misconception of cost/coverage.
03/2018	Education on process and importance of utilization via PM meeting and quarterly office visits.	Provider office staff not pulling gap reports daily.

4. Program Name: Asthma Medication Management

Measure Description and Relevance

Florida Health Care Plans uses the measure listed below to gauge the impact of this program on care process, care outcome or cost/utilization. We explain why the measure is a relevant method to assess the impact of this program.

Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018

Measure Name	Relevance
Medication Management for People with Asthma	Consistently taking daily asthma medicine as directed is one of the most important steps in managing asthma. Taking an asthma controller helps prevent an asthma attack and the overuse of rescue inhalers. Increasing member adherence to their asthma medication helps FHCP ensure optimal health and wellness of our asthmatic members.

Methodology

- The following measure(s) used HEDIS specifications: **Medication Management for People with Asthma**

Product Line	Goal or Benchmark	1/1/18 – 12/31/18 Results	Goal Met?
Commercial	75% adherence: 44.77 50% adherence: 68.07	75% adherence: (88/204) 43.14 50% adherence: (137/204) 67.16	No No
Marketplace HMO	75% adherence: 49.74 50% adherence: *N/A	75% adherence: (54/109) 49.54 50% adherence: (85/109) 77.98	No *N/A

*Denotes measures with less than the required denominator for reporting.

Baseline Analysis

For the baseline measurement period, FHCP compared HEDIS Medication Management for People with Asthma rates to goal (5-point rate increase) outlined in the strategy. Two rates are measured – the percentage of members who remained on an asthma controller medication for at least 50% of their treatment period and those that remained on it for at least 75% of their treatment period.

Results fell below the performance goal by 1.63 (75% adherence) and 0.91 (50% adherence) percentage points for the commercial population. Results fell below the performance goal by 0.2 (75% adherence) percentage points for the marketplace HMO group. Because of these results, we concluded there was an opportunity to improve performance. Results of our barrier analysis are below.

Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018

A group of internal staff completed the initial opportunity and barrier analysis. Participants included representatives from quality management, VSI, practice management, and administration.

Barrier	Opportunity	Selected for Improvement?
Members forget to take medication as prescribed (i.e. feel fine and don't think they need it).	Increase awareness and stress importance of consistently taking controller medication.	Yes
Providers feel overwhelmed with the number of measures they need to address with a member.	Make work flows more efficient. Leverage other providers (i.e. nurses) to balance out responsibility.	Yes

Actions

FHCP implemented the following actions to address the identified barriers and improve Medication Management for People with Asthma effectiveness:

Date Initiated	Action Implemented	Barriers Addressed
1/1/2018	Reminder letters sent to members with persistent asthma on a controller explaining how controllers work and importance of consistently taking the medication.	Member forgets to take medication as prescribed (i.e. feel fine and don't think they need it).
4/1/2018	RN calls members to identify barriers and offers assistance.	Member forgets to take medication as prescribed (i.e. feel fine and don't think they need it).
4/1/2018	Memos sent to providers with persistent asthma patients. The intent is to ensure that they remind the members to fill the controller medication consistently.	Providers feel overwhelmed with the number of measures they need to address with a member.

5. Program Name: Readmission Prevention Initiative

Measure Description and Relevance

Florida Health Care Plans uses the measures listed below to gauge the impact of this program on care process, care outcome or cost/utilization related to readmissions. We explain why the measure is a relevant method to assess the impact of this program.

Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018

Measure Name	Relevance
Readmission Prevention Initiative	Reducing early (<30 days) hospital readmissions is a policy priority aimed at improving healthcare quality. Initiatives with highly supportive discharge interventions will enhance patient capacity to enact and avoid readmissions. (Leppin et al, 2014)

Methodology

- The following measure(s) used Claims Data to calculate readmission rates.
2018 <30 day All Cause Readmissions

Product Line	Goal or Benchmark	1/1/18 – 12/31/18 Results	Goal Met?
Commercial	<10.95%	(192/1,915) 10.03%	Yes
Marketplace	<12.98%	(304/2194) 13.86%	No

Baseline Analysis

For the baseline measurement period, FHCP used claims data to calculate 2017 readmission rates for the Commercial and Marketplace Product lines. After adjudication and reconciliation of all claims, re-admission rates noted in the 2018 Population Health Strategy for both product lines were adjusted for the analysis.

Goal: 0.5% reduction in readmission rates

Comparing the 2018 to the 2017 dates of service, Commercial readmission rates fell 0.92 percentage points below the performance goal for the Commercial product line and, and 0.88 percentage points above goal for the for the Marketplace product line. Therefore, we concluded there was an opportunity to improve performance. Results of our barrier analysis are below.

A group of internal staff completed the initial opportunity and barrier analysis. Participants included representatives from Utilization Management, VSI, Practice Management, and Administration.

Barrier	Opportunity	Selected for Improvement?
Lack of 7 day follow up post hospital Discharge	Real time notification to Primary Care Physicians on discharge planning, with scheduled follow up at discharge.	Yes

Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018

Barrier	Opportunity	Selected for Improvement?
Provider schedules do not have the flexibility to schedule appointments within the 5 business days allowed.	Make workflows more efficient. Leverage other providers (i.e. nurses) to balance out responsibility.	Yes
Provider office staff scheduling patients between 10-14 days post discharge	Improve providers understanding of the measure and goals.	Yes

Actions

FHCP implemented the following actions to address the identified barriers and improve patient outcomes; hence reducing readmission rates.:

Date Initiated	Action Implemented	Barriers Addressed
8/2018	Utilization Review Case Managers are notifying Case Management Coordination of Care on admission, to Timely Notification to ensure that CM can address discharge needs and secure a follow up appointment with the members PCP.	Patient needing assistance to understand discharge instruction and navigate next steps in their health care needs.
10/2018	Practice Management/Managers educated regarding the measure and the goals that 7 day follow up aimed to achieve	Practices did not feel they were notified timely and where unaware of hospitalizations/discharges
05/2019	Physician Leaders addressing provider education on importance of 7 day follow post hospitalization.	Providers understanding the intent of the follow up and the outcomes/goals

6. Program Name: Health Services Navigation

Measure Description and Relevance

Florida Health Care Plans uses the measures listed below to gauge the impact of this program on care process, care outcome or cost/utilization related to Emergency Room Utilization. We explain why the measure is a relevant method to assess the impact of this program.

Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018

Measure Name	Relevance
Health Services Navigation	Primary care–related emergency department (PCR-ED) utilization, including for conditions that are preventable or treatable with appropriate primary care, is associated with decreased efficiency of and increased costs to the health system. (Enard, et al, 2013) A program designed to assist members with navigation of services within their primary care network, improves member outcomes and reduces health care cost.

Methodology

- The following measure(s) used claims data to identify members with multiple chronic conditions:
 - o Heart Failure and Renal insufficiency
 - o Diabetes and Hypertension

Emergency Room Visits: Heart Failure and Renal insufficiency

Product Line	2017 Baseline Utilization Per K	1/1/18 – 12/31/18 Per K	Increase/ Decrease	Goal Met?
Commercial	0	0	Unchanged	N/A
Marketplace	0.03	0.05	↑	No

Emergency Room Visits: Diabetes and Hypertension

Product Line	2017 Baseline Utilization Per K	1/1/18 – 12/31/18 Per K	% Increase/ Decrease	Goal Met?
Commercial	4.78	4.18	0.6	Yes
Marketplace	4.46	5.63	1.17	No

Baseline Analysis

For the baseline measurement period, FHCP used claims data to identify members with multiple chronic conditions who sought care three times within a six- month period. Heart Failure/Renal Insufficiency and Diabetes/ Hypertension were selected as the two measures with multiple chronic conditions.

At the time of analysis, we determined that the baseline data and subsequently, the goals were incorrect for both measures. Further analysis revealed that the Heart Failure/Renal Insufficiency measure was not statistically significant to evaluate.

Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018

Diabetes and Hypertension: The Commercial Emergency Room utilization rate fell 0.6 percentage points below the previous year's baseline which did not meet the performance goal of a 2% reduction. The Marketplace Emergency Room utilization rate increased by 1.17 percentage points, also not meeting the goal. Therefore, we concluded there was an opportunity to improve performance. Results of our barrier analysis are below.

A group of internal staff completed the initial opportunity and barrier analysis. Participants included representatives from Utilization Management, VSI, Practice Management, and Administration.

Barrier	Opportunity	Selected for Improvement?
Member understanding of alternatives to care	Ongoing education regarding services offered. Increased access to care locations	Yes
Lack of Primary Care Physician (PCP) or relationship with PCP	Increased focus on Transition of Care (TOC) and enrollment onboarding to connect members with PCP	Yes
Difficulty obtaining appointment on urgent need basis	Collaboration with practice Management via sharing of information, accessing the ADT list for member outreach	Yes

Actions

FHCP implemented the following actions to address the identified barriers and improve patient outcomes; reduce the use of emergency services in place of primary care:

Date Initiated	Action Implemented	Barriers Addressed
10/2018	Open access to the Admissions, Discharges and Transfers (ADT) list offered at a statewide level to identify FHCP members in real time.	Providers can follow the ADT to identify members on their panel, utilizing Emergency room services, to increase outreach, education and follow up.
05/2019	Medical Director of Practice Management added to address provider relations and member access to care.	Provider preference on how practice schedules members and allows for scheduling openings to address urgent needs.

**Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018**

7. Case Management (CM) Member Satisfaction Survey

Methodology

The case management member satisfaction survey population includes all members discharged alive from CM who were enrolled for at least 60 days during the measurement year. Exclusions included: deceased members, members who opted out, members enrolled in hospice or long-term care, members enrolled less than 60 days and members that no longer had eligible benefits.

The survey consists of seven questions using a three-point scale: “Not Satisfied”, “Satisfied”, and “Very Satisfied”. CM established a goal of 85% for those members who are “Very Satisfied” when responding to survey questions.

Surveys were mailed to the members address on record. If the member did not return his or her survey within 30 days, the CM office coordinator contacted the member via phone.

This report includes results from the last three years for the following product lines: Commercial and Marketplace. Survey response rate information is summarized below.

Product line	Total in CM 2018	# Sent Survey 2018	# Surveys Received 2018	Response Rate 2018	Response Rate 2017	Response Rate 2016
Commercial	84	84	47	55.95%	47.92%	100%
Marketplace	123	123	70	56.91%	46.81%	11.1%
Total	207	207	117	56.52%	47.37%	50%

Results and Analysis

The tables below provide the results by question for each accredited product line.

Commercial Survey Results*

Survey Questions	2016	2017	2018	Goal Met?
My Case Manager explained the reason for Case Management Coordination of Care services.	7/7 100%	22/23 96%	37/45 82%	No
My Case Manager treated me with courtesy and respect.	7/7 100%	21/23 91%	42/45 93%	Yes
My Case Manager explained my condition(s) and doctors' recommendations.	6/7 90%	20/23 87%	33/45 73%	No

Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018

Survey Questions	2016	2017	2018	Goal Met?
My Case Manager understood my healthcare needs and what was important to me.	5/7 71%	20/23 87%	39/45 87%	Yes
Provided verbal and/or written information that helped me reach my goals.	6/7 90%	18/23 78%	33/45 73%	No
My Case Manager provided instructions or written materials that I could use to help manage my health.	7/7 100%	20/23 87%	39/47 83%	No
Overall, I was satisfied with the program.	7/7 100%	23/23 100%	39/47 83%	No

Results are reported for those members that responded "Very Satisfied" to each survey question

Marketplace Survey Results*

Survey Questions	2016	2017	2018	Goal Met?
My Case Manager explained the reason for Case Management Coordination of Care services.	1/1 100%	20/22 91%	58/70 83%	No
My Case Manager treated me with courtesy and respect.	1/1 100%	20/22 91%	63/70 90%	Yes
My Case Manager explained my condition(s) and doctors' recommendations.	1/1 100%	19/22 86%	57/70 81%	No
My Case Manager understood my healthcare needs and what was important to me.	1/1 100%	20/22 91%	60/70 86%	Yes
Provided verbal and/or written information that helped me reach my goals.	0/1 0%	18/22 82%	55/70 79%	No
My Case Manager provided instructions or written materials that I could use to help manage my health.	1/1 100%	20/22 91%	61/70 87%	Yes
Overall, I was satisfied with the program.	1/1 100%	20/22 91%	63/70 90%	Yes

*Results are reported for those members that responded "Very Satisfied" to each survey question

**Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018**

Quantitative Analysis – Commercial

The FHCP CM satisfaction goal is 85% for those members who answered each survey question “Very Satisfied”.

In 2018, questions that met or exceeded the 85% goal were:

- My case manager treated me with courtesy and respect (93%)
- My case manager understood my healthcare needs and what was important to me (87%)

All the remaining questions were below the performance goal. Since 2016, CM survey results are trending down for all questions except for those mentioned above.

Quantitative Analysis – Marketplace

FHCP CM satisfaction goal is 85% for those members who answered each survey question “Very Satisfied”.

In 2018, questions that met or exceeded the 85% goal were:

- My case manager treated me with courtesy and respect (90%)
- My case manager understood my healthcare needs and what was important to me (86%)
- My Case Manager provided instructions or written materials that I could use to help manage my health (87%)
- Overall, I was satisfied with the program (90%)

The remaining three questions fell below the 85% performance goals and although the goal was met for two of the survey questions, satisfaction rates decreased for all seven measures between 2017 and 2018. 2016 data is not used in this analysis because it is not statistically significant

Qualitative Analysis

To identify opportunities to improve performance, FHCP conducted a barrier analysis to identify the root causes of member dissatisfaction with the CM process.

Member Dissatisfaction with CM Barrier Analysis Results

Barrier	Opportunity	Selected for Improvement?
Case Managers may not adequately explain the reason for case management services	Ongoing training to provide case managers with strategies to ensure members understand case management services.	Yes

Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018

Member Dissatisfaction with CM Barrier Analysis Results

Barrier	Opportunity	Selected for Improvement?
Short- and long-term condition goals may not be evident to the members	Case Manager training regarding the meaning of setting meaningful member goals.	Yes
Member educational materials may not meet their needs	Identify documentation tools to assess health literacy. Evaluate current educational materials	Yes
Members may not have a good understanding of their conditions or comprehend physician recommendations	Engage in communication strategies to educate members about their conditions and physician treatment documentation	Yes

Planned Actions

Date Initiated	Action Implemented	Barriers Addressed
8/2018	Integrated documentation tool to assess health literacy. Utilize tools on FHCP member portal and through health education to support education. Offer options for delivery of materials e.g., mail, email, directing to website	Member educational materials may not meet their needs Members may not have a good understanding of their conditions or comprehend physician recommendations
2/2019	Increase contact rate to member to include face to face and telephonic visits. After acute events such as hospitalization and provider office visit, review health condition and plan of care with members	Case Managers may not adequately explain the reason for case management services

**Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018**

Date initiated	Action Implemented	Barriers Addressed
8/2019	Medical Reviewer to assist with goal setting and recommendations. CM	Short- and long-term condition goals may not be evident to the members
4/2018	Utilization of QI Web MCG for goal setting and evidenced base care. Weekly physician advisor review of complex cases to support concise medical goals and recommendations.	

8. Healthy Me Checklist Member Satisfaction Survey

Methodology

The Healthy Me Checklist was a tool created in 2018 intended to provide FHCP members with a snapshot of their health and wellness status as well as the steps they can take to reach optimal health. It includes recommended tests, screenings, shots and medications specifically tailored to each member's needs. Every member received the tool and as a pilot program, we conducted a survey with our FHCP employee population. The future is to send the tool to all our members and conduct a survey of the entire population annually. The survey was conducted using Survey Monkey. An email was sent to all employees from Human Resources including a link and instructions on completing the survey.

This report includes results from 2018 for the following product line: Commercial. Survey response rate information is summarized below.

Product line	Total in Program 2018	# Sent Survey 2018	# Surveys Received 2018	Response Rate 2018
Commercial	1,081	1,326	174	13.12%
Total	1,081	1,326	174	13.12%

**Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018**

Results and Analysis

The table below provides results by question for the Commercial product line.

Commercial Survey Results

Survey Questions	2018	Goal Met?
How easy was the Healthy Me Checklist to understand?	158/171 92.40%	Yes
How clear were the health benefits (descriptions) of the screenings, tests and shots on your Healthy Me Checklist?	152/172 88.37%	Yes
How accurate did you feel the results were on your Healthy Me Checklist?	133/172 77.33%	Yes
Did you speak with your PCP about your Healthy Me Checklist?	29/172 16.86%	No
If yes, how much do you feel that the Healthy Me Checklist helped you talk to your doctor about your health/wellness goals?	26/92 28.26%	No
If no, how likely are you to speak with your PCP about your Healthy Me Checklist in the next 6 months?	87/162 53.70%	Yes
Did you schedule an appointment for a screening, test or shot that appeared on your checklist?	50/170 29.41%	No
If yes, which screening, test, or shot did you schedule? (check all that apply)	Varied	N/A
If no, how likely are you to schedule a needed screening, test or shot in the next 6 months?	87/144 60.42%	Yes
How satisfied are you with the Healthy Me Checklist as a tool to improve your health?	115/168 68.45%	Yes
May we contact you about your survey answers?	48/159 30.19%	N/A
Do you have any comments or suggestions about the Healthy Me checklist? Please feel free to provide additional feedback here.	Varied	N/A

+Results are reported for the very easy/easy, extremely clear/very clear, very accurate/accurate, yes, a great deal/a lot, very likely/likely, very satisfied/satisfied responses to each question.

**Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018**

Quantitative Analysis

FHCP's satisfaction goal is 50%. In 2018, the satisfaction areas that met this goal were the following:

- How easy was the Healthy Me Checklist to understand?
- How clear were the health benefits (descriptions) of the screenings, tests and shots on your Healthy Me Checklist?
- How accurate did you feel the results were on your Healthy Me Checklist?
- If no, how likely are you to speak with your PCP about your Healthy Me Checklist in the next 6 months?
- If no, how likely are you to schedule a needed screening, test or shot in the next 6 months?
- How satisfied are you with the Healthy Me Checklist as a tool to improve your health?

The remaining three questions were below the performance goal.

The following three questions were not scored:

- May we contact you about your survey answer?
- If yes, which screening, test, or shot did you schedule? (check all that apply)
- Do you have any comments or suggestions about the Healthy Me checklist? Please feel free to provide additional feedback here.')

Since the Healthy Me Checklist was a 2018 initiative, this was the first year the survey was conducted. FHCP will continue to conduct an annual survey on this tool to track trends and identify areas for improvement.

Qualitative Analysis

To identify opportunities to improve performance, FHCP conducted a barrier analysis to identify the root causes of member dissatisfaction with the Healthy Me Checklist process. A group of internal staff completed the initial opportunity and barrier analysis. Participants included representatives from Quality Management, Practice Management, VSI, and Member Services. The barriers and opportunities are noted below.

Population Health Management Program Effectiveness
Florida Health Care Plans
Report Period: From 1/1/2018 to 12/31/2018

Member Dissatisfaction with Healthy Me Checklist Barrier Analysis Results

Barrier	Opportunity	Selected for Improvement?
Member hesitance of getting necessary tests, screenings, shots and medications (i.e. fear of unknown, lack of time, past unpleasant experience).	Increase awareness and stress importance of recommendations through communication and education.	Yes
Member distrust in report due to inaccuracies.	Work with VSI team to spot check reports for accuracy before disseminating.	Yes

Planned Actions

Date Initiated	Action Implemented	Barriers Addressed
5/23/19	Reviewed a sample of 10% of Healthy Me Checklists for accuracy. Inaccuracies and discrepancies were shared with VSI team for investigation and modification of data.	Member distrust in report due to inaccuracies.

Reporting

This QI activity was reported to the following QI committees:

Committee Name	Meeting Date	Committee Actions or Recommendations
HOPE Committee	10/09/2019	Approved, send to PI Council
PIC	10/16/2019	Approved as written

References:

Enard, K. R., & Ganelin, D. M. (2013). Reducing preventable emergency department utilization and costs by using community health workers as patient navigators. *Journal of healthcare management / American College of Healthcare Executives*, 58(6), 412–428.

Leppin, A. L., Gionfriddo, M. R., Kessler, M., Brito, J. P., Mair, F. S., Gallacher, K., ... Montori, V. M. (2014). Preventing 30-day hospital readmissions: a systematic review and meta-analysis of randomized trials. *JAMA internal medicine*, 174(7), 1095–1107. doi:10.1001/jamainternmed.2014.1608 retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4249925/>

**Continuity and Coordination Between
Medical Care and Behavioral Health Care**

**Measurement Year
January 1, 2019 through December 31, 2019**

Introduction

Continuity and coordination between medical care and behavioral health care requires focused and proactive assessment. A patient with a medical or surgical condition may have a behavioral

complication or comorbidity. Likewise, a patient with a behavioral disorder may have a medical comorbidity or there may be medical implications. The delivery system may or may not have within its structure a mechanism to ensure the seamless transfer of information between medical and behavioral care. This lack of structure, commonly found in the industry today, can cause members to experience discontinuity.

The goals of the monitoring and evaluation process are to promote seamless, continuous, and appropriate care to members. This report includes the results of monitoring key aspects of coordination between medical and behavioral care, identifies areas of discontinuity, and recommends focused interventions to improve continuity.

Florida Health Care Plan assessed six specific areas measuring different aspects of continuity and coordination of care for the time periods reported. The six areas required in NCQA's Standards include:

1. The exchange of information between behavioral health care and primary care practitioners and other relevant medical delivery system practitioners or providers;
2. The appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care;
3. The appropriate use of psychopharmacological medications;
4. The process of screening and the management of patients with coexisting disorders;
5. The implementation of a primary or secondary behavioral health program; and
6. Special needs of members with severe and persistent mental illness

The body of the report summarizes monitors, results, and analysis for each area listed above. The conclusion section provides specific recommendations to improve continuity and coordination of care between medical and behavioral health practitioners within the Florida Health Care Plans community.

The Monitoring and Evaluation Plan

Table 1 Summary of Monitors

Specific Area Monitored	Description of Monitor	Frequency	Time Period Monitored
1. Exchange of information	Average rating of Provider Satisfaction with availability and communication from Mental Health practitioners	Annually	1/1/2019-12/31/19
2. Appropriate Diagnosis, Treatment and Referral	Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication. - Initiation Phase: The percentage of children 6 to 12 years of age diagnosed with ADHD who had one follow-up visit with a practitioner within a month of the first prescription of ADHD medication. - Continuation and Maintenance Phase: The percentage of children 6 to 12 years of age with a prescription for ADHD medication who remained on the medication for at least 210 days and had at least two follow-up visits in nine months subsequent to the Initiation Phase.	Annually using HEDIS	1/1/2019-12/31/19
3. Psychopharmacological medications	Antidepressant Medication Management - Acute Phase Treatment: The percentage of members who remained on antidepressant medication during the entire acute treatment phase. - Continuation Phase Treatment: The percentage of members who remained on antidepressant medication for at least six months.	Annually using HEDIS	1/1/2019-12/31/19
4. Screening and Management of Coexisting Disorders	The proportion of Case Management patients who screened positive on the PHQ-9 who had a follow-up appointment with the primary care physician or behavioral health provider and were treated for a depressive disorder.	Annually	1/1/2019-12/31/19
5. Preventive Behavioral Health Program	The proportion of Case Management patients screened for depression.	Annually	1/1/2019-12/31/19
6. Meeting the needs of members with Severe and Persistent Mental Illness	The percentage of members with SPMI diagnosis who had an encounter with a Behavioral Health Provider and followed up with the PCP within 6 months.	Annually	1/1/2019-12/31/19

Monitor 1 – Exchange of Information

Measure Definition:

To determine average practitioner satisfaction rating with the quality of communications and access and availability between behavioral health and medical care, Florida Health Care Plans sent a survey to Primary Care physicians, specialists, and behavioral health practitioners across the four networks. This survey incorporates provider satisfaction for all lines of business. The goal was at least a score of 3.5 on a Likert 5-point scale.

Results and Analysis:

On February 9, 2020, there were 1,692 surveys distributed to affiliate FHCP Primary Care Physicians, Specialist Physicians, including behavioral health physicians and ancillary providers, followed by one additional distributions March 11, 2020. The method for survey administration was via email for IPA and physicians employed by Florida Health Care Plans and all other physicians were sent by mail with self-addressed pre-paid return envelopes. There were no incentives offered for completing the survey. FHCP considers a return of 25% to be a statistically significant return for analysis of provider satisfaction. 399 providers participated in the survey for a return rate of 23.6%, which did not meet the goal of a 25% response rate, for the purpose of this report, under current COVID 19 restrictions, 23.6% was deemed a significant sampling for analysis.

The survey results were reported by PCPs (Internists, General Practitioners, and Family Practice Physicians) and by Behavioral Health, Medical, and Surgical Specialties.

Questions were:

1. Rating of geographic availability of providers and timely access of appointments
2. Rating of communication concerning the provision of appropriate & timely information to efficiently manage patient's care?

Response options ranged from 5=Excellent to 1=Poor

****Results are the average from East Volusia Network, Southeast Volusia network, West Volusia Network, Flagler, and St Johns County.**

The Plan has both staff and contracted Mental Health providers in its five county networks; including psychiatrists, psychologists, and licensed mental health therapists, including extended network providers and supplemental providers, and facilities. The results are as follows:

****Provider Survey – Evaluation of Mental Health Services**

<i>Measure Exchange of information</i>	<i>Goal</i>	<i>2020 Results</i>	<i>2019 Results</i>	<i>2018 Results</i>
<i>Mental Health Availability</i>	3.5	3.69	3.85	3.79
<i>Mental Health Communication</i>	3.5	4.04	3.98	3.98

Analysis:

The 2020 aggregate result with Mental Health Availability was 3.69, and the results for satisfaction with Mental Health Communication rating was 4.04. The 2020 results exceeded the performance goal. The average score decreased with mental health availability over the last three years and increased with mental health communication. Satisfaction with access decreased

by 0.1 points and communication increased by 0.06 points from 2018 measurement periods, but from 2019 decreased by 0.16 percentage points for access and increased by 0.06 in percentage points for communication. Over the previous three report periods, the results for the provider satisfaction survey regarding mental health availability and communication has been stable and remained above the performance goal of 3.5.

No opportunities for improvement were identified. In addition, staff medical and behavior health providers can access each other's notes in the electronic health record.

Monitor 2 – Appropriate Diagnosis, Treatment and Referral of Behavioral Health Disorders Commonly Seen in Primary Care

FHCP seeks to improve the HEDIS Measure: Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication.

Measure Definition:

The following two rates of this measure assess follow-up care for children prescribed an ADHD medication:

- **Initiation Phase:** The percentage of children 6 to 12 years of age diagnosed with ADHD who had one follow-up visit with a practitioner within a month of the first prescription of ADHD medication.
- **Continuation and Maintenance Phase:** The percentage of children 6 to 12 years of age with a prescription for ADHD medication who remained on the medication for at least 210 days and had at least two follow-up visits in nine months subsequent to the Initiation Phase.

Results

Appropriate Diagnosis, Treatment and Referral	2020 FHCP HEDIS NUM/DEN Rate	2019 FHCP HEDIS NUM/DEN Rate	2018 FHCP HEDIS NUM/DEN Rate
Initiation Phase	32/67 47.76	17/49 34.69	22/45 48.89
Continuation & Maintenance Phase	10/20 50	8/17 N/A QNS	8/12 66.67

Analysis:

HEDIS results are reported for the last three years. Marketplace population could not be analyzed due to insufficient quantity of children. The denominator relates to the small population that meets the monitor Appropriate Diagnosis, Treatment and Referral of Behavioral Health Disorders Commonly Seen in Primary Care. The population for the initiation and continuation phase had a slight increase in this report period. The 2020 HEDIS rate for Commercial members in the Initiation Phase increased by 13.07 percentage points where previous report periods trended downward and remained 1.13 percentage points lower than the HEDIS rate of 2018. The Continuation and Maintenance Phase had variations due to the even smaller population that meets this measure and remains 16.67 percentage points below the 2018 HEDIS rate. The variations with a small quantity of children impact the reported rates. Therefore, due to the relatively small and persistently fluctuating denominator it is difficult to determine the impact from the interventions for this population

Analysis of Effectiveness of Improvement Actions

Historically there is a small population that meets the criteria for the initiation and continuation phase with the relatively small and persistently fluctuating denominator it is difficult to determine the impact of interventions for this population. The percentage of children 6 to 12 years of age is low in respect to the population of the health plan and even more so children in this population who are diagnosed with ADHD

However small, it is important to understand barriers that may impact the population of children:

- Low Health Literacy or lack understanding of diagnosis, value of treatment, or how to self-manage
- Difficulty coping with ADHD by caregiver or child
- Caregiver or child do not place treatment plan as goal or priority to achieve goals
- ADHD includes care plan with the school system seen as barrier to caregiver or child with coping difficulties
- Concern with medication side effect, misuse, regimen and medication adjustments, or cost
- Appointments with caregiver and child required to fill controlled medication may not be priority
- Financial Strain or low income may prevent parent from seeking treatment, follow up, or filling medications.
- Lack of social support or community programs
- Difficulty making lifestyle changes
- Children treated by PCP and not referred to a behavioral health team that could provide support through education, provide resources, and counsel the family unit
(Attention-Deficit Hyperactivity Disorder, Pediatric- Self Care, CCG: C-0062, 2019)

As noted above several barriers can impact the treatment and care of children with Attention Deficit/Hyperactivity Disorder for caregiver and child.

Conclusion:

FHCP will continue to monitor the opportunity to evaluate and improve the effectiveness of our actions.

Date Initiated	Barriers Addressed	Action Implemented	Outcome
2019	Parents may not understand or find value to the treatment plan for ADHD:: medication side effects, labs and appointments to monitor treatment and required for medication refills; caregiver and child is required to attend the duration of the appointment which can be difficult for the child and unnerving to	Behavioral Health Quality LCSW began late 2019 to review processes, assist with follow up care, provide education on diagnosis and treatment regimen, and self-management skills 2020 plan for targeted data for population to engage in treatment plan	Actions did not impact this report period TBD

Date Initiated	Barriers Addressed	Action Implemented	Outcome
	the parent. Family dynamics and societal influences can impact ongoing care.		
2018 ongoing	Financial strain- cost associated with ongoing appointments and medications	Behavioral Health Quality LCSW provide resources and assist with prescription programs or find pharmacy with lower cost	2020 plan for targeted data for population to engage in treatment plan TBD

Monitor 3 - The Appropriate Use of Psychopharmacological Medications

Depression, even the most severe cases, is a highly treatable disorder. The American Psychiatric Association recommends treatment of depression with antidepressant medication; along with other behavioral therapies such as psychotherapy. When medications are prescribed, it is important that they be continued for the full therapeutic effect to occur. Patients are tempted to stop medications too soon because they feel better and think they are no longer needed or they are bothered by the medication side effects. Medication selection is based on the clinical response required to reach recovery and should be continued for at least four to nine months to prevent a relapse into depression.

Florida Health Care Plans measured Antidepressant Medication Management (AMM) as part of the HEDIS measures. This measure assesses two facets of pharmacological management of depression among patients 18 years and older.

- Acute Phase Treatment: The percentage of members who remained on antidepressant medication for 84 days (12 weeks) during the entire acute treatment phase.
- Continuation Phase Treatment: The percentage of members who remained on Antidepressant medication for at least 180 days (six months).

Results

<i>Psychopharmacological medications</i> Commercial	HEDIS 2020 NUM/DEN Rate	HEDIS 2019 NUM/DEN Rate	HEDIS 2018 NUM/DEN Rate
AMM: Acute Phase	393/572 68.71	288/482 59.75	222/371 59.84
AMM: Continuation Phase	305/572 53.32	211/482 43.78	150/371 40.43

<i>Psychopharmacological medications</i> Marketplace	HEDIS 2020 NUM/DEN Rate	HEDIS 2019 NUM/DEN Rate	HEDIS 2018 NUM/DEN Rate
AMM: Acute Phase	514/764 67.28	319/520 61.35	209/330 63.33
AMM: Continuation Phase	394/764 51.57	247/520 47.50	151/330 45.76

Analysis:

In 2020, the HEDIS data for Commercial population in the Acute Phase treatment showed the rate increased by 8.96 percentage points from the previous report period indicative of an improvement in performance. In 2020, the Continuation Phase Treatment had an improvement in performance reflected by 9.54 percentage points from the previous report period. Both measures trended upward in performance over the last three years.

In 2020, the HEDIS measure for Marketplace population in the Acute Phase treatment showed the rate increase by 5.93 percentage points from 2019 indicative of an improvement in performance. In 2020, the Continuation Phase Treatment had an improvement in performance reflected by 4.07 percentage points. Both measures trended upward in performance over the last three years. Below we discuss the impact our 2019 actions contributed to improving these rates.

The Plan established an internal performance goal to increase the rate by 10 percentage points in the report measure. The goal was not met for any of the products or measures; therefore, a Barrier Analysis and Action Plan was required.

Date Initiated	Barriers Addressed	Action Implemented	Outcome
2019	Members do not like side effects of antidepressant medications and stop taking them.	- LCSW hired to join Quality Management staff in 4th quarter 2019 for medication monitoring. - Educated members and helped with provider appointments or access to telehealth services.	Although late in 2019, the action showed improvement for Marketplace population and the Commercial population. Will continue to evaluate impact of action.
2018 ongoing	Members fail follow up after initiating antidepressant treatment because members stop taking medications due to side effects or can't afford the prescriptions.	- Doctor on Demand psychiatry has a lower copayment than office visit. - Doctor on Demand provided 125 psychiatry visits in 2017, 370 in 2018 and 484 in 2019. - LCSW coordinated care between member and provider to assist with office visits or telehealth services. - LCSW coordinated medication refills between provider and member. - Zoom telehealth visits offered beginning in late 2018 to improve ease of access, with no associated cost to member. 32 Zoom visits were performed in 2018, 190 in 2019. Bariatrics LMHC had 2 telehealth patients in 2018 and 2 in 2019.	Impact on 2020 HEDIS rates are indicative of progress to improve the measure. Number of member visits using service continued to increase. Continue to promote Doctor on Demand and Zoom visits with Behavioral Health providers. Will continue to evaluate impact on rates.
2018 ongoing	Medication cost may be a barrier	LCSW helped members get medications filled at non-FHCP	The impact on HEDIS 2020 indicated progress toward improvement.

Date Initiated	Barriers Addressed	Action Implemented	Outcome
		pharmacies where copayments were less.	Continue to promote Doctor on Demand and Zoom visits for psychiatric care. Will continue to evaluate impact on rates.

Monitor 4 - Coexisting Medical and Behavioral Disorders and Monitor 5 - Preventive Behavioral Health Program

In the presence of depression, patients have been shown to disproportionately elevate rates of medical utilization and health care costs, including outpatient care and hospitalizations. In the elderly, with at least one chronic condition, a diagnosis of depression increases the odds of acute medical services. This suggests improvements in clinical management, access to mental health services and coordination of care could reduce utilization. Screening for depression is now recommended as a part of routine primary care. Forty seven percent of patients screened resulted in a new depression diagnosis; however, the overall rate of patients who are screened for depression is less than 5%. (Ayse Akincigil, 2017)

To gauge the impact of its complex case management program Florida Health Care Plans (FHCP) monitors the screening and management of patients with a coexisting depression disorder. This measure examines percentage of complex case management members screened for depression and the number of complex case management members who screened positive on the PHQ-9 who had at least one appointment with a practitioner or who received treatment (either prescription &/or therapy) within 30 days after identification of potential depression. The PHQ2/PHQ9 Depression screening tool is used to assess symptoms of depressive behavior for newly enrolled and established complex care patients. Continued screening is performed on an annual basis, at minimum, for patients who remain enrolled.

The USPSTF selected the PHQ-2 and PHQ-9 as valid screening tools for depressions confirming that the PHQ-2 shows 97% sensitivity and 67% specificity in adults, while the PHQ-9 shows 61% sensitivity and 97% specificity in adults. (U.S. Preventive Services Task Force, 2009)

Measure Definition:

Members who answer “Yes” to one or more PHQ2 questions receive PHQ9 screening. A PHQ9 score ≥ 15 is considered a positive indicator of depressive behavior.

FHCP established the following internal performance goals:

- 100% of newly enrolled and established complex care members will be screened with the PHQ-2 during the initial assessment and annually thereafter.
- 100% of newly enrolled and established complex care members who screened ≥ 15 on the PHQ-9 will have their Primary Care Physician notified.
- 90% of the members who screened ≥ 15 on the PHQ-9 will have at least one appointment with a practitioner or will receive treatment (either prescription &/or therapy) within 30 days after identification of potential depression.

Results and Analysis:

Florida Health Care Plans assessed its processes for screening and managing patients with coexisting disorders. All Case Management patients are screened for depression using the PHQ-2 and PHQ-9 screening tools.

Complex Care	2019-2020	2018-2019	2017-2018
Total newly identified complex members that participated >61 days	50	115	312
PHQ-2 screen	50/50 100%	112/115 97%	308/312 99%
Percent scored positive on PHQ2 had a PHQ 9 screen	6/6 100%	12/13 92%	43/44 98%
Percent scored positive on PHQ9 whose PCP was notified by task, phone, or fax.	0/0 N/A	0/0 N/A	4/4 100%
Percent scored positive on PHQ9 had a follow-up PCP visit	0/0 N/A	0/0 N/A	4/4 100%
Percent scored ≥ 15 on PHQ 9 started on Medication &/or therapy	0/0 N/A	0/0 N/A	4/4 100%

Measure Results 7/1/2018 – 6/30/2019

There were fifty newly enrolled or established complex care members of the Marketplace and Commercial population during the 2018/2019 measurement period. Out of the fifty members, all were eligible for screening. Fifty or one hundred percent of the Marketplace and Commercial members enrolled in the Chronic Complex program had a PHQ-2 performed. The target goal of one hundred percent was achieved. Six out of the fifty members scored positive on the PHQ-2 and seven were further screened using the PHQ-9 tool. Out of the six members that had a positive PHQ-9, all screened less than fifteen points (≥ 15 by organizational policy on the PHQ-9) for depression and did not require a referral to his/her PCP for follow-up. However, one member with a PHQ-9 score of thirteen was already established with a psychiatrist and Licensed Clinical Social Worker and was receiving treatment. One member with a PHQ-9 score of twelve was assisted with a Behavioral Health appointment. The remaining members scored less than seven. Members that have an ongoing active therapeutic relationship established with a behavioral health provider and/ or prescribed anti-depressant, at the time of screening, are monitored for compliance with follow-up appointments and/or medications refilled.

Performance Goal 1:

Florida Health Care Plans established an internal performance goal of one hundred percent of complex cases would be screened for depression on admission to the complex care program. The results showed one hundred percent compliance with all members eligible for screening.

Conclusion:

The goal was met. There were no further opportunities for improvement identified at this time. Staff in-service that addressed performance and processes for PHQ-2 and PHQ-9 to improve the measure from the previous report year were successful. Chart audits reinforce education and performance for this measure.

Performance Goal 2:

Florida Health Care Plans established an internal performance goal of 100% of complex cases that screen positive with a score of ≥ 15 on the PHQ-9 survey receive follow-up for depression by Primary Care or Behavioral Health. There were no Marketplace or Commercial members that met the criteria or had a positive indicator of depressive behavior.

Conclusion:

There was an insufficient quantity to measure this performance goal. There were no opportunities for improvement identified at this time

Performance Goal 3:

Florida Health Care Plans established an internal performance goal of 100% of complex cases that screen positive on the PHQ-9 survey would have the Primary Care Physician notified of results by task, fax, or phone. All positive screens identified by Case Management are noted in the Electronic Health Record and assigned for review to determine notification to the Primary Care Physician. For PCP's without E HR access the results are phoned or faxed. The Primary Care Physician may elect to follow-up and treat or refer to Behavioral Health Practitioner(s). There were no members that met the criteria for the intervention.

Conclusion:

There was insufficient data to measure this performance goal. There were no opportunities for improvement identified at this time

Monitor 6: Members with severe and persistent mental illness

Severe and Persistent Mental Illness or SPMI is the term used for a variety of disabling mental health diseases. Generally accepted as SPMI are diagnoses of Bipolar disorder, Severe Depression, Schizophrenia, Schizoaffective disorder and Nonorganic Psychosis. These illnesses cause inability to function for those effected, multiple hospitalizations, inability to maintain medication regimens, chronic noncompliance regarding treatment recommendations, and intensive interventions to assist the person to maintain some control of his/her life.

Studies show that treatment teams with focus on psychosocial rehabilitation and functional modalities along with medication management is the most successful at assisting these people in lessening the severity of their illness. In an effort to look holistically at Florida Health Care Plan members who have these diagnoses, a report was generated to determine the following:

Population with one of the SPMI diagnoses who had a behavioral health visit during the measurement year and two primary care visits. Coordination between behavioral health and the PCP were focused on managing comorbidities as well as medication interactions and side effects. It was decided that FHCP should formulate a stretch goal of 70% compliance with two follow up appointments with the PCP. All product lines are treated the same.

Members with SPMI Diagnosis that had at least one Behavioral Health Visit also had two PCP Follow-Up Visits Within the Reporting Period.

Product line	2019	Percent PCP Visit	2018	Percent PCP Visit	2017	Percent PCP Visit
Commercial	1988	18.66%	1941	17.36%	1906	13.64%
Marketplace	2214	27.78%	2182	28.28%	2176	21.97%

Analysis

Florida Health Care Plans did not meet the stretch goal of 70% for PCP follow up in Commercial or Marketplace product lines for the measurement period of 2019. The Commercial product line has remained lower than the Marketplace product line over the last three years. However, when trending the data over time, the Commercial product line continued to show an improvement in performance over the last three years. From the previous year, the Commercial product line increased by 1.3 percentage points, between 2017 to 2018 increased by 3.72 percentage points, and between 2017 to 2019 increased by 5.02 percentage points. The Marketplace had a slight decrease by 0.5 percentage points from the previous year. However, between 2017 to 2018 measurement year the Marketplace product line increased by 6.31 percentage points and between 2017 to 2019 increased by 5.81 percentage points. Progress has been made toward improvement of this measure with greater than five percentage points over the last three years. However, to achieve the stretch goal of 70 percent over a one-year time is unrealistic due to the severity of mental illness. The following report year FHCP will formulate a minimum goal of 25%, target goal of 50% and a maximum goal of 70%.

There have been changes in the structure of the FHCP Behavioral Health Team with the removal of two PCP Physician Advisors, and addition of Clinical Director of Behavioral Health, LCSW, Supervisor of Behavioral Health LCSW, and Supervisor of Case Management Utilization Review. The team focuses on follow up for Behavioral Health and not PCP appointments.

FHCP Behavioral Health Case Management Team consist of

- Director of Psychiatry,
- Clinical Director of Behavioral Health, LCSW
- Supervisor of Behavioral Health LCSW
- Psychiatrists,
- Licensed Mental Health Counselors
- Licensed Clinical Social Workers,
- Administrator of Utilization Management,
- Manager of Utilization Management
- Case Managers of Utilization Review
- Supervisor of Case Management Utilization Review

Barriers/Opportunities for Improvement, Actions, and Outcomes

The team completed a barrier analysis to determine opportunities to improve the compliance of this population with a secondary benefit of reducing inpatient admissions and readmissions.

Date Initiated	Barriers Addressed	Action Implemented	Outcome
2020	No representation for PCP in the team meetings	• Consideration for involvement of Practice Management or PCP for focus on two primary care visits.	TBD
2019-2020	Members have co-morbid conditions that are related to uncontrolled medical	• Developed collaborative case review between Coordination of Care CM RN, CM LCSW and UM	Implemented in the last quarter of 2019. Impact TBD.

Date Initiated	Barriers Addressed	Action Implemented	Outcome
	and behavioral health disorders, further complicating their ability to follow a treatment plan.	Behavioral Health RN to discuss interventions and outcomes individual to each member.	
2018-2019	Members disengaged in treatment recommendations and do not understand the benefits of treatment	2019 Planning to hire a LCSW as a Quality reviewer to assist with this measure 2018 Hired new staff in UM with behavioral health expertise to assist with care coordination between facility and behavioral health providers; integrated Coordination of Care services whereby the RN Case Manager partners with the behavioral health and UM team. High risk members are reviewed with physician advisors and CMO for further recommendations	The addition of the LCSW Quality Reviewer occurred late in 2019 and would not impact this report period. Impact TBD.
2016-2017	Due to the nature of these illnesses, there is difficulty for the member to function much of the time, and therefore they have difficulty making and keeping an appointment with the physician.	- Expanded program for outreach by LCSW to members in their home to assist with coordination of care. Completed 686 visits but no impact in 2017. - Late 2018 began Zoom visits by Behavioral Health Providers with 32 visits in 2018, 190 in 2019. - Doctors on Demand psychiatry visits: 125 in 2017, 370 in 2018, 484 in 2019.	Efforts have shown improvement over the last three years through alternative ways to offer appointments. Will continue to facilitate telehealth visits through CM LCSW, Zoom visits by Behavioral Health providers and Doctor on Demand. Will continue to evaluate impact on rates.

Committee Review and Recommendations

Committee Name	Review Date	Recommendations
H.O.P.E. Committee	June 15, 2020	Approved as written; send to Performance Improvement Council
PI Council	June 17, 2020	Approved as written.

References:

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Florida Health Care Plans

Continuity and Coordination of Medical Care

January 1, 2018 to December 31, 2018

Introduction

Numerous studies have demonstrated discontinuity in the medical care system. Lack of communication and care coordination increases the potential for error in the health care system, a patient safety concern. Florida Health Care Plans monitors aspects of continuity and coordination of medical care, and initiates actions as needed to improve continuity.

During 2018, Florida Health Care Plans monitored the following aspects of continuity and coordination of medical care:

- The percentage of hospitalized members who were discharged home, discharged home under the care of home health, or left against medical advice that have at least one follow-up within 7 days with their Primary Care Physician or Specialist within 7 days
- The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or emergency department (ED) visits on or between January 1st - November 30th of the measurement year and were dispensed appropriate medications.
- The percentage of Diabetic eye exams for members age 18-75 years of age who completed a retinal or dilated eye exam by optometrist or ophthalmologist in the measurement year.
- The Percentage of Members 18 and older that experienced an acute inpatient stay during the year, that was followed by an unplanned acute readmission for any diagnosis within thirty days, and the predicated probability of an acute readmission within the measurement year.

This report describes the monitoring methodology, results, analysis, and action for each monitor.

Monitor 1: The Percentage of Discharged Patients Who Had a Follow-Up Visit with Their PCP or Specialist within 7 Days

Methodology

- A follow-up visit within 7 days of discharge is a recommendation to prevent re-admission and has been a chosen organizational goal. FHCP instituted the goal of 70% compliance of post hospital discharge visits with a PCP or specialist within 7 days.
- FHCP monitored hospitalized members that were discharged home either alone or with a caregiver, home with the auspices of home health care, or left the hospital AMA and completed one follow up visit to their PCP or specialist within 7 days of discharge.
- The reporting period occurs from January 1st through December 31st of the calendar year using a 3 month claims runout to provide adequate submission of claims.

Florida Health Care Plans calculated the rate of members discharged who had a follow-up visit with their PCP or Specialists within 7 days using claims data in the third quarter of 2018. Members in the populations were defined in the denominator as total discharges (exclusions: surgical and postpartum discharges, discharged to skilled nursing facilities, or discharged to Hospice) within the measurement period and the numerator defined as members that completed a follow-up visit with a physician within 7 days after discharge. Surgical and postpartum discharges are excluded because the post discharge visits are included in the cost of service and claims are not submitted.

Table 1 Results: Commercial Members

Post Hospital Discharge Follow Up Within 7 Days	1/1/2018-12/31/2018	1/1/2017-12/31/2017	1/1/2016-12/21/2016
Numerator	206	288	251
Denominator	406	551	522
Rate	51%	52%	48.1%
Performance Goal	70%	70%	70%

Commercial Quantitative Analysis

Table 1 reflects the last three service years. During this look-back period, the Commercial members remained below the Performance Goal and were 19 percentage points from meeting the desired goal of 70 percent. The results had a slight decrease from 2017 by 1 percentage point, indicating no improvement. However, the 2017 reporting period was higher than that of 2016 by 3.9 percentage points. Respectively, between the reporting years of 2016 and 2018 the rate demonstrated slight progress to improve follow up. Within the 2018 measure, the rates increased over a span of one to two weeks to reflect the outcome of continued attempts to fulfill post discharge follow up care: within seven business days at 51 percentage points, a ten day follow up was met at sixty-two percentage points and a fourteen day follow up was met at sixty-nine percentage points.

Table 2 Results: Marketplace

Post Hospital Discharge Follow Up Within 7 Days	1/1/2018-12/31/2018	1/1/2017-12/31/2017	1/1/2016-12/21/2016
Numerator	379	239	128
Denominator	746	496	304
Rate	51%	48%	42.11%
Performance Goal	70%	70%	70%

Marketplace Quantitative Analysis

Table 2 reflects the last three service years. During this look-back period, the Marketplace members remained below the Performance Goal and were 19 percentage points from meeting the desired goal of 70 percent. The results increased by 3 percentage points. However, the 2018 reporting period continued to increase and was higher than that of 2016 by 8.89 percentage points. Respectively, between the reporting years of 2016 and 2018 the rate demonstrated progress to improve follow up. Within the 2018 measure, the rates increased over a span of one to two weeks to reflect the outcome of continued attempts to fulfill post discharge follow up care: within seven business days at 51 percentage points, a ten day follow up was met at sixty percentage points and a fourteen day follow up was met at sixty-eight percentage points.

Qualitative Analysis

Further analysis was completed to better understand the overall trend across the Commercial and Marketplace product lines. Regarding the seven day follow up, Commercial product line remained

stable and the Marketplace product line increased, with the combined rate of 51 percent with minimal improvement but remained below the performance goal of 70 percent.

Efforts to date have not had a significant impact on the commercial rate. For Marketplace while initial efforts showed improvement, over the last two years the rate has stabilized and now the same fifty-one percentage points as the commercial rate. PCP offices may defer hospital follow up to the specialist whereby the specialist recommends a follow up after the recommended seven days. Another barrier are members that have already returned to work, work the same as office hours, and decline an office visit due to limited leave time or too busy. Availability in the schedule may not be conducive to their work schedule. Regarding members referred by Utilization Management to the Case Management services, there were no exclusions for the referral data and therefore not all are counted in the measure. Out of the members assisted by Case Management services 55.9 % of members met goals for transition of care between inpatient setting to home. Others were not assisted due to no longer eligible with the plan at 2.02%, unable to contact at 18.04%, deceased at 1.8%, refused assistance at 10.2%, went to long term care or Hospice at 4.2%, and transferred or arranged a provider at 7.1% which extended the recommended seven day follow up. It was noted that the members who were discharged from an acute inpatient setting that met criteria for this measure received contact attempts within one business day post hospital discharge by the RN Case Manager and additionally within one to three business days from the provider office. The continuity and coordination of medical care after hospital discharge has processes in place to improve transition of care from hospital to home.

Discharge Planning Process Review:

- FHCP staffs the area hospitals with on-site hospitalists.
- FHCP Utilization Management Case Managers have access to the electronic medical records for multiple contracted hospitals but communicate by telephone and fax with all out of network hospitals.
- Discharge planning is completed by the hospitals' case management personnel.
- FHCP Case Management staff and hospitalists work closely with hospital case management staff to encourage post hospital follow up.
- Hospital census and prior day's discharge list is available to the Administrator of Practice Management and FHCP Practice Managers on working business days and office staff call members to schedule a follow up appointment within the seven days of discharge.
- UM medical advisors, CM nurses, and the hospitalists refer members who are admitted to the hospital with complex health conditions, multiple readmissions, multiple medications, or presenting barriers of social determinants to the Case Management Coordination of Care Department.
- UM staff tasks or faxes notification of admission and discharge to the PCP in order to provide current information for the post discharge visit.
- FHCP Health Information Management prioritized faxed hospital records to be entered into the electronic medical records and in tandem coordinates request of records from the hospital census.

Members referred to the Case Management Coordination of Care Department who declined to enroll in the program were assisted as needed and given the opportunity to participate on a short-term/one-time basis. This option provides the opportunity to assist members with their immediate needs and/or concerns, identify psychosocial barriers, and provide health coaching and care coordination. The

members that did not respond to department contact were mailed a letter that described services and welcomed contact and the Case Manager followed up with the respective PCP or specialist to facilitate appropriate post discharge follow up.

Barriers/Opportunities for Improvement, Actions, and Outcomes

Based on the analysis of the performance for the Commercial and Marketplace populations, Florida Health Care Plans implements actions to improve performance.

Date Initiated	Barriers Addressed	Action Implemented	Outcome
2018 Ongoing	Working members often returned to work and declined an appointment to avoid time from work. Members fail to update demographics creating barriers for contact.	• Flexible scheduling available to meet individual member needs. • Members referred to the Coordination of Care Department are mailed a notification letter to anticipate a call by a RN Case Manager for transition of care that welcomed calling for assistance • RN Case Managers contact providers to coordinate a post hospital follow up when unable to reach member or member declined assistance • RN Case manager to collaborate with Practice Managers if difficulty scheduling a post hospital follow up within 7 days. • RN Case Managers to collaborate with physician advisors when unresolved barriers exist that impede a timely follow up: assists with peer to peer or to provide recommendations.	• There was slight improvement for the reporting period. Implemented 2019: • The CMRN continue to follow with a chart audit to evaluate completion of post hospital follow up care. • Medical Director of Practice Management hired to assist with education to low performing practitioners regarding initiatives. • Medical Director of Quality Improvement and Utilization Management hired to assist with medical review to improve measures.

2018 ongoing	Members transitioned to home from the inpatient setting do not recognize the importance of follow up with provider within 7 days of discharge or have difficulty getting out to an appointment due to a debilitated health state.	• CMRN explain necessity of follow up and assist in facilitating appointment. • The goal for post hospital discharge contact within 1 business day of notification implemented in 2018. • The members targeted as high-risk identified by UM process contact while inpatient prior to discharge as appropriate. • Members identified as high risk for readmission or difficulty getting to an appointment due to a debilitated health state are referred to an In-Home Provider services.	In 2018 report period 2,523 members with no exclusions were referred by UM to prompt post hospital contact, 51 were not eligible with insurance and excluded from contact, 1,857 members were reached by the CMRN and 615 members were unable to be contacted. Out of those assisted 55.9% met transition of care goals from hospital to home. The hospital discharge notification letter is mailed to all members with department contact information. In 2017 there were 98 referrals to In-Home Providers and in 2018 there were 244 In-home Provider Referrals. There was a 60% increase of referrals to the In-Home Provider service to assist members with transition and coordination of care. 161 members were discharged from TOC services and 68 members required PCP services from the service.

Monitor 2: Pharmacotherapy Management for Chronic Obstructive Pulmonary Disease

Methodology

Florida Health Care Plans calculated the percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter on or between January 1 – November 30 of the measurement year and who were dispensed appropriate medications and set a performance goal of 70 percent. Rates are reported for two product lines: Commercial and Marketplace.

1. Dispensed a systemic corticosteroid within 14 days of the event.
2. Dispensed a bronchodilator within 30 days of the event.

Table 1 Results Commercial and Marketplace product lines:

Measure Pharmacotherapy Management of COPD Exacerbation	HEDIS 2019	HEDIS 2018	HEDIS 2017
Commercial	Percentile	Percentile	Percentile
Systemic Corticosteroid within 14 days of event	10 th 67% Numerator – 20 Denominator -30	90 th 87% Numerator – 27 Denominator – 31	<10 th 56% Numerator – 26 Denominator - 46
Bronchodilator within 30 days of event	10 th 73% Numerator – 22 Denominator – 30	25 th 74% Numerator – 23 Denominator – 31	<10 th 56% Numerator – 26 Denominator – 46
Marketplace			
Systemic Corticosteroid within 14 days of event	No members met the criteria	No members met the criteria	Not Reported Numerator – 2 Denominator - 4
Bronchodilator within 30 days of event	No Members met the criteria	No Members met the criteria	Not Reported Numerator – 2 Denominator - 4

Note: The eligible population for this measure is based upon acute inpatient discharges or Emergency Department not per member. It is possible for the denominator to include multiple events for the same individual.

Quantitative Analysis

Table 1 reflects the last three service years for Commercial and Marketplace. During this look-back period, the rates for Commercial members fluctuated mainly due to statistical variation due to relatively small denominators and no Marketplace members met the denominator criteria for the measure.

The rates of Commercial product line for dispensed systemic Corticosteroid within 14 days of the event decreased by 20 percentage points from the 2018 to 2019 period and fell below the 70th percent goal by 3 percentage points. The Bronchodilator dispensed within 30 days of the event decreased by 1 percentage points from the 2018 to 2019 period for Commercial members but remained above the 70th percent goal. The measure is not required for the Marketplace members, but data can be queried by the certified software. No Marketplace members met the denominator criteria over the last two years.

Qualitative Analysis

The results for Measure 2 Pharmacotherapy Management for Chronic Obstructive Pulmonary Disease showed a slight decline in the 2019 HEDIS report period for Commercial members, but that was mainly due to statistical variation in the rate due to relatively small denominators. Members who

did not receive appropriate treatment were audited post discharge through claims data by the RN Quality Reviewer to determine the appropriateness of treatment and compliance for medication fills.

Conclusion:

The RN Quality reviewer provided an educational letter to the PCP regarding need for medication management to be addressed during the 7-day post hospital visit. The RN Quality Reviewer notified the Case Management Coordination of Care Department of complex members assigned to the RN Case Manager to evaluate and coordinate medication management for the Pharmacotherapy Management of COPD Exacerbation. The Utilization Management department refers members admitted with the diagnosis of COPD to the Case Management Coordination of Care Department to monitor for treatment and appropriate post hospital follow up.

Both actions occur before the 7-day period. Overall the measure shows the effectiveness of outpatient management due to a significant growth in the population served by FHCP and the even lower number of members indicated in the denominator that had an acute inpatient discharge or ED encounter on or between January 1-November 30 of measurement year.

Barriers/Opportunities for Improvement, Actions, and Outcomes

Based on the analysis of performance for Commercial and Marketplace populations, FHCP implements actions to improve performance.

Date Initiated	Barriers Addressed	Action Implemented	Outcome
2018 Ongoing	Members self-reported that they have medication at home and did not fill hospital discharge medications. Member prescriptions may be outdated, or the supply ran out, and what they have at home was not reflected as a prescription fill for the measure.	Intense COPD education regarding requirements for post discharge. PCPs and In-Home Providers are reminded to inquire of their patients if they have an adequate and current supply of the bronchodilator and prednisone at home, and whether they need a new prescription. Beginning in Fall of 2018, Utilization Management nurses were given the PCE quality measure specifications and a list of the PCE drugs in the Formulary. These RNs received training by the UM Manager and worked	The percentage rates declined as did the number of members that had an associated ED visit or hospitalization which correlates with improved outpatient management of COPD. Statistical variations fluctuate related to the relatively small denominators. The 2019 HEDIS rates trended downward but the statistical variance related to the relatively small denominators. In 2018 report period 2,523 members with no exclusions were referred by UM to prompt post hospital follow up to include medication reconciliation. 51 were not eligible with insurance and

Date Initiated	Barriers Addressed	Action Implemented	Outcome
		with hospitalists for our members to be prescribed the 2 meds upon discharge. Case Managers continue to complete post hospital medication reconciliation to identify members that did not receive or fill the required PCE drugs. The Case Managers coordinate care through the PCP or specialist.	excluded from contact. 1,857 members were reached by the CMRN. 615 members were unable to be contacted. Members not reached by phone who did not indicate appropriate medication fills within FHCP systems prompted the CMRN to follow up with the physician regarding the prescriptions indicated in the PCE measure.
2017	Inconsistent prescribing practices by practitioners.	Measure is discussed at the PCP and specialist leadership meetings as well as Quality and Patient Safety where physicians are present. GAP reports provided for physician review and intervention.	Met goal and retired this measure. There is an indication of improvement in collaborative treatment efforts for members that received the corticosteroid/bronchodilator in the outpatient setting.

Date Initiated	Barriers Addressed	Action Implemented	Outcome
2017	Data incorrectly identifies members as having an exacerbation based on incorrect coding of the COPD diagnosis. Members came to the hospital for an issue other than COPD, ex. knee surgery. A chest x-ray to prepare them for surgery may show COPD, COPD changes, or stable COPD. The radiologist codes COPD as the primary diagnosis and it placed them into the measure population.	In 2017 An internal audit and study of the PCE measure was conducted to examine the low rates- 40 out of 100 members on the current PCE non-compliant list do not have COPD #1 diagnosis on the hospital claim. COPD was listed as the primary diagnosis on the radiologist non-institutional claim for these 40 members. It counted in the measure because the place of service for the x-ray is part of the hospital visit. The majority occurred at one hospital.	Problem identified and retired this measure. In 2017, data collection was corrected- adjustment of the actual number of members who had an actual COPD exacerbation in 2017 showed an improvement in the rates.
2016 Ongoing	Member may be homebound and unable to see a PCP or specialist to reconcile medications	Members may be referred to an In-Home Provider for an ARNP to reconcile medications and encourage compliance.	In 2018 the Case Managers referred 244 members to In Home Provider Services for face to face visit to include reconciliation of medications. This is a 60% increase of referrals from previous year of 98 members.

Monitor 3: The Percentage of Members 18 to 75 years of Age Who Completed a Retinal or Dilated Eye Exam by Optometrist or Ophthalmologist in the Measurement Year.

Methodology

Florida Health Care Plans calculated the percentage of Commercial and Marketplace members eighteen to eighty-five years of age who have Diabetes and had either a retinal or dilated eye exam by an optometrist or ophthalmologist in the measurement year. The population identified were members with Diabetes who received appropriate testing. Members excluded from the measure were any member with gestational diabetes or steroid-induced diabetes.

Table 1 Results: Commercial Members

Retinal or Dilated Eye Exam by an optometrist or ophthalmologist	1/1/2018-12/31/2018	1/1/2017-12/31/2017
Numerator	222	217
Denominator	411	409
Rate	54.01%	53.06 %
Percentile	25 th	50 th

Commercial Quantitative Analysis

A baseline comparison between 2017 to 2018 HEDIS without focused intervention showed a stable rate but a decline when comparing year over year percentiles.

Table 2 Results: Marketplace

Retinal or Dilated Eye Exam by an optometrist or ophthalmologist	1/1/2018-12/31/2018	1/1/2017-12/31/2017
Numerator	203	199
Denominator	411	411
Rate	49.39%	48.42%
Percentile	25 th	25 th

Marketplace Quantitative Analysis

A baseline comparison between 2017 to 2018 HEDIS without focused intervention showed a slight improvement in the rate and but the percentile remained unchanged.

Qualitative Analysis

It is recommended that members with diabetes have an annual retinal eye exam by an optometrist or ophthalmologist. Practitioners provide recommendations for the annual eye exam. There are multifactorial barriers that impact compliance. When completed at a contracted optometrist or ophthalmologist or outside of the plan the consultation is not always communicated back to the primary care physician or endocrinologist which impacts the continuity of care. Members that complete the exams at a contracted provider or outside of the plan do not understand the importance of the care coordination between providers therefore impacting analysis. Members may not understand the disease progression and need for early detection, nor complete eye exam when no visual disturbances are noted, or fear of the exam. Cost factor and appointment availability for exams may prohibit follow through. Office hours for the working-class lack flexibility or availability that is convenient for the member. The optometrist or ophthalmologist office does not notify the referring provider when appointments are not kept which would facilitate education between the member and referring provider. Previous actions have been as follows: the RN Quality reviewer provides an educational letter to the PCP regarding the need for annual retinal or dilated eye exam by an optometrist or ophthalmologist; the FHCP Healthy Me Program notifies members of recommended exams that are required or outstanding.

Conclusion:

FHCP recognizes a deficit in the continuity and coordination of care throughout the continuum and as noted the actions have not effectively improved the compliance of retinal or dilated eye exam by an optometrist or ophthalmologist.

In an effort to improve the rates, additional interventions have been initiated in 2019. This includes PCPs use of RetinaVue, receiving retinal eye exams at no cost, and reminder messages on diabetic medication prescription bottles.

Barriers/Opportunities for Improvement, Actions, and Outcomes

Based on the analysis of performance for Commercial and Marketplace populations, FHCP implements actions to improve performance.

Date Initiated	Barriers Addressed	Action Implemented	Outcome
2018	Lack of collaboration between providers regarding completion of retinal eye exam. Routine eye exams are often not considered as necessary communication between providers.	Quality Management attempts to engage the PCP and endocrinologist to ensure the eye exam is completed. Measure is discussed at the PCP and specialist leadership meetings as well as Quality and Patient Safety where physicians are present.	2018 Quality Management met with providers that had identified gaps in care for the population managed; the goal for practices to contact the members to coordinate care. Further outcome will be determined in next review.
2018	Members may not understand the importance of the diabetic retinal eye exam, fear the exam, find appointments conflict with work schedule, or decline paying for another healthcare related exam when no visual disturbance.	RN Case Managers will send the FHCP form for completion of Diabetic eye exam that requests records faxed to FHCP Medical Records Department to improve communication and collaboration between providers. RN Case Manager provides optometrists available on plan or coordinate an order from PCP to an ophthalmologist. RN CM educate members regarding early detection to prevent blindness. RN CM arrange Retina Vue through FHCP provider.	2019 implemented CMRN to coordinate appointments for FHCP Retina Vue offered to members with no copayment to facilitate access of care.
2018	Providers are not consistently educating members to complete a DM eye exam or	The Medical Practices are sent the gap reports (HEDIS measures that require	GAP report action only impacted members that were seen.

Date Initiated	Barriers Addressed	Action Implemented	Outcome
	why it is necessary. PCP often recommend member to self-refer to an optometrist and do not generate an order to the ophthalmologist. Offices do not always provide the DM eye exam form that provides opportunity for collaboration between providers.	attention) weekly and employed physician offices can access the report daily as needed. It allows for real time interventions when the member is seen by the physician. A joint effort throughout the health plan ensures members receive recommended care. PCPs are reminded of the required measure that members with Diabetes require an eye exam. Quality Management (QM) also outlined in the HEDIS/Star Provider Guide. QM monitors whether the DM eye exam occurs and may contact the PCP and staff as needed.	2018 Quality Management reviewed GAP report with providers and practice managers; goal for the medical practices to contact the members for the Diabetic eye exam. 2019 implemented the Retina Vue in an endocrinologist office shared with one PCP with a goal to expand through FHCP. 2019 Pharmacy implemented a bottle cap message on diabetic prescriptions as a reminder to get DM eye exam.

Monitor 4: Plan All-Cause Readmissions

Methodology

Discharge from the hospital is a critical transition point in a member's care. Hospital readmission is associated with longer lengths of stay and higher mortality rates. Most often, hospital readmissions are commonly related to Congestive Heart Failure, Acute Myocardial Infarction, Chronic Obstructive Pulmonary Disease, and Pneumonia.

Using HEDIS data, FHCP chose the Plan All -Cause Readmission (PCR) measure for the Commercial and Marketplace populations. PCR assess the rate of adult (ages 18-64) inpatient stays that are followed by an unplanned acute readmission for any diagnosis with 30 days after discharge.

Exclusions include members in hospice, pregnancy, a principal diagnosis of a condition originating in the perinatal period, and deaths during the hospital stay.

Table 1 Results: Commercial Members

Plan All-Cause Readmission	1/1/2018-12/31/2018	1/1/2017-12/31/2017
Numerator	56	84
Denominator	771	951
Rate	7.26%	8.83%
Percentile	75 th	25 th

Commercial Quantitative Analysis

This report is a baseline comparison between 2017 to 2018 HEDIS without focused intervention. The rate decreased by 1.57 percentage points and the percentile showed a significant increase from the 25th percentile to the 75th percentile.

Table 2 Results: Marketplace

Plan All-Cause Readmission	1/1/2018-12/31/2018	1/1/2017-12/31/2017
Numerator	79	40
Denominator	730	464
Rate	10.82%	8.62%
Percentile	<10 th	25 th

Marketplace Quantitative Analysis

When comparing data between 2017 and 2018, the rate increased by 2.2 points and the percentile decreased from the 25th to the <10th percentile.

Qualitative Analysis

Further analysis was completed to better understand the overall trend across the Commercial and Marketplace product lines regarding Measure 4. The PCR rate for 2018 for Commercial members showed a significant improvement while Marketplace rates increased between 2017 and 2018.

Members who experience a readmission are referred to a Case Manager and the Primary Care Physician is notified of the readmission to queue a prompt follow up. The continuity and coordination of medical care after hospital discharge has processes in place to improve transition of care from hospital to home.

Discharge Planning Process Review:

- FHCP staffs the area hospitals with on-site hospitalists.
- FHCP Utilization Management Case Managers have access to the electronic medical records for multiple contracted hospitals but communicate by telephone and fax with all out of network hospitals.
- Discharge planning is completed by the hospitals' Case Management personnel.
- FHCP Case Management staff and hospitalists work closely with hospital Case Management staff to encourage post hospital follow up.

- Hospital census and prior day's discharge list is available to the Administrator of Practice Management and FHCP Practice Managers on working business days and office staff call members to schedule a follow up appointment within the seven days of discharge or earlier.
- UM medical advisors, CM nurses, and the hospitalists refer members who are admitted to the hospital with complex health conditions, multiple readmissions, multiple medications, or presenting barriers of social determinants to the Case Management Coordination of Care Department.
- UM provides a readmission list to CMO, UM Medical Director, Practice Management Medical Director, Administrator of Practice Management, FHCP Practice Managers, and providers.
- UM staff tasks or faxes notification of admission and discharge to the PCP in order to provide current information for the post discharge visit.
- UM staff refer readmissions to CM staff for early contact and collaborative recommendations to improve discharge planning.
- FHCP Health Information Management prioritized faxed hospital records to be entered into the electronic medical records and in tandem coordinates request of records from the hospital census.
- FHCP monitors all readmissions for root cause, ensure linked with a FHCP Case Manager.

Members that experience readmissions are often associated with longer lengths of stay have associated iatrogenic complications that further impact quality of life and decline in health. The impact of readmissions increases stressors from financial burden, loss of work, limited ability to self-care, lack of available caregiver, or limited comprehension due to fatigue and deconditioning. Members receive many calls once discharged home from hospital transition of care programs, Home Health Care Agencies, Multiple Providers, and Case Managers which can cause frustration to the member and families. Members who are referred to the Case Management Coordination of Care Department who declined participation or unable to contact are followed through CM record audit to collaborate with the providers. The members referred were mailed a letter that described services and welcomed contact to facilitate assistance post discharge follow up with concerns or questions.

Barriers/Opportunities for Improvement, Actions, and Outcomes

Based on the analysis of performance for Commercial and Marketplace populations, FHCP implements actions to improve performance.

Date Initiated	Barriers Addressed	Action Implemented	Outcome
2018	Members decline prompt hospital follow up due to poor health conditions.	RN Case managers arrange in-home provider services with ARNP for transitional care. Providers contact members to discuss importance of prompt follow up to coordinate needed appointments and Home Health Care.	In 2018 the Case Managers referred 244 members to In Home Provider Services for face to face visit to include reconciliation of medications. This is a 60% increase of referrals from previous year of 98 members.
2018	Members are not aware of importance for timely follow up or do not keep recommended appointments. Members do not take or do not refill prescribed medications due to lack of understanding or side effects.	RN Case Managers audit member records for uncontrolled health conditions, lack of provider follow up, medication non-adherence, and barriers of social determinants to address gaps with members and providers. RN Case Managers perform a medication reconciliation on all members offered services, coordinate follow up care and educate members. RN Case Managers offer remote patient monitoring through Interactive Health at Home with actionable data to partner with providers in medical management.	Implemented 2019 a CM Medical Reviewer provides goal setting and recommendations to improve health outcomes. Medical Reviewer provides peer to peer with providers and clinical pharm D to facilitate medical management with identified members not improving on the IHAH program or address high risk medical issues and gaps in care. Members that declined services were left open to audit charts and coordinate care with providers.

Reporting

This QI activity reported to the following QI committees:

Committee Name	Meeting Date	Committee Actions or Recommendations
H.O.P.E. Committee	10/09/2019	Approved, send to PI Council
Performance Improvement Council	10/16/2019	Approved as written.

Florida Health Care Plans

2018

Behavioral Health Member Experience Analysis

Measurement Year January 1, 2018 – December 31, 2018

Florida Health Care Plans
Behavioral Health Member Satisfaction Analysis
January 1, 2018 – December 31, 2018

Introduction

Analysis of Behavioral Health member satisfaction information helps managed care organizations identify aspects of performance that do not meet member expectations and initiate actions to improve performance. Florida Health Care Plans has employed and contracted Behavioral Health psychiatrists, doctoral level psychologists, Licensed Clinical Social Workers, and therapists. Services provided include outpatient psychiatric therapy, intensive outpatient program for members with substance abuse issues, partial hospital program, residential care, inpatient psychiatric, and substance abuse care, depending upon member benefits and needs. FHCP monitors multiple aspects of Behavioral Health member satisfaction annually for all members, including:

- Member complaints
- Member appeals
- Member satisfaction surveys

This report describes the monitoring methodology, results, and analysis for each satisfaction data source, and actions initiated to improve member satisfaction.

Member Complaints

Florida Health Care Plans defines a complaint as any expression of dissatisfaction of a subscriber i.e., dissatisfaction with the administration, claims practices, or provision of services, which relates to the quality of care provided by a provider pursuant to the organization's contract and which is submitted to the organization or to a state agency. A complaint is based on the content of the member's complete call, and not simply on the tone of the caller. A category code is assigned based upon the main issue in the complaint. Some complaints relate to multiple issues. Due to information system design, only the main complaint category code is assigned to each complaint. If complaint relates to multiple issues, more than one case may be initiated in order to address each complaint separately. Therefore, this data reflects the number of complaints received from members but may still understate the total number of various complaint issues raised by members. A grievance is defined as a written (*or verbal in the case of a Fast or Urgent*) complaint submitted by or on behalf of a subscriber to an organization or a state agency regarding the:

1. Availability, coverage for the delivery, the quality of health care services, satisfaction with the delivery of services, claims practices, or general practices, policies and procedures.
2. Matters pertaining to the contractual relationship between a subscriber and an organization
Disagreement with the organization's decision to transfer a request for an Expedited Appeal to a Standard Appeal timeframe. A grievance does not include a written complaint submitted by, or on behalf of, a subscriber eligible for a grievance and appeals procedure provided by an organization pursuant to Contract with the federal government under Title XVIII of the Social Security Act. Florida Health Care Plans defines an appeal as a request to reconsider a claim or service denial.
3. Grievance, appeals, and complaints are categorized by mode of submission. Mode of submission is defined as verbal versus written (e.g. telephone, fax or email) and coded based on the main issue in the complaint. If complaint relates to multiple issues, more than one case may be initiated in order to

address each complaint separately.

Member complaints are documented and tracked through documentation in the Correspondence Unit Tracking (CUT) System utilizing codes that are specific to each category of complaints and appeals.

Table 1 demonstrates the categories and cross mapping of areas of focus within Florida Health Care Plans (FHCP), and include:

1. Billing and Financial Issues;
 - a. Appeals for denials of out of network services where members are balance billed
 - b. Incorrect coding of Claim by provider
 - c. Practitioners balance billing members for services
 - d. Disputes of deductibles and co-payments
 - e. Cost of service
2. Quality of Care Issues
3. Access Issues
4. Attitude and Service-Related Issues
5. Quality of Practitioner Office Site

Rates for grievance and appeals or complaints per 1000 members for each year are determined by dividing the number of complaints for the year by the number of members and multiplying by 1000. To identify key areas of focus, all complaints are reviewed. Due to the subjective nature of complaints, it is possible to categorize a single issue under different codes. Miscoding occasionally occurs. When miscoding trends are identified, feedback is provided to all front-line Member Services Staff via Management. Feedback and training are also given based on changes in regulatory guidelines.

The Customer Satisfaction Committee monitors complaint data on a quarterly and summarizes complaint data on an annual basis. This document summarizes the results and analysis of Behavioral Health for the January 1, 2018 – December 31, 2018 measurement period.

Table 1: Complaint Categories

CUT Category Code	Cause Code	Definition	NCQA Category
AC	A201	Access Time to Appointment	Access or Quality
	A202	Wait Time in Office	
	A203	Location of Facilities	
	A204	Telephone Delay / No Call Back	
	A207	Choice of Plan Provider	
	A209	Procedure Cancelled	
	A213	Delay in Service	
	A215	Appointment Cancelled	
	A216	Testing Appointment / Wait	
	A217	Surgery Wait	
	A205	Access Time to an Urgent Appointment	
PP	P403	Desired Service Not Provided	
	P406	Contract/Benefit	
	P402	Claim denied by FHCP	Billing & Financial
	P404	Cost of service	
	P405	Premium billing complaint	
	P406	Contract/Benefits Complaint	
	P411	Member Requests Waiver of a Copay	
	P412	Member Requests Reimbursement of a Copay	
	P425	Claims Processing Problem	
	P426	Balance Billing Problem	
QU	Q104	Dissatisfaction with Equipment / Facility	Quality of Care
	Q107	Inappropriate Treatment	
	Q109	Test Results Not Relayed	
	Q112	Unhappy with Treatment	
	Q113	Complaint with Outcome of Treatment	
	Q114	Complaint Regarding Patient Instructions	
	Q115	Continuity of Care / Delay of Care	
	Q149	QUALITY COMPLAINT ENTERED IN QUANTROS	
ST	S301	Poor Communication	Attitude and Service
	S305	Unprofessional	

Commercial Population Analysis

Commercial Complaints:

Table 2: Annual Complaint Data (N = Complaints per 1000 members)

Complaints Category	2017	2018	Preformance Goals	Preformance Goals met
Billing/Financial	0	0.05	<2.0	Yes
Access	0	0.03	<2.0	Yes
Attitude/Service	0.06	0.03	<2.0	Yes
Quality of care	0	0	<2.0	Yes
Quality of Practiioner office site	0	0	<2.0	Yes
Total Average	0.012	0.022	<10.0	Yes

Analysis

FHCP's goal is to not exceed a total of 10 Per 1000 Behavioral Health Appeals (two per category measured), which was met for 2018.

There was a total of four behavioral health complaints in 2018. The Billing/Financial complaint were related members contractual co-pay responsibilities associated with required visit for medication re-fill and office no show fees. There was one Access complaint related to providers office needing to reschedule an appointment and one Attitude & Service complaint where a member was dissatisfied with office communication about prescription refills. There were no complaints related to Quality of Care, or Quality of Provider Office site.

Overall, there was no significant difference in number of commercial member complaints (4) in 2018 as compared to the 2017 (3) measurement year. In 2017, of three behavioral health complaints, two were related to member dissatisfaction with office prescription policy and one was related to physician being late for the appointment.

All complaint categories are discussed quarterly at the Customer Satisfaction meeting with the CMO, and representatives from FHCP Member Services, Central Referrals, Provider & Contract Services, and Quality Management departments where strategies for improvement are discussed.

Commercial Appeals

An “appeal” is a request for review or reconsideration of an adverse organizational determination (e.g. *denied: pre-service/prior authorization request in advance of obtaining the service; concurrent discontinued service review or post-service claim/service that has already been rendered*).

Table 3: Commercial Annual Appeals data (N = Appeals per 1000 members)

Appeals Category	2017	2018	Preformance Goals	Preformance Goals met
Billing/Financial	0.05	0.08	<2.0	Yes
Access	0.05	0.11	<2.0	Yes
Attitude/Service	0	0	<2.0	Yes
Quality of care	0	0	<2.0	Yes
Quality of Practiioner office site	0	0	<2.0	Yes
Total Average	0.02	0.038	<2.0	Yes

Analysis

FHCP’s goal is to not exceed a total average of 10 Per 1000 Behavioral Health Appeals (two per category measured), which was met for 2018. For the January 1, 2018 – December 31, 2018 measurement period, there was a total of seven appeals, six involved members requesting services by an out of network provider when in-network providers were available. The seventh complaint was related to member not meeting medical necessity criteria for desire level of care as well as seeking services with an out of network provider. FHCP did not receive any member appeals related to Quality of care, Attitude & Service, or Quality of Practitioner office site during this reporting period. There was no significant difference in the number of appeals in 2018 (7) as compared to the 2017 (6) measurement year; nor, was there significant change in the number of access appeals (4 verses 3, in 2017). Additionally, two of the seven appeals related to financial/billing issues involved the same member and the same provider. Member was not seeking out of network services, verbalized had choosen a contracted provider that was not available on her selected plan-type in error. Identification of trends are discussed quarterly at the Customer Satisfaction meeting with the CMO, and representatives from FHCP Member Services, Central Referrals, Provider & Contract Services, and Quality Management departments where strategies for improvement are discussed.

Marketplace Population BH Analysis

Marketplace Complaints:

Table 6: Annual Complaint Data (N = Complaints per 1000 members)

Complaints Category	2017	2018	Performance Goals	Performance Goals met
Billing/Financial	0.04	0.06	<2.0	Yes
Access	0.11	0.03	<2.0	Yes
Attitude/Service	0.07	0.14	<2.0	Yes
Quality of care	0	0.03	<2.0	Yes
Quality of Practitioner office site	0	0	<2.0	Yes
Total Average	0.044	0.052	<10.0	Yes

Analysis

FHCP's goal is to not exceed a total of 10 Per 1000 Behavioral Health Complaints (two per category measured), was met for 2018. There were five related to Attitude & Service, two for Billing/Financial, one for Access, and one for Quality of Care. Attitude & Service complaints were related to poor communication between themselves and the provider, primarily concerning treatment plan and member perception that physician was unprofessional. The Access complaint was related to member desired to remain in residential treatment center when national guidelines were no longer met. The Billing/Financial complaint were related members contractual co-pay responsibilities and office no show fees. The Quality of Care complaint involved a new member perception of a delay in referral to Behavioral Health. There were no changes in the total number of behavioral health complaints with a total of nine complaints documented in 2017 and nine complaints in 2018. There were nine (9) Marketplace Behavioral Health complaints for the 2018 measurement period as compared to a total of ten (10) in the 2017 measurement year, which is 10% percent reduction. However, there was an 80% decrease in the number of access complaints (1) as compared to 2017(5). Complaints related to Attitude & Service continued to center around member dissatisfaction with treatment plans (medication prescriptions, drug testing, and refill policies), Billing & Financial centered round member contractual financial obligations (co- pays, no show fees).

All complaint categories are discussed quarterly at the Customer Satisfaction meeting with the CMO, and representatives from FHCP Member Services, Central Referrals, Provider & Contract Services, and Quality Management departments where strategies for improvement are discussed.

Marketplace Appeals:

Table 7: Annual Appeals data (N = Appeals per 1000 members)

Appeals Category	2017	2018	Preformance Goals	Preformance Goals met
Billing/Financial	0.14	0	<2.0	Yes
Access	0.04	0	<2.0	Yes
Attitude/Service	0	0	<2.0	Yes
Quality of care	0	0	<2.0	Yes
Quality of Practiioner office site	0	0	<2.0	Yes
Total Average	0.036	0	<10.0	Yes

Analysis

There were no Marketplace Behavioral Health appeals for the 2018 measurement period as compared to a total of five in the 2017 measurement year. Which is 100% percent reduction in Behavioral Health appeals.

The Customer Satisfaction Committee monitor appeals data on a quarterly basis.

Commercial Member Behavioral Health Satisfaction Survey

In 2019, FHCP conducted a survey to measure Commercial member satisfaction with behavioral health within the past 12 months. The Commercial ECHO member satisfaction survey was administered by an external survey vendor, SPH Analytics, formerly The Myers Group (TMG). SPH followed a 5-wave mail-only survey methodology to administer Member Satisfaction Surveys from May 2019 through July of 2019. Florida Health Care Plans' sample size is 1,763. SPH collected 281 mail surveys from the eligible Florida Health Care Plans population. After adjusting for ineligible members, the response rate is 16.3%. A response rate is only calculated for those members who are eligible and able to respond.

For comparison purposes, results are presented by Summary Rates. The Summary Rate is the sum of the proportion of respondents who selected the most positive response options ("Usually" and "Always;" "Yes;" "2 days or less;" 10 days or less;" "None;" "8-10;" "Not a problem;" "Much better" and "A little better;" and "Excellent" and "Very Good") for

the attribute. Results are compared to the TMG book of business utilizing the z test to determine statistical differences.

Table 7: Commercial ECHO Survey response rates

Survey Population	2019 Response rate	2018 Response rate	2017 Response rate
Commercial HMO	16.30%	10.40%	13.90%

Table 7a: Commercial Echo Survey Results

Summary of Benchmark Comparisons
SPH 2018 Book of Business Percentiles

Florida Health Care Plan, Inc.
ECHO™ Member Satisfaction Survey

188 Behavioral Health Service User Respondents

Composites and Key Questions	Summary Rate*	2019 Florida Health Care Plan, Inc. Percentile Ranking**	2018 SPH Book of Business Benchmark***	2018 SPH BoB Percentiles			
				25th	50th	75th	90th
Getting Treatment Quickly	85.5%	92nd	65.7%	51.3%	55.4%	63.3%	65.7%
Q3. In the last 12 months, how often did you get the professional counseling you needed on the phone?	35.0%	53rd	37.4%	34.3%	36.4%	43.3%	50.8%
Q5. In the last 12 months, when you needed counseling or treatment right away, how often did you see someone as soon as you wanted?	95.5%	99th	88.1%	61.2%	88.3%	74.6%	79.3%
Q8. In the last 12 months, not counting the times you needed counseling or treatment right away, how often did you get an appointment for counseling or treatment as soon as you wanted?	77.0%	41st	78.1%	71.7%	79.0%	84.7%	87.9%
How Well Clinicians Communicate	83.8%	67th	84.8%	80.0%	86.5%	94.5%	96.3%
Q13. In the last 12 months, how often did the people you went to for counseling or treatment listen carefully to you?	83.8%	59th	88.9%	83.4%	89.8%	95.3%	96.8%
Q14. In the last 12 months, how often did the people you went to for counseling or treatment explain things in a way you could understand?	85.3%	90th	88.8%	84.4%	90.5%	98.3%	98.8%
Q15. In the last 12 months, how often did the people you went to for counseling or treatment show respect for what you had to say?	94.5%	54th	90.8%	85.5%	93.0%	97.0%	97.8%
Q16. In the last 12 months, how often did the people you went to for counseling or treatment spend enough time with you?	81.3%	60th	87.3%	82.2%	87.2%	93.8%	95.6%
Q19. In the last 12 months, how often were you involved as much as you wanted in your counseling or treatment?	92.0%	65th	84.7%	78.9%	85.7%	92.8%	95.1%
Informed About Treatment Options	41.2%	17th	50.8%	42.1%	50.8%	58.6%	63.4%
Q20. In the last 12 months, were you told about self-help or support groups, such as consumer-run groups or 12-step programs?	32.7%	10th	45.2%	35.0%	44.8%	54.2%	59.8%
Q21. In the last 12 months, were you given information about different kinds of counseling or treatment that are available?	49.7%	12th	59.5%	51.3%	59.4%	65.4%	71.0%
Access to Treatment and Information from Health Plan	80.2%	85th	69.7%	63.3%	75.4%	78.4%	81.0%
Q27. In the last 12 months, how much of a problem, if any, were delays in counseling or treatment while you waited for approval?	81.3%	59th	87.3%	82.0%	89.5%	92.6%	94.8%
Q29. In the last 12 months, how much of a problem, if any, was it to get the help you needed when you called customer service?	69.2%	82nd	67.4%	52.9%	58.9%	67.1%	73.4%
Office Wait Time (Q12)	77.2%	51st	74.2%	61.8%	76.8%	87.2%	90.6%
Informed about Medication Side Effects (Q18)	83.3%	54th	77.7%	74.7%	78.4%	80.9%	82.4%
Received Information about Managing Condition (Q22)	78.9%	23rd	83.3%	79.1%	83.3%	87.8%	89.9%
Informed about Patient Rights (Q23)	82.6%	39th	83.2%	80.5%	83.7%	87.1%	90.0%
Ability to Refuse Medication and Treatment (Q24)	90.7%	77th	81.8%	76.0%	79.8%	89.2%	93.7%
Rating of Counseling or Treatment (Q25)	77.3%	55th	74.2%	70.6%	75.4%	81.4%	83.2%

- At or above the 90th percentile.
- At or above the 75th percentile, but below the 90th percentile.
- At or above the 50th percentile, but below the 75th percentile.
- At or above the 25th percentile, but below the 50th percentile.
- Below the 25th percentile.

* Summary Rates represent the most favorable response percentage(s).

** Ranking indicates where your plan's Summary Rate ranks when compared to all other plans in the 2018 ECHO Book of Business. Summary Rates that are below the 10th percentile are shown as "<10th."

*** The SPH Analytics 2018 ECHO Book of Business benchmark consists of data from 35 plans representing 77,904 adult respondents, including 14,641 Behavioral Health Service Users. See Technical Notes for more information.

(SPHAnalytics.com, 2019)

Commercial ECHO Analysis

Florida Health Care Plans' satisfaction goal is to meet or exceed SPH Analytics Adult Book of Business 90th percentile rates. FHCP, ranked in the 92nd percentile for "Getting Treatment Quickly" composite as compared to 69th in 2018. FHCP ranked in the 85th percentile as compared to 82nd in "Access to Treatment and Information from Health Plan" composite and dropped from the 86th to 67th percentile in the "How well Clinicians Communicate" Composite. Though FHCP met the percentile goal in only one composite, it scored significantly higher when compared to the 2018 SPH Analytics ECHO Book of Business for the following Composites: *Getting Treatment Quickly*, *How Well Clinicians Communicate* and *Access to Treatment and Information from Health Plan*.

Marketplace Member Behavioral Health Satisfaction Survey

Prior to 2018, The Marketplace member satisfaction survey was administered by FHCP, as the numbers of Marketplace members who accessed Behavioral Health Services was insignificant. For comparison purposes, results are presented by Summary Rates. The Summary Rate was the sum of the proportion of respondents who selected the most positive response options ("Usually" and "Always").

In 2018 and in 2019, FHCP conducted a survey of Marketplace members to measure satisfaction with behavioral health in the past 12 months. The ECHO survey was administered by an external survey vendor, SPH Analytics, formerly The Myers Group (TMG). SPH followed a 5-wave mail-only survey methodology to administer the Member Satisfaction Survey from May 2019 through July of 2019.

Florida Health Care Plan, Inc.'s sample size is 1500. SPH collected 240 mail surveys from the eligible Florida Health Care Plan, Inc. population. After adjusting for ineligible members, your response rate is 16.70%. A response rate is only calculated for those members who are eligible and able to respond.

Table 9: Marketplace Survey response rates

Survey Population	2019 Response Rate	2018 Response Rate	2017 Response Rate
Market place	16.70%	12.50%	15.40%

Table 9a: Marketplace Survey Results (SPHAnalytics.com, 2019)

Summary of Benchmark Comparisons SPH 2018 Book of Business Percentiles				Florida Health Care Plan, Inc. ECHO® Member Satisfaction Survey			
174 Behavioral Health Service User Respondents							
Composites and Key Questions	Summary Rate*	2019 Florida Health Care Plan, Inc. Percentile Ranking**	2018 SPH Book of Business Benchmark***	2018 SPH BoB Percentiles			
				25th	50th	75th	90th
Getting Treatment Quickly	50.8%	19th	55.7%	51.3%	55.4%	63.3%	65.7%
Q3. In the last 12 months, how often did you get the professional counseling you needed on the phone?	25.5%	<10th	37.4%	34.3%	36.4%	43.3%	50.8%
Q5. In the last 12 months, when you needed counseling or treatment right away, how often did you see someone as soon as you wanted?	55.8%	<10th	68.1%	61.2%	68.3%	74.6%	79.3%
Q6. In the last 12 months, not counting the times you needed counseling or treatment right away, how often did you get an appointment for counseling or treatment as soon as you wanted?	71.1%	24th	78.1%	71.7%	79.0%	84.7%	87.9%
How Well Clinicians Communicate	51.4%	64th	64.8%	60.0%	66.5%	74.5%	76.3%
Q13. In the last 12 months, how often did the people you went to for counseling or treatment listen carefully to you?	52.1%	55th	68.8%	63.4%	69.8%	75.3%	76.8%
Q14. In the last 12 months, how often did the people you went to for counseling or treatment explain things in a way you could understand?	51.4%	54th	68.8%	64.4%	70.5%	76.1%	76.8%
Q15. In the last 12 months, how often did the people you went to for counseling or treatment show respect for what you had to say?	64.3%	53rd	90.6%	85.5%	93.0%	97.0%	97.6%
Q16. In the last 12 months, how often did the people you went to for counseling or treatment spend enough time with you?	60.7%	58th	87.3%	82.2%	87.2%	92.6%	95.6%
Q19. In the last 12 months, how often were you involved as much as you wanted in your counseling or treatment?	68.5%	56th	94.7%	76.9%	85.7%	92.9%	95.1%
Informed About Treatment Options	46.6%	36th	50.9%	42.1%	50.3%	58.8%	63.4%
Q20. In the last 12 months, were you told about self-help or support groups, such as consumer-run groups or 12-step programs?	43.2%	47th	45.2%	35.0%	44.8%	54.2%	59.8%
Q21. In the last 12 months, were you given information about different kinds of counseling or treatment that are available?	59.0%	13th	59.5%	51.3%	59.4%	65.4%	71.0%
Access to Treatment and Information from Health Plan	64.9%	27th	69.7%	63.3%	73.4%	78.4%	81.0%
Q27. In the last 12 months, how much of a problem, if any, were delays in counseling or treatment while you waited for approval?	66.4%	<1st	87.3%	82.0%	89.5%	92.6%	94.8%
Q29. In the last 12 months, how much of a problem, if any, was it to get the help you needed when you called customer service?	45.3%	<10th	57.4%	52.9%	58.9%	67.1%	73.4%
Office Wait Time (Q12)	74.6%	44th	74.2%	61.3%	76.5%	87.2%	90.6%
Informed about Medication Side Effects (Q18)	61.5%	76th	77.7%	74.7%	78.4%	80.8%	82.4%
Received Information about Managing Condition (Q22)	75.5%	12th	83.3%	75.1%	85.3%	87.8%	89.9%
Informed about Patient Rights (Q23)	79.7%	19th	83.2%	80.5%	85.7%	87.1%	90.0%
Ability to Refuse Medication and Treatment (Q24)	82.0%	73th	81.8%	76.0%	78.3%	89.2%	93.7%
Rating of Counseling or Treatment (Q25)	71.4%	35th	74.2%	76.6%	75.4%	81.4%	83.2%

■ At or above the 90th percentile.
 ■ At or above the 75th percentile, but below the 90th percentile.
 ■ At or above the 50th percentile, but below the 75th percentile.
 ■ At or above the 25th percentile, but below the 50th percentile.
 ■ Below the 25th percentile.

* Summary Rates represent the most favorable response percentage(s).

** Ranking indicates where your plan's Summary Rate ranks when compared to all other plans in the 2018 ECHO Book of Business. Summary Rates that are below the 10th percentile are shown as "<10th."

*** The SPH Analytics 2018 ECHO Book of Business benchmark consists of data from 35 plans representing 2,104 adult respondents, including 1464 Behavioral Health Service Users. See Technical Notes for more information.

Marketplace ECHO Analysis

Florida Health Care Plans' satisfaction goal is to meet 90 percentile satisfaction rates. The goal was not met for any composite. FHCP dropped from the 91st percentile ranking to 19th in *"Getting treatment quickly"* composite. There was an improvement in *"How well clinicians communicate"* composite, up from 42nd to 64th percentile, as well as an increase in *"Informed about Treatment Options"* composite up from <10 to 36th percentile. The *"Access to Treatment and Information from Health Plan Composite"* remained relatively the same with a score of 27th as compared to the previous score of 25th percentile. All percentile scores were significantly lower as compared to the SPH Analytics ECHO Book of Business.

Opportunities Identified Across Satisfaction Data Sources

To identify opportunities to improve performance, Florida Health Care Plans examined all sources of member satisfaction data to identify common issues across the various data sources. A team of internal staff completed the initial opportunity and barrier analysis. Participants included representatives from Customer Service, Claims, Medical Services, Practice Management, Accreditation, and Quality Management. (Tables 10 – 10a)

For the ECHO Survey, if the composite Summary Rate Score percentage is at or above the 75th percentile when compared to the 2018 SPH Analytics ECHO Book of Business Summary Rate Score and the composite is determined to be a Key Driver by the multiple linear regression analysis, the composite is considered a plan Strength. If the composite is a Key Driver and the Summary Rate Score is below the 50th percentile when compared to the 2018 SPH Analytics ECHO Book of Business Summary Rate Score, the composite is considered a plan Opportunity. If a Key Driver has a Summary Rate Score that is between the 50th and 75th percentile when compared to the 2018 SPH Analytics Book of Business Summary Rate Score, then it is suggested that it be monitored as it could become a Strength or an Opportunity in the future, depending on the health plan's success in that area. (SPHAnalytics.com, 2019)

Table 10: Opportunities Identified Across Satisfaction Data Sources Commercial Members

Improvement Opportunity	Member Complaints	Member Appeals	ECHO Satisfaction Survey
Billing/Financial	#1 Complaint by Volume	#2 appeal by Volume (3)	N/A
Attitude and Service	#2 Complaint by Volume (1)	N/A	86th
Access	#2 Complaint by Volume (1)	#1 Appeal by Volume (4)	69th and 23nd
Quality of Care	N/A	N/A	N/A
Quality of Practitioner Office Site	N/A	N/A	N/A

Table 10a: Opportunities Identified Across Satisfaction Data Sources Marketplace Members

Improvement Opportunity	Member Complaints	Member Appeals	ECHO Satisfaction Survey
Attitude and Service	#1 complaint by volume (5)	N/A	64th
Access	#3 complaint by volume (1)	N/A	19th & 27th
Quality of Care	#3 complaint by volume (1)	N/A	<10th
Billing and Financial	#2 complaint by volume (2)	N/A	N/A
Quality of Practitioner Office Site	N/A	N/A	N/A

Barrier Analysis

Opportunities for Improvement and recommendations were discussed by the team. “Barriers and Opportunities”, for both the Commercial and Marketplace population, were combined to select improvements for the following areas: (Tables 11 & 12)

Table 11: Attitude and Service

Barrier	Opportunity	Selected for Improvement?
Member perception of provider/office unprofessionalism/rudeness	- Contractual providers and FHCP Provider services are notified of all complaints related to member perception of poor communication &/or unprofessional/rude staff. - Customer Service team monitors complaints on quarterly basis for trends and address as appropriate. - New company-wide “Relationship” training program for improved Customer Satisfaction - Establishment of FHCP Communication Team with biweekly meetings for the on-going assessment of member Omni-channel communication issues	Yes
Member perception of the lack of communication- Members felt that Provider did not listen to their concerns especially regarding medications though many policies are driven by regulatory statutes.	- Formation of Net Provider Score work group for organization evaluation of member survey feedback and actionable interventions - Make office policy more transparent as related to pill	Yes

	count, urine testing, regulatory prescribing changes. • Use Social media outlets, blogs and physical signage as new federal regulations are released related to narcotic, and other prescription controls as mandated. • Member Engagement Coordinator hired for the coordination of communication avenues for new and existing members	

Table 12: Access

Barrier	Opportunity	Selected for Improvement?
Members felt that there was a delay in obtaining an appointment	Increase number of employed and contracted behavioral health providers in all service areas Communication related to access to BH providers via DoD	Yes
Members felt there was not enough choice in plan providers	Increase number of employed and contracted behavioral health providers in all service areas. Communication related to access to BH providers via DoD	Yes

Table 13: Planned Actions

Date Initiated	Action Implemented	Barriers Addressed
March 2018	Make office policy more transparent as related to pill count, urine testing, regulatory prescribing changes. Use Social media outlets, blogs and physical signage as new federal regulations are released related to narcotic, and other prescription controls as mandated.	Members felt that Provider did not listen to their concerns especially regarding medications though many policies are driven by regulatory statutes. Poor Communication with provider Members felt that Provider did not listen to their concerns as it related to their desired "treatment" plan verses polices in place to comply with regulatory guidelines. Physician adherence to policy/protocols viewed as "rude" or unprofessional.
January 2017	Added Provider/ Member Services liaison in St. Johns, Brevard & Seminole Co. to further educate and assist contract providers with resources to manage FHCP members.	Perceived lack of Behavioral Health providers and a delay in obtaining an appointment

2017 January 2018	Initiate education and outreach activities to BH practitioners and members regarding the availability of new practitioners locally and through Doctor on Demand Identified Zoom application as possible application for testing for Video visits in 2018. Started MD Video- conferencing initiative Member portal with intuitive provider search indicating level of participation by provider Utilization of Social Media outlets, blogs, website, and member portal to communicate when new providers onboard, DoD and Telemedicine & video visits Contracted with additional Behavioral Health providers in all counties serviced by FHCP. BH providers now in satellite locations twice a week. (2017) DoD (2016) and Video/ Telemedicine visits (2018)	
January 2017- on-going	Review B.H. Access results with FHCP Provider Services Administrator and B.H. Leadership to keep them abreast of survey results and to plan response to same	Limited number of behavioral health prescribers in the service area and network and their schedules tend to be full
October 2018 August 2019	Formation of Net Provider Score work group for organization evaluation of member survey feedback and actionable interventions i.e.) blogs and social media blast related to DoD and Zoom Telemedicine availability Member Engagement Coordinator position developed for the coordination of Communication & educational needs	Member perception of the lack of communication and limitation of BH providers with increase request for OON providers

2018 Planned Actions Impact Analysis:

The Customer Satisfaction team also discussed the results of the 2018 analysis and the impact of the planned actions

The team discussed the impact of the mandatory “Relationship training’ for improved Customer Satisfaction and Net Promoter Score Work group survey analysis for 2018. It was determined that the attitude and service complaints were more related to member dis-satisfaction with office policies verses actual unprofessional/rude staff. Members were unhappy with need to complete urine screening, pill counts, discussions related to adherence, etc. and perceived provider requirement for such (in order to comply with treatment plan) as unprofessional and/or rude. With the total number of complaints (6) representing only 0.03% of all 2018 office visits (18063), the team determined that actions initiated in 2018 to address attitude & service were appropriate and will be on-going.

The Customer Satisfaction team also discussed the FHCP Practitioner Availability Analysis for January 2018 to December 2018. The analysis reveals for Commercial and Marketplace/QHP members, the FHCP Network meets all standards and measurements for availability for High Volume Behavioral Health. Currently eighty-six (86%) of the High-Volume Behavioral Health – Prescribing Practitioners are open to accepting new HMO members and members have geographic access within 30 miles of their residence to other behavioral health providers. In 2018, the FHCP Network initiated real time video visits with Behavioral Health Therapists and Psychiatrists, allowing initial and follow up visits with the same provider on a scheduled basis. These video visits can be used for any behavioral health condition, including addiction. This service is not counted in the Practitioner Availability Analysis but significantly improves access to behavioral health services for FHCP members. Since start in 2018, there has been a significant increase in the use of Telemedicine/ video visits with a total of 131 Telemedicine Behavioral health visits in the first three quarters of 2019 verses 26 in 2018, representing a 403.85% increase in the use of video visits. Additionally, there was a 106% increase in total Behavioral Health Providers gained in 2018, as compared to 2017 and a 2.82% increase in the number of behavioral health appointments (Table 14 & 15). With the total number of complaints decreasing by 60% (2017(5) verses 2018(2)), the team determined that actions initiated in 2018 to address access were appropriate and will be on-going.

Table: 14 Behavioral Health Provider Availability

Behavioral Health Providers	2018	2017
Total # of BH Prescribers left FHCP	5	7
Total # of BH Non Prescribers left FHCP	14	11
Total: Left	19	18
	2018	2017
Total # of BH Prescribers joined FHCP	30	21
Total # of BH Non Prescribers joined FHCP	61	32
Total: Joined	91	53

Table:15 Behavioral Health Appointments

Behavioral Health Appointments
2018
18,063
2017
17,567

This QI4/NET4 activity was reported to the following QI committees:

Committee Name	Meeting Date	Committee Actions or Recommendations
Customer Satisfaction	9/30/2019	Approved, send to PI Council.
PI Council	10/16/2019	Approved as written.

References:

SPHAnalytics.com. (2019). 2019 ECHO®Member Satisfaction Survey Florida Health Care Plans Project Number: 9130203. Duluth: SPHAnalytics.

2018 Florida Health Care Plans

Member Satisfaction Analysis
Commercial & Marketplace

Q1 4 / NET 4

**Florida Health Care Plans
Member Satisfaction Analysis
(January 01, 2018 – December 31, 2018)**

Introduction

Analyses of member satisfaction information helps managed care organizations identify aspects of performance that do not meet member expectations and initiate actions to improve performance. Florida Health Care Plans monitors multiple aspects of Commercial and Medicare member satisfaction on an annual basis, including:

- Member complaints
- Member appeals
- Member satisfaction surveys

This report describes the monitoring methodology, results, and analysis for each satisfaction data source, and actions initiated to improve member satisfaction.

Member Complaints

Florida Health Care Plans defines a complaint as any expression of dissatisfaction of a subscriber i.e., dissatisfaction with the administration, claims practices, or provision of services, which relates to the quality of care provided by a provider pursuant to the organization's contract and which is submitted to the organization or to a state agency. A complaint is based on the content of the member's complete call and not simply on the tone of the caller. A category code is assigned based upon the main issue in the complaint. Grievance, appeals, and complaints are categorized by mode of submission. Mode of submission is defined as verbal versus written (e.g. telephone, fax, or email) and coded based on the main issue in the complaint. If complaint relates to multiple issues, more than one case may be initiated to address each complaint separately.

A grievance is defined as a written (*or verbal in the case of a Fast or Urgent*) complaint submitted by or on behalf of a subscriber to an organization or a state agency regarding the:

- (a) Availability, coverage for the delivery, the quality of health care services, satisfaction with the delivery of services, claims practices, or general practices, policies and procedures.
- (b) Matters pertaining to the contractual relationship between a subscriber and an organization
- (c) Disagreement with the organization's decision to transfer a request for an Expedited Appeal to a Standard Appeal timeframe. A grievance does not include a written complaint submitted by or on behalf of a subscriber eligible for a grievance and appeals procedure provided by an organization pursuant to the contract with the federal government under Title XVIII of the Social Security Act.

Member complaints are documented and tracked through documentation in the Correspondence Unit Tracking System (CUT) utilizing codes that are specific to each category of complaints and appeals.

Table 1 demonstrates the categories and cross mapping of areas of focus within Florida Health Care Plans (FHCP), and include:

1. Billing and Financial Issues
2. Quality of Care Issues;
3. Access Issues; and
4. Attitude and Service Related Issues
5. Quality of Practitioner Office Site

Table 1 Complaint Categories

CUT Category Code	Cause Code	Definition	NCQA Category
AC	A201	Access Time to Appointment	Access or Quality
	A202	Wait Time in Office	
	A203	Location of Facilities	
	A204	Telephone Delay / No Call Back	
	A207	Choice of Plan Provider	
	A209	Procedure Cancelled	
	A213	Delay in Service	
	A215	Appointment Cancelled	
	A216	Testing Appointment / Wait	
	A217	Surgery Wait	
	A205	Access Time to an Urgent Appointment	
PP	P403	Desired Service Not Provided	
	P406	Contract/Benefit	
	P402	Claim denied by FHCP	Billing & Financial
	P404	Cost of service	
	P405	Premium billing complaint	
	P406	Contract/Benefits Complaint	
	P411	Member Requests Waiver of a Copay	
	P412	Member Requests Reimbursement of a Copay	
	P425	Claims Processing Problem	
	P426	Balance Billing Problem	
QU	Q104	Dissatisfaction with Equipment / Facility	Quality of Care
	Q107	Inappropriate Treatment	
	Q112	Unhappy with Treatment	
	Q115	Continuity of Care / Delay of Care	
	Q149	QUALITY COMPLAINT ENTERED IN QUANTROS	
ST	S301	Poor Communication	Attitude and Service
	S305	Unprofessional	

Rates for grievance and appeals or complaints per 1000 members for each year are determined by dividing the number of complaints for the year by the number of members and multiplying by 1000. To identify key areas of focus, all complaints are reviewed. Due to the subjective nature of complaints, it is possible to categorize a single issue under different codes. Miscoding occasionally occurs. When miscoding trends are identified, feedback is provided to all front-line Member Services Staff via Management. Feedback and training are also given based on changes in regulatory guidelines.

The Customer Satisfaction Committee monitors complaint data on a quarterly and annual basis.

Commercial Member Experience

Table 2: 2018 Commercial Member Complaints

Complaint Category	Q1 2018		Q1 2017		Q2 2018		Q2 2017		Q3 2018		Q3 2017		Q4 2018		Q4 2017		Total 2018		Total 2017	
	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000
Billing/Financial	3	0.08	4	0.06	4	0.11	3	0.04	9	0.25	9	0.14	8	0.22	7	0.11	24	0.66	23	0.36
Access	18	0.5	13	0.21	13	0.36	15	0.22	11	0.3	26	0.4	23	0.63	#	0.26	65	1.78	71	1009
Attitude and Service	11	0.3	29	0.46	15	0.41	20	0.3	22	0.6	28	0.5	23	0.63	#	0.3	71	1.95	98	1051
Quality of Care	17	0.47	6	0.09	6	0.17	3	0.04	9	0.25	8	0.12	16	0.44	6	0.09	48	1.32	13	0.36
Quality of Practitioner Office Site	0	0	0	0	1	0.03	0	0	0	0	0	0	1	0.03	1	0.16	2	0.05	1	0.15

The tables below provide details about the complaint issues by categories.

Table 2a: 2018 Commercial Attitude/Service Complaints

ATTITUDE/SERVICES		Q1		Q2		Q3		Q4		CY 2018	
CUT Codes	Attitude/Service subcategories	#	%	#	%	#	%	#	%	#	%
S301	Poor Communication	6	55%	9	60%	13	60%	10	43%	38	53%
S302	Unprofessional	5	45%	6	40%	9	40%	13	57%	33	46%

Table 2b: 2018 Commercial Access Complaints

ACCESS		Q1		Q2		Q3		Q4		CY 2018	
CUT Code	Access subcategories	#	%	#	%	#	%	#	%	#	%
A202	Wait time in office	0	0%	1	8%	0	0%	4	18%	5	8%
A213	Delay in Service	7	39%	1	8%	2	18%	7	30%	17	26%
A201	Access time to an Appointment	1	6%	1	8%	0	0%	1	4%	3	5%
A204	Telephone Delay/No call back	2	11%	2	15%	3	27%	1	4%	8	12%
A203	Location of Facilities	0	0%	0	0%	0	0%	0	0%	0	0%
A205	Access to Urgent Appointment	0	0%	0	0%	0	0%	0	0%	0	0%
A215	Appointment Cancelled	1	6%	2	15%	2	18%	2	9%	7	11%
A207	Choice of Plan Provider	6	33%	2	15%	4	36%	2	9%	14	22%
A210	Hours of operation	0	0%	1	8%	0	0%	0	0%	1	2%
P403	Desired Service not provided	1	6%	3	23%	0	0%	4	17%	8	12%
P406	Contract/Benefit	0	0%		0%	0	0%	1	4%	1	2%
P409	Enrollment / Disenrollment Complaint	0	0%		0%		0%	1	4%	1	2%

Table 2C: 2018 Quality of Care

Quality		Q1		Q2		Q3		Q4		CY 2018	
CUT Code	Subcategories	#	%	#	%	#	%	#	%	#	%
Q104	Dissatisfaction with Equipment/Facility	0	0%	1	14%	0	0%	2	12%	3	6%
Q107	Inappropriate Treatment	2	12%	0	0%	0	0%	0	0%	2	4%
Q112	Unhappy with treatment	12	71%	5	71%	6	67%	9	53%	32	64%
Q115	Continuity/Delay of care	3	18%	1	14%	3	33%	6	35%	13	26%

Table 2d: 2018 Commercial Billing & Finance

BILLING & FINANCIAL		Q1		Q2		Q3		Q4		CY 2018	
CUT Code	Subcategories	#	%	#	%	#	%	#	%	#	%
P403	Desired Service not provided	0	0%	0	0%	5	56%	3	38%	8	32%
P404	Cost of Service	3	75%	3	75%	3	33%	3	38%	12	48%
P405	Premium Billing	0	0%	0	0%	0	0%	0	0%	0	0%
P407	Fraud & abuse Complaint	0	0%	1	25%	0	0%	0	0%	1	4%
P406	Contract/Benefit	0	0%	0	0%	1	11%	2	25%	3	12%
P425	Claims Processing	0	0%	0	0%	0	0%	0	0%	0	0%
P426	Balanced Billing	0	0%	0	0%	0	0%	0	0%	0	0%
P411	Co-pay Waiver	0	0%	0	0%	0	0%	0	0%	0	0%
P412	Co-pay reimbursement	1	25%	0	0%	0	0%	0	0%	1	4%

Analysis

Attitude and Service issues accounted for thirty-four (34) percent and were the highest number of complaints from Commercial members in 2018. Most complaints in this category related to poor communication between member and providers. No specific trend was identified related to the type of communication or provider. This data correlates with the Commercial CAHPS Key Drivers of Overall Plan rating, indicating FHCP should note an opportunity to address provider communication. FHCP ranked in the 44th percentile for “How Well Doctors Communicate”. The Summary Rates of these Key Drivers are

compared to the Summary Rates of all other plans in the 2018 Quality Compass All Plans (Tables 7a, c & d)

Access issues at thirty-one (31) percent were the second highest number of complaints. Most access complaints in 2018 continue to be related to the member's perception about a delay in service. The delay in service complaints were comprised of complaints against contracted providers and primary care providers timeliness in the submission of orders for referrals, DME and/ or prescriptions. Additionally, FHCP contracted with a new Dermatology group whom utilized mid-level practitioners in several sites, which did not please members. There were no provider specific trends identified. This data correlates with the Commercial CAHPS Key Drivers of Overall Plan rating, indicating an opportunity for FHCP to improve access for needed care and timeliness. FHCP ranked in the 53rd percentile for *"Getting Needed Care"* and in the 88th percentile for *"Getting Care Quickly"*. The Summary Rates of these Key Drivers are compared to the Summary Rates of all other plans in the 2018 Quality Compass All Plans (Table 7a, c & d).

The third highest number of complaints from Commercial members in 2018 was Quality of Care at 23 percent. Sixty-four percent of these complaints consisted of members not understanding or were unhappy with treatment plan/procedure protocols. Twenty-three percent was member perception of delay-in-care. No specific trend was identified with any plan benefit or provider. This data correlates with the Commercial CAHPS Key Drivers of Overall Plan rating, indicating an opportunity for FHCP to improve access for needed care and timeliness. FHCP ranked in the 53rd percentile for *"Getting Needed Care"* and in the 88th percentile for *"Getting Care Quickly"*. The Summary Rates of these Key Drivers are compared to the Summary Rates of all other plans in the 2018 Quality Compass All Plans (Table 7c & d) The complaints are handled individually by the Member Services department. The provider is contacted to facilitate the referral/ordering process and complaints related to member service staff are managed by the employee's supervisors.

All complaint categories are discussed quarterly at the Customer Satisfaction meeting with the CMO, and representatives from FHCP Member Services, Central Referrals, Provider & Contract Services, and Quality Management departments where strategies for improvement are discussed.

Overall, the total number of Commercial member complaints @ 5.76 per 1000 in 2018 was a 1.94/1000 increase as compared to the 2017 (3.35/1000). In the commercial CAPHS Benchmark Comparisons for 2018, FHCP ranked 6.8 percent higher than national benchmark for *"Rating of Health Plan"*. (Table 7b)

COMMERCIAL Appeals

An "appeal" is a request for review or reconsideration of an adverse organizational determination (e.g. denied: pre-service/prior authorization request in advance of obtaining the service; concurrent discontinued service review or post-service claim/service that has already been rendered).

The Utilization Management Committee and Customer Satisfaction Committee monitor appeals data on a quarterly basis. This document summarizes the results and analysis for 2018. FHCP did not receive any member appeals related to quality of care, attitude, service or quality of practitioner office site during this reporting period.

Table 3: 2018 Commercial Appeals Data

Appeal Category	Q1 2018		Q1 2017		Q2 2018		Q2 2017		Q3 2018		Q3 2017		Q4 2018		Q4 2017		Total 2018		Total 2017	
	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000
Billing/Financial	15	0.42	12	0.19	18	0.5	12	0.18	40	1.1	8	0.12	18	0.49	8	0.27	91	2.50	58	1.6
Access	14	0.39	16	0.26	19	0.52	19	0.28	5	0.14	14	0.22	11	0.3	8	0.24	49	1.35	78	2.15
Attitude and Service	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Quality of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Analysis

Commercial Appeals for Billing and Financial reasons accounted for 65% of the total Appeals in 2018 and included:

- Benefit exclusion &/or exhaustion of benefits
- processing of claims that resulted in a higher cost sharing for the member (deductible and co-insurance)

Appeals for Access reasons accounted for 35% included:

- Formulary exceptions (accounted for 35% of all access complaints)
- requests for out of network providers,
- exclusions to the members' plan,
- did meet established guidelines

Overall, there was a 2.14/1000 (3.84/1000) increase in the total number of Commercial Appeals verses 2017 (1.7/1000) however the reasons for Commercial Billing/Financial Appeals and Commercial Access Appeals remained the same.

Commercial CAHPS Member Satisfaction Survey

The Commercial CAHPS member satisfaction survey is administered annually by an external survey vendor using the survey protocol defined in current HEDIS specifications and the Z test to define statistical significance in differences between years. This report includes results from the last two years for the Commercial product line.

Table 4 Commercial CAHPS Survey response rates for the last two-years

Survey Population	2018 Response Rate	2017 Response Rate	2016 Response Rate
Commercial HMO	23.9%	29.6%	26.1%

(Symphony Performance, Inc 2018)

Table 4a: Summary of Trend and Benchmark Comparisons for 2018

SPH Analytics Book of Business (Non-PPO) Mean and Percentiles

COMPOSITES, ATTRIBUTES, AND KEY QUESTIONS	Valid n	2018	2017	2016	2018 SPH Book of Business Non-PPO	2018 Public Report Non-PPO	2018 Quality Compass All Plans, Non-PPO
Getting Needed Care		87.4%	89.0%	90.4%	86.9%	86.3%	86.2%
14 Getting care, tests, or treatments necessary	342	89.2%	91.8%	90.7%	89.3%	88.8%	88.5%
25 Obtained appointment with specialist as soon as needed	251	85.7%	86.2%	90.1%	84.5%	84.0%	84.0%
Getting Care Quickly		89.9%	88.2%	88.7%	85.5%	84.9%	84.8%
4 Obtaining needed care right away	181	92.3%	89.4%	94.0%	88.2%	88.3%	82.0%
6 Obtained appointment for care as soon as needed	329	87.5%	87.0%	83.5%	82.9%	82.2%	88.3%
How Well Doctors Communicate		95.0%	95.5%	97.1%	95.2%	95.1%	95.0%
17 Doctors explained things in an understandable way	327	96.6%	96.4%	98.3%	95.7%	96.0%	96.0%
18 Doctors listened carefully to you	327	94.8%	94.8%	97.4%	95.1%	94.9%	94.8%
19 Doctors showed respect for what you had to say	325	95.7%	96.4%	97.4%	96.2%	96.3%	96.2%
20 Doctors spent enough time with you	326	92.9%	94.4%	95.3%	93.7%	93.1%	93.0%
Health Plan Customer Service		90.2%	91.5%	91.1%	88.5%	88.4%	88.4%
35 Getting information/help from customer service	123	88.2%	87.0%	87.2%	82.3%	82.1%	82.3%
36 Treated with courtesy and respect by customer service staff	122	94.3%	96.0%	94.9%	94.8%	94.7%	94.6%
Claims Processing		90.9%	87.4%	92.1%	89.0%	88.7%	88.7%
40 Claims handled quickly	126	88.9%	86.4%	91.0%	87.5%	87.7%	90.0%
41 Claims handled correctly	127	92.9%	88.3%	93.1%	90.4%	90.0%	87.6%

Significance Testing: Green – Significantly higher percentage when compared to current year data. Red – Significantly lower percentage when compared to current year data. No color denotes that there was no significant difference between the percentages or that there was insufficient sample size to conduct the statistical test. All significance testing is performed at the 95% significance level. (Symphony Performance, Inc 2018)

Table 4b: Commercial Benchmark Comparisons for 2018

SPH Analytics Book of Business (Non-PPO) Mean and Percentiles



Summary Rate Scores

Florida Health Care Plan, Inc.
 Please see Technical Notes for more information.

RATING ITEMS	Valid n	2018	2017	2016	2018 SPH Book of Business Non-PPO	2018 Public Report Non-PPO	2018 Quality Compass All Plans, Non-PPO
Rating Questions (8+9+10)							
13 Rating of Health Care	347	80.7%	81.9%	82.2%	78.9%	77.6%	77.5%
23 Rating of Personal Doctor	360	85.8%	85.4%	86.2%	84.1%	84.7%	84.9%
27 Rating of Specialist	238	84.9%	80.7%	86.4%	85.8%	84.7%	84.7%
42 Rating of Health Plan	382	70.4%	74.3%	74.6%	68.0%	63.9%	63.6%

Significance Testing: Green – Significantly higher percentage when compared to current year data. Red – Significantly lower percentage when compared to current year data. No color denotes that there was no significant difference between the percentages or that there was insufficient sample size to conduct the statistical test. All significance testing is performed at the 95% significance level. (Symphony Performance, Inc 2018)

Table 4c: Commercial Trended Survey Results

Plan Percentile Rankings		Florida Health Care Plan, Inc. Please see Technical Notes for more information.			
COMPOSITES, ATTRIBUTES, AND KEY QUESTIONS		Plan Summary Rate	2018 SPH Book of Business Non-PPO	2018 Public Report Non-PPO	2018 Quality Compass All Plans, Non-PPO
Getting Needed Care		87.4%	40th	54th	53rd
14 Getting care, tests, or treatments necessary		89.2%	36th	47th	45th
25 Obtained appointment with specialist as soon as needed		85.7%	46th	57th	57th
Getting Care Quickly		89.9%	84th	90th	88th
4 Obtaining needed care right away		92.3%	84th	84th	99th
6 Obtained appointment for care as soon as needed		87.5%	80th	88th	37th
How Well Doctors Communicate		95.0%	44th	44th	42nd
17 Doctors explained things in an understandable way		96.6%	57th	54th	54th
18 Doctors listened carefully to you		94.8%	42nd	45th	41st
19 Doctors showed respect for what you had to say		95.7%	32nd	35th	34th
20 Doctors spent enough time with you		92.9%	36th	42nd	42nd
Health Plan Customer Service		90.2%	63rd	60th	56th
35 Getting information/help from customer service		86.2%	71st	75th	73rd
36 Treated with courtesy and respect by customer service staff		94.3%	34th	31st	32nd
Claims Processing		90.9%	56th	63rd	60th
40 Claims handled quickly		88.9%	50th	51st	35th
41 Claims handled correctly		92.9%	70th	69th	87th

2018 Commercial Adult Survey - 31

Significance Testing: Green – Significantly higher percentage when compared to current year data. Red – Significantly lower percentage when compared to current year data. No color denotes that there was no significant difference between the percentages or that there was insufficient sample size to conduct the statistical test. All significance testing is performed at the 95% significance level. (Symphony Performance, Inc 2018)

Table 4d: Key Drivers of Overall Health Plan Rating



Florida Health Care Plan, Inc.
Please see Technical Notes for more information.

This Opportunity Analysis displays both high performing measures and measures that are opportunities for improvement.

STRENGTH – Summary Rates **at or above the 75th percentile** when compared to the 2018 SPH Analytics Book of Business.

MONITOR – Summary Rates **at or above the 50th percentile and below the 75th percentile** when compared to the 2018 SPH Analytics Book of Business should be monitored, as they do have a significant impact on members' overall ratings.

OPPORTUNITY – Summary Rates that fall **below the 50th percentile** when compared to the 2018 SPH Analytics Book of Business should be investigated and improved upon.



Rating of Health Plan

These Composites have been identified by SPH as Key Drivers of Rating of Health Plan.

Claims Processing	Monitor
Customer Service	Monitor
Getting Needed Care	Opportunity

Rating of Health Care

These Composites have been identified by SPH as Key Drivers of Rating of Health Care.

How Well Doctors Communicate	Opportunity
Getting Needed Care	Opportunity

Rating of Personal Doctor

These Composites have been identified by SPH as Key Drivers of Rating of Personal Doctor.

How Well Doctors Communicate	Opportunity
Coordination of Care	Monitor

The Summary Rates of these Key Drivers are compared to the Summary Rates of all other plans in the 2018 Non-PPO SPH Analytics Commercial Adult Book of Business benchmark. Depending on how these composite scores rank they are placed into one of three action categories: Plan Strength (Market & Maintain), Plan Opportunity (Investigate & Improve), Area to Monitor. (Symphony Performance, Inc 2018)

Florida Health Care Plans CAHPS satisfaction goal is to meet or exceed Quality Compass and 90th percentile of the national benchmark. In 2018, Access, as shown in the *Getting Care Needed* ranked in the 53rd percentile, *Getting Care Quickly* at the 88th percentile, and *How well Doctors Communicate* in the 42nd percentile. Claims processing improved to the 60th percentile. *Attitude & Service* as shown in the *Customer Service* composite dropped to 56th percentile. FHCP rated in the 79th percentile for *Rating of Health Care*, and 77th percentile for *Rating of Health Plan*. The *Rating of Personal Doctor* was in the 85th percentile and in the 23rd percentile for *Rating of specialist*.

In 2018, FHCP *Rating of Health Plan* score was significantly higher when compared to trend and/or benchmark data for the SPH Analytics Book of Business (Non-PPO) Mean and Percentiles. However, it still did not meet the 90th percentile goal of the Quality Compass. (Symphony Performance, Inc 2018)

Marketplace Member Experience

Table 5: 2018 Marketplace Member Complaints

Complaint Category	Q1 2018		Q1 2017		Q2 2018		Q2 2017		Q3 2018		Q3 2017		Q4 2018		Q4 2017		Total 2018		Total 2017	
	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000
Billing/Financial	10	0.27	6	0.27	2	0.06	6	0.27	5	0.14	16	0.78	6	0.18	6	0.3	23	0.65	37	1.32
Access	18	0.48	9	0.4	19	0.52	14	0.65	25	0.72	10	0.5	18	0.54	17	0.87	80	2.26	50	1.79
Attitude and Service	23	0.62	26	1.17	21	0.58	24	1.1	30	0.87	18	0.87	23	0.69	30	0.53	97	2.14	98	3.5
Quality of Care	3	0.08	1	0.04	7	0.19	5	0.23	10	0.29	6	0.29	8	0.24	10	0.51	28	0.79	22	0.78
Quality of Practitioner Office Site	0	0	1	0.04	0	0	0		1	0.03	0		1	0.03	0		2	0.06	1	0.36

In 2018, the highest numbers of complaints were related to Attitude & Service at 52%, where the member perceived the PCP or specialist office was unprofessional, followed by Access at 35%.

Table 5a: 2018 Marketplace Attitude and Service

ATTITUDE/SERVICES		Q1		Q2		Q3		Q4		CY 2018	
CUT Codes	Attitude/Service subcategories	#	%	#	%	#	%	#	%	#	%
S301	Poor Communication	12	52%	15	71%	22	73%	13	57%	62	64%
S302	Unprofessional	11	48%	6	29%	8	27%	10	43%	35	36%

The highest number/percentage of attitude/service complaints was member perception PCP or specialist office had poor communication.

Table 5b: 2018 Marketplace Quality

Quality		Q1		Q2		Q3		Q4		CY 2018	
CUT Code	Subcategories	#	%	#	%	#	%	#	%	#	%
Q104	Dissatisfaction with Equipment/Facility	0	0%	0	0%	1	9%	1	11%	2	7%
Q107	Inappropriate Treatment	0	0%	1	14%	1	9%	1	11%	3	10%
Q112	Unhappy with treatment	2	66%	4	57%	7	64%	3	33%	16	53%
Q115	Continuity/Delay of care	1	33%	2	28%	2	18%	4	44%	9	30%

The highest number/percentage of Quality complaints were member unhappiness with treatment, followed by member perception there was a delay in care.

Table 5c: 2018 Marketplace Access

ACCESS		Q1		Q2		Q3		Q4		CY 2018	
CUT Code	Access subcategories	#	%	#	%	#	%	#	%	#	%
A202	Wait time in office	1	6%	0	0%	2	8%	1	6%	4	5%
A213	Delay in Service	5	28%	3	16%	8	32%	5	28%	21	26%
A201	Access time to an Appointment	2	11%	3	16%	2	8%	2	11%	9	11%
A204	Telephone Delay/No call back	2	11%	1	5%	4	16%	5	28%	12	15%
A203	Location of Facilities	1	6%	1	5%	1	4%	0	0%	3	4%
A205	Access to Urgent Appointment	1	6%	0	0%	0	0%	0	0%	1	1%
A215	Appointment Cancelled	0	0%	1	5%	1	4%	0	0%	2	3%
A207	Choice of Plan Provider	5	28%	1	5%	2	8%	1	6%	9	11%
A210	Hours of operation	0	0%	0	0%	0	0%	0	0%	0	0%
P403	Desired Service not provided	0	0%	7	39%	5	20%	3	17%	15	19%
P406	Contract/Benefit	0	0%	2	11%	0	0%	0	0%	2	3%
P409	Enrollment / Disenrollment Complaint	1	6%	0	0%	0	0%	1	6%	2	3%

Majority of Access complaints in 2018 were related to members' perception of a delay in service in the receipt of test results and Specialist referrals.

Table 5d: 2018 Marketplace Billing and Financial Matters

BILLING & FINANCIAL		Q1		Q2		Q3		Q4		CY 2018	
CUT Code	Subcategories	#	%	#	%	#	%	#	%	#	%
P403	Desired Service not provided	1	10%	0	0%	0	0%	0	0%	1	4%
P404	Cost of Service	6	60%	2	100%	2	40%	4	67%	14	61%
P405	Premium Billing	0	0%	0	0%	1	20%	0	0%	1	4%
P407	Fraud & abuse Complaint	2	20%	0	0%	0	0%	0	0%	2	8%
P406	Contract/Benefit	0	0%	0	0%	1	20%	0	0%	1	4%
P425	Claims Processing	1	10%	0	0%	1	20%	0	0%	2	8%
P426	Balanced Billing	0	0%	0	0%	0	0%	1	17%	1	4%
P411	Co-pay Waiver	0	0%	0	0%	0	0%	1	17%	1	4%
P412	Co-pay reimbursement	0	0%	0	0%	0	0%	0	0%	0	0%

The highest number/percentage of complaints for billing/financial matters was Cost of Service/claims processing. Members were not satisfied with contractual cost-sharing responsibilities.

Analysis

Attitude and Service issues were the highest number of complaints from Marketplace members in 2018 accounting for 46% of the total complaints, followed by Access complaints at 38%. (Tables 5a & c) The Attitude and Service complaints were related to poor communication between member and providers. No specific trend was identified related to the type of communication or provider. This data correlates with the Marketplace CAHPS Key Drivers of Overall Plan rating, indicating FHCP should note an opportunity to address provider communication. FHCP ranked in the 38th percentile for *“How Well Doctors Communicate”*. The Summary Rates of these Key Drivers are compared to the Summary Rates of all other plans in the 2018 Quality Compass All Plans (Tables 8a, & c)

Access Complaints were related to member’s perception about a delay in service. The delay in service complaints were related to member’s perception of a delay in getting a referral, appointment or prescription, delay in receipt of test results or return phone calls timely, and/or not receiving the service they desired. There was no trend identified related to the type of access, service, and/or provider. This data correlates with the Marketplace CAHPS Key Drivers of Overall Plan rating, indicating FHCP should note an opportunity to address, *“Getting Needed Care”* and provider communication. FHCP ranked in the 53rd percentile in *“Getting Needed Care”*, in the 88th percentile in *“Getting Care Quickly”* and in 38th percentile for *“How Well Doctors Communicate”*. The Summary Rates of these Key Drivers are compared to the Summary Rates of all other plans in the 2018 Quality Compass All Plans (Tables 8a, & c)

Quality Complaints were related to member dissatisfaction with treatment recommendation though provider followed nationally accepted medical guidelines /practices. Additionally, member’s perceived delay in getting needed information or prescriptions (i.e. test results) for needed treatment. FHCP does have a Follow-my- Health application which allows members to access and communicate with FHCP providers. Additionally, members can review and order prescription re-fills online and via mobile application. FHCP ranked in the 83rd percentile in *“Access to Care”*, in the 88th percentile in *“Rating of all Health Care”*. However as previously identified FHCP ranked in the 38th percentile for *“How Well Doctors Communicate”*. The Summary Rates of these Key Drivers are compared to the Summary Rates of all other plans in the 2018 Quality Compass All Plans. (Tables 8a & c) All Complaints are monitored for trends.

All complaint categories are handled individually by Member Services staff and are brought to Customer Satisfaction Meeting for discussion monthly. The customer satisfaction meeting is attended by the Chief Executive Officer, Chief Medical Officer, and administrative representatives from quality management, enrollment, provider and contract services, marketing, member services, pharmacy, utilization management, and practice management. Strategies for improvement are discussed. No trends were identified in any category.

Appeals

An “appeal” is a request for review or reconsideration of an adverse organizational determination (e.g. *denied: pre-service/prior authorization request in advance of obtaining the service; concurrent discontinued service review or post-service claim/service that has already been rendered*).

The Utilization Management Committee and Customer Satisfaction Committee monitor appeals data and all out of network service request on a quarterly and annual basis. This document summarizes the results and analysis for 2018. FHCP did not receive any member appeals related to attitude, service, or quality during this reporting period.

Table 5: Marketplace Appeals Data

Appeal Category	Q1 2018		Q1 2017		Q2 2018		Q2 2017		Q3 2018		Q3 2017		Q4 2018		Q4 2017		Total 2018		Total 2017	
	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000	#	Per 1000
Billing/Financial	18	0.48	4	0.18	17	0.47	8	0.37	21	0.61	11	0.54	17	0.51	8	0.4	73	2.06	42	1.5
Access	25	0.67	13	0.58	25	0.69	15	0.68	22	0.64	13	0.63	23	0.69	15	0.77	95	2.68	56	2
Attitude and Service	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Quality of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Majority of appeals in 2018, were related to Formulary Exception request, followed by members' misunderstanding of contractual responsibilities related to cost share.

Analysis

Marketplace Appeals for Billing and Financial reasons (57%) in 2018 included processing of claims that resulted in a higher cost sharing (deductible and co-insurance) for the member at 56% and post-service claims on services that are exclusions to the plan benefit, require Prior-authorization, or exceeded plan benefits. Appeals for Access reasons (43%) included requests for formulary exceptions (49%), out of network providers (15%), exclusions to the members' plan and "doesn't meet established guidelines".

Table 6: Out-of-Network Services data collection

Out-of-Network (OON)	2018 OON Request, Total	2018 OON Request, per 1000	2017 OON Request, Total	2017 OON Request, per 1000	2016 OON Request, Total	2016 OON Request, per 1000
Marketplace Out of Network Request	1274	36.94	996	35.2	209	12.67

All member requests for out-of-network services, regardless of the reason or outcome of the request

Transitional/continuity of care issues was the highest number of out of network request from Marketplace members in 2018, followed by request to see Point of Service providers at the HMO reimbursement level, the remaining request were members seeking referrals to OON specialist before accessing in-network providers. Eighty percent of the requests were approved. There were no trends related to providers or services.

Marketplace CAHPS Member Satisfaction Survey

The QHP Enrollee Survey is administered annually to enrollees of all QHPs by HHS-approved QHP Enrollee Survey vendors, using a standardized protocol to facilitate QHP comparison within and across Marketplaces. The Health Plan Composite Measures and Overall Plan ratings shows the national average for all QHP reporting units; FHCP reporting unit's case-mix adjusted mean score on a 0–100 scale; and whether FHCP reporting unit's score was significantly greater than, less than, or equal to the national average. This report contains the results from the 2018 for the Marketplace product line. Please be aware that all numbers throughout this report are unadjusted and will not match the Case-Mix Adjustment report provided by CMS, which was not available at the time of this report. (2018 Symphony Performance Health, Inc)

Table 8: Marketplace CAHPS Survey response rates for the last two-years

Survey Population	2018 Response Rate	2017 Response Rate
Marketplace	25.2%	23.2%

Table 8a: Ratings for Health Plan Composite Measures

QHP Scaled Mean Scores	2018	2017	2018 SPH BoB	2018 SPH BoB Percentile Rank	2017 CMS National Data
Access to Care	82.8	NA	79.8	83rd	NA
Getting information in a Needed Language or Format	38.6	NA	NA	NA	71.5
How Well Doctors Communicate	90.5	92.1	90.9	38th	90.0
How Well Doctors Coordinate Care and Keep Patients Informed	85.9	87.0	83.6	78th	83.7
Getting Information About the Health Plan and Costs of Care	66.3	68.4	57.7	90th	57.6
Health Plan Customer Service	81.6	76.3	73.9	96th	NA
Enrollee Experience with Cost	82.7	83.0	79.5	84th	79.1
Rating of All Health Care	86.1	86.7	82.8	88th	82.3
Rating of Personal doctor	89.1	90.9	89.1	58th	88.7
Rating of Specialist	86.1	87.5	87.1	31st	87.4
Rating of Health Plan	80.9	76.7	73.8	91st	73.2

*Table 8a shows FHCP's 2018 unadjusted mean score on a 0–100 scale; and whether the score was significantly **greater than**, **less than**, or equal to the national average. (Symphony Performance, Inc 2018).*

FHCP goal for member satisfaction for Marketplace members is to exceed the scaled mean score set by CMS. In 2017, CMS standardize all measure scores by calculating national percentile ranks, based on one national, all-product reference group. CMS intends to provide the national percentile ranks each year, so issuers can calculate their own standardized measure scores. FHCP met or exceeded the scale mean scores except for “Rating of Specialist” and “Getting information in a needed language or format”.

The composite score for “Rating of Specialist” is a single item measure. FHCP’s score dropped from the SPH BoB from the 54th percentile in 2017 to the 31st in 2018. As previously noted, CMS has not released the 2018 case-mixed adjusted scale mean scores at the time of this report.

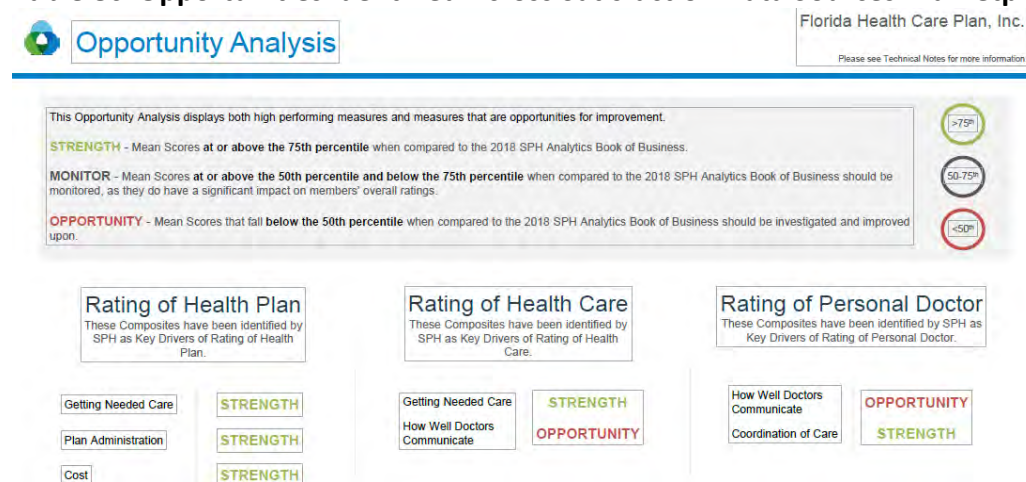
Table 8b: Cultural Competence: Getting information in a needed language or format

FHCP Scaled Mean Scores						
SUMMARY INDICATOR: ENROLLEE EXPERIENCE						
	Valid n	2018	2017	2018 SPH Book of Business	2018 SPH Percentile Rank	2017 CMS National Data
Cultural Competence		NA	NA	73.9	NA	71.5
11 Obtained interpreter when needed	NA	NA	NA	64.7	NA	73.5
47 Forms available in preferred language	45	83.7	86.4	92.0	12th	88.6
49 Forms available in needed format	NA	NA	NA	63.2	NA	62.2

The composite score for “Getting information in a needed language or format” is derived from the above three survey questions.

There were not enough respondents to questions # 11 and question # 49 to allow reporting. On question 47, FHCP’s score was 83.7 which is average as compared to the national mean score of 92.0. FHCP currently has policies and processes in place to identify languages and ethnic background of network providers to assess whether they meet the language needs and cultural preferences of the members and publishes the information in the provider directories. FHCP partners with Florida Deaf services and contracts with a Language Line Service. Additionally, during the 2018 calendar year, there was no organizational complaints related getting information in a needed language format. Therefore, no barriers are identified.

Table 8c: Opportunities Identified Across Satisfaction Data Sources Marketplace Members



In 2018 Opportunity analysis displays both high performing and low performing measures that provide opportunities for improvement

Opportunities Analysis

To identify opportunities to improve performance, Florida Health Care Plans examined all sources of member satisfaction data to identify common issues across the various data sources. A team of internal staff completed the initial opportunity and barrier analysis. Participants included representatives from customer service, claims, medical services, Practice Management, accreditation, and quality management. Tables 9 and 10 display the common opportunities to improve member satisfaction identified across the multiple data sources.

Table 9: Opportunities Identified Across Satisfaction Data Sources Commercial Members

Improvement Opportunity	Member Complaints	Member Appeals	CAHPS Quality Compass % Rank
Attitude and Service	#1 complaint by volume	N/A	44 th percentile
Access to Care	#2 complaint by volume	#1 appeal by volume	54 th / 90 th percentile
Quality of care	#3 complaint by volume	N/A	70 th percentile
Billing & Financial	#4 complaint by volume	#2 appeal by volume	60 th percentile

Table 10: Opportunities Identified Across Satisfaction Data Sources Marketplace Members

Improvement Opportunity	Member Complaints	Member Appeals	CAHPS Satisfaction Survey
Attitude and Service	#1 complaint by volume	N/A	78 th percentile
Access to Care	#2 complaint by volume	#1 appeal by volume	83 rd percentile
Quality of care	#3 complaint by volume	N/A	88 th percentile
Billing & Financial	#4 complaint by volume	#2 appeal by volume	84 th percentile

Opportunities for improvement and recommendations were discussed by the team for the following: Both Commercial member and Marketplace member Barriers and Opportunities were combined to select improvements. (Tables 11-12b)

Table 11: 2016 Billing and Financial Barrier Analysis Results

Barrier	Opportunity	Selected for Improvement?
Members with Triple Option and Point of Service Plans expect HMO level of benefit coverage for services received outside of HMO network	• Educate members more thoroughly during open enrollment regarding the cost associated with utilizing the Triple Option benefit • Web based directory with specific Tier designations by provider	Yes
High deductible plans and high co-insurance create financial difficulties for members who utilize services	• Educate members and prospective members more thoroughly during open enrollment. • Provide Cost Estimation tools both telephonically and web-based	Yes

Barrier	Opportunity	Selected for Improvement?
	Community Resource Coordinators work with members to assess finances and suggest ways to redistribute money	Yes

Table 11a: Attitude and Service Barrier Analysis Results

Barrier	Opportunity / Action	Selected for Improvement?
Member perception of provider/office unprofessionalism/rudeness Member perception of the lack of communication	- Contractual providers and FHCP Provider services are notified of all complaints related to member perception of poor communication &/or unprofessional/rude staff. - Customer Service team monitors complaints on quarterly basis for trends and address as appropriate. - Establishment of FHCP Communication Team with biweekly meetings for the on-going assessment of member Omni-channel communication issues - New company-wide "Relationship" training program	Yes

Table 11b: Access to Care Barrier Analysis Results

Barrier	Opportunity / Action	Selected for Improvement?
New members attempting to access a provider who are new to them having difficulty with transition of care	- Referral nurses, Case Managers and Member Services staff transition new members to assist them with medications, office visits, and DME. - Increased Transition of care staff to 3 FTE RN's.	Yes

Perceived delay in delivery of services: Referrals, prescriptions, Telephonic call backs, test results	• Initiation of Follow-My-Health • Initiation of Home Docs • Initiation of Doctors on Demand- e-visits • Member portal • Pharmacy system upgrade and telephonic message when Rx are ready	Yes

Table 12: Planned Actions- Billing and Financial

Date Initiated	Action Implemented Billing and Financial	Barriers Addressed
Ongoing 2014 2018	• Member newsletter explained HMO vs. Triple Option Plans • Member portal with intuitive provider search indicating level of participation by provider	Members with Triple Option and Point of Service Plans expect HMO level of benefit coverage for services received outside of HMO network
2016 2018	• Implementation/planning of new member portal that will show member specific benefits, cost- saving options, and plan specific network • Designated CSR for FHCP application support i.e.) Member Portal and Follow My Health. • Increases CSR to 2 FTE for application support • IT Member-facing support desk for complex web/mobile application support	Members with Triple Option and Point of Service Plans expect HMO level of benefit coverage for services received outside of HMO network High deductible plans and high co-insurance create financial difficulties for members who utilize services Educate member's on functionality of self-help tools on cost saving options, formulary, and network.
Ongoing 2014 2017	• Outpatient Community Resource Coordinators assist members with finding resources for high cost medications and services. • Increase CRC staffing to 3	Education of members on cost saving options, formulary, and network. Members with limited income have difficulty paying for medical care
2019	• New position: Member Engagement Coordinator- to oversee various member-facing department educational opportunities	Coordinate member-facing departments member educational needs
2019	• Corporate CPI to educate all member -facing employees on Member portal and mobile application	On-going member education on the information readily available via the member portal as it relates to their specific benefits

Table 12a: Planned Action- Attitude and Service

Date Initiated	Action Implemented Attitude and Service	Barriers Addressed
On-going 2018	• “Relationship Training” mandatory Customer Service training for all FHCP staff • Monitor on monthly basis complaints r/t to providers and discuss at Customer Satisfaction meeting. • Providers with trends are placed on corrective action plan &/or scheduled to attend regular meetings w/ FHCP to troubleshoot issues as the arise	Member perception of provider/office unprofessionalism/rudeness Notify Provider services and the provider when complaints are received.
2016 2017 2018 2018	• Follow My Health – provides member access to their Medical information such as test results, etc. • FHCP new member portal (Health Trio) provides member specific information related cost sharing, providers, formularies, referral processes, etc. • Contractual providers and FHCP Provider services are notified of all complaints related to member perception of poor communication &/or unprofessional/rude staff. • Customer Service team monitors complaints on quarterly basis for trends and address as appropriate. • Establishment of FHCP Communication Team with biweekly meetings for the on-going assessment of member Omni-channel communication issues • Formation of Net Provider Score work group for organization evaluation of member survey feedback and actionable interventions	Member perception of the lack of communication Monitor for trends that may need addressed. Notify Provider services and the provider when complaints are received. Ensure timely and accurate communications are made available to members

Table 12b: Planned Actions- Access

Date Initiated	Action Implemented Access	Barriers Addressed
2016	• Implementation of new company website with intuitive navigation	Education of members on cost saving options, formulary, and network

Date Initiated	Action Implemented Access	Barriers Addressed
On-going 2015 2015 2016 2017	- Marketing and sales personnel trained to explain plans clearly and effectively - Community Liaison's by service area to promote network provider expansion - Initiate a Transition of care form - Direct telephone line for Transition of care needs 2016 FTE RN for Transition of Care (TOC) needs - Increased to 3 FTE RN TOC	High deductible plans and high co-insurance create financial difficulties for new members who utilize services and need access assistance Expansion of provider networks through out Service areas
Ongoing 2014 2017	- Outpatient Community Resource (CRC) Coordinators assist members with finding resources for high cost medications and services. - Increased to 3 FTE CRC	Members with limited income have difficulty paying for medical care
On-going 2015 2016 2018 2017 2015-2018	- Nurses assigned to new members with complex needs to assist in transition of care. - Expanded extended hours clinics at FHCP locations throughout Volusia County. - Contracted with Doctor on Demand (Telehealth) - Initiated FHCP employed provider e-visits - Contract with Home Docs - Opening of new FHCP pharmacy locations in Volusia, Brevard, & Seminole Co. and expanded contract pharmacy service areas - Extended pharmacy hours - Establishment of FHCP Communication Team with biweekly meetings for the on-going assessment of member Omni-channel communication issues - Formation of Net Provider Score work group for organization evaluation of member survey feedback and actionable interventions	New members attempting to access a provider who is new to them having difficulty with transition of care Limited Office Hours / access Limited Office Hours / access Address needs of those who cannot get to appt. Member education of available services that they perceive or not available

The QI6 activity was reported to the following committees:

Committee Name	Meeting Date	Committee Actions or Recommendations
Customer Satisfaction	06/19/2019	Approved by email vote; sent to PI Council
Performance Improvement Council	07/17/2019	Approved as written

Credentialing – 2018 Summary

Florida Health Care Plans Credentialing staff assists the organization in maintaining a constructive relationship with providers and facilities maintains and revises credentialing policies, and provides timely verification of credentials for providers and facilities to ensure that they have the requisite education, licensure and competence to provide services to FHCP members safely and effectively.

In 2018:

- The following credentialing policy was revised and approved:
 - QM018 Rev_13 Continuous Quality Monitoring of FHCP Providers
- Effective October 2018, advanced practice licensure for nursing has been changed from ARNP (Advanced Registered Nurse Practitioner) to APRN (Advanced Practice Registered Nurse).
- Stephen Keen, MD was appointed to the Credentialing & Peer Review Committee to replace Dr. Lafferty in December 2018.
- During the Florida Blue Annual Audit, FB requested a process improvement plan for maintaining Medicare Opt Out verifications. Effective January 2019, credentialing staff will check Medicare Opt Out status for each provider using their NPI number as the unique identifier during initial and recredentialing. This will replace verifying FHCP providers against the First Coast Service Options report on a quarterly basis.
- No practitioners were terminated due to quality reasons in 2018.

Summary of provider and facility credentialing/recredentialing files processed 2017 vs. 2018:

2017 Providers	
Initials	140
Recreds	119

2018 Providers	
Initials	141
Recreds	64

2017 Facilities	
All types	20

2018 Facilities	
All types	13

Total 259

Total 205

Total 20

Total 13

Florida Health Care Plans (FHCP)
Annual Pharmacy Services Telephone Quality and Accuracy Review
Report Period: 01/01/18 – 12/31/18

This report annually summarizes the measurement methods, results, analysis and, when appropriate, improvement actions for the quality and accuracy of customer service calls, specifically related to pharmacy and benefits calls.

Measurement Methodology

A quarterly report is prepared by the Administrator of Pharmacy Services and presented to the Pharmacy and Therapeutics Committee, then to Performance Improvement Committee. Each of the four pharmacy service representatives (PSRs) interact with members and pharmacies or other departments on a member's behalf, via the telephone. The quarterly report is comprised of a monthly sampling of ten (10) calls per PSR, 40 calls total/month, 120 calls/quarter, and 480calls/year. The sampling method is accomplished utilizing "silent monitoring" via FHCP's Cisco Compliance Recording System during incoming calls to the Pharmacy Services Department. Calls are randomly chosen for monitoring after the month's end. Monitored calls constituted 4.3% of all incoming calls to the Pharmacy Services Department in 2018. Each call is categorized by call type as follows: pharmacy inquiry, medical inquiry, or behavioral health inquiry. Each monitored call is assessed utilizing a monitoring tool checking for the following:

- Accuracy of response
- Whether the issue was addressed in one contact
- Whether the call was forwarded to another person and the PSR stayed on the line until the next person answered
- Ensuring that HIPAA protocol was followed
- Whether an appropriate response was given

Finally, calls are categorized by the type of pharmacy inquiry and by NCQA standards.

Pharmacy inquiries include:

- Answering billing and processing questions from outside pharmacies.
- Completing prescription record requests for tax, housing, and legal purposes.
- Requesting early refill authorization for prescriptions.
- Answering questions about co-pay and co-insurance, deductible and maximum out of pocket status. Also, assisting members with complaints, refund requests, and co-pay waiver information.
- Determining how and when to obtain exceptions, referrals, and authorizations for specific medications, as applicable.
- Determining plan-specific information related to benefits and coverage of pharmacies or products.
- Answering formulary questions.
- Answering Transition Benefit questions.

Florida Health Care Plans (FHCP)
Annual Pharmacy Services Telephone Quality and Accuracy Review
Report Period: 01/01/18 – 12/31/18

- Assisting members with Pharmacy Portal questions, accuracy, and customer satisfaction comments as related to pharmacy portal navigation and content.
- Assisting members with navigation of fhcp.com.

NCQA Standards which provide members with the information they need to understand their pharmacy benefit by telephone are:

- Determine financial responsibility for a drug, based on pharmacy benefit.
- Initiate the exception process.
- Order a refill for an existing, unexpired mail-order prescription.
- Find the location of an in-network pharmacy.
- Conduct a pharmacy proximity search based on zip code.
- Determine potential drug-drug interactions
- Determine a drugs common side effects and significant risks.
- Determine the availability of generic substitutes.

All FHCP Member calls for all FHCP lines of business are monitored using the same measurement methodology.

Every attempt is made to provide information related to pharmacy benefit and operations in one call. If information is not available to the pharmacy services representative answering the telephone, the member is transferred to the Claims, Member Services, or Referrals departments, or a Retail or Clinical Pharmacist as necessary for assistance with these inquiries. The transfer will occur from a live person to another live person.

Results

The both tables below, Pharmacy Inquiries by Quarter and NCQA Standard Inquires by Quarter, show the number of calls each quarter, the total number and percentage of calls received, and the annual number and percentage of calls received per inquiry.

Florida Health Care Plans (FHCP)
Annual Pharmacy Services Telephone Quality and Accuracy Review
Report Period: 01/01/18 – 12/31/18

Pharmacy Inquiries by Quarter

Inquiry	Q1	Q2	Q3	Q4	Total Calls by Inquiry	Annual % Calls by Inquiry (480)
Outside Pharmacy Billing Questions	51	15	18	31	115	23.96
Prescription Record Request	0	0	1	2	3	0.63
Early Prescription Refill Request	28	80	66	47	221	46.04
Co-Pay/Deductible Question	10	5	2	22	39	8.13
Referral Question	5	0	2	2	9	1.88
Pharmacy Benefit Question	9	10	5	9	32	6.67
Formulary Question	10	9	9	5	33	6.88
Transition Letter Question	0	0	0	0	0	0
Pharmacy Portal Question	0	0	0	0	0	0
FHCP.COM Question	0	0	0	0	0	0
Total Calls by Quarter	113	119	103	118	453	94.38
Percentage of Calls by Quarter (120)	94.2	99.2	85.8	98.3		

NCQA Standard Inquiries by Quarter

NCQA Standard Monitored	Q1	Q2	Q3	Q4	Total Calls by Inquiry	Annual % Calls by Inquiry (480)
1. Determine financial responsibility for a drug based on the pharmacy benefit	2	0	0	0	2	0.42
2. Initiate the exception process	3	0	1	0	4	0.83
3. Order a refill for an existing, unexpired, mail order prescription	0	0	0	0	0	0
4. Find the location of an in-network pharmacy	2	0	0	2	4	0.83
5. Conduct a proximity search based on zip code	0	0	0	0	0	0
6. Determine potential drug-drug interactions	0	0	0	0	0	0
7. Determine a drug's common side effects	0	0	0	0	0	0
8. Determine the availability of a generic substitute	0	0	0	0	0	0
Total Calls by Quarter	7	0	1	2	10	2.08
Quarterly % of calls (120)	5.8	0.0	0.8	1.7	8.3	

Florida Health Care Plans (FHCP)
Annual Pharmacy Services Telephone Quality and Accuracy Review
Report Period: 01/01/18 – 12/31/18

The table below, Quality and Accuracy of Pharmacy Benefit Pharmacy Service Calls 2018, displays the number of calls that met each criterion in the reporting period, the percent compliance for each criterion, and the Overall Compliance Rate by for each quarter. In Q3, because of a recording system failure, only 104 calls could be monitored for that time period.

Quality and Accuracy of Pharmacy Benefit Pharmacy Service Calls 2018

	Pharm Q1	Pharm Q2	Pharm Q3	Pharm Q4
Total # calls monitored	120	120	104	120
Accurate Response Given by PSR	118	120	104	120
Compliance	98.3%	100%	100%	100%
HIPAA Compliant	120	120	104	120
Compliance	100%	100%	100%	100%
Handled in One Contact	120	119	104	120
Compliance	100%	99.2%	100%	100%
Forward Call and Stayed on Line	120	120	104	119
Compliance	100%	100%	100%	99.2%
Appropriate Action Taken	120	120	104	120
Compliance	100%	100%	100%	100%
Overall Compliance Rate	99.66%	99.84%	100%	99.84%

Total % Pharmacy Compliance Q1-Q2 2018	Total % Pharmacy Compliance Q3-Q4 2018	Total % Pharmacy Compliance Q1-Q4 2018
99.75%	99.92%	99.84%

Analysis and Action

In 2018, the plan established a performance goal of 100% compliance in all categories annually. Calls pertaining to pharmacy benefits were rated as compliant in two (2) of the five (5) categories, HIPAA Compliant and Appropriate Action Taken.

Areas with opportunities for improvement in pharmacy benefit calls are:

- Accurate Response Given by Pharmacy Service Representative
- Handled in One Contact
- Forward Call and Stayed on Line

The Pharmacy Services Office received a total of 11,071 calls in 2018 compared to a total of 13,715 calls in 2017. The decrease can be attributed to a phone extension system within the pharmacy office to route incoming calls to the proper team, Pharmacy Services Office or PBM Audit team. Early Prescription Refill

Florida Health Care Plans (FHCP)
Annual Pharmacy Services Telephone Quality and Accuracy Review
Report Period: 01/01/18 – 12/31/18

Requests (221) were the top calls coming into the Pharmacy Services Office in 2018. These calls were mostly due to members going on vacation which are tracked centrally in the Pharmacy Services Office. The second highest amount of calls (115) came in from Outside Pharmacy Billing Questions. This was mainly due to membership and service area growth. In April 2018, in an effort to control the volume of calls to Pharmacy Service Office, a group email system was implemented. This was identified as an opportunity for improvement and permitted the 16 FHCP owned and operated pharmacies to email their needs to the office rather than calling. This reduced the number of calls that came into the Pharmacy Services Office. At the same time, a phone extension system was implemented which routed the calls to the team, PSR or PBM Audit, best able to respond to the question or need. Together, these two additions gave more time for the PSRs to help patients and answer outside calls in the most efficient manner.

Barrier	Opportunity	Intervention	Date Implemented
All calls cannot be answered in one call. Pharmacy Services only has access to pharmacy systems.	Continue to monitor accuracy of calls answered by Pharmacy Services and appropriateness of transfers to another source.	- Continuous training on who can best meet member needs in Pharmacy and in FHCP. - Clarified policy that a warm transfer to another FHCP Department is the standard of quality.	Ongoing
Need another pharmacy services representative to replace one that moved to the PBM department .	An increase in membership and the movement of one staff member to the PBM department led to the decision to hire another representative.	One pharmacy services rep was hired in June 2016 in order to handle increased call volume and to replace the PSR changing depts.	June 2016 and ongoing training.

Florida Health Care Plans (FHCP)
Annual Pharmacy Services Telephone Quality and Accuracy Review
Report Period: 01/01/18 – 12/31/18

Barrier	Opportunity	Intervention	Date Implemented
Report does not directly address NCQA standard inquiries.	Reorganize this Annual report to highlight NCQA standards.	Rewrote this Annual report and updated associated data files to accommodate request to include NCQA standards in a more direct manner.	October 2017
Both Pharmacy Service and PBM Audit calls came into the Pharmacy Services Office creating a high volume of calls.	Reduce volume of calls to Pharmacy Services.	Added a group email and phone extension system to separate calls to Pharmacy Services and PBM Audit teams.	April 2018

Committee Reporting Summary

The results, analysis and actions reported in this summary report were reported to the following committees on:

Committee Receiving Report Report Dates	
Pharmacy and Therapeutics Committee	3/12/2019
Performance Improvement Council	4/17/2019

Florida Health Care Plans (FHCP)
Annual Pharmacy Services Website Quality and Accuracy Review
Report Period: 01-01-2018 – 12-31-2018

This report annually summarizes the measurement methods, results and analysis pertaining to the assessment of quality and accuracy of member benefit information on FHCP.com and on the Pharmacy Portal website. Methods for correcting deficiencies, when indicated, and opportunities for improvement are also discussed.

Measurement Methodology

A quarterly report is prepared by the Administrator of Pharmacy Services and presented to the Pharmacy and Therapeutics Committee. The quarterly report documents results of the testing of the access, functionality, quality (the degree to which the services offered to members meet established goals or outcomes), and accuracy (how correct or precise the information provided is) of the FHCP Website and Pharmacy Portal each month. The test includes defined criteria, expected results, detailed actual results, deficiencies, and opportunities for improvement if necessary. Eighteen testing scenarios were used to evaluate FHCP and OptumRx's performance on the NCQA standards and internal criteria. Six questions targeted OptumRx's quality and accuracy in providing information to members about their pharmacy benefit using OptumRx's Pharmacy Portal. Four questions targeted FHCP's ability to meet NCQA standards via fhcp.com. FHCP further tested eight internal areas of pharmacy benefit information for availability and accuracy, five on correct and current formularies, a Prior Authorization (PA) Policy, a PA Medication List, and the Commercial/ QHP Discount Medication List.

NCQA MEM WEBSITE FACTORS AND RESPONSIBILITY

Factor	FHCP	OptumRx
1. Determine a member's financial responsibility based on pharmacy benefit		X
2. Initiate the exception process	X	
3. Order a refill for an existing, unexpired mail order prescription	X	
4. Find the location of an in-network pharmacy	X	
5. Conduct a pharmacy proximity search based on zip code	X	
6. Determine potential drug-drug interactions		X
7. Determine a drug's common side effects and significant risks		X
8. Determine the availability of generic substitution		X

The goal was to provide 100% performance in quality and accuracy.

Florida Health Care Plans (FHCP)
Annual Pharmacy Services Website Quality and Accuracy Review
Report Period: 01-01-2018 – 12-31-2018

Results

The table below displays the number of scenarios that were tested, the number that met the quality criteria in the reporting period, the number that produced accurate results and the percent compliance for each quarter.

Quality and Accuracy of Pharmacy Website 2018

	Pharm Q1	Pharm Q2	Pharm Q3	Pharm Q4
Total # tests/qtr	54	54	54	54
Total # quality goals met	51	54	54	54
Total # accuracy goals met	51	48	51	51
Compliance	94.4%	94.4%	97.2%	97.2%

Analysis and Action

In 2018, the plan established a performance goal of 100% compliance in both quality and accuracy in all categories annually.

Criteria which met the performance goal were as followed:

- OptumRx NCQA standards of drug-drug interaction, side effects and risks, and generic substitution.
- All of the FHCP NCQA standards were functioning properly and accurately.
- All FHCP internal criteria were functioning properly and accurately.

Criteria which did not meet the performance goal were all OptumRx issues as follows:

- Determining financial responsibility based on benefit.
- Determining financial responsibility based on benefit at a non-preferred pharmacy.
- Identifying in-network pharmacies.

For 2018, analysis of the FHCP.com and Pharmacy Portal shows all FHCP, and most OptumRx, criteria functioned properly, giving member's information about their pharmacy benefit. The 100% goal for quality was met, except in March when a temporarily unavailable message caused members to not get pricing for their medication. Deficiencies in accuracy happened when pricing was wrong for non-covered pharmacies and when non network pharmacies were incorrectly listed as covered.

Florida Health Care Plans (FHCP)
Annual Pharmacy Services Website Quality and Accuracy Review
Report Period: 01-01-2018 – 12-31-2018

OptumRx implemented a new Pharmacy Portal platform early in 2018 which caused these errors. Three CIC cases were opened with OptumRx to correct these deficiencies, in March (quality), April (accuracy), and June (accuracy) of 2018. The issues about the temporarily unavailable message in March and the pharmacies not pricing correctly in April have been resolved. The issue of showing pharmacies that are not in our network from June has been partially resolved by showing the FHCP pharmacies and Walgreens as Plan Preferred Pharmacies. Removing the non-covered pharmacies completely is still outstanding.

Opportunities for Improvement

The three deficiencies have been opportunities for improvement. FHCP worked together with OptumRx to fix and test these areas until resolutions were found. FHCP will continue to monitor any new requirements and opportunities for improvement and reflect these in the 2019 Website Testing Tool to ensure FHCP continues to provide excellent pharmacy web and portal service to its members.

Committee Receiving Report Report Dates	
Pharmacy and Therapeutics Committee	3/12/2019
Performance Improvement Council	4/17/2019

Florida Health Care Plans
Practitioner Access Analysis
January 1, 2018 to December 31, 2018
Commercial, Marketplace and Medicare

Introduction

Consumers value timely access to medical care. Florida Health Care Plans (FHCP) monitors primary care, behavioral health, and high-volume and high-impact specialty care practitioner access for routine and urgent appointments as well as primary care after-hours access accessibility annually against its standards, and initiates actions as needed to improve. This report describes access monitoring methodology, results, analysis, and action.

Section I: Primary Care Physician Appointment Access

Standards and Methodology

FHCP monitors primary care physician (PCP) appointment accessibility and after-hours' access to ensure members have access to primary care 24 hours a day, 7 days a week.

FHCP does so by utilizing responses captured in the annual CAHPS survey for Commercial, Marketplace/ACA and Medicare members. FHCP also records and follows up on member complaints and appeals regarding access to their primary care physician and records requests for and utilization of out-of-network access, using such data to monitor and identifying issues members may experience with access to primary care services. The FHCP Provider Services Department also conducts telephone surveys to ensure after-hour care information is available to members.

The following are the CAHPS questions utilized in this standard:

For Commercial:

- “6. In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor’s office or clinic as soon as you needed?”
- “4. In the last 12 months, when you needed care right away, how often did you get care as soon as you needed?”

For Marketplace/ACA:

- “6. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor’s office or clinic as soon as you needed?”

“4. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?”

For Medicare:

“4. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?”

“6. In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?”

Table 1 lists the PCP standards, measurement method, and measurement frequency for each aspect of performance that is monitored.

Table 1: Standards and Measurement Methods by Access Measure

Access Measure	Standard and Performance Goal	Measurement Method	Measurement Frequency
Primary care routine appointments	At least 80% of members report they always or usually obtained check-up or routine care as soon as they needed (CAHPS question 6)	CAHPS member satisfaction survey	Annually
Primary care urgent appointments	At least 80% of members report they always or usually obtained urgent appointments as soon as they needed (CAHPS question 4)	CAHPS member satisfaction survey	Annually
Utilization of Out of Network PCPs	Utilization rate of HMO members with claims for routine Out of Network PCP services within FHCP service area is less than 15 claims per 1000 members	Claim analysis	Annually
Access complaint analysis for appointments	Rate of member complaints about appointment access is less than 0.5 per 1000 Members	Complaint analysis	Annually

Table 1: Standards and Measurement Methods by Access Measure

Access Measure	Standard and Performance Goal	Measurement Method	Measurement Frequency
Access appeal analysis appointments	Rate of member appeals about appointment access is less than 0.5 per 1000 Members	Appeal analysis	Annually
Primary care after hours care	100% of PCP offices surveyed have an after-hours access mechanism that meets health plan standards	Calls to PCP offices after hours (details below)	Annually

Results

Table 2: Measurement Results and Comparison to Performance Goal by Appointment Type and Product Line

Access Measure	Standard	Results	Goal Met? (Yes/No)
Primary care routine appointments	80% or more results of members report they always or usually obtained check-up or routine care as soon as needed	Commercial –87.5% Marketplace –78.8% Medicare –88.1%	Yes No Yes
Primary care urgent appointments	80% or more results of members report they always or usually obtained urgent appointments as soon as needed	Commercial –92.3% Marketplace –84.4% Medicare –89.8%	Yes Yes Yes

**Table 2: Measurement Results and Comparison to Performance Goal
by Appointment Type and Product Line**

Access Measure	Standard	Results	Goal Met? (Yes/No)
Utilization of Out of Network PCP s	Rate of HMO members with routine claims for Out of Network PCPs within the FHCP service area is less than 15 claims per 1000 members	Commercial HMO members with Out of Network routine claims = 8.13 per 1000 members Marketplace HMO members with Out of Network routine claims = 21.04 per 1000 members Medicare HMO members with Out of Network routine claims = 11.59 per 1000 members	Yes No Yes
PCP Access complaint analysis	Rate of member complaints regarding appointment access is less than 0.5 per 1000 members	Commercial Member complaints = .06 per 1000 members Marketplace member complaints = .20 per 1000 members Medicare member complaints = .48 per 1000 members	Yes Yes Yes
PCP Access appeal analysis	Rate of member appeals about appointment access is less than 0.5 per 1000 members	Commercial Member appeals = 0 per 1000 members Marketplace member appeals = 0 per 1000 members Medicare member appeals = 0 per 1000 members	Yes Yes Yes

**Table 2: Measurement Results and Comparison to Performance Goal
by Appointment Type and Product Line**

Access Measure	Standard	Results	Goal Met? (Yes/No)
Primary care after hours care	100% of PCP offices surveyed have an after-hours access mechanism that meets health plan standards	100% of PCP offices have an after-hours access mechanism that meets health plan standards (See details of survey below)	Yes

Analysis of PCP Appointment Access Results

CAHPS results reported that for routine appointment access, 87.4% of Commercial members and 88.1% Medicare members reported they usually or always obtained care when needed, not when needed right away. This meets FHCP's performance goal of at least 80%. 78.8% of Marketplace/ACA members reported that they always or usually obtained a check-up or routine care as soon as needed. This is an improvement over 2017 by less than one percentage point, a non-significant change. While the Marketplace results did not meet the 80% FHCP benchmark, CAHPS reported that the rates achieved are considered within the average range when compared to the National Averages of 80.2%.

For urgent appointment access, 92.3% of Commercial members and 89.9% of Medicare CAHPS respondents reported that they usually or always obtained needed care right away (urgent appointments). 84.4% of Marketplace/ACA members reported that they usually or always obtained needed care right away (urgent appointments), a significant improvement over 78.68% in 2017. All lines exceeded the 80% FHCP benchmark.

FHCP's monthly average membership in 2018 was 34,951 Commercial members, 34,034 Marketplace/ACA members and 14,500 Medicare members. The overall average was 83,985 members.

In reviewing member complaints regarding PCP Access, FHCP received eight (8) from Commercial members, nine (9) from Marketplace/ACA members for a total of 17 in 2018. The number of complaints remained the same in comparison to 17 in 2017. Commercial member complaints reported were not actually related to PCP access. These complaints were most commonly related to perception about a delay in service related to referrals to specialists, DME and/or prescriptions.

From a network contracting and access by PCP perspective, Marketplace membership is considered a sub-category of FHCP's commercial membership. PCP contract requirements and service payments are the same for all commercial members, including members in the Marketplace sub-category. Provider panel assignments do not differentiate between Marketplace and Commercial membership. Since these

components are the same, Marketplace membership is geographically located throughout FHCP's service area in the same proportions as Commercial membership. FHCP has performed a more in-depth analysis as to why Marketplace members survey results were lower than that of commercial members.

A clue to the root cause of not meeting FHCP's PCP access goal for Marketplace members was found through analysis of Marketplace member complaints. Most PCP service complaints from Marketplace members related to new members having difficulty with transition of care and/or establishing themselves with new PCP. While all complaints were resolved to the member's satisfaction by FHCP Member Services staff, further examination specifically identified access barriers and opportunities.

In-depth practitioner level analysis revealed no instances of multiple access complaints or appeals about a specific PCP or PCP office that would indicate a trend or pattern related to non-availability of timely appointments. The analysis did show that unlike Commercial members who have had prior health coverage by FHCP or other health plans, new Marketplace members automatically assigned by FHCP to their PCP do not always appear to understand that they should use their assigned PCP. They also may not recognize the importance of having a PCP for preventive care or to coordinate their care within FHCP's network as fully as FHCP's Commercial membership.

FHCP received 7 complaints from Medicare members concerning PCP access to care in 2018 compared to 7 complaints in 2017. This remains low as Medicare membership remained consistent from 2017 and resulted in a complaint rate of 0.50 per 1,000 members. Medicare member complaints were also related to perceptions about a delay in service related to referrals to specialists, DME and/or prescriptions. All complaints were resolved to the member's satisfaction by FHCP Member Services staff.

There were 0 appeals from Commercial, Marketplace and Medicare members related to primary care access in 2018. Other appeals generally were for formulary exceptions, for requests for out of network providers and exclusions to the members plan, but not for PCP access.

Claims data was analyzed to determine member utilization of out of network PCPs for routine care inside FHCP's service area by HMO members in all product lines. Marketplace utilization was highest reporting 21.04 claims per 1000 Marketplace members, followed by claims for non-par PCP services to Medicare members at 11.59 claims per 1000 members. Commercial membership utilization of non-par PCP services was lowest at 8.13 claims per 1000 members. Approval rates for such services ranged from 90% to 99%, confirming that FHCP had an effective process for reviewing and paying non-par PCP claims that met coverage criteria.

Additional analysis of Marketplace out of network utilization revealed a possible process issue regarding PCP assignment which could contribute to member's accessing non-par PCP's or PCP's to whom they are not assigned. When a member does not select a PCP, and FHCP proactively assigns members, PCP assignments are followed-up by letters that are manually generated and mailed, which can cause a delay in member notification. The

letters are very plain, black and white, and are mailed to members as paper documents. Members may not open and read them. Members therefore do not realize they are assigned to an in-network PCP and use non-participating PCP's for routine care inside FHCP's service area.

PCP After-Hours Access Measurement Methodology

A universe of all Participating PCP group practice offices was used to assess whether the offices have an after-hours access mechanism which meets FHCP standards. FHCP surveyed 358 PCP practices in FHCP's HMO networks for Medicare, Commercial, and Marketplace/QHP Members. Most PCP's participate in all three networks, so where there is overlap that PCP group practice can count for each Network's results.

FHCP staff completed the Group Demographics cells, filling in the group name, telephone number (use the number published in the practitioner directory), practice location address and names of PCPs in the practice. One call covers all PCPs practicing at the practice location. Staff completed the Survey Data Collection Information cells, filling in the date and time of data collection, the name of the staff person conducting the survey, and the survey type. Calls are made AFTER normal business hours, OR on weekends or holidays only and not during the business day.

The FHCP After-Hours Access Survey Protocol is organized into three sections based on the type of after-hours access the office location has: answering service, answering machine, or no response. Also, the answering service and answering machine sections have two sub-categories: urgent requirement, and emergency requirement.

Results from each surveyed practice are calculated to determine the office's score in relation to the following criteria.

- a. Answering service response standard for urgent situations: The answering service will either offer to page the doctor on call, so that the doctor can call Member back; or offer to telephonically transfer Member's call directly to the doctor on call.
- b. Answering service response standard for emergency situations: The answering service will direct the Member to contact 911 or go to nearest ER if he/she feels it is too emergent to wait for doctor to call them.
- c. Recorded response standard for urgent or emergency care: The PCP office telephone recording shall provide instructions on how to page the doctor if a situation is urgent; or instructs the Member to call 911 for emergencies or go to the nearest ER or urgent care center if the situation cannot wait until the next business day.

PCP After-Hours Access Results

FHCP surveyed all PCP offices which totaled 358. 100% of them had an acceptable method of providing after-hours access for members. Of the 358 compliant practices, 125 utilize an answering service, 233 use a recorded message, and one provider forwards his office phones directly to himself via a cell phone for after hour coverage. The PCPs who answer

their own calls results are counted under Answering Service. Please see a more detailed analysis of the results below:

Number of PCP Offices	Number Surveyed Completed On	% Surveyed Completed
358	358	100%

Table 3 After-Hours Access Detailed Results

Criteria	# & % Compliant	Comments
Answering service urgent situations: The service will either offer to page the doctor on call, so that the doctor can call member back; or offer to telephonically transfer member's call directly to the doctor on call	125 of applicable PCP Offices Compliant 100% of PCP Offices Compliant	All PCP offices met the criterion.
Answering service emergency situations: The service will direct the member to contact 911 or go to nearest ER if he/she feels it is too emergent to wait for doctor to call them	125 of applicable PCP Offices Compliant 100% of PCP Offices Compliant	All PCP offices met the criterion.
Recorded response urgent or emergency care: The recording shall provide instructions on how to page the doctor if a situation is urgent; or instructs the member to call 911 for emergencies or go to the nearest ER or urgent care center if the situation cannot wait until the next business day	233 of applicable PCP Offices Compliant 100% of PCP Offices Compliant	All PCP offices met the criterion.

Access Barrier Analysis

While Commercial, Medicare and Marketplace members have appropriate access for both routine and urgent appointments, there could be an improvement in Marketplace members' perception of access to routine appointments as the CAHPS result was less than goal while remaining near or above the National Average for Marketplace respondents.

Further analysis identified a barrier for Marketplace members' PCP access. FHCP's process of assigning newly insured members to their PCP was identified as a contributing factor. Per FHCP Policy, all members who do not select a PCP upon enrollment, or who did not use FHCP's online PCP assignment tool, are automatically assigned by FHCP to a PCP in geographic proximity to their place of residence within the first 60 days of enrollment. New Commercial and Medicare members, due to their history of being

insured, tend to already have an established relationship with a PCP and select their PCP when enrolling. However, Marketplace members who have historically been uninsured or underinsured have not had regular access to a PCP, did not select a PCP, and were assigned by FHCP to a PCP located near their home. Members were sent a form letter advising them of this assignment and given an opportunity to select a different PCP at any time.

Members were given limited information about how to use the online PCP assignment tool to make this change, along with telephone numbers for Member Services. While PCP assignment tool reports indicated that Marketplace members were the highest utilizers of the tool for initial PCP selection, the percentage who accessed the tool was low. A review of out of network PCP utilization indicated that even though the Marketplace members had been assigned to a participating PCP, and there was adequate PCP access within FHCP's network, Marketplace members claims utilization for the review period indicated that they obtained services from non-participating PCP's at a higher rate than Medicare or commercial members.

An additional barrier identified was that participating network PCP's did not use FHCP tools to identify new members who were assigned to their panels. Combined with Marketplace member delay in PCP assignment, a lack of member and PCP interaction resulted in transition of care issues and Marketplace member complaints regarding establishing with their new PCP.

Table 4 Access Barrier Analysis Results

New Marketplace members automatically assigned by FHCP to their PCP do not understand that they should use their assigned PCP. They also may not recognize the importance of having a PCP. FHCP PCP assignments are followed by letters that are manually generated and mailed, which can cause a delay in member notification. The letters are very plain, black and white, and are mailed to members as paper documents. Members may not open and read them. Members use non-participating PCP's for routine care inside FHCP's service area.	Continue to educate Marketplace members regarding the importance of quickly selecting and having a PCP to coordinate their care and transition to FHCP's network.	Y
	Improvement is needed in the timeliness, format, content, and delivery of PCP assignment information sent to members.	Y
	Claim denials related to routine care by out of network PCP's could be a "teachable moment" and help educate members regarding the need to use their assigned PCP, or to select a different participating PCP from FHCP's network.	N

Table 4 Access Barrier Analysis Results

PCP's do not realize when new members are assigned to their panel. This results in issues with member access to initial appointments and transition of care.	PCP tools within the Provider Portal should include easy to use reports to identify newly assigned members to the PCP panel.	Y
	PCP's should receive additional training and information regarding use to the Provider Portal relating to PCP panel additions or deletions.	Y
	PCP's should be encouraged to reach out to newly assigned panel members to establish a physician/patient relationship	Y
Members need a way to more easily access their PCP for routine follow ups, medication refills, etc.	Expand telemedicine (Zoom) capability of FHCP staff providers to conduct telemedicine visits with patients to improve routine appointment access.	Y

Below is a summary of the actions FHCP will implement:

Table 5 Planned Actions

Date Initiated	Action Implemented	Barriers Addressed
3/1/2019	Generate letters using MC400 claim and enrollment data via a print and mailing vendor to more quickly generate and mail professionally designed letters. Vendor must be able to produce proof of mailing date and time for letters	FHCP PCP letters are manually generated and mailed, which can cause a delay in member notification. The letters are very plain, black and white, and are mailed to members as paper documents. Members may not open and read them.
1/1/2019	PCP tools within the Provider Portal should be enhanced to include easy to use reports to identify newly assigned members to the PCP panel.	PCP's do not realize when new members are assigned to their panel. This results in issues with member access to initial appointments and transition of care

Table 5 Planned Actions

Date Initiated	Action Implemented	Barriers Addressed
4/1/2019	PCP's received additional training and information regarding use to the Provider Portal relating to PCP panel additions or deletions.	PCP's do not realize when new members are assigned to their panel. This results in issues with member access to initial appointments and transition of care
4/1/2019	PCP's encouraged to reach out to newly assigned panel members to establish a physician/patient relationship	PCP's do not realize when new members are assigned to their panel. This results in issues with member access to initial appointments and transition of care

Section II: Behavioral Health Appointment Access

FHCP monitors behavioral health appointment access to determine whether members can receive timely appointments based on severity of illness. FHCP does so by conducting telephone surveys by staff to ensure appointment access to both prescriber and non-prescriber behavioral health Practitioners is available to members; recording and following up on member complaints and appeals regarding access to behavioral health services; utilizing responses captured in the annual CAHPS ECHO survey for Commercial and Medicare members; and compiling requests for and utilization of out-of-network data to monitor and identify issues members may experience with access to behavioral healthcare services practitioners and providers..

Table 7 sets forth the access standards, measurement method, and measurement frequency for each aspect of performance that is monitored for both prescribing and non-prescribing Practitioners.

Table 7: Behavioral Health Standards and Measurement Methods by Appointment and Practitioner Type			
Access Measure	Standard and Performance Goal	Measurement Method	Measurement Frequency
Prescriber behavioral health non-life threatening emergency appointments	85% will provide access to care for a non-life-threatening emergency within 6 hours	Appointment access survey	Annually

Table 7: Behavioral Health Standards and Measurement Methods by Appointment and Practitioner Type			
Access Measure	Standard and Performance Goal	Measurement Method	Measurement Frequency
Prescriber behavioral health non-life-threatening emergency appointments	100% will refer members to other available network practitioners or to the ER when unable to provide access to care for a non-life-threatening emergency within 6 hours	Appointment access survey	Annually
Prescriber behavioral health urgent appointments	85% of offices report a first available urgent appointment is open for a patient within 48 hours of patient request	Appointment access survey	Annually
Prescriber behavioral health new patient routine appointments	80% of offices report a third available routine appointment is open for a new patient within 10 business days of patient request	Appointment access survey	Annually
Prescriber behavioral health established patient routine follow-up appointments	80% of offices report a third available routine appointment is open for an established patient within 14 days.	Appointment access survey	Annually
Non-prescriber behavioral health non-life threatening emergency appointments	85% will provide access to care for a non-life-threatening emergency within 6 hours	Appointment access survey	Annually
Non-prescriber behavioral health non-life threatening emergency appointments	100% will refer members to other available network practitioners or to the ER when unable to provide access to care for a non-life-threatening emergency within 6 hours	Appointment access survey	Annually

Table 7: Behavioral Health Standards and Measurement Methods by Appointment and Practitioner Type			
Access Measure	Standard and Performance Goal	Measurement Method	Measurement Frequency
Non-prescriber behavioral health urgent appointments	85% of offices report a first available urgent appointment is open for a patient within 48 hours of patient request	Appointment access survey	Annually
Non-prescriber behavioral health new patient routine appointments	80% of offices report a third available routine appointment is open for a new patient within 10 business days of patient request	Appointment access survey	Annually
Non-prescriber behavioral health established patient routine follow-up appointments	80% of offices report a third available routine appointment is open for an established patient within 14 days	Appointment access survey	Annually
Complaints about behavioral health access	Rate of member complaints about behavioral health appointment access is less than 0.5 per 1000 members	Complaint analysis	Annually
Appeals about behavioral health access	Rate of member appeals about behavioral health appointment access is less than 0.5 per 1000 members	Appeals analysis	Annually
HMO member - urgent and routine requests for out-of-network access to behavioral healthcare service practitioners and providers.	Rate of HMO member requests for urgent and routine referrals to out of network behavioral health practitioners and providers is less than 0.5 per 1000 members	Referral Request analysis	Annually
HMO member - utilization of out of network	Rate of HMO member claims from out of network behavioral health practitioners and providers	Claims analysis	Annually

Table 7: Behavioral Health Standards and Measurement Methods by Appointment and Practitioner Type			
Access Measure	Standard and Performance Goal	Measurement Method	Measurement Frequency
behavioral healthcare service practitioners and providers.	is less than 15 per 1000 members		
ECHO survey results re routine and urgent appt access for Getting Treatment Quickly	Rate of member responses about behavioral health Getting Treatment Quickly ECHO Plan summary rate is at or greater than 70%.	ECHO Member Satisfaction Survey Q3, Q5, and Q8	Annually

FHCP measures behavioral health access to Routine and Urgent Appointments through a survey of Practitioner offices. Provider Services surveys all applicable network (Medicare, Commercial & Marketplace) Practitioner office locations for self-reporting.

Response to the survey is monitored, with repeat surveys sent to those practices that do not respond to the initial survey. Follow-up to obtain completed surveys from non-responsive practices continues over a six week period with a response rate goal of sixty percent (60%).

The Appointment Access survey questions are asked once for each office location, and data is recorded for the open appointments, regardless of the Practitioner who has open appointments. For routine appointments, data is gathered on first, second and third available appointments. Our routine appointment standard is based on the date of the third available appointment because it is the most sensitive method for detecting offices which have access issues since first and second available appointments often represent cancellations and while those open appointment slots frequently are available in a timely fashion, they often do not work for members. Urgent appointment data is gathered for the first available urgent appointment slot in the office.

Results

Table 8 displays the survey response rate data.

Table 8: Response Rate Data					
Practitioner Type	# Office locations w/Practitioner type	# Office locations responding to survey	# Practitioners represented by offices responding to survey	# Practitioners of this type in the Network	% of Practitioner type results represent out of total contracted practitioners of that type
BH Prescribers	29	28	54	55	98%
BH Non-Prescribers	82	80	145	149	97%

Table 9: Behavioral Health Standards and Measurement Results by Appointment and Practitioner Type			
Access Measure	Standard and Performance Goal	Results	Goal Met? (Yes/No)
Prescriber behavioral health non-life-threatening emergency appointments	85% will provide access to care for a non-life-threatening emergency within 6 hours	90% of offices report a first available non-life-threatening emergency appointment within 6 hours	Yes
Prescriber behavioral health non-life-threatening emergency appointments	100% will refer members to other available network practitioners or to the ER when unable to provide access to care for a non-life-threatening emergency within 6 hours	100% of offices report that they refer members to other available network practitioners or to the ER when unable to provide access to care for a non-life-threatening emergency within 6 hours	Yes

Table 9: Behavioral Health Standards and Measurement Results by Appointment and Practitioner Type			
Access Measure	Standard and Performance Goal	Results	Goal Met? (Yes/No)
Prescriber behavioral health urgent appointments	85% of offices report a first available urgent appointment is open for a patient within 48 hours of patient request	86% of offices report a first available urgent appointment is open for a patient within 48 hours of patient request	Yes
Prescriber behavioral health new patient routine appointments	80% of offices report a third available routine appointment is open for a new patient within 10 business days of patient request	34% of offices report a third available routine appointment is open for a new patient within 10 business days of patient request	No
Prescriber behavioral health established patient routine follow-up appointments	80% of offices report a third available routine appointment is open for an established patient within 14 days of patient request	62% of offices report a third available routine appointment is open for an established patient within 14 days of patient request	No
Non-prescriber behavioral health non-life-threatening emergency appointments	85% will provide access to care for a non-life-threatening emergency within 6 hours	90% of offices report a first available non-life-threatening emergency appointment within 6 hours or refer members to the ER	Yes
Non-prescriber behavioral health non-life threatening emergency appointments	100% will refer members to other available network practitioners or to the ER when unable to provide access to care for a non-life-threatening emergency within 6 hours	100% of offices refer members to other available network practitioners or to the ER when unable to provide access to care for a non-life-threatening emergency within 6 hours	Yes

Table 9: Behavioral Health Standards and Measurement Results by Appointment and Practitioner Type			
Access Measure	Standard and Performance Goal	Results	Goal Met? (Yes/No)
Non-prescriber behavioral health urgent appointments	85% of offices report a first available urgent appointment is open for a patient within 48 hours of patient request	86% of offices report a first available urgent appointment is open for a patient within 48 hours of patient request	Yes
Non-prescriber behavioral health new patient routine appointments	80% of offices report a third available routine appointment is open for a new patient within 10 business days of patient request	77% of offices report a third available routine appointment is open for a new patient within 10 business days of patient request	No
Non-prescriber behavioral health established patient routine follow-up appointments	80% of offices report a third available routine appointment is open for an established patient within 14 days of patient request	85% of offices report a third available routine appointment is open for an established patient within 14 days of patient request	Yes
HMO member -urgent and routine requests for out-of-network access to behavioral healthcare service practitioners and providers.	Rate of HMO member requests for urgent and routine referrals to out of network behavioral health practitioners and providers is less than 0.5 per 1000 members	Commercial = .11 per 1000 members	Yes
		Marketplace = .29 per 1000 members	Yes
		Medicare = .34 per 1000 members	Yes
HMO member utilization of out-of-network access to behavioral healthcare service practitioners and providers.	Rate of HMO member utilization of out of network behavioral health practitioners and providers is less than 15 per 1000 members	Commercial = 4.69 per 1000 members	Yes
		Marketplace = 7.64 per 1000 members	Yes
		Medicare = 11.03 per 1000 members	Yes
Complaints about behavioral health access	Rate of member complaints about behavioral health	Commercial = 0.02 per 1,000 members	Yes

Table 9: Behavioral Health Standards and Measurement Results by Appointment and Practitioner Type			
Access Measure	Standard and Performance Goal	Results	Goal Met? (Yes/No)
	appointment access is less than 0.5 per 1000 members	Marketplace = 0.0 per 1,000 members Medicare = 0.07 per 1,000 members	Yes Yes
Appeals about behavioral health access	Rate of member appeals about behavioral health appointment access is less than 0.5 per 1000 members	Commercial = 0.00 per 1,000 members Marketplace = 0.18 per 1,000 members Medicare = 0.0 per 1,000 members	Yes Yes Yes
ECHO survey results re routine and urgent appt access for Getting Treatment Quickly	Rate of member responses about behavioral health Getting Treatment Quickly ECHO Plan summary rate is at or greater than 70%.	Commercial = 64.4% Marketplace = 67.3% Medicare = 73.2%	No No Yes

Behavioral Health prescriber offices did not meet the standard for routine and follow-up appointment access for both new and established patients with 34% meeting the standard for new patients and 62% for established. However, 86% met the 48-hour access standard for established patient urgent appointments. Ninety percent (90%) of offices reported a first available non-life-threatening emergency appointment within six hours and therefore met the standard of 85%. One hundred percent (100%) of prescribing practitioner offices reported that when they could not offer an appointment for non-life-threatening emergency appointments within 6 hours, they would refer the member to an available participating provider or to the ER for care. These findings are not surprising given that there continues to be a limited number of BH prescribers available in the network and within our five-county service area and there is presently a state-wide shortage of psychiatrists. Doctor on Demand telemedicine video conference services are available to all members for initial and ongoing behavioral care and are not represented in the above survey results.

BH non-prescriber offices met the standard for routine and follow-up appointment access for established patients at a rate of 85%. BH non-prescriber offices failed to meet the standard with only 77% having routine appointment access for new patients. BH non-prescriber offices successfully met the 48-hour standard for urgent visits with 86%

reporting a first available urgent appointment open. 90% of offices reported a first available non-life-threatening appointments in 6 hours which met the 85% standard. Again, all indicated that when they could not offer an appointment for non-life-threatening emergency appointments within 6 hours, they would refer the member to an available participating provider or to the ER for care.

From the foregoing, it can be determined that it is difficult for both prescribing and non-prescribing practices to work in patients with urgent and/or non-life threatening emergencies into their schedules due to high volume of patients being treated.

Requests for access to non-par behavioral health practitioners and providers for each individual product line met the FHCP goal of less than .05 referral requests per 1000 members. The goal for utilization of non-par behavioral health practitioners and providers based on 15 claims per 1000 members for each line of business was also met.

While timely access to appointment standards are a challenge, minimal requests for access to along with actual utilization of non-par behavioral health practitioners and providers strongly corresponds to the overall lack of such access in FHCP's service area for all residents, not just FHCP members. A limited number of behavioral health providers, especially prescribing behavioral health practitioners continues to be a barrier for the community and FHCP. FHCP member access to behavioral health providers via telemedicine has been useful in addressing access over the past three years.

Additional data revealed there was only one member complaint received about access to routine appointments during the review period from a Commercial member. This complaint was due to having had a scheduled appointment cancelled and rescheduled. There were no complaints from Marketplace/ QHP members or Medicare members regarding BH access.

There were no recorded Appeals during the review period related to access to behavioral health appointments or care.

ECHO survey results for Commercial, Marketplace members did not meet the composite standard of 70% with Commercial scoring at 64.4% overall which is an improvement over 57.1% in 2017, and Marketplace scoring 67.3%. Medicare results met the 70% standard with scoring at 73.2% which declined slightly from 74% in 2017. The lowest scoring results for Commercial members indicated that they did not feel they had received professional counseling needed by telephone (Q3) (at only 28.1% an increase over 26.2% in 2017). They did indicate that they saw a counselor and received counseling when desired(Q5) at a much higher rate of 77.1% than reported in 2017 (66.7%). They also reported they received other counseling or treatment as soon as desired (Q8) at a much higher rate of 88.1% again over 2017 (78.4%). Medicare members felt they received professional counseling needed by telephone (Q3) at a rate of 55.0% a slight decline over 55.6% in 2017. Medicare members also felt they received desired counseling or treatment when desired (Q5 and Q8) 79.5% and 81.5% respectively. The Marketplace respondents reflected similar results with 51.5% (Q3), 73.0%(Q5) and 77.4% (Q8) with only the members responding that they did not

receive the professional counseling they needed by telephone. Both Q5 and Q8 responses for the Marketplace met or exceeded the standard.

Although there were 18 new BH providers added to the network in 2018, it is worth noting demand has continued to outpace available local behavioral health service providers. More residents have behavioral health coverage through Marketplace/ACA plans. Therefore, demand continues to be a challenge giving the number of available providers in FHCP's five-county service area and the State of Florida overall.

A group of internal staff completed the initial barrier analysis. Participants included the behavioral health clinical director, chief medical officer, and two provider relations representatives.

The group brainstormed the following potential barriers and opportunities for improvement:

Table II Barrier Analysis Results

Barrier	Opportunity	Selected for Improvement?
Limited number of behavioral health prescribers in the service area and network and their schedules tend to be full	Continue to recruit BH practitioners to join FHCP's staff in all service areas. Continue to add non-staff BH practitioners to FHCP network.	Y
Limited access to FHCP staff follow-up BH services by video conferencing	Expand video conference capabilities with FHCP staff BH practitioners.	Y
BH practitioners are unaware that members have telemedicine benefits where they could refer members for routine care which would allow them more time on their schedule to "work in" non-life threatening emergency patients	Continue to educate network Behavioral Health providers regarding the availability of telemedicine psychiatry services and encourage use of same for routine care.	N

Action

Table 12 Planned Actions

Date Initiated	Action Implemented	Barriers Addressed
01/01/2019	Recruit BH practitioners to join FHCP's staff in all service areas. Continue to add non-staff BH practitioners to FHCP network.	Limited number of behavioral health prescribers in the service area and network and their schedules tend to be full
01/01/2019	Expand video conference capabilities with FHCP staff BH practitioners.	Limited access to FHCP staff follow-up BH services by Video conferencing

Section III: Specialty Care Physician Appointment Access

Standards and Methodology

FHCP monitors OB/GYN, medical oncology and radiation oncology routine and urgent appointment accessibility to ensure members have access to high volume and high impact specialty medical care in a timely fashion.

In addition to monitoring specific high volume and high impact access, FHCP monitors and identifies issues members may experience with access to non-behavioral specialty care, practitioners and providers by utilizing responses captured in the annual CAHPS survey for Commercial, Marketplace/QHP and Medicare members; recording and following up on member complaints and appeals regarding access to specialty care; compiling requests for and utilization of out-of-network data; and by conducting telephone surveys to ensure appointments are available to Members.

The following are the CAHPS questions related to specialist appointment access are utilized in this standard:

- Commercial – (Q25) “In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed?”
- Marketplace/ACA – (Q31) “In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?”
- Medicare – (Q29) “In the last 6 months, how often was it easy to get appointments with specialists?”

Rates for requests and appeals related to out of network providers per 1000 members for each year are determined by dividing the number of requests, claims, complaint and appeals for the year by the total number of members and multiplying by 1000.

The specialty care physician appointment access standards, measurement method, and measurement frequency for each aspect of performance that is monitored is listed in Table 14 below:

Table 14: Standards and Measurement Methods by Access Measure

Access Measure	Standard and Performance Goal	Measurement Method	Measurement Frequency
OB/GYN new patient routine appointments	70% of offices report a third available routine appointment is open for a new patient within 14 days of patient request	Office appointment access survey	Annually
OB/GYN established patient routine appointment	80% of offices report a third available routine appointment is open for an established patient within 14 days of patient request	Office appointment access survey	Annually
OB/GYN new patient urgent appointment	85% of offices report the first available urgent appointment is open for a new patient within 48 hours of patient request	Office appointment access survey	Annually
OB/GYN established patient urgent appointment	85% of offices report the first available urgent appointment is open for an established patient within 48 hours of patient request	Office appointment access survey	Annually
Medical Oncology new patient routine appointments	70% of offices report a third available routine appointment is open for a new patient within 14 days of patient request	Office appointment access survey	Annually
Medical Oncology established patient routine appointment	80% of offices report a third available routine appointment is open for an established patient within 14 days of patient request	Office appointment access survey	Annually

Table 14: Standards and Measurement Methods by Access Measure

Access Measure	Standard and Performance Goal	Measurement Method	Measurement Frequency
Medical Oncology new patient urgent appointment	85% of offices report the first available urgent appointment is open for a new patient within 48 hours of patient request	Office appointment access survey	Annually
Medical Oncology established patient urgent appointment	85% of offices report the first available urgent appointment is open for an established patient within 48 hours of patient request	Office appointment access survey	Annually
Radiation Oncology new patient routine appointments	70% of offices report a third available routine appointment is open for a new patient within 14 days of patient request	Office appointment access survey	Annually
Radiation Oncology established patient routine appointment	80% of offices report a third available routine appointment is open for an established patient within 14 days of patient request	Office appointment access survey	Annually
Radiation Oncology new patient urgent appointment	85% of offices report the first available urgent appointment is open for a new patient within 48 hours of patient request	Office appointment access survey	Annually
Radiation Oncology established patient urgent appointment	85% of offices report the first available urgent appointment is open for an established patient within 48 hours of patient request	Office appointment access survey	Annually
Complaints	Rate of member complaints about appointment access is less than 0.5 per 1000 members	Complaint analysis	Annually

Table 14: Standards and Measurement Methods by Access Measure

Access Measure	Standard and Performance Goal	Measurement Method	Measurement Frequency
Appeals	Rate of member appeals about appointment access is less than 0.5 per 1000 members	Appeal analysis	Annually
Specialty appointments	At least 80% of members report they always or usually obtained appointments as soon as they needed	CAHPS member satisfaction survey	Annually
Requests for Out of Network Specialty Care	Rate of requests for HMO members to be referred to out of network specialty providers is less than 25 per 1000 members	Referral analysis	Annually
Utilization of Out of Network Specialty Care	Utilization for HMO members of out of network specialty providers is less than 50 per 1000 members	Claims analysis	Annually

FHCP measures high volume and high impact medical specialty appointment access through a survey of Practitioner offices. FHCP's Provider Services Department surveys all applicable network (Medicare, Commercial & Marketplace) Practitioner office locations for self-reporting. Response to the survey is monitored, with repeat surveys sent to those practices that do not respond to the initial survey. Follow-up to obtain completed surveys from non-responsive practices continues over a 6 week period with a response rate goal of sixty percent (60%). The survey questions are asked once for each office, and data is recorded for the open appointments, regardless of the Practitioner who has open appointments.

For routine appointments, data is gathered on first, second and third available appointments. Our routine appointment standard is based on the date of the third available appointment because it is the most sensitive method for detecting offices which have access issues since first and second available appointments often represent cancellations and while those open appointment slots frequently are available in a timely fashion, they often do not work for members. Urgent appointment data is gathered for the first available urgent appointment slot in the office.

Table 15: Response Rate Data					
Practitioner Type	# Office locations w/Practitioner type	# Office locations responding to survey	# Practitioners represented by offices responding to survey	# Practitioners of this type in the Network	% of Practitioner type results represent out of total contracted practitioners of that type
OB/GYN	44	44	132	132	100%
Medical Oncology	27	27	161	161	100%
Radiation Oncology	16	16	103	103	100%

Results

Table 16: Measurement Results and Comparison to Performance Goal
by Access Measure

Access Measure	Standard	Results	Goal Met? (Yes/No)
OB/GYN new patient routine appointments	70% of offices report a third available routine appointment is open for a new patient within 14 days of patient request	50% of offices report a third available routine appointment is open for a new patient within 14 days of patient request	No
OB/GYN established patient routine appointment	80% of offices report a third available routine appointment is open for an established patient within 14 days of patient request	73% of offices report a third available routine appointment is open for an established patient within 14 days of patient request	No
OB/GYN new patient urgent appointment	85% of offices report the first available urgent appointment is open for a new patient within 48 hours of patient request	80% of offices report the first available urgent appointment is open for a new patient within 48 hours of patient request	No
OB/GYN established patient urgent appointment	85% of offices report the first available urgent appointment is open for an established patient within 48 hours of patient request	82% of offices report the first available urgent appointment is open for an established patient within 48 hours of patient request	No

**Table 16: Measurement Results and Comparison to Performance Goal
by Access Measure**

Access Measure	Standard	Results	Goal Met? (Yes/No)
Medical Oncology new patient routine appointments	70% of offices report a third available routine appointment is open for a new patient within 14 days of patient request	100% of offices report a third available routine appointment is open for a new patient within 14 days of patient request	Yes
Medical Oncology established patient routine appointment	80% of offices report a third available routine appointment is open for an established patient within 14 days of patient request	100% of offices report a third available routine appointment is open for an established patient within 14 days of patient request	Yes
Medical Oncology new patient urgent appointment	85% of offices report the first available urgent appointment is open for a new patient within 48 hours of patient request	100% of offices report the first available urgent appointment is open for a new patient within 48 hours of patient request	Yes
Medical Oncology established patient urgent appointment	85% of offices report the first available urgent appointment is open for an established patient within 48 hours of patient request	100% of offices report the first available urgent appointment is open for an established patient within 48 hours of patient request	Yes
Radiation Oncology new patient routine appointments	70% of offices report a third available routine appointment is open for a new patient within 14 days of patient request	100% of offices report a third available routine appointment is open for a new patient within 14 days of patient request	Yes
Radiation Oncology established patient routine appointment	80% of offices report a third available routine appointment is open for an established patient within 14 days of patient request	100% of offices report a third available routine appointment is open for an established patient within 14 days of patient request	Yes

**Table 16: Measurement Results and Comparison to Performance Goal
by Access Measure**

Access Measure	Standard	Results	Goal Met? (Yes/No)
Radiation Oncology new patient urgent appointment	85% of offices report the first available urgent appointment is open for a new patient within 48 hours of patient request	100% of offices report the first available urgent appointment is open for a new patient within 48 hours of patient request	Yes
Radiation Oncology established patient urgent appointment	85% of offices report the first available urgent appointment is open for an established patient within 48 hours of patient request	100% of offices report the first available urgent appointment is open for an established patient within 48 hours of patient request	Yes
Complaints - Appointment Access – OB/GYN	Rate of member complaints about appointment access is less than 0.5 per 1000 members	Commercial 0.02 complaints per 1,000 members	Yes
		Marketplace 0.00 complaints per 1,000 members	Yes
		Medicare 0.00 complaints per 1,000 members	Yes
Complaints Appointment Access – Medical Oncology	Rate of member complaints about appointment access is less than 0.5 per 1000 members	Commercial 0.00 complaints per 1,000 members	Yes
		Marketplace 0.00 complaints per 1,000 members	Yes
		Medicare 0.00 complaints per 1,000 members	Yes

**Table 16: Measurement Results and Comparison to Performance Goal
by Access Measure**

Access Measure	Standard	Results	Goal Met? (Yes/No)
Complaints Appointment Access – Radiation Oncology	Rate of member complaints about appointment access is less than 0.5 per 1000 members	Commercial 0.00 complaints per 1,000 members	Yes
		Marketplace 0.00 complaints per 1,000 members	Yes
		Medicare 0.00 complaints per 1,000 members	Yes
OB/GYN Appeals related to Access	Rate of member appeals about Access is less than 0.5 per 1000 members	Commercial 0.02 appeals per 1,000 members	Yes
		Marketplace 0.00 appeals per 1,000 members	Yes
		Medicare 0.00 appeals per 1,000 members	Yes
Medical Oncology Appeals related to Access	Rate of member appeals about Access is less than 0.5 per 1000 members	Commercial 0.02 appeals per 1,000 members	Yes
		Marketplace 0.00 appeals per 1,000 members	Yes
		Medicare 0.00 appeals per 1,000 members	Yes

**Table 16: Measurement Results and Comparison to Performance Goal
by Access Measure**

Access Measure	Standard	Results	Goal Met? (Yes/No)
Radiation Oncology Appeals related to Access	Rate of member appeals Access is less than 0.5 per 1000 members	Commercial 0.00 appeals per 1,000 members	Yes
		Marketplace 0.00 appeals per 1,000 members	Yes
		Medicare 0.07 appeals per 1,000 members	Yes
Specialty appointments	At least 80% of members report they always or usually obtained appointments as soon as they needed	Commercial –85.7%	Yes
		Marketplace –86.7%	Yes
		Medicare – 83.1%	Yes
Requests for Out of Network Specialty Care	Rate of requests for HMO members to be referred to out of network specialty providers is less than 25 per 1000 members	Commercial = 20.43 per 1000 members	Yes
		Marketplace = 36.94 per 1000 members	No
		Medicare = 48.90 per 1000 members	No
Utilization of Out of Network Specialty Care	Utilization for HMO members of out of network specialty providers is less than 50 per 1000 members	Commercial = 34.48 per 1000 members	Yes
		Marketplace = 44.54 per 1000 members	Yes
		Medicare = 70.90 per 1000 members	No

Analysis

None of the OB/GYN standards were met for appointment access for this reporting period. Only 50% of OB/GYN practices reported a third available appointment for new patients, 73% of practices reported a third available routine appointment was available to

established patients, 80% of offices reported a first available urgent appointment for new patients within 48 hrs and 82% of office reported a first available appointment was open for an established patient within 48 hrs. This gap was consistent in all geographic locations within FHCP's service area and indicates OB/GYN offices do not have excess capacity.

One hundred percent (100%) of the medical oncology practices met the access standards for new and established patients for both routine and urgent appointments.

One hundred percent (100%) of the radiation oncology practices met all access standards including new patient urgent appointments.

The volume of member complaints about specialty care access is very low and there was 1 complaint about OB/GYN access. One Commercial member complaint was due to a perceived delay in services. There were no complaints about medical oncology and radiation oncology access during this measurement period. There were no Medicare member complaints.

The CAHPS surveys did not bear out the same access concern that the FHCP access survey for provider appointments for OB/GYN revealed as greater than 80% of members reported that they always or usually obtained appointments as soon as they needed.

Specific to high impact and high-volume specialties, there were no Medicare member appeals regarding access to ON/GYN, or medical oncology providers. There was one Medicare member appeal related to radiation oncology and a request to see a provider out of our service area. There was one Commercial member appeal related to OB/GYN access and one Commercial appeal related to medical oncology.

Only commercial members met the goal of less than 25 per 1000 member requests for access to out of network non-behavioral health specialty providers during 2018. Transitional/continuity of care issues produced the highest number of out of network requests from commercial and Marketplace members in 2018, followed by requests to see Point of Service providers at the HMO reimbursement level. The remaining requests were members seeking referrals to OON specialists before accessing in-network providers. Eighty percent of OON requests were approved. There were no trends related to providers or services.

A review of actual utilization of out of Network non-behavioral health specialty practitioners revealed that both commercial and Marketplace members utilized such practitioners below the goal of 50 claims per 1000 members.

For Medicare members, lack or limited number subspecialists generated a higher proportion of out of network provider specialist requests. Medicare utilization of such specialists was substantially higher at 71 claims per 1000 Medicare members as compared to non-Medicare members. Closer review of these claims found the majority were for out of area emergency care, or subspecialty care not available within FHCP's network. Eighty-five percent (85%) of Medicare member out of network claims were approved which

indicates FHCP has a consistent process for review and payment of claims that meet coverage criteria.

FHCP is aware that there are additional reasons why members might be requesting or obtaining out-of-network services. Claims data indicated that primary care physicians recently added to the network in 2017 and 2018 generated many claims from out-of-network specialists where the PCP referred members in error. Also, FHCP processed and paid claims for services received by an out-of-network practitioner in a network hospital. Personal preference in this situation was not a factor.

Table 18 Barrier Analysis Results

Barrier	Opportunity	Selected for Improvement?
Possible issue with access to timely OB appointments for new and established patients based on FHCP access survey.	Access to timely initiation of OB care appears to be a community wide issue. FHCP will work with participating OB practices to facilitate member access.	Y
Provider perceived delay in delivery of services: Referrals, prescriptions, Telephonic call backs, test results	Initiate electronic referral process via provider portal Educate providers regarding Pharmacy system upgrade to improve electronic prescribing process Educate Providers regarding members use of Member Portal and Follow My Health tool so that Providers support FHCP member education efforts.	Y

Action

Table 19 Planned Actions

Date Initiated	Action Implemented	Barriers Addressed
01/01/2019	FHCP will work with participating OB practices to facilitate member access.	Access to timely initiation of OB care appears to be a community wide issue.
03/11/2019	Initiate electronic referral process via provider portal	Provider perceived delay in delivery of services: Referrals, prescriptions, telephonic call backs, test results
01/01/2019	Educate providers regarding Pharmacy system upgrade to improve electronic prescribing process Educate Providers regarding members use of Member Portal and Follow My Health tool so that Providers support FHCP member education efforts.	

Reporting

This QI activity was reported to the following QI committees:

Table 20 Committee Reporting

Committee Name	Meeting Date	Committee Actions or Recommendations
Customer Satisfaction Committee	09/13/2019	Approved, send to PI Council.
Process Improvement Council	9/18/2019	Approved as written.

Practitioner Availability Analysis *January 2018 to December 2018* *Commercial, Marketplace and Medicare*

Introduction

Because managed care plans require members to utilize a designated practitioner and provider network, FHCP must ensure there are adequate numbers and geographic distribution of primary care, behavioral health, and specialty care practitioners to meet member needs as well as providers. FHCP monitors practitioner and provider availability annually against its standards, and initiates actions as needed to improve practitioner and/or provider availability. This report describes the monitoring methodology, results, analysis, and action.

Member Cultural Needs and Preferences

FHCP analyzes data about member cultural needs and preferences annually to determine whether the current practitioner network is meeting these needs unless there are significant changes in either membership or Network composition.

Member cultural needs and preferences are assessed through:

- CAHPS survey results on respondent race and ethnicity
- Member complaints regarding cultural needs and preferences
- US census data on resident race distribution for FHCP's service area, as available
- US census data on proportion of residents that speak a language other than English, as available
- Member complaints regarding language needs

The following are the CAHPS survey results on respondent's race for the Commercial, Marketplace/Qualified Health Plan (QHP) and Medicare surveys:

Commercial HMO Membership:

Trended CAHPS Data: Racial Composition of Respondents			
	2016	2017	2018
Total Number answering question	295	322	398
White	90.4%	87.2%	84.3%
Black or African-American	6.0%	9.3%	11.5%
Hispanic	6.1%	6.4%	5%
Asian	2.5%	1.6%	1.8%
Other	3.2%	5.1%	5.0%

Marketplace/QHP Membership:

Trended Survey Data: Racial Composition of Respondents			
	2016	2017	2018
Total Number answering question	110	212	156
White	84.55%	82.55%	87.0%
Black or African-American	0.0%	6.13%	6.1%
Hispanic	0.0%	12.26%	10.9%
Asian	0.0%	0.0%	6.1%
Other	0.0%	0.0%	0.0%

Medicare HMO Membership:

Trended CAHPS Data: Racial Composition of Respondents			
	2016	2017	2018
Total Number answering question	397	398	373
White	94.8%	95.1%	95%
Black or African-American	4.7%	4.4%	4%
Hispanic	0.0%	2.9%	0.0%
Asian	0.0%	0.0%	0.0%
Other	0.0%	0.0%	0.0%

The 2018 CAHPS Commercial percentage of self-reported White members decreased to 84.3% compared to 87.2% in 2017. However, Black/African American members increased to 11.5% in 2018 from 9.3% in 2017, while the percentage of Hispanic/Latino members decreased to 5 % in 2018 from 6.4% in 2017. Asian members increased slightly to 1.8% in 2018 from 1.6% in 2017. Members reporting as “other” decreased slightly from 5.1% in 2017 to 5.0% in 2018.

The CAHPS survey was performed for Marketplace/QHP membership. The 2018 CAHPS results reported that 87% of the respondents were White which represented an increase over 82.55% reported in 2017. Black/African-American respondents were 6.1% in 2018 which represented a slight decrease from 2017 where there were 6.13% respondents noted. Hispanic/Latino respondents decreased from 12.26% respondents in 2017 to 10.9% in 2018.

The 2018 Medicare CAHPS survey identified that 95% of members reporting were White and 4% were Black or African American. Hispanic/Latino, Asian and American Indian or Alaska Native collectively made up the remaining 1% of members responding.

There were no member complaints in 2018 about practitioners not meeting racial, ethnic, or cultural needs.

U.S. Census data from the 2010 Census for FHCP’s service area of Volusia, Seminole, Flagler, Brevard and St. Johns Counties, Florida, provides racial composition data. The U.S. Census Bureau also provides estimates for future years based on the 2010 Census results. There was no estimate for 2018, so FHCP utilized the last year currently available which was 2017. The estimated racial compositions are as follows:

Volusia County:

Category	2010	% of Total	Estimated 2017 %
Total:	494,597		518,660
White	408,256	84.30%	82.9%
Black or African American	51,791	10.5%	10.6%
Hispanic/Latino	55,217	11.2%	12.9%
American Indian and Alaska Native	1,778	0.4%	0.4%
Asian	7,567	1.5%	1.8%
Native Hawaiian and Other Pacific Islander alone	204	0.0%	0%
Two or more races:	10,510	2.1%	2.1%

Flagler County:

Category	2010	% of Total	Estimated 2017 %
Total:	95,696		105,015
White	78,710	82.30%	82.6%
Black or African American	10,884	11.40%	10.3%
Hispanic/Latino	8,251	8.60%	10%
American Indian and Alaska Native	267	0.30%	0.4%
Asian	2,046	2.10%	2.5%
Native Hawaiian and Other Pacific Islander alone	59	0.10%	0.0%
Two or more races:	2,186	2.30%	2.1%

Seminole County:

Category	2010	% of Total	Estimated 2017%
Total:	422,718		449,260
White	330,664	78.20%	78.3%
Black or African American	47,107	11.10%	11.5%
Hispanic/Latino	72,457	17.10%	20.1%
American Indian and Alaska Native	1,386	0.30%	0.2%
Asian	15,692	3.70%	4.3%
Native Hawaiian and Other Pacific Islander alone	285	0.10%	0.1%
Two or more races:	12,190	2.90%	3.3%

Brevard County:

Category	2010	% of Total	Estimated 2017 %
Total:	543,376		568,183
White	450,927	83.00%	82.9%
Black or African American	54,799	10.10%	10.2%
Hispanic/Latino	43,943	8.10%	9.7%
American Indian and Alaska Native	809	0.10%	0.3%
Asian	11,349	2.10%	2.4%
Native Hawaiian and Other Pacific Islander alone	514	0.10%	0.1%
Two or more races:	14,370	2.60%	2.8%

St Johns County:

Category	2010	% of Total	Estimated 2017 %
Total:	180,624		226,578
White	161,720	89.5%	89.0%
Black or African American	9829	5.4%	5.1%
Hispanic/Latino	8797	4.9%	6.4%
American Indian and Alaska Native	388	.02%	0.3%
Asian	3782	2.1%	2.7%
Native Hawaiian and Other Pacific Islander alone	52	0.0%	0.1%
Two or more races:	3371	1.9%	2.3%

A comparison of FHCP member racial data from CAHPS to the US census data for Volusia, Seminole, Flagler, Brevard and St. Johns Counties reveals that FHCP's membership racial composition is less diverse than Census data especially for Marketplace/QHP and Medicare products. For example, Census data reflects a higher percentage of Hispanic/Latino populations than does FHCP's membership. FHCP only reflects 5.0% Hispanic/Latino under Commercial products, and 10.9% Hispanic/ Latino under Marketplace/QHP.

The proportion of households in the service area that speak a language other than English was also obtained from US 2010 Census Bureau 5-year American Community Survey for 2013-2017. Results indicated that 13.2% of the Volusia County population speaks a language other than English, with 68.9% able to speak English "very well". For Flagler County, 14.4% of the total population speaks a language other than English, with 57.8% able to speak English "very well". For Seminole County 21.1% of the population speaks a language other than English, with 71.5% able to speak English "very well". For Brevard County 10.4% of the population speaks a language other than English, with 66.9% able to speak English "very well". For St Johns County 8.3% of the population speaks a language other than English, with 74.7% able to speak English "very well".

Spanish is typically the language most frequently spoken other than English within the FHCP Service Area. Interestingly, in Flagler County, where Indo-European languages previously were reported to be spoken slightly more often than Spanish, this year's analysis showed that Spanish has now exceeded the prior reported Indo-European rate by .5%. Since FHCP's Hispanic population is significantly less than that of its service area, it would appear that higher populations of FHCP members speak English in comparison to the population of the FHCP service area.

FHCP examines available data about network practitioner's ability to meet member's cultural and linguistic needs. Today, FHCP does not have reliable data on practitioner race, as this data point is an optional item on the practitioner credentialing application. However, FHCP does have reliable data on practitioners who speak languages other than English. The results of this analysis are below:

Language	Number	Language	Number
Arabic	16	Macedonian	1
Armenian	1	Malayalam	1
Bengali	1	Marathi	1
Burmese	1	Persian/Farsi	5
Castilian	5	Polish	2
Chinese	9	Portuguese	10
Chinese, Mandarin	1	Punjabi	12
Chinese, Yue (Cantonese)	1	Romanian	3
Creole	1	Russian	13
Faroese	1	Sindhi	1
Filipino	4	Spanish	217
French	35	Swahili	1
German	8	Tagalog	9
Hebrew	1	Taiwanese	3
Hindi	75	Tamil	11
Hindustani	9	Telugu	3
Hungarian	3	Ukrainian	7
Icelandic	1	Urdu	28
Italian	16	Vietnamese	6
Korean	1		
Lithuanian	1		

Upon comparing data for practitioners who speak languages other than English with the proportion of individuals in the service area who speak other languages, it was determined that FHCP's network meets member needs. Five percent (5%) of the FHCP Commercial members responding to the CAHP's survey indicated that they were of Hispanic/Latino origin while 10.9% of Marketplace indicated the same.

Currently, 217 of FHCP practitioners speak Spanish. This proportion of Spanish speaking practitioners also is comparable to the overall population of FHCP's service area. Also, per the Census data, 6.1% of the population in Flagler County speaks an Indo-European language. FHCP currently has 35 practitioners who speak French, 16 who speak Italian, 13 who speak Russian, 10 who speak Portuguese, 3 who speak Romanian, and 8 who speak German.

There were no member complaints in 2018 regarding language needs or linguistic barriers.

Analysis Results

In sum, based on available data, we conclude that members have the following cultural and linguistic needs which should be met by network practitioners:

- Black/African American practitioners in all counties for Marketplace/ QHP membership.
- Hispanic/Latino practitioners in Seminole County.
- Practitioners that speak Spanish in Seminole County
- Practitioners that speak Indo-European languages in Flagler County

FHCP will take in consideration the foregoing when recruiting additional practitioners to its networks.

Availability Standards and Methodology

Practitioner availability monitoring is completed for primary care practitioners, high volume and high impact specialty care practitioners, and high volume behavioral health practitioner types.

FHCP defines primary care practitioners as family practitioners, pediatrics, internal medicine and general practitioners.

FHCP identifies High Volume Specialties through analysis of the number of visits by specialty. For 2018, FHCP identified High Volume Specialties for Commercial and Marketplace products as Obstetricians/Gynecologists. The High Volume Specialty for Medicare was Gynecology.

High Impact Specialties are defined as Practitioners who treat conditions that have high mortality and morbidity rates and where such treatment requires significant resources. For 2018, FHCP identified High Impact Specialties for Commercial, Marketplace and Medicare as Medical and Radiation Oncology Practitioners.

FHCP identifies High Volume Behavioral Health Practitioner types for Commercial, Marketplace and Medicare through analysis of encounters/number of visits. For 2018 identified High Volume Behavioral Health Practitioner types were: Psychiatrists, Licensed Mental Health Counselors, and Licensed Clinical Social Workers.

Table 1a lists the standards, measurement method, and measurement frequency for each Practitioner type or discipline for which Availability is monitored. Monitoring takes place at the Commercial, Marketplace and Medicare product line.

COMMERICAL

Table 1a: Availability Standards and Measurement Methods by Practitioner Type

Practitioner Type	Standard	Measurement Method	Measurement Frequency
Primary Care Practitioners – Pediatricians	1 Pediatrician for every 2500 members age birth to 18 years	Ratio of PCPs per members	Annually
	At least 75% of Pediatric PCP panels will be open to new members	Ratio of open PCP panels per total number of PCP panels	Annually
	80% or more of Members age birth to 18 years will have a Pediatric PCP office within 20 miles of member residence	GeoAccess	Annually
Primary Care Practitioners – Internal Medicine	1 Internal Medicine PCP for every 2500 members age 18 years and older	Ratio of PCPs per members	Annually
	At least 75% of Internal Medicine PCP panels will be open to new members	Ratio of open PCP panels per total number of PCP panels	Annually
	85% or more of Members age 18 and older will have an Internal Medicine PCP office within 20 miles of member residence	GeoAccess	Annually

COMMERICAL

Table 1a: Availability Standards and Measurement Methods by Practitioner Type

Practitioner Type	Standard	Measurement Method	Measurement Frequency
Primary Care Practitioners – Family Practice or General Practice	1 FP or GP PCP for every 2500 members ages 2 years and older	Ratio of PCPs per members	Annually
	At least 75% of PCP panels will be open to new members	Ratio of open PCP panels per total number of PCP panels	Annually
	85% or more of Members ages 2 and older will have a FP or GP PCP office within 20 miles of member residence	GeoAccess	Annually
All Primary Care Practitioners	1 PCP for every 2500 members	Ratio of PCPs per members	Annually
	At least 75% of PCP panels will be open to new members	Ratio of open PCP panels per total number of PCP panels	Annually
	85% or more of Members will have a PCP office within 15 miles of member residence	GeoAccess	Annually
OB/GYN	At least 90% will be open to accepting new HMO members	Percent of open Network Practitioners per total Practitioners of Specialty	Annually
	90% or more of Members will have an OB/GYN office within 20 miles of member residence	GeoAccess	Annually

COMMERICAL

Table 1a: Availability Standards and Measurement Methods by Practitioner Type

Practitioner Type	Standard	Measurement Method	Measurement Frequency
Medical Oncology	At least 95% will be open to accepting new HMO members 90% or more of Members will have a Medical Oncology office within 20 miles of member residence	Percent of open Network Practitioner per total par Practitioners of specialty GeoAccess	Annually Annually
Radiation Oncology	At least 95% will be open to accepting new HMO members 90% or more of Members will have a Radiation Oncology office within 20 miles of member residence	Percent of open Network Practitioners per total par Practitioners of specialty GeoAccess	Annually Annually
High volume behavioral health prescribing Practitioners: Psychiatrist (MD/DO)	At least 90% will be open to accepting new HMO members 90% or more of Members will have a psychiatrist office within 30 miles of member residence	Percent of open Network Practitioners per total par Practitioners of Specialty GeoAccess	Annually Annually

COMMERICAL

Table 1a: Availability Standards and Measurement Methods by Practitioner Type

Practitioner Type	Standard	Measurement Method	Measurement Frequency
High volume behavioral health Practitioner: Licensed Mental Health Counselor (LMHC)	At least 90% will be open to accepting new HMO members	Percent of open Network Practitioners per total par Practitioners of Specialty	Annually
	90% or more of Members will have a LMHC office within 30 miles of member residence	GeoAccess	Annually
High volume behavioral health Practitioner: Licensed Clinical Social Worker (LCSW)	At least 90% will be open to accepting new HMO members	Percent of open Network Practitioners per total par Practitioners of Specialty	Annually
	90% or more of Members will have a LCSW office within 30 miles of member residence	GeoAccess	Annually
Emergency Care	90% or more of Members will have Emergency Care available within 30 miles of member residence	GeoAccess	Annually
Urgent Care Centers	90% or more of Members will have a Urgent Care Center within 30 miles of member residence	GeoAccess	Annually

MARKETPLACE

Table 1b: Availability Standards and Measurement Methods by Practitioner Type

Practitioner Type	Standard	Measurement Method	Measurement Frequency
Primary Care Practitioners – Pediatricians	1 Pediatrician for every 2500 members age birth to 18 years	Ratio of PCPs per members	Annually
	At least 75% of Pediatric PCP panels will be open to new members	Ratio of open PCP panels per total number of PCP panels	Annually
	80% or more of Members age birth to 18 years will have a pediatric PCP office within 20 miles of member residence	GeoAccess	Annually
Primary Care Practitioners – Internal Medicine	1 Internal Medicine PCP for every 2500 members age 18 years and older	Ratio of PCPs per members	Annually
	At least 75% of Internal Medicine PCP panels will be open to new members	Ratio of open PCP panels per total number of PCP panels	Annually
	85% or more of Members age 18 and older will have an Internal Medicine PCP office within 20 miles of member residence	GeoAccess	Annually

MARKETPLACE

Table 1b: Availability Standards and Measurement Methods by Practitioner Type

Practitioner Type	Standard	Measurement Method	Measurement Frequency
Primary Care Practitioners – Family Practice or General Practice	1 FP or GP PCP for every 2500 members ages 2 years and older	Ratio of PCPs per members	Annually
	At least 75% of PCP panels will be open to new members	Ratio of open PCP panels per total number of PCP panels	Annually
	85% or more of Members ages 2 and older will have a FP or GP PCP office within 20 miles of member residence	GeoAccess	Annually
All Primary Care Practitioners	1 PCP for every 2500 members	Ratio of PCPs per members	Annually
	At least 75% of PCP panels will be open to new members	Ratio of open PCP panels per total number of PCP panels	Annually
	85% or more of Members will have a PCP office within 15 miles of member residence	GeoAccess	Annually
OB/GYN	At least 90% will be open to accepting new HMO members	Percent of open Network Practitioners per total Practitioners of Specialty	Annually
	90% or more of Members will have an OB/GYN office within 20 miles of member residence	GeoAccess	Annually

MARKETPLACE

Table 1b: Availability Standards and Measurement Methods by Practitioner Type

Practitioner Type	Standard	Measurement Method	Measurement Frequency
Medical Oncology	At least 95% will be open to accepting new HMO members	Percent of open Network Practitioner per total Spec 1 par Practitioners of specialty	Annually
	90% or more of Members will have a Medical Oncology office within 20 miles of member residence	GeoAccess	Annually
Radiation Oncology	At least 95% will be open to accepting new HMO members	Percent of open Network Practitioners per total Spec 2 par Practitioners of specialty	Annually
	90% or more of Members will have a Radiation Oncology office within 20 miles of member residence	GeoAccess	Annually
High volume behavioral health prescribing Practitioners: Psychiatrist (MD/DO)	At least 90% will be open to accepting new HMO members	Percent of open Network Practitioners per total par Practitioners of Specialty	Annually
	90% or more of Members will have a psychiatrist office within 30 miles of member residence	GeoAccess	Annually

MARKETPLACE

Table 1b: Availability Standards and Measurement Methods by Practitioner Type

Practitioner Type	Standard	Measurement Method	Measurement Frequency
High volume behavioral health Practitioner: Licensed Mental Health Counselor (LMHC)	At least 90% will be open to accepting new HMO members 90% or more of Members will have a LMHC office within 30 miles of member residence	Percent of open Network Practitioners per total par Practitioners of Specialty GeoAccess	Annually Annually
High volume behavioral health Practitioner: Licensed Clinical Social Worker (LCSW)	At least 90% will be open to accepting new HMO members 90% or more of Members will have a LCSW office within 30 miles of member residence	Percent of open Network Practitioners per total par Practitioners of Specialty GeoAccess	Annually Annually
Emergency Care	90% or more of Members will have Emergency Care available within 30 miles of member residence	GeoAccess	Annually
Urgent Care Centers	90% or more of Members will have a Urgent Care Center within 30 miles of member residence	GeoAccess	Annually

MEDICARE

Table IC: Availability Standards and Measurement Methods by Practitioner Type

Practitioner Type	Standard	Measurement Method	Measurement Frequency
Primary Care Practitioners – Internal Medicine	1 Internal Medicine PCP for every 2500 members age 18 years and older	Ratio of PCPs per members	Annually
	At least 75% of Internal Medicine PCP panels will be open to new members	Ratio of open PCP panels per total number of PCP panels	Annually
	85% or more of Members age 18 and older will have an Internal Medicine PCP office within 20 miles of member residence	GeoAccess	Annually
Primary Care Practitioners – Family Practice or General Practice	1 FP or GP PCP for every 2500 members ages 2 years and older	Ratio of PCPs per members	Annually
	At least 75% of PCP panels will be open to new members	Ratio of open PCP panels per total number of PCP panels	Annually
	85% or more of Members ages 2 and older will have a FP or GP PCP office within 20 miles of member residence	GeoAccess	Annually

MEDICARE

Table IC: Availability Standards and Measurement Methods by Practitioner Type

Practitioner Type	Standard	Measurement Method	Measurement Frequency
All Primary Care Practitioners	1 PCP for every 2500 members	Ratio of PCPs per members	Annually
	At least 75% of PCP panels will be open to new members	Ratio of open PCP panels per total number of PCP panels	Annually
	90% or more of Members will have a PCP office within 15 miles of member residence	GeoAccess	Annually
Gynecology	At least 90% will be open to accepting new HMO members	Percent of open Network Practitioners per total Practitioners of Specialty	Annually
	90% or more of Members will have an OB/GYN office within 20 miles of member residence	GeoAccess	Annually
Medical Oncology	At least 95% will be open to accepting new HMO members	Percent of open Network Practitioner per total Specialist Practitioners of specialty	Annually
	90% or more of Members will have a Medical Oncology office within 20 miles of member residence	GeoAccess	Annually

MEDICARE

Table IC: Availability Standards and Measurement Methods by Practitioner Type

Practitioner Type	Standard	Measurement Method	Measurement Frequency
Radiation Oncology	At least 95% will be open to accepting new HMO members	Percent of open Network Practitioners per total Spec 2 par Practitioners of specialty	Annually
	90% or more of Members will have a Radiation Oncology office within 20 miles of member residence	GeoAccess	Annually
High volume behavioral health prescribing Practitioners: Psychiatrist (MD/DO)	At least 90% will be open to accepting new HMO members	Percent of open Network Practitioners per total par Practitioners of Specialty	Annually
	90% or more of Members will have a psychiatrist office within 30 miles of member residence	GeoAccess	Annually
High volume behavioral health Practitioner: Licensed Mental Health Counselor (LMHC)	At least 90% will be open to accepting new HMO members	Percent of open Network Practitioners per total par Practitioners of Specialty	Annually
	90% or more of Members will have a LMHC office within 30 miles of member residence	GeoAccess	Annually

MEDICARE

Table 1C: Availability Standards and Measurement Methods by Practitioner Type

Practitioner Type	Standard	Measurement Method	Measurement Frequency
High volume behavioral health Practitioner: Licensed Clinical Social Worker (LCSW)	At least 90% will be open to accepting new HMO members	Percent of open Network Practitioners per total par Practitioners of Specialty	Annually
	90% or more of Members will have a LCSW office within 30 miles of member residence	GeoAccess	Annually

Availability Results:

COMMERICAL

Table 2a: Availability Measurement Results and Comparison to Performance Goals by Practitioner Type

Practitioner Type	Standard	Results	Goal Met? (Yes/No)
Primary Care Practitioners – Pediatricians	1 Pediatrician for every 2500 members age birth to 18 years	1 PCP / 35 members	Yes
	At least 75% of Pediatric PCP panels will be open to new members	99% of PCP panels that are open	Yes
	80% or more of Members will have a pediatric PCP office within 20 miles of member residence	99.7% of members have at least 1 pediatric PCP within 20 miles	Yes

COMMERICAL

Table 2a: Availability Measurement Results and Comparison to Performance Goals by Practitioner Type

Practitioner Type	Standard	Results	Goal Met? (Yes/No)
Primary Care Practitioners – Internal Medicine	1 Internal Medicine PCP for every 2500 members age 18 years and older	1 PCP / 213 members	Yes
	At least 75% of Internal Medicine PCP panels will be open to new members	87% of PCP panels that are open	Yes
	85% or more of Members age 18 and older will have an Internal Medicine PCP office within 20 miles of member residence	99.6% of members have at least 1 IM PCP within 20 miles	Yes
Primary Care Practitioners – Family Practice or General Practice	1 FP or GP PCP for every 2500 members ages 2 years and older	1 PCP / 107 members	Yes
	At least 75% of PCP panels will be open to new members	86% of PCP panels that are open	Yes
	85% or more of Members ages 2 and older will have a FP or GP PCP office within 20 miles of member residence	99.6% of members have at least 1 FP or GP PCP within 20 miles	Yes
All Primary Care Practitioners	1 PCP for every 2500 members	1 PCP / 65 members	Yes
	At least 75% of PCP panels will be open to new members	90% of PCP panels that are open	Yes
	85% or more of Members will have a PCP office within 15 miles of member residence	99.3% of members have at least 1 PCP within 15 miles	Yes

COMMERICAL

Table 2a: Availability Measurement Results and Comparison to Performance Goals by Practitioner Type

Practitioner Type	Standard	Results	Goal Met? (Yes/No)
High Volume Specialty: Obstetrics and Gynecology	At least 90% will be open to accepting new HMO members	97% are accepting new HMO members	Yes
	90% or more of Members will have a OB/GYN office within 20 miles of member residence	99.6% of members have at least one OB/GYN within 20 miles	Yes
High Impact Specialty: Medical Oncology	At least 95% will be open to accepting new HMO members	99% are accepting new HMO members	Yes
	90% or more of Members will have a Medical Oncology office within 20 miles of member residence	99.6% of members have at least one Medical Oncologist within 20 miles	Yes
High Impact Specialty: Radiation Oncology	At least 95% will be open to accepting new HMO members	100% are accepting new HMO members	Yes
	90% or more of Members will have a Radiation Oncology specialty office within 20 miles of member residence	99.6% of members have at least one Radiation Oncologist within 20 miles	Yes
High volume behavioral health prescribing Practitioner. Psychiatrist (M.D./D.O.)	At least 90% will be open to accepting new HMO members	86% are accepting new HMO members	No*
	90% or more of Members will have a psychiatrist office within 30 miles of member residence	100% of members have at least one psychiatrist within 30 miles	Yes

COMMERICAL

Table 2a: Availability Measurement Results and Comparison to Performance Goals by Practitioner Type

Practitioner Type	Standard	Results	Goal Met? (Yes/No)
High volume behavioral health Practitioner - Licensed Mental Health Counselor (LMHC)	At least 90% will be open to accepting new HMO members	99% are accepting new HMO members	Yes
	90% or more of Members will have a LMHC office within 30 miles of member residence	100% of members have at least one LMHC within 30 miles	Yes
High volume behavioral health Practitioner - Licensed Clinical Social Worker (LCSW)	At least 90% will be open to accepting new HMO members	93% are accepting new HMO members	Yes
	90% or more of Members will have a LCSW office within 30 miles of member residence	100% of members have at least one LCSW within 30 miles	Yes
Emergency Care	90% or more of Members will have a Specialty office within 30 miles of member residence	100% of members have access to at least one emergency care facility within 30 miles	Yes
Urgent Care Centers	90% or more of Members will have a Specialty office within 30 miles of member residence	100% of members have access to at least one urgent care facility within 30 miles	Yes

MARKETPLACE

Table 2B: Availability Measurement Results and Comparison to Performance Goals by Practitioner Type

Practitioner Type	Standard	Results	Goal Met? (Yes/No)
Primary Care Practitioners – Pediatricians	1 Pediatrician for every 2500 members age birth to 18 years	1 PCP/26 members	Yes
	At least 75% of Pediatric PCP panels will be open to new members	99% of PCP panels that are open	Yes
	80% or more of Members will have a pediatric PCP office within 20 miles of member residence	99.7% of members have at least 1 pediatric PCP within 20 miles	Yes
Primary Care Practitioners – Internal Medicine	1 Internal Medicine PCP for every 2500 members age 18 years and older	1 PCP /288 members	Yes
	At least 75% of Internal Medicine PCP panels will be open to new members	87% of PCP panels that are open	Yes
	85% or more of Members age 18 and older will have an Internal Medicine PCP office within 20 miles of member residence	99.7% of members have at least 1 IM PCP within 20 miles	Yes
Primary Care Practitioners – Family Practice or General Practice	1 FP or GP PCP for every 2500 members ages 2 years and older	1 PCP/ 140 members	Yes
	At least 75% of PCP panels will be open to new members	86% of PCP panels that are open	Yes
	85% or more of Members ages 2 and older will have a FP or GP PCP office within 20 miles of member residence	99.7% of members have at least 1 FP or GP PCP within 20 miles	Yes

MARKETPLACE

Table 2B: Availability Measurement Results and Comparison to Performance Goals by Practitioner Type

Practitioner Type	Standard	Results	Goal Met? (Yes/No)
All Primary Care Practitioners	1 PCP for every 2500 members	1 PCP /83 members	Yes
	At least 75% of PCP panels will be open to new members	90% of PCP panels that are open	Yes
	85% or more of Members will have a PCP office within 15 miles of member residence	99.3% of members have at least 1 PCP within 15 miles	Yes
High Volume Specialty: Obstetrics and Gynecology	At least 90% will be open to accepting new HMO members	97% are accepting new HMO members	Yes
	90% or more of Members will have a OB/GYN office within 20 miles of member residence	99.7% of members have at least one OB/GYN within 20 miles	Yes
High Impact Specialty: Medical Oncology	At least 95% will be open to accepting new HMO members	99% are accepting new HMO members	Yes
	90% or more of Members will have a Medical Oncology office within 20 miles of member residence	99.7% of members have at least one Medical Oncologist within 20 miles	Yes
High Impact Specialty: Radiation Oncology	At least 95% will be open to accepting new HMO members	100% are accepting new HMO members	Yes
	90% or more of Members will have a Radiation Oncology office within 20 miles of member residence	99.6% of members have at least one Radiation Oncologist within 20 miles	Yes

MARKETPLACE

Table 2B: Availability Measurement Results and Comparison to Performance Goals by Practitioner Type

Practitioner Type	Standard	Results	Goal Met? (Yes/No)
High volume behavioral health prescribing Practitioner. Psychiatrist (M.D./D.O.)	At least 90% will be open to accepting new HMO members 90% or more of Members will have a psychiatrist office within 30 miles of member residence	86% are accepting new HMO members 100% of members have at least one psychiatrist within 30 miles	No* Yes
High volume behavioral health Practitioner - Licensed Mental Health Counselor (LMHC)	At least 90% will be open to accepting new HMO members 90% or more of Members will have a LMHC office within 30 miles of member residence	99% are accepting new HMO members 100% of members have at least one LMHC within 30 miles	Yes Yes
High volume behavioral health Practitioner - Licensed Clinical Social Worker (LCSW)	At least 90% will be open to accepting new HMO members 90% or more of Members will have a LCSW office within 30 miles of member residence	93% are accepting new HMO members 100% of members have at least one LCSW within 30 miles	Yes Yes
Emergency Care	90% or more of Members will have Emergency Care available within 30 miles of member residence	100% of members have access to at least one emergency care facility within 30 miles	Yes
Urgent Care Centers	90% or more of Members will have a Urgent Care Center within 30 miles of member residence	100% of members have access to at least one urgent care facility within 30 miles	Yes

MEDICARE

Table 2c: Availability Measurement Results and Comparison to Performance Goals by Practitioner Type

Practitioner Type	Standard	Results	Goal Met? (Yes/No)
Primary Care Practitioners – Internal Medicine	1 Internal Medicine PCP for every 2500 members age 18 years and older	1 PCP / 102 members	Yes
	At least 75% of Internal Medicine PCP panels will be open to new members	85% of PCP panels that are open	Yes
	85% or more of Members age 18 and older will have an Internal Medicine PCP office within 20 miles of member residence	99.6% of members have at least 1 IM PCP within 20 miles	Yes
Primary Care Practitioners – Family Practice or General Practice	1 FP or GP PCP for every 2500 members ages 2 years and older	1 PCP/ 63 members	Yes
	At least 75% of PCP panels will be open to new members	86% of PCP panels that are open	Yes
	85% or more of Members ages 2 and older will have a FP or GP PCP office within 20 miles of member residence	99.7% of members have at least 1 FP or GP PCP within 20 miles	Yes
All Primary Care Practitioners	1 PCP for every 2500 members	1 PCP/ 39 members	Yes
	At least 75% of PCP panels will be open to new members	85% of PCP panels that are open	Yes
	90% or more of Members will have a PCP office within 15 miles of member residence	99.4% of members have at least 1 PCP within 15 miles	Yes

MEDICARE

Table 2c: Availability Measurement Results and Comparison to Performance Goals by Practitioner Type

Practitioner Type	Standard	Results	Goal Met? (Yes/No)
High Volume Specialty: Gynecology	At least 90% will be open to accepting new HMO members	98% are accepting new HMO members	Yes
	90% or more of Members will have a OB/GYN office within 20 miles of member residence	99.6% of members have at least one OB/GYN within 20 miles	Yes
High Impact Specialty: Medical Oncology	At least 95% will be open to accepting new HMO members	99% are accepting new HMO members	Yes
	90% or more of Members will have a Medical Oncology office within 20 miles of member residence	99.6% of members have at least one Medical Oncologist within 20 miles	Yes
High Impact Specialty: Radiation Oncology	At least 95% will be open to accepting new HMO members	100% are accepting new HMO members	Yes
	90% or more of Members will have a Radiation Oncology office within 20 miles of member residence	99.5% of members have at least one Radiation Oncologist within 20 miles	Yes
High volume behavioral health prescribing Practitioner. Psychiatrist (M.D./D.O.)	At least 90% will be open to accepting new HMO members	93% are accepting new HMO members	Yes
	90% or more of Members will have a psychiatrist office within 30 miles of member residence	100% of members have at least one psychiatrist within 30 miles	Yes

MEDICARE

Table 2c: Availability Measurement Results and Comparison to Performance Goals by Practitioner Type

Practitioner Type	Standard	Results	Goal Met? (Yes/No)
High volume behavioral health Practitioner - Licensed Mental Health Counselor (LMHC)	At least 90% will be open to accepting new HMO members	100% are accepting new HMO members	Yes
	90% or more of Members will have a LMHC office within 30 miles of member residence	100% of members have at least one LMHC within 30 miles	Yes
High volume behavioral health Practitioner - Licensed Clinical Social Worker (LCSW)	At least 90% will be open to accepting new HMO members	100% are accepting new HMO members	Yes
	90% or more of Members will have a LCSW office within 30 miles of member residence	100% of members have at least one LCSW within 30 miles	Yes

Analysis of Results

For Commercial and Marketplace/QHP members, the FHCP Network meets all standards and measurements for availability for PCP, High Volume, High Impact Practitioners, High Volume Behavioral Health – Non-Prescribing, Emergency Care, and Urgent Care Centers.

However, currently only 86% of the High-Volume Behavioral Health – Prescribing Practitioners are open to accepting new HMO members even though members have geographic access within 30 miles of their residence. Eighty-six percent (86%) does not meet the 90% standard for accepting new members. The FHCP Network includes real time video visits with Behavioral Health Therapists and Psychiatrists. It allows initial and follow up visits with the same provider on a scheduled basis. These video visits can be used for any behavioral health condition, including addiction. This service is not counted in the analysis but significantly improves access to behavioral health services for FHCP members. Access to prescribing Behavioral Health providers continues to be a community-wide issue in our service areas.

For Medicare members, the FHCP Network meets all standards and measurements for availability for PCP, High Volume and High Impact Practitioner.

Action

As an identified issue, FHCP has taken the following actions to address this issue:

- In 2018, FHCP contracted with 17 additional MDs and 1 DO for Behavioral Services.
- FHCP continues to have the program by which psychiatry and psychology specialties services offered by our telemedicine vendor, Doctor on Demand. FHCP members can use this service to access both prescribing and non-prescribing Behavioral Health providers for care from any location via a secure online application. This service is available to all FHCP members. The availability of specific providers via Doctor on Demand are not accounted for in this data.
- FHCP continues to identify potential Behavioral Health prescribing providers within our service area either via contracting with existing Practitioners in the community or by recruiting Practitioner(s) to its staff.

Reporting

Table 8 Committee Reporting

Committee Name	Meeting Date	Committee Actions or Recommendations
Contracting Committee	May 15, 2019	Approved.
Customer Satisfaction	May 16, 2019	Approved; send to PI Council.
Performance Improvement /Committee	July 17, 2019	Approved.

Appendix I - CMS Required Reports

CMS Standards for Medicare Network Practitioner Availability

For Medicare membership in Volusia, Flagler, Seminole, Brevard and St Johns Counties, FHCP must annually demonstrate that it offers an adequate Network to provide access for Medicare covered services, as required by 42 CFR 422.122(a)(1). Standards for the number (quantity) and geographic distribution (time and distance) of Medicare Network Practitioners and Providers are set forth by CMS annually in the CMS Health Service Delivery (HSD) Reference file for each County within FHCP's Medicare product service area. This Reference file sets forth the following:

- a. Standards for Number of Practitioners and Providers. The CMS requirements for minimal number of Practitioners and Providers by county in the Medicare service area as detailed below for 2018:

Practitioner Specialty 2018	CMS Practitioner Quantity Standard				
	Volusia Medicare	Flagler Medicare	Seminole Medicare	Brevard Medicare	St Johns Medicare
Primary Care	28	7	16	29	11
Allergy and Immunology	1	1	1	1	1
Cardiology	5	2	3	5	2
Chiropractor	2	1	1	2	1
Dermatology	3	1	2	3	1
Endocrinology	1	1	1	1	1
ENT/Otolaryngology	1	1	1	2	1
Gastroenterology	2	1	2	3	1
General Surgery	5	2	3	5	2
Gynecology, OB/GYN	1	1	1	1	1
Infectious Diseases	1	1	1	1	1
Nephrology	2	1	1	2	1
Neurology	2	1	2	3	1
Neurosurgery	1	1	1	1	1
Oncology - Medical, Surgical	4	1	2	4	2
Oncology - Radiation	1	1	1	2	1
Ophthalmology	4	1	3	5	2

Practitioner Specialty 2018	CMS Practitioner Quantity Standard				St Johns Medicare
	Volusia Medicare	Flagler Medicare	Seminole Medicare	Brevard Medicare	
Orthopedic Surgery	4	1	2	4	2
Physiatry, Rehabilitative Medicine	1	1	1	1	1
Plastic Surgery	1	1	1	1	1
Podiatry	4	1	2	4	2
Psychiatry	3	1	2	3	1
Pulmonology	3	1	2	3	1
Rheumatology	2	1	1	2	1
Urology	2	1	2	3	1
Vascular Surgery	1	1	1	1	1
Cardiothoracic Surgery	1	1	1	1	1
Acute Inpatient Hospital Beds	201	51	112	211	74
Cardiac Surgery Program	1	1	1	1	1
Cardiac Catheterization Services	1	1	1	1	1
Critical Care Services/Intensive Care	1	1	1	1	1
Outpatient Dialysis	1	1	1	1	1
Surgical Services (Outpatient or ASC)	1	1	1	1	1
Skilled Nursing Facilities	1	1	1	1	1
Diagnostic Radiology	1	1	1	1	1
Mammography	1	1	1	1	1
Physical Therapy	1	1	1	1	1
Occupational Therapy	1	1	1	1	1
Speech Therapy	1	1	1	1	1
Inpatient Psychiatric Facility Services	1	1	1	1	1
Home Health	1	1	1	1	1
Durable Medical Equipment	1	1	1	1	1
Outpatient Infusion/Chemotherapy	1	1	1	1	1

- b. Standard for Geographic Access. The CMS requirements for travel time and distance to Practitioners and Providers by county in the Medicare service area as detailed below for 2018. The standards require FHCP to demonstrate that ninety percent (90%) of Medicare Members (or more) have access to at least one Practitioner/Provider, for each specialty type, within CMS established time and distance requirements for the period being measured.

CMS Practitioner Time & Distance Standards 2018		Volusia	Flagler	Seminole	Brevard	St Johns
Primary Care - (see Notes)	Time (Minutes)	15	15	15	15	15
	Distance (Miles)	10	10	10	10	10
Allergy and Immunology	Time (Minutes)	45	45	45	45	60
	Distance (Miles)	30	30	30	30	40
Cardiology	Time (Minutes)	30	30	30	30	30
	Distance (Miles)	20	20	20	20	20
Chiropractor	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30
Dermatology	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30
Endocrinology	Time (Minutes)	60	60	60	60	60
	Distance (Miles)	40	40	40	40	40
ENT/Otolaryngology	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30
Gastroenterology	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30
General Surgery	Time (Minutes)	30	30	30	30	30
	Distance (Miles)	20	20	20	20	20
Gynecology, OB/GYN	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30
Infectious Diseases	Time (Minutes)	60	60	60	60	60
	Distance (Miles)	40	40	40	40	40
Nephrology	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30
Neurology	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30
Neurosurgery	Time (Minutes)	60	60	60	60	60
	Distance (Miles)	40	40	40	40	40
Oncology - Medical, Surgical	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30
Oncology - Radiation/ Radiation Oncology	Time (Minutes)	60	60	60	60	60
	Distance (Miles)	40	40	40	40	40
Ophthalmology	Time (Minutes)	30	30	30	30	30
	Distance (Miles)	20	20	20	20	20

Orthopedic Surgery	Time (Minutes)	30	30	30	30	30
	Distance (Miles)	20	20	20	20	20
Physiatry, Rehabilitative Medicine	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30
Plastic Surgery	Time (Minutes)	60	60	60	60	60
	Distance (Miles)	40	40	40	40	40
Podiatry	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30
Psychiatry	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30
Pulmonology	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30
Rheumatology	Time (Minutes)	60	60	60	60	60
	Distance (Miles)	40	40	40	40	40
Urology	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30
Vascular Surgery	Time (Minutes)	60	60	60	60	60
	Distance (Miles)	40	40	40	40	40
Cardiothoracic Surgery	Time (Minutes)	60	60	60	60	60
	Distance (Miles)	40	40	40	40	40
Acute Inpatient Hospital	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30
Cardiac Surgery Program	Time (Minutes)	60	60	60	60	60
	Distance (Miles)	40	40	40	40	40
Cardiac Cath Services	Time (Minutes)	60	60	60	60	60
	Distance (Miles)	40	40	40	40	40
Critical Care/ICU Services	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30
Outpatient Dialysis	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30
Surgical Services (Outpatient or ASC)	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30
Skilled Nursing Facilities	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30
Diagnostic Radiology	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30
Mammography	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30
Physical Therapy	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30
Occupational Therapy	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30

Speech Therapy	Time (Minutes)	60	70	45	45	45
	Distance (Miles)	40	45	30	30	30
Inpatient Psychiatric Facility Services	Time (Minutes)	70	70	70	70	70
	Distance (Miles)	45	45	45	45	45
Outpt. Infusion/Chemotherapy	Time (Minutes)	45	45	45	45	45
	Distance (Miles)	30	30	30	30	30

Tables 3-7 below provide results for monitoring against the standards for adequate numbers and distance of practitioners and providers by county for the Medicare network. The Access Requirements columns show the proportion of members who met the time and distance geographic location standards. The Provider Requirements columns show whether the number of practitioners or providers met the minimum number standards for that county.

Table 3 – Volusia County Medicare Network Availability Results

Table 4 – Flagler County Medicare Network Availability Results

Table 5 – Seminole County Medicare Network Availability Results

Table 6 – Brevard County Medicare Network Availability Results

Table 7 – St Johns County Medicare Network Availability Results

Table 3 – Volusia County Medicare Practitioner Network Availability Results

Spec Code	Specialty Description	Pct With Access	Pct Without Access	Avg Dist	Avg Time	Met Access	Required Prvs	Servicing Prvs	Met Prvs	Met Overall
S03	Primary Care	99.6	0.4	2.0	2.3	Y	30	366	Y	Y
007	Allergy and Immunology	99.9	.1	7.8	9.2	Y	1	10	Y	Y
008	Cardiology	99.5	0.5	4.2	5.0	Y	5	37	Y	Y
010	Chiropractor	100.0	0.0	2.8	3.2	Y	2	59	Y	Y
011	Dermatology	100.0	0.0	5.5	6.4	Y	3	22	Y	Y
012	Endocrinology	100.0	0.0	4.5	5.3	Y	1	24	Y	Y
013	ENT/Otolaryngology	100.0	0.0	6.1	7.2	Y	2	20	Y	Y
014	Gastroenterology	100.0	0.0	4.2	5.1	Y	3	38	Y	Y
015	General Surgery	99.6	0.4	5.7	6.9	Y	5	20	Y	Y
016	Gynecology, OB/GYN	100.0	0.0	3.5	4.2	Y	1	53	Y	Y
017	Infectious Diseases	100.0	0.0	5.7	6.9	Y	1	9	Y	Y
018	Nephrology	100.0	0.0	4.0	4.6	Y	2	30	Y	Y
019	Neurology	100.0	0.0	3.7	4.3	Y	3	32	Y	Y
020	Neurosurgery	100.0	0.0	7.9	9.7	Y	1	14	Y	Y
021	Oncology - Medical, Surgical	100.0	0.0	3.9	4.5	Y	4	46	Y	Y
022	Oncology - Radiation/Radiation O...	100.0	0.0	6.8	8.1	Y	2	20	Y	Y
023	Ophthalmology	99.4	.06	3.5	4.1	Y	5	38	Y	Y
025	Orthopedic Surgery	99.5	0.5	3.7	4.4	Y	4	37	Y	Y
026	Physiatry, Rehabilitative Medicine	99.9	0.1	7.8	9.2	Y	1	10	Y	Y
027	Plastic Surgery	100.0	0.0	9.3	11.3	Y	1	12	Y	Y
028	Podiatry	100.0	0.0	6.3	7.5	Y	4	35	Y	Y
029	Psychiatry	100.0	0.0	3.1	3.7	Y	3	87	Y	Y
030	Pulmonology	100.0	0.0	3.6	4.2	Y	3	32	Y	Y
031	Rheumatology	100.0	0.0	4.1	4.8	Y	2	14	Y	Y
033	Urology	100.0	0.0	4.6	5.5	Y	3	29	Y	Y
034	Vascular Surgery	100.0	0.0	4.9	5.8	Y	1	31	Y	Y
035	Cardiothoracic Surgery	100.0	0.0	13.4	16.6	Y	1	7	Y	Y
040	Acute Inpatient Hospitals	100.0	0.0	4.2	5.0	Y	217	2684	Y	Y

041	Cardiac Surgery Program	100.0	0.0	10.0	12.2	Y	1	6	Y	Y
042	Cardiac Catheterization Services	100.0	0.0	10.0	12.2	Y	1	7	Y	Y
043	Critical Care Services – Intensive...	100.0	0.0	10.0	12.2	Y	1	7	Y	Y
044	Outpatient Dialysis	100.0	0.0	4.0	4.7	Y	1	35	Y	Y
045	Surgical Services (Outpatient or...	100.0	0.0	4.7	5.4	Y	1	22	Y	Y
046	Skilled Nursing Facilities	100.0	0.0	4.4	5.2	Y	1	22	Y	Y
047	Diagnostic Radiology	100.0	0.0	3.3	3.9	Y	1	32	Y	Y
048	Mammography	100.0	0.0	4.7	5.7	Y	1	19	Y	Y
049	Physical Therapy	100.0	0.0	3.3	3.9	Y	1	31	Y	Y
050	Occupational Therapy	99.9	0.1	8.2	10.1	Y	1	8	Y	Y
051	Speech Therapy	100.0	0.0	8.3	10.1	Y	1	7	Y	Y
052	Inpatient Psychiatric Facility Servi...	100.0	0.0	8.2	9.9	Y	1	10	Y	Y
057	Outpatient Infusion/Chemotherapy	99.8	0.2	9.3	11.1	Y	1	6	Y	Y

Table 4 – Flagler County Medicare Practitioner Network Availability Results

Spec Code	Specialty Description	Pct With Access	Pct Without Access	Avg Dist	Avg Time	Met Access	Required Prvs	Servicing Prvs	Met Prvs	Met Overall
S03	Primary Care	97.4	2.6	2.7	3.2	Y	8	188	Y	Y
007	Allergy and Immunology	100.0	0.0	5.5	6.1	Y	1	6	Y	Y
008	Cardiology	100.0	0.0	3.7	4.3	Y	2	26	Y	Y
010	Chiropractor	100.0	0.0	3.4	3.8	Y	1	47	Y	Y
011	Dermatology	100.0	0.0	5.8	6.5	Y	1	11	Y	Y
012	Endocrinology	100.0	0.0	4.9	5.7	Y	1	19	Y	Y
013	ENT/Otolaryngology	100.0	0.0	5.5	6.1	Y	1	14	Y	Y
014	Gastroenterology	100.0	0.0	4.7	5.5	Y	1	30	Y	Y
015	General Surgery	100.0	0.0	7.1	8.8	Y	2	19	Y	Y
016	Gynecology, OB/GYN	100.0	0.0	3.9	4.5	Y	1	42	Y	Y
017	Infectious Diseases	100.0	0.0	23.6	27.5	Y	1	6	Y	Y
018	Nephrology	100.0	0.0	5.1	6.0	Y	1	22	Y	Y
019	Neurology	100.0	0.0	4.4	4.9	Y	1	24	Y	Y
020	Neurosurgery	100.0	0.0	5.5	6.8	Y	1	15	Y	Y
021	Oncology - Medical, Surgical	100.0	0.0	7.1	8.7	Y	1	35	Y	Y
022	Oncology - Radiation/Radiation O...	100.0	0.0	24.2	28.0	Y	1	17	Y	Y
023	Ophthalmology	100.0	0.0	3.6	4.3	Y	2	31	Y	Y
025	Orthopedic Surgery	100.0	0.0	3.5	4.2	Y	1	35	Y	Y
026	Physiatry, Rehabilitative Medicine	100.0	0.0	5.5	6.2	Y	1	7	Y	Y
027	Plastic Surgery	100.0	0.0	7.1	8.7	Y	1	9	Y	Y
028	Podiatry	100.0	0.0	6.9	8.4	Y	1	10	Y	Y
029	Psychiatry	100.0	0.0	3.6	4.0	Y	1	76	Y	Y
030	Pulmonology	100.0	0.0	5.7	6.4	Y	1	22	Y	Y
031	Rheumatology	100.0	0.0	21.3	24.1	Y	1	10	Y	Y
033	Urology	100.0	0.0	6.9	8.5	Y	1	23	Y	Y
034	Vascular Surgery	100.0	0.0	5.3	5.9	Y	1	24	Y	Y
035	Cardiothoracic Surgery	100.0	0.0	22.0	26.0	Y	1	5	Y	Y
040	Acute Inpatient Hospitals	100.0	0.0	7.1	8.7	Y	54	2112	Y	Y
041	Cardiac Surgery Program	100.0	0.0	22.0	26.0	Y	1	5	Y	Y
042	Cardiac Catheterization Services	100.0	0.0	7.1	8.7	Y	1	6	Y	Y
043	Critical Care Services – Intensive...	100.0	0.0	7.1	8.7	Y	1	5	Y	Y
044	Outpatient Dialysis	100.0	0.0	3.6	4.3	Y	1	16	Y	Y
045	Surgical Services (Outpatient or...	100.0	0.0	21.4	24.2	Y	1	15	Y	Y
046	Skilled Nursing Facilities	100.0	0.0	4.5	5.0	Y	1	17	Y	Y
047	Diagnostic Radiology	100.0	0.0	3.4	4.0	Y	1	21	Y	Y
048	Mammography	100.0	0.0	4.0	4.6	Y	1	12	Y	Y
049	Physical Therapy	100.0	0.0	5.2	5.9	Y	1	16	Y	Y
050	Occupational Therapy	100.0	0.0	5.8	6.5	Y	1	6	Y	Y

051	Speech Therapy	100.0	0.0	5.8	6.5	Y	1	6	Y	Y
052	Inpatient Psychiatric Facility Servi...	100.0	0.0	23.6	27.1	Y	1	7	Y	Y
057	Outpatient Infusion/Chemotherapy	97.5	2.5	24.1	28.0	Y	1	5	Y	Y

Table 5 – Seminole County Medicare Practitioner Network Availability Results

Spec Code	Specialty Description	Pct With Access	Pct Without Access	Avg Dist	Avg Time	Met Access	Required Prvs	Servicing Prvs	Met Prvs	Met Overall
S03	Primary Care	95.5	5.5	2.6	3.5	Y	17	143	Y	Y
007	Allergy and Immunology	100.0	0.0	6.7	9.4	Y	1	9	Y	Y
008	Cardiology	100.0	0.0	4.6	6.0	Y	3	25	Y	Y
010	Chiropractor	100.0	0.0	4.0	5.6	Y	1	43	Y	Y
011	Dermatology	100.0	0.0	4.1	5.6	Y	2	16	Y	Y
012	Endocrinology	100.0	0.0	7.6	10.3	Y	1	11	Y	Y
013	ENT/Otolaryngology	100.0	0.0	4.8	6.5	Y	1	9	Y	Y
014	Gastroenterology	100.0	0.0	6.2	8.4	Y	2	20	Y	Y
015	General Surgery	100.0	0.0	7.8	10.6	Y	3	16	Y	Y
016	Gynecology, OB/GYN	100.0	0.0	6.	8.2	Y	1	35	Y	Y
017	Infectious Diseases	100.0	0.0	14.6	17.9	Y	1	7	Y	Y
018	Nephrology	100.0	0.0	6.2	8.7	Y	1	19	Y	Y
019	Neurology	100.0	0.0	6.0	8.2	Y	2	23	Y	Y
020	Neurosurgery	100.0	0.0	5.1	6.9	Y	1	12	Y	Y
021	Oncology - Medical, Surgical	100.0	0.0	4.0	5.5	Y	2	35	Y	Y
022	Oncology - Radiation/Radiation	100.0	0.0	5.6	7.6	Y	1	12	Y	Y
023	Ophthalmology	100.0	0.0	5.0	7.2	Y	3	22	Y	Y
025	Orthopedic Surgery	100.0	0.0	4.7	6.4	Y	2	18	Y	Y
026	Physiatry, Rehabilitative Medicine	100.0	0.0	8.2	10.9	Y	1	6	Y	Y
027	Plastic Surgery	100.0	0.0	6.0	8.0	Y	1	11	Y	Y
028	Podiatry	100.0	0.0	5.4	7.6	Y	2	25	Y	Y
029	Psychiatry	100.0	0.0	4.7	6.2	Y	2	62	Y	Y
030	Pulmonology	100.0	0.0	6.0	8.6	Y	2	16	Y	Y
031	Rheumatology	100.0	0.0	5.8	8.1	Y	1	10	Y	Y
033	Urology	100.0	0.0	5.4	7.7	Y	2	24	Y	Y
034	Vascular Surgery	100.0	0.0	5.3	7.1	Y	1	30	Y	Y
035	Cardiothoracic Surgery	100.0	0.0	32.7	43.9	Y	1	6	Y	Y
040	Acute Inpatient Hospitals	100.0	0.0	6.4	8.7	Y	118	1952	Y	Y
041	Cardiac Surgery Program	100.0	0.0	8.8	12.2	Y	1	5	Y	Y
042	Cardiac Catheterization Services	100.0	0.0	8.8	12.2	Y	1	6	Y	Y
043	Critical Care Services – Intensive...	100.0	0.0	8.8	12.2	Y	1	4	Y	Y
044	Outpatient Dialysis	100.0	0.0	4.1	5.5	Y	1	30	Y	Y
045	Surgical Services (Outpatient or...	100.0	0.0	5.7	7.9	Y	1	15	Y	Y
046	Skilled Nursing Facilities	100.0	0.0	5.5	7.3	Y	1	17	Y	Y
047	Diagnostic Radiology	100.0	0.0	3.6	4.8	Y	1	22	Y	Y
048	Mammography	100.0	0.0	5.2	7.0	Y	1	11	Y	Y
049	Physical Therapy	100.0	0.0	3.9	5.4	Y	1	22	Y	Y
050	Occupational Therapy	100.0	0.0	8.7	12.0	Y	1	4	Y	Y
051	Speech Therapy	100.0	0.0	8.7	12.0	Y	1	4	Y	Y
052	Inpatient Psychiatric Facility	100.0	0.0	15.9	22.3	Y	1	8	Y	Y
057	Outpatient Infusion/Chemotherapy	100.0	0.0	14.4	17.6	Y	1	4	Y	Y

Table 6 – Brevard County Medicare Practitioner Network Availability Results

Spec Code	Specialty Description	Pct With Access	Pct Without Access	Avg Dist	Avg Time	Met Access	Required Prvs	Servicing Prvs	Met Prvs	Met Overall
S03	Primary Care	99.5	.05	2.1	2.4	Y	32	232	Y	Y
007	Allergy and Immunology	94.5	5.5	16.9	20.6	Y	1	13	Y	Y
008	Cardiology	100.0	0.0	3.6	4.1	Y	6	29	Y	Y
010	Chiropractor	100.0	0.0	4.4	5.4	Y	2	49	Y	Y
011	Dermatology	100.0	0.0	3.6	4.1	Y	3	22	Y	Y
012	Endocrinology	100.0	0.0	.90	10.8	Y	1	16	Y	Y
013	ENT/Otolaryngology	100.0	0.0	5.7	6.5	Y	2	18	Y	Y
014	Gastroenterology	100.0	0.0	4.9	5.7	Y	3	34	Y	Y
015	General Surgery	100.0	0.0	4.0	4.6	Y	6	17	Y	Y
016	Gynecology, OB/GYN	100.0	0.0	3.9	4.7	Y	1	39	Y	Y
017	Infectious Diseases	100.0	0.0	16.4	18.2	Y	1	9	Y	Y
018	Nephrology	100.0	0.0	5.5	6.4	Y	2	29	Y	Y
019	Neurology	100.0	0.0	4.0	4.7	Y	3	36	Y	Y
020	Neurosurgery	100.0	0.0	23.4	28.7	Y	1	13	Y	Y
021	Oncology - Medical, Surgical	100.0	0.0	5.4	6.2	Y	4	40	Y	Y
022	Oncology - Radiation/Radiation	100.0	0.0	5.7	6.8	Y	2	13	Y	Y
023	Ophthalmology	100.0	0.0	3.8	4.3	Y	5	26	Y	Y
025	Orthopedic Surgery	100.0	0.0	4.0	4.7	Y	4	25	Y	Y
026	Physiatry, Rehabilitative Medicine	93.6	6.4	17.5	20.1	Y	1	9	Y	Y
027	Plastic Surgery	100.0	0.0	16.5	18.9	Y	1	10	Y	Y
028	Podiatry	100.0	0.0	3.9	4.4	Y	4	35	Y	Y
029	Psychiatry	100.0	0.0	4.7	5.5	Y	3	62	Y	Y
030	Pulmonology	100.0	0.0	5.5	6.3	Y	3	29	Y	Y
031	Rheumatology	100.0	0.0	6.0	6.9	Y	2	13	Y	Y
033	Urology	100.0	0.0	4.5	5.1	Y	3	29	Y	Y
034	Vascular Surgery	100.0	0.0	4.7	5.5	Y	1	31	Y	Y
035	Cardiothoracic Surgery	100.0	0.0	19.5	21.9	Y	1	7	Y	Y
040	Acute Inpatient Hospitals	100.0	0.0	6.0	7.2	Y	229	2161	Y	Y
041	Cardiac Surgery Program	100.0	0.0	6.0	7.3	Y	1	6	Y	Y
042	Cardiac Catheterization Services	100.0	0.0	6.0	7.3	Y	1	6	Y	Y
043	Critical Care Services – Intensive...	100.0	0.0	6.0	7.3	Y	1	5	Y	Y
044	Outpatient Dialysis	100.0	0.0	6.2	7.2	Y	1	29	Y	Y
045	Surgical Services (Outpatient or...	100.0	0.0	5.4	6.1	Y	1	22	Y	Y
046	Skilled Nursing Facilities	100.0	0.0	4.4	5.1	Y	1	20	Y	Y
047	Diagnostic Radiology	100.0	0.0	3.0	3.4	Y	1	30	Y	Y
048	Mammography	100.0	0.0	4.2	4.8	Y	1	18	Y	Y
049	Physical Therapy	100.0	0.0	3.4	4.0	Y	1	23	Y	Y
050	Occupational Therapy	100.0	0.0	5.8	6.8	Y	1	7	Y	Y
051	Speech Therapy	100.0	0.0	6.0	7.3	Y	1	6	Y	Y
052	Inpatient Psychiatric Facility	100.0	0.0	16.3	19.2	Y	1	9	Y	Y
057	Outpatient Infusion/Chemotherapy	100.0	0.0	7.5	9.3	Y	1	6	Y	Y

Table 7 – St Johns County Medicare Practitioner Network Availability Results

Spec Code	Specialty Description	Pct With Access	Pct Without Access	Avg Dist	Avg Time	Met Access	Required Prvs	Servicing Prvs	Met Prvs	Met Overall
S03	Primary Care	96.7	3.3	2.9	3.3	Y	11	90	Y	Y
007	Allergy and Immunology	100.0	0.0	6.1	6.7	Y	1	8	Y	Y
008	Cardiology	96.7	3.3	5.6	6.2	Y	2	12	Y	Y
010	Chiropractor	100.0	0.0	5.7	6.3	Y	1	22	Y	Y
011	Dermatology	100.0	0.0	5.8	6.4	Y	2	9	Y	Y

012	Endocrinology	100.0	0.0	6.8	8.3	Y	1	18	Y	Y
013	ENT/Otolaryngology	100.0	0.0	5.7	6.5	Y	1	10	Y	Y
014	Gastroenterology	100.0	0.0	5.2	5.8	Y	1	15	Y	Y
015	General Surgery	95.5	4.5	6.4	7.0	Y	2	7	Y	Y
016	Gynecology, OB/GYN	100.0	0.0	4.3	4.8	Y	1	16	Y	Y
017	Infectious Diseases	100.0	0.0	6.5	7.2	Y	1	5	Y	Y
018	Nephrology	100.0	0.0	6.1	6.7	Y	1	9	Y	Y
019	Neurology	100.0	0.0	5.7	6.4	Y	1	11	Y	Y
020	Neurosurgery	100.0	0.0	6.1	6.8	Y	1	12	Y	Y
021	Oncology - Medical, Surgical	99.7	.03	6.5	7.2	Y	2	15	Y	Y
022	Oncology - Radiation/Radiation	100.0	0.0	6.5	7.1	Y	1	12	Y	Y
023	Ophthalmology	100.0	0.0	4.4	5.0	Y	2	18	Y	Y
025	Orthopedic Surgery	99.1	.9	5.2	5.8	Y	2	21	Y	Y
026	Physiatry, Rehabilitative Medicine	99.7	.03	6.4	7.1	Y	1	2	Y	Y
027	Plastic Surgery	100.0	0.0	6.5	7.2	Y	1	7	Y	Y
028	Podiatry	100.0	0.0	4.3	4.8	Y	2	10	Y	Y
029	Psychiatry	100.0	0.0	3.5	3.9	Y	1	22	Y	Y
030	Pulmonology	99.7	.3	5.8	6.4	Y	1	10	Y	Y
031	Rheumatology	100.0	0.0	5.9	6.6	Y	1	10	Y	Y
033	Urology	100.0	0.0	6.6	7.3	Y	1	4	Y	Y
034	Vascular Surgery	100.0	0.0	6.4	7.1	Y	1	18	Y	Y
035	Cardiothoracic Surgery	100.0	0.0	6.5	7.2	Y	1	5	Y	Y
040	Acute Inpatient Hospitals	99.7	.3	6.5	7.2	Y	77	796	Y	Y
041	Cardiac Surgery Program	100.0	0.0	6.5	7.2	Y	1	3	Y	Y
042	Cardiac Catheterization Services	100.0	0.0	6.5	7.2	Y	1	4	Y	Y
043	Critical Care Services – Intensive...	99.7	.3	6.5	7.2	Y	1	3	Y	Y
044	Outpatient Dialysis	100.0	0.0	6.3	6.9	Y	1	7	Y	Y
045	Surgical Services (Outpatient or...	100.0	0.0	5.9	6.6	Y	1	9	Y	Y
046	Skilled Nursing Facilities	100.0	0.0	6.8	7.6	Y	1	6	Y	Y
047	Diagnostic Radiology	100.0	0.0	6.2	6.9	Y	1	7	Y	Y
048	Mammography	100.0	0.0	6.2	6.9	Y	1	5	Y	Y
049	Physical Therapy	100.0	0.0	3.3	3.7	Y	1	12	Y	Y
050	Occupational Therapy	100.0	0.0	4.2	4.6	Y	1	3	Y	Y
051	Speech Therapy	100.0	0.0	15.8	17.7	Y	1	2	Y	Y
052	Inpatient Psychiatric Facility	100.0	0.0	6.2	6.9	Y	1	6	Y	Y
057	Outpatient Infusion/Chemotherapy	100.0	0.0	6.3	7.0	Y	1	2	Y	Y

FHCP meets the number and geographic availability required by CMS for Medicare for each service area county.

Monitoring Potential Practitioner Quality Concerns January 1 to June 30, 2018

Florida Health Care Plans (FHCP) monitors member complaints involving network & staff practitioners and organizational providers on an ongoing basis. FHCP also monitors adverse events for Primary Care Practitioners and high-volume Behavioral Health providers. The Quality Management department tracks, trends, and investigates these issues as part of ongoing credentialing monitoring.

The following categories of member complaints are included in this analysis:

- Quality of care (QU)
- Grievance (GR)
- Staff (ST)
- Policy & Procedure (PP)
- Access (AC)

The following adverse event categories are included in this analysis:

- Clinical Treatment Concern
- Complications after surgery
- Delay in Care
- Failure to Diagnose
- Failure to Refer
- Readmission
- Wrong Medication
- Wrong Treatment

Member Complaint Monitoring

FHCP investigates all member complaints. Quality Management conducts a more detailed investigation when the volume of member complaints within the reporting period exceeds a threshold of 10 complaints for a staff provider or 5 complaints for a contracted provider. FHCP tracks complaints on a rolling 6-month basis; for any given month, complaints are reviewed for the prior 6-month period and are monitored on an aggregate basis for that time-frame. As such, data can include complaints reported during months that extend beyond the time-frame noted on the analysis report. If complaints do not exceed thresholds, the data is tracked for future trends.

Complaint Trends by Practitioner Type		
Criteria	This report period January 1 to June 30, 2018	Previous report period July 1 to December 31, 2017
Number of staff providers with 10 complaints	0	0
Number of contracted providers with 5 complaints	1*	0

No individual practitioners exceeded complaint thresholds in the January to June reporting period, however a new Dermatology group* #040169 (PAR 11/1/2017) was initially identified in January as having a high number of member complaints in the three months since the new contract was initiated. Continued monitoring in the following six months identified a total of 23 complaints reported to Member Services between January 1 and June 30 in the following categories: Staff, Quality, Access, Grievance, and Policy & Procedure.

The complaint trend was reported to the Customer Satisfaction Committee monthly from January to June. All but two of the 23 complaints were submitted between January 1 and March 25, as the new plan year was beginning. Committee discussion with Network Services, the CMO and Credentialing staff identified that this group was contracted to replace another large

Monitoring Potential Practitioner Quality Concerns January 1 to June 30, 2018

Dermatology group no longer in-network at the end of 2017. 18 of the 23 complaints were determined to be access and staffing issues related to the network change. Members who complained were generally unhappy with the group change, unfamiliar doctors and staff, office locations, wait-times for appointments, etc. One policy (PP) complaint was deferred to the Compliance Department for investigation of a possible HIPAA issue identified in one office. One Grievance (GR) was incorrectly coded to this practice and should have been coded to the termed Dermatology group; no quality of care concerns were identified for either group in this instance.

At the time of Committee reporting, interventions were already being implemented by Network Services and the CEO to address scheduling, staffing and general access issues through regular meetings with the group's practice management. The group also purchased a dedicated phone line for FHCP member scheduling. No quality of care issues were identified in follow-up review of complaints coded "QU" or "GR". Between May and June, there was only one new complaint. QM Staff will continue to monitor this group for new or continued trends and report as needed.

Complaint Details by Practitioner January – June		
Provider	Total	Complaints by Category
#040469*	23	GR – 6 QU – 3 ST – 3 PP – 1 AC – 10

*Group number; no single provider was identified as exceeding thresholds

Ongoing trend monitoring – no prior trends were being followed during this reporting period.

Analysis of facility (organizational provider) issues: While ongoing monitoring for organizational providers is not required by NCQA, FHCP trends facility complaints in order to improve customer service and quality of care. For the 6 month period January 1 to June 30, 2018, there were no complaint trends identified for any organizational providers.

Adverse Event Monitoring

Adverse events are tracked for PCPs and high-volume Behavioral Health Providers. When an adverse event occurs, FHCP's complaint and incident reporting systems are queried to determine if there are any trends for the practitioner or facility. A more detailed investigation occurs when a trend is identified. If potential quality of care issues are identified by Risk Management or Quality Management staff, these trends are reported to the Credentialing and Peer Review Committee.

There were no trends identified for any individual PCP during the reporting period.

Adverse Events by Category/Month – Primary Care (PCP)						
	January	February	March	April	May	June
Clinical Treatment Concern	1	1	1	0	0	1
Complications after surgery	0	0	0	0	0	0
Delay in Care	1	0	0	2	1	0

Monitoring Potential Practitioner Quality Concerns January 1 to June 30, 2018

Adverse Events by Category/Month – Primary Care (PCP)						
Failure to Diagnose	0	0	0	0	0	0
Failure to Refer	0	0	0	0	0	0
Readmission	0	0	0	0	0	0
Wrong Medication	1	0	0	1	1	1
Wrong Treatment	0	0	0	0	0	0
Total:	3	1	1	3	2	2

There were no trends identified for any individual BH provider during the reporting period.

Adverse Events by Category/Month – Behavioral Health (BH)						
	January	February	March	April	May	June
Clinical Treatment Concern	0	0	0	0	0	0
Complications after surgery	0	0	0	0	0	0
Delay in Care	0	0	0	0	0	0
Failure to Diagnose	0	0	0	0	0	0
Failure to Refer	0	0	0	0	0	0
Readmission	0	0	0	0	0	0
Wrong Medication	0	0	0	0	0	0
Wrong Treatment	0	0	0	0	0	0
Total:	0	0	0	0	0	0

Committee	Review Date	Actions
Credentialing & Peer Review	July 17, 2018	Approved as submitted

Monitoring Potential Practitioner Quality Concerns July 1 to December 31, 2018

Florida Health Care Plans (FHCP) monitors member complaints involving network & staff practitioners and organizational providers on an ongoing basis. FHCP also monitors adverse events for Primary Care Practitioners and high-volume Behavioral Health providers. The Quality Management department tracks, trends, and investigates these issues as part of ongoing credentialing monitoring.

The following categories of member complaints are included in this analysis:

- Quality of care (QU)
- Policy & Procedure (PP)
- Grievance (GR)
- Access (AC)
- Staff (ST)

The following adverse event categories are included in this analysis:

- Clinical Treatment Concern
- Complications after surgery
- Delay in Care
- Failure to Diagnose
- Failure to Refer
- Readmission
- Wrong Medication
- Wrong Treatment

Member Complaint Monitoring

FHCP investigates all member complaints. Quality Management conducts a more detailed investigation when the volume of member complaints within the reporting period exceeds a threshold of 10 complaints for a staff provider or 5 complaints for a contracted provider. FHCP tracks complaints on a rolling 6-month basis; for any given month, complaints are reviewed for the prior 6-month period and are monitored on an aggregate basis for that time-frame. As such, data can include complaints reported during months that extend beyond the time-frame noted on the analysis report. If complaints do not exceed thresholds, the data is tracked for future trends.

Complaint Trends by Practitioner Type		
Criteria	This report period July 1 to December 31, 2018	Previous report period January 1 to June 30, 2018
Number of staff providers with 10 complaints	0	0
Number of contracted providers with 5 complaints	0	1*

*Group; no single provider was identified as exceeding thresholds

No individual practitioners exceeded complaint thresholds in the July to December reporting period.

Ongoing trend monitoring – no prior trends were being followed during this reporting period.

Monitoring Potential Practitioner Quality Concerns July 1 to December 31, 2018

Analysis of facility (organizational provider) issues: While ongoing monitoring for organizational providers is not required by NCQA, FHCP trends facility complaints in order to improve customer service and quality of care. For the 6 month period July 1 to December 31, 2018, there were no complaint trends identified for any organizational providers.

Adverse Event Monitoring

Adverse events are tracked for PCPs and high-volume Behavioral Health Providers. When an adverse event occurs, FHCP's complaint and incident reporting systems are queried to determine if there are any trends for the practitioner or facility. A more detailed investigation occurs when a trend is identified. If potential quality of care issues are identified by Risk Management or Quality Management staff, these trends are reported to the Credentialing and Peer Review Committee.

There were no trends identified for any individual PCP during the reporting period.

Adverse Events by Category/Month – Primary Care (PCP)						
	July	August	September	October	November	December
Clinical Treatment Concern	1	0	0	0	0	0
Complications after surgery	0	0	0	0	0	0
Delay in Care	0	0	0	2	0	0
Failure to Diagnose	0	0	0	0	0	0
Failure to Refer	0	0	0	0	0	0
Readmission	0	0	0	0	0	0
Wrong Medication	1	0	0	1	1	0
Wrong Treatment	0	0	0	0	0	0
Total:	2	0	0	3	1	0

There were no trends identified for any individual BH provider during the reporting period.

Adverse Events by Category/Month – Behavioral Health (BH)						
	July	August	September	October	November	December
Clinical Treatment Concern	0	0	0	0	0	0
Complications after surgery	0	0	0	0	0	0
Delay in Care	0	0	0	0	0	0
Failure to Diagnose	0	0	0	0	0	0
Failure to Refer	0	0	0	0	0	0
Readmission	0	0	0	0	0	0
Wrong Medication	0	0	0	0	0	0
Wrong Treatment	0	0	0	0	0	0
Total:	0	0	0	0	0	0

Monitoring Potential Practitioner Quality Concerns
July 1 to December 31, 2018

Committee	Review Date	Actions
Credentialing & Peer Review	April 30, 2019	

Florida Health Care Plans
Quality and Accuracy of Customer Service Process Emails
Report Period: 1-1-2018-12-31-2018

Florida Health Care Plans (FHCP) monitors emails coming into Member Services across all product lines. This report summarizes the 2018 measurement methods, results, analysis, and applicable interventions pertaining to the quality and accuracy of responses to member emails, specifically those relating to benefit issues.

Measurement Methodology

The numerator specifications were the total number of emails audited that met all three compliance measures. The denominator specifications were the total number of emails randomly selected for audit.

Data Sources:

The email, email reply, and Correspondence Unit Tracking System (CUT) documentation.

Performance Goal:

FHCP's goal for 2018 was to have 95% of all emails answered timely, accurately, and appropriately (HIPAA).

In 2018, FHCP averaged 384 member emails per month. A sample size of 15 per month was randomly chosen for monitoring. The monitoring process consisted of administrative review of the email, the email reply, and Correspondence Unit Tracking System (CUT) documentation. A monitoring tool was used to monitor emails, checking for the following: (Addendum A)

- Accuracy of response and appropriateness of email response
- Whether the email was addressed in one business day
- Whether HIPAA protocol was followed

Emails to the Member Services Department include:

- Benefit, deductible, co-insurance inquiries
- Provider selection inquiries
- FHCP online application(s) assistance
- Referral process inquiries
- Pharmacy questions
- Complaints, grievances, and appeals

Three-member service representatives are responsible for all email responses and the supervisor is responsible for reviewing responses prior to the replies being sent. A secure system is utilized for All Email responses are delivered in a secure system.

Florida Health Care Plans
Quality and Accuracy of Customer Service Process Emails
Report Period: 1-1-2018-12-31-2018

Results:

The tables 1 and 2 below display the number of emails that met each criterion in the reporting period as compared to the previous year, and the percent compliance for each criterion.

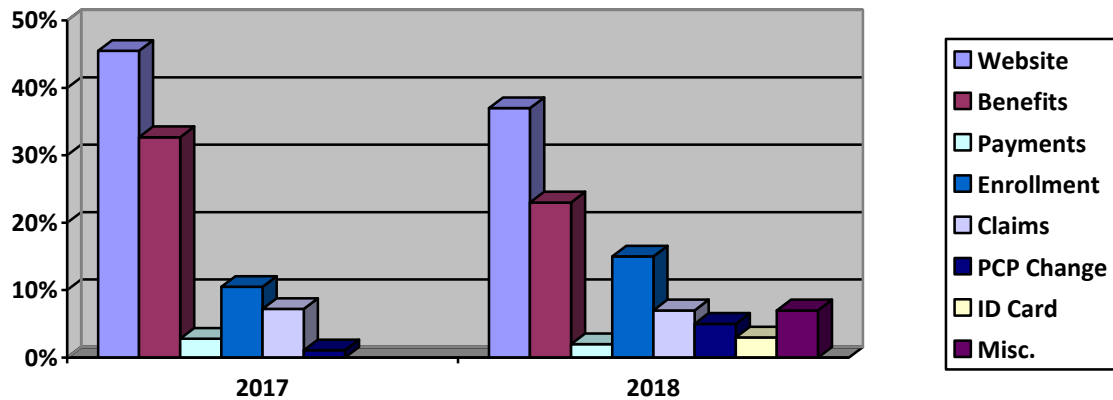
Table 1:

Quality and Accuracy of Member Service Emails 2017				
	Q1	Q2	Q3	Q4
Total # of emails	1147	642	278	188
Total # emails monitored	45	45	45	45
Accurate response given by CSR and handled appropriately	45	45	45	45
Compliance	100%	100%	100%	100%
HIPAA Compliant	45	45	45	45
Compliance	100%	100%	100%	100%
Handled in one business day	43	45	44	45
Compliance	96%	100%	98%	100%

Table 2:

Quality and Accuracy of Member Service Emails 2018				
	Q1	Q2	Q3	Q4
Total # of emails	1640	1028	886	1056
Total # emails monitored	45	45	45	45
Accurate response given by CSR and handled appropriately	45	45	45	45
Compliance	100%	100%	100%	100%
HIPAA Compliant	45	45	45	45
Compliance	100%	100%	100%	100%
Handled in one business day	41	44	44	45
Compliance	91%	97%	97%	100%

Florida Health Care Plans
Quality and Accuracy of Customer Service Process Emails
Report Period: 1-1-2018-12-31-2018



Analysis and Action

Website inquiries rank first across all quarters averaging 37%, followed by benefit inquiries at 23% and enrollment inquiries at 15%.

The plan established a performance goal of 95%. The overall compliance rate in 2018 for emails responded to within one business day was 96.25%, which met goal. The overall compliance rate for emails responded to with correct answer was 100% and met goal. The overall rate for those HIPAA compliant was 100% and met goal. Total compliance rate was 98.75%.

FHCP exceeded goal for all criterion, therefore no barrier analysis needed. The supervisor will continue to review all emails, and formally audit a random sample each month. Annually, the Customer Satisfaction Committee reviews the email audit report.

Committee Reporting Summary

The following QI committees receive the results, analysis, and actions of the email audit:

Committee Receiving Report	Report Dates
Customer Satisfaction Committee	February 20, 2019
Performance Improvement Council	April 17, 2019

Florida Health Care Plans
Quality, Accuracy, and Timeliness of Customer Service Process
Report Period: 1-1-2018 – 12-31-2018

Florida Health Care Plans (FHCP) monitors calls coming into Member Services across all product lines. This report summarizes the 2018 measurement methods, results, analysis, and applicable interventions pertaining to the quality, accuracy, and timeliness of responses to customer service calls, specifically those relating to benefit or pharmacy issues.

Measurement Methodology

In 2018, three percent of all in-coming calls were monitored, monthly. The monitoring process consisted of silent listening of the call and review of the call documentation in the Correspondence Unit Tracking System (CUT). Call types were categorized as follows: pharmacy inquiry, benefits inquiry, complaint, grievance, or appeal.

A monitoring tool was used to monitor calls, checking for the following:
(Addendum A)

- Accuracy of response and appropriateness of call handling if sent to another source
- Whether the issue was addressed in one contact
- Whether the call was forwarded to another person and representative stayed on the line
- Ensuring that HIPAA protocol was followed

Member Service Representatives can answer benefit questions and inquiries related to the following:

- Determining how and when to obtain referrals and authorizations for specific services, as applicable
- Plan specific information related to benefits and exclusions of services or products.
- Assisting member to order a new ID card
- Changing a Primary Care Physician
- Assisting members with access to a counselor for complaints, grievances, and appeals, refund requests, and co-pay waiver requests
- Questions about co-pay and co-insurance, deductible and maximum out of pocket status; every attempt is made to provide information related to financial responsibility for a specific service or treatment from a specified provider. If information is not available to member services department, member is transferred to the Cost Estimation Line for assistance with these inquiries.
- Other calls received by member services include complaints, grievance and appeals, which are documented and sent to a member services counselor for processing.

Florida Health Care Plans
Quality, Accuracy, and Timeliness of Customer Service Process
Report Period: 1-1-2018 – 12-31-2018

Member Services Representatives can initiate the following actions related to pharmacy inquiries:

- Initiating the exception process
- Finding the location of an in-network pharmacy
- Conducting a proximity search based on zip code

Pharmacy inquiries that require transfer to the pharmacy include:

- Determining the financial responsibility for a drug based on the pharmacy benefit
- Ordering a refill for an existing, unexpired mail-order prescription
- Determining potential drug-drug interactions
- Questions regarding medication side effects
- Determining the availability of generic substitutes

Results

Table A displays the number of calls that met each criterion in the reporting period, and the percent compliant for each criterion.

Table A: Quality and Accuracy of Pharmacy and Benefit Customer Service Calls 2018

	Pharm Q1	Pharm Q2	Pharm Q3	Pharm Q4	Benefit /Other Q1	Benefit/ other Q2	Benefit/ other Q3	Benefit/ other Q4
Total # calls monitored	356	239	214	187	1032	671	625	801
Accurate response given by CSR and handled appropriately	324	236	208	179	1016	658	620	789
Compliance	91%	99%	97%	96%	98%	98%	99%	98%
HIPAA Compliant	356	239	214	187	1032	671	625	801
Compliance	100%	100%	100%	100%	100%	100%	100%	100%
Handled in one contact	330	228	201	176	985	642	601	778
Compliance	93%	95%	94%	94%	95%	96%	96%	97%
Forward call Stayed on line	100%	100%	100%	100%	100%	100%	100%	100%
Informational								
Had to leave voicemail	0	0	0	0	0	0	0	0
Sent to a Counselor	26	11	13	11	47	29	24	23
Overall Compliance Rate	96%	98.25%	97.75%	97.5%	98.25%	98.5%	98.75%	98.75%

Total % Pharmacy Compliance 2018	Total % Benefits Compliance 2018
97.4%	98.6%

Florida Health Care Plans
Quality, Accuracy, and Timeliness of Customer Service Process
Report Period: 1-1-2018 – 12-31-2018

Analysis and Action

FHCP established a performance goal of 90% compliance in all categories annually. In 2018, calls pertaining to pharmacy benefits were rated as compliant in all four categories. Calls pertaining to non-pharmacy benefits were rated as compliant in all four categories. Calls pertaining to grievance, complaints, or appeals were rated as compliant in all four categories.

Criteria that met or exceeded the performance goal of 90% for the year for both pharmacy and non-pharmacy benefit calls are:

- Accurate response by customer service representative and handled appropriately
- HIPAA compliant
- Handled in one contact
- Forward call and stayed on line

Criteria that met or exceeded the performance goal of 90% for the year for Pharmacy benefit calls are:

- Accurate response given by CSR and handled appropriately
- HIPPA Compliant
- Handled in one contact
- Forward Call and stayed on line

Criteria that met or exceeded the performance goal of 90% for the year for both grievances, complaint and appeal calls are:

- Accurate response by customer service representative and handled appropriately
- HIPAA compliant
- Handled in one contact
- Forward call and stayed on line

Criteria that met or exceeded non-pharmacy benefit calls are:

- Accurate response given by CSR and handled appropriately
- HIPPA Compliant
- Handled in one contact
- Forward Call and stayed on line

Florida Health Care Plans
Quality, Accuracy, and Timeliness of Customer Service Process
Report Period: 1-1-2018 – 12-31-2018

Table B: Timeliness of Customer Service Calls

CALL TIMELINESS	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017
	Q1 Monthly Average	Q1 Monthly Average	Q2 Monthly Average	Q2 Monthly Average	Q3 Monthly Average	Q3 Monthly Average	Q4 Monthly Average	Q4 Monthly Average	Calendar Year Totals	Calendar Year Totals
Call Volume	16282	16046	10330	10240	9607	8284	11315	10507	142601	135231
Abandonment Rate	4.17%	2.42%	2.11%	1.31%	2.97%	1.49%	3.01%	1.59%	3.06%	1.87%
Average Speed to Answer (seconds)	43	19	15	8	21	8	19	10	25	13

Analysis and Action

FHCP established a performance goal of ≤ 5 percent abandonment rate and an average speed to answer rate of ≤ 30 second annually. In 2018, this data was compiled on a weekly basis and presented to the Customer Satisfaction Committee on a quarterly basis.

In 2018, the overall population (88125) increased by 11.25% as compared to 2017 (79214). Though, FHCP anticipated membership growth and hired an additional two staff members; the customer service representative to member ratio decreased by only 3%.

There was a 5.45 percent increase in call volume as compared to 2017. January had the highest volume of calls at 22471, the average speed to answer at 1 minute 42 seconds and abandonment rate at 8%. The majority of calls were inquiring related to change of PCP, payments, and ID cards. Additionally, there were an increase number of calls from new members with technical support request for FHCP's web/mobile based applications.

February had the second highest call volume at 12316 calls, a 2.1% abandonment rate, and 13 second speed to answer rate.

Based on the Quality, Accuracy, and Timeliness analysis, Table C identifies barriers, opportunities, and interventions, required to improve performance.

Table C: Barrier Analysis

Barrier	Opportunity	Intervention	Date Implemented

Florida Health Care Plans
Quality, Accuracy, and Timeliness of Customer Service Process
Report Period: 1-1-2018 – 12-31-2018

Barrier	Opportunity	Intervention	Date Implemented
Due to new product lines (Medicare, Commercial QHP expansion, and self-funded), call volume was greater than anticipated with inquires that required longer handle times and necessitated transfers due to issues with the enrollment and finance.	Continue to monitor accuracy of calls answered by CSR and appropriateness of transfers to another source.	Continuous CSR Training on New Product lines and Benefits in order to meet member needs.	January 2014 and Ongoing
	Evaluate current MS workflow processes that contribute to prolonged handle time and abandonment rates, i.e.) Technical support for Web/mobile base issues and Transition of Care needs.	Utilize MS Counselors to take overflow calls	January 2014 and Ongoing
		Increase staffing with three temporary employees.	December 2016
		Establish a separate phone line and dedicated CSR to manage calls related to technical support issues associated with Member Portal, FHCP mobile app, and Follow My Health.	January 2016 – on-going
		Establish a separate phone line and dedicated CSR to manage Transition of Care needs for newly enrolled members.	January 2016-ongoing
		Re-structure the MS phone tree to provide Member selections for cashier, finance or enrollment. Allow member to communicate via member portal with various departments directly.	January 2017-on-going 2018
		Enrollment, Finance, & claims have initiated Cisco agent with rolling phone tree	2017-2018

Florida Health Care Plans
Quality, Accuracy, and Timeliness of Customer Service Process
Report Period: 1-1-2018 – 12-31-2018

Barrier	Opportunity	Intervention	Date Implemented
An increase in call volume and in documentation of calls for all members, especially for QHP members slowed process for answering calls in a timely manner	Evaluate current enrollment process for the issuance of ID cards	Contract with outside vendor to process ID Cards. Allow ID card request & printing of temporary cards via Member portal	January 2017
	Initiate planning for increase temporary staffing and associated training earlier, (July).	Grievance and appeals counselors serve as backup for CSR. Addition of 2 G&A counselors.	Jan 2015 and ongoing
	Evaluate current MS document workflow processes that contribute to prolonged handle time and abandonment	Increase staffing with three temporary employees.	July 2016-ongoing for first quarter each calendar year
		Request IT to prioritize system/software revisions to streamline MS documentation workflow	July 2016- ongoing

Florida Health Care Plans
Quality, Accuracy, and Timeliness of Customer Service Process
Report Period: 1-1-2018 – 12-31-2018

Barrier	Opportunity	Intervention	Date Implemented
Increase in enrollment into Follow My Health, Doctors on Demand, FHCP mobile application and member portal	Route technical calls to expert.	Assigned 2 CSR's to provide exclusive technical support	Jan 2015 and ongoing
	Migrating to new member portal (H3O): Health Trio-9/2017	Establish a dedicated phone line and CSR to manage calls related to technical support issues associated with Member Portal, FHCP mobile app, and Follow My Health.	January 2016
		H3O Portal support for Password resets and unlocking accounts delegated to the vendor	July 2017
		An internal Application support team developed and takes ownership of issues through resolution, including member correspondence.	2017
		Transition of Care needs for newly enrolled members have been re-assigned to Case management department	March 2018
Increase handle time for the management of technical issues related to FHCP applications	Streamline process for managing technical assistance calls	Restructure of the phone tree to route inquires related to technical issues to a dedicated line with voice mail capability Password reset assistance delegated to the vendor	2016 2018

Florida Health Care Plans
Quality, Accuracy, and Timeliness of Customer Service Process
Report Period: 1-1-2018 – 12-31-2018

Barrier	Opportunity	Intervention	Date Implemented
Increase in product lines and geographical expansion, increased the volume of members requiring transition of care assistance.	Streamline process for managing transition of care calls	Transition of Care needs for newly enrolled members have been re-assigned to Case management department. TOC with dedicated phone number and email address	2018

Results: FHCP met the performance goals of 90% compliance in all the Quality and Accuracy categories. Additionally, FHCP met the performance goal of ≤ 5 percent abandonment rate and an average speed to answer rate of ≤ 30 second annually. However, it is the consensus of the team that FHCP increasing memberships along with complex, time consuming processes that have inherently require multiple touches and prolonged handle time be reviewed and updated.

Committee Reporting Summary

The results, analysis, and actions reported in this summary report were reported to the following QI committees on:

Committee Receiving Report	Report Dates
Customer Satisfaction Committee	April 17, 2019
Performance Improvement Council	July 17, 2019

Florida Health Care Plans

Summary of Interrater Reliability Testing from MCG Learning Management System

Sandra Sanderson, RN BHCS, MHCA

Contents

Central Referrals Department – Pre-service	2
Case Studies	2
Conclusion:	3
Case Management Utilization Review – Concurrent Care Medical	3
Case Studies	3
Conclusion:	3
Case Management Utilization Review – Home Health Care.....	4
Case Studies	4
Conclusion:	4
Case Management Utilization Review – Skilled Nursing Facilities.....	4
Case Studies	4
Conclusion:	5
UMPs – Medical / Surgical/Appeals.....	5
Case Studies	5
Case Studies	6
Utilization Management Physicians– Pre-service -Ambulatory Care	6
Case Studies	6
Conclusion:	6
UMPs - Behavioral Health.....	6
Case Studies	6
Case Management Utilization Review – Concurrent Care Behavioral Health.....	6
Plan for UM Education and Further Testing.....	7

Summary of Interrater Reliability Testing from MCG 22nd and 23rd Edition

The Utilization Management Division tests for proficiency with interpreting MCG Guidelines annually. The test questions are representative of Ambulatory Care, Inpatient & Surgical Care, Recovery Center Care and Home Care and Behavioral Health; these are assigned based on employee title and job description. Florida Health Care Plans (FHCP) follows the recommendation of MCG, which sets the goal of a passing score at 80% or above.

FHCP upgraded to MCG Cite CareWebQI interactive software in November of 2017. The new MCG Learning Management System (LMS) was upgraded on May 15, 2019, at which time competency was measured in the interactive environment under the 22nd and 23rd edition of MCG content. The Summary of Changes were reviewed by all clinicians and the Utilization Management Physicians (UMPs), at the Physician Leadership meeting. The Summary of Changes and the new MCG guidelines were approved and adopted by leadership as FHCP's nationally recognized criteria. FHCP continues to utilize the tools in the Cite CareWebQI, in order to manage all pre-service, concurrent service, and post service requests. In addition, Central Referrals, Skilled Nursing and Home Health Care determinations are managed through Cite CareWebQI for preservice, urgent/current, and case management discharge care planning.

At the completion of the initial testing, 97.4% of the FHCP staff passed within the three allowable attempts, while 2.6% of the staff failed one or more case studies after three attempts. The staff with a failing score in any case scenario, were provided with feedback and rationale for the correct answer; as well as a review of the case individually with the Administrator of Utilization management. They were then provided with a fourth attempt to achieve a passing score which resulted in a 100% passing rate.

Date: June 20, 2019- October 10-2019

Central Referrals Department – Pre-service

Three pre-service cases were presented to 12 reviewers. The method for testing was computerized. Each reviewer logged into the MCG Learning Management System (LMS) with an individual password. Each reviewer was given the same three case studies and three attempts to complete the testing with a passing score of >80%.

Each case analyzed for:

- Clinical indications for test or service based on patient history and a review of guidelines
- Guideline identification
- Guideline status: based on clinical history and review of guideline; did patient meet clinical indications for requested service or procedure

Case Studies

1. IRR case study AC, 23-05 **Procedures and Diagnostics: Wound Care: Plaque Psoriasis (23rd Edition)**
 - All 12 reviewers scored 100% on the total allowable attempts.
2. IRR case study ISC, 23-13, **Optimal Recovery Guidelines: General Surgery: Splenectomy (23rd Edition)**
 - 11 reviewers scored 100% on the first attempt
 - One reviewer scored 91% on the first attempt
3. IRR case BHC, 23-33, **Behavioral Health: Therapeutic Services: Post Traumatic Stress Disorder (23rd Edition)**
 - All 12 reviewers scored 100% on the first attempt

Conclusion:

All of the 12 Central Referrals reviewers exceeded the goal of 80% pass rate. Remediation and review were not required for testing purposes. All new staff are trained to use the Cite CareWebQI during orientation and must demonstrate competency.

Case Management Utilization Review – Concurrent Care Medical

Three concurrent cases were presented to ten reviewers, the Administrator of Utilization Management Division and the Manager, for a total of 12 urgent concurrent reviewers. The method for testing was computerized and each reviewer logged into the MCG LMS with their individual password. Each reviewer was given the same three case studies in CareWebQI and three attempts to complete the testing with a passing score of at least 80%.

Each case asked for:

- Clinical indications for the process or service
- Guidelines identification
- Guideline status: whether met criteria based on clinical indications based on the interactive tool
- Guideline status for recommended length of stay
- Variance status for avoidable day(s)

Case Studies

- IRR case GRC, 23-18, **General Recovery Guidelines: Body Systems: Fasciotomy, Compartment Syndrome (23rd Edition)**
 - Five reviewers scored 100% on the first attempt
 - Two reviewers scored 81 % on the first attempt
 - One reviewer scored 81% on the second attempt
 - One reviewer scored 94 % on the second attempt
 - Three reviewers scored 88% on the first attempt.
- IRR case ISC, 23-10, **Observation Guidelines: Abdominal Pain (23rd Edition)**
 - Seven reviewers scored 90% on the first attempt
 - One reviewer scored a 90% on the second attempt
 - Four reviewers scored 100% on the first attempt
- IRR case GRC, A23-17, LTACH, **General Recovery Guidelines: Acute Respiratory Failure / Smoke Inhalation - Auth-Only (23rd Edition)**
 - Eight reviewers scored 100% on the first attempt
 - One reviewer scored 100% on the second attempt
 - Three reviewers scored 83% on the first attempt

Conclusion:

All twelve (12) UM reviewers exceeded the goal of 80% pass rate. There were no failing scores; therefore, review and a training plan was not necessary.

Case Management Utilization Review – Home Health Care

Five Home Health cases were analyzed by two reviewers. The method for testing was computerized and each reviewer logged into the MCG LMS with their individual password. Each reviewer was given the same three case studies within CareWebQI and three attempts to complete the testing with a passing score of 80% or greater.

Case Studies

1. IRR case HC, 23-21, **Optimal Recovery Guideline, Skin and Wound Care: (23rd Edition)**
 - One reviewer scored 100% on the first attempt
 - One reviewer scored a 25% on the third attempt
2. IRR case HC, 23-23, **Optimal Recovery Guideline: Thoracic and pulmonary Disorders: Pnuemonia (23rd Edition)**
 - Both reviewers scored 92% on the first attempt
3. IRR case HC, 23-22, **Optimal Recovery Guideline Pediatrics: Traumatic Brain Injury (23rd Edition)**
 - Both reviewers scored 92% on the first attempt

Conclusion:

Both reviewers exceeded the passing goal of 80% for 2/3 cases. The reviewer who did not pass the IRR case 23-21 was provided a 1:1 review of the case and the rationale for the answers within the case study. After reviewing the rationale, the reviewer was provided a 4th attempt. Proficiency was proven, after the reviewer scored an 81% on the 4th attempt; therefore remediation, beyond routine updates and systems review was not necessary.

Case Management Utilization Review – Skilled Nursing Facilities

Three Skilled Nursing Facility cases were presented to two reviewers. The method for testing was computerized and each reviewer logged into the MCG LMS with their individual password. Each reviewer was given the same three case studies, a link to MCG, and three attempts to complete the testing with a passing score of >80% or greater.

Case Studies

- IRR case RFC, 23-25, **Optimal Recovery Guideline: Subacute/Skilled Nursing Facility:**
 - One reviewer scored 100% on the first attempt
 - One reviewer scored 93% on the first attempt
- IRR case RFC, RFC, 23-27, **Optimal Recovery Guideline: Subacute/Skilled Nursing Facility: Stroke (23rd Edition)**
 - One reviewer scored 100% on the first attempt
 - One reviewer scored 93% on the first attempt
- IRR case RFC, RFC, 23-28. **Optimal Recovery Guideline: Subacute/Skilled Nursing Facility: Osteomyelitis (23rd Edition)**
 - Both Reviewers scored 100% on the third attempt

Conclusion:

Both reviewers exceeded the passing goal of 80% within the allowable attempts. Proficiency was proven, therefore remediation, beyond routine updates and systems review was not necessary.

UMP - IRR Testing

March 2019 22nd Edition

Utilization Management Physicians – Medical / Surgical/Appeals

Three medical necessity cases were presented to four UMPs. The UMPs make final determinations in the Urgent/Concurrent inpatient setting. The method for testing was computerized and each reviewer logged into the MCG LMS with their individual password. Each physician was given the same three case studies within the interactive CareWebQI by MCG.

Each case asked for:

- Clinical indications for the process or service
- Guidelines identification
- Guideline status: whether met criteria based on clinical indications
- Guideline status for recommended length of stay
- Variance status for avoidable day(s)

Case Studies

1. IRR case ISC, A22-74, **Optimal Recovery Guidelines: Infectious Disease: Cellulitis (22nd Edition)**
 - Two physicians scored 100% on the first attempt
 - One physician scored 83%, on the first attempt
 - One physician received 1:1 remediation after failing the first 3/3 attempts and scored a 100% on the 4th attempt.
 - During the case review the physician noted that he was unfamiliar with the MCG LMS and struggled to access the guideline. Questions within the test referred directly to the guideline, as a result, he made an educated guess at the correct answers. The UMP then contacted the Administrator and reviewed the case; the LMS website navigation was reviewed as well. Administration opened the testing for a 4th opportunity to take the exam.
2. IRR Case ISC, A22-113, **Optimal Recovery Guideline Nuerology, Acute Ischemic Stroke (22nd Edition)**
 - All Four physicians scored 100% on the first attempt
3. IRR case ISC, ISC, 22-107, **Observation Care Heart Failure (22nd Edition)**
 - One physician scored 100% on the first attempt
 - Two physicians scored 93% on the first attempt
 - One physician scored an 86% on the first attempt.

Case Studies

Utilization Management Physicians– Pre-service -Ambulatory Care

Two medical necessity cases were presented to four UMPs. The UMPs make final determinations in the Urgent/Concurrent inpatient setting. Method for testing was by computer. Each physician signed into the MCG Learning Management Systems with a password. Each physician was given the same two case studies within the interactive CareWebQI by MCG.

Each case asked for:

- Clinical indications for the pre-service request for services
- Guideline identification
- Guideline status: based on whether criteria met clinical indications for inpatient admission on the interactive CareWebQI whether met criteria based on clinical indications based on the interactive
- Guideline status for recommended length of stay
- Variance status for avoidable day(s)

Case Studies

1. IRR Case ISC, A22-113, **Optimal Recovery Guideline Nuerology, Acute Ischemic Stroke (22nd Edition)**
 - All three Pre-service UMPs scored 100% on the first attempt
2. IRR case ISC, A22-74, **Optimal Recovery Guidelines: Infectious Disease: Cellulitis (22nd Edition)**
 - All three Pre-service UMPs scored 100% on the first attempt

Conclusion:

All Non-Behavioral Health UMPs met the goal of 80% pass rate, therefore there was no need for additional training.

Utilization Management Physicians - Behavioral Health

Three behavioral health cases were presented to three Behavioral UMPs and one UM Registered Nurse reviewer. Method for testing was computerized. Each individual signed into the MCG Learning Management System with an individual password.

Each case asked for:

- Clinical indications for service or admission
- Guideline identification
- Guideline status: whether met criteria based on clinical indications
- Guideline status for recommended length of stay
- Variance status for avoidable day(s)

Case Studies

Case Management Utilization Review – Concurrent Care Behavioral Health

1. BHC, A23-29, **Behavioral Health: Anorexia Nervosa Auth Only (23rd Edition)**
 - Two Psychiatrists scored 100% on the first attempt

- One Registered Nurse Reviewer, scored 83% on the second attempt
- 2. BHC, A23-30 , **Behavioral Health: Post Traumatic Stress Disorder - Auth Only (23rd Edition)**
 - Two Licensed Psychiatrists scored 100% on the first attempt
 - One Registered Nurse Reviewer, scored 83% on the second attempt
- 3. BHC, A23-31, **Behavioral Health: Substance Related Disorders- Auth Only (23rd Edition)**
 - Two Psychiatrists scored 100% on the first
 - One Registered Nurse Reviewer, scored 100% on the first attempt

Conclusion:

All Behavioral Health UMPs and the Behavioral Health Reviewer met the goal of 80% pass rate for all three cases

Plan for UM Education and Further Testing

- MCG 22nd Edition was released February 28th, 2018. The CareWebQI upgrade to the 22nd edition occurred seamlessly on July 9, 2018 during a scheduled upgrade.
- March 27th, 2019: MCG successfully upgraded CareWebQI® site to CareWebQI 10.2 and migrated to the 23rd Edition of MCG guidelines.
- Behavioral Health training will continue utilizing case conferences weekly with Behavioral Health physicians. Clinical information is reviewed against the current diagnosis, and discussion regarding treatment progress and extended stay is reviewed.
- Interdisciplinary Team Meetings will continue each week to review active cases and use of the CarewebQI criteria for determinations. Guidelines utilized to make determination for medical necessity are reviewed weekly on hospitalized members for appropriateness. Discussions regarding criteria, for extended stay, discharge needs, and other pertinent referrals are conducted during this weekly meeting.
- All UM Department reviewers and physicians will be tested after the release of the MCG 24th Edition) for Interrater Reliability (second quarter of 2020).
- Newly appointed UMPs and reviewers will receive training and testing and be included in routine scheduled assessments.

Committee Reporting

Committee	Date	Recommendation
Health Outcomes and Patient Engagement Committee (HOPE)	12/04/2019	Approved, send to PI Council
PI Council	12/18/2019	Approved as written.

UM Timeliness Report
10-01-2018 through 03-31-2019

Non-Behavioral Health Timeliness

Commercial Non-behavioral UM Decisions within timeframe

	Urgent Concurrent	Urgent Preservice	Non-urgent Preservice	Post Service
Numerator	1166	27	4065	95
Denominator	1184	27	4065	95
Rate	98.5%	100%	100%	100%

Commercial Non-behavioral UM Notifications within timeframe

	Urgent Concurrent	Urgent Preservice	Non-urgent Preservice	Post Service
Numerator	1166	27	4065	95
Denominator	1184	27	4065	95
Rate	98.5%	100	100%	100%

Marketplace Non-behavioral UM Decisions within timeframe

	Urgent Concurrent	Urgent Preservice	Non-urgent Preservice	Post Service
Numerator	2070	46	5324	260
Denominator	2070	46	5324	260
Rate	100%	100%	100%	100%

Marketplace Non-behavioral UM Notifications within timeframe

	Urgent Concurrent	Urgent Preservice	Non-urgent Preservice	Post Service
Numerator	2070	46	5323	260
Denominator	2070	46	5324	260
Rate	100%	100%	99.9%	100%

Behavioral Health Timeliness

Commercial Behavioral UM Decisions within timeframe

	Urgent Concurrent	Urgent Preservice	Non-urgent Preservice	Post Service
Numerator	58	0	14	3
Denominator	58	0	14	3
Rate	100%	N/A	100%	100%

Commercial Behavioral UM Notifications within timeframe

	Urgent Concurrent	Urgent Preservice	Non-urgent Preservice	Post Service
Numerator	58	0	14	3
Denominator	58	0	14	3
Rate	100%	N/A	100%	100%

Marketplace Behavioral UM Decisions within timeframe

	Urgent Concurrent	Urgent Preservice	Non-urgent Preservice	Post Service
Numerator	213	0	17	26
Denominator	213	0	17	26
Rate	100%	N/A	100%	100%

Marketplace Behavioral UM Notifications within timeframe

	Urgent Concurrent	Urgent Preservice	Non-urgent Preservice	Post Service
Numerator	213	0	17	26
Denominator	213	0	17	26
Rate	100%	N/A	100%	100%

Pharmacy Timeliness

Commercial Pharmacy UM Decisions within timeframe

	Urgent Concurrent	Urgent Preservice	Non-urgent Preservice	Post Service
Numerator	30	5	773	0
Denominator	30	5	773	0
Rate	100%	100%	100%	N/A

Commercial Pharmacy UM Notifications within timeframe

	Urgent Concurrent	Urgent Preservice	Non-urgent Preservice	Post Service
Numerator	30	5	773	0
Denominator	30	5	773	0
Rate	100%	100%	100%	N/A

Marketplace Pharmacy UM Decisions within timeframe

	Urgent Concurrent	Urgent Preservice	Non-urgent Preservice	Post Service
Numerator	49	5	1017	2
Denominator	49	5	1017	2
Rate	100%	100%	100%	100%

Marketplace Pharmacy UM Notifications within timeframe

	Urgent Concurrent	Urgent Preservice	Non-urgent Preservice	Post Service
Numerator	49	5	1017	2
Denominator	49	5	1017	2
Rate	100%	100%	100%	100%

Timeliness Report Analysis

Florida Health Care Plans policies and procedures include requirements for timeframe adherence for all product lines and all stages of Utilization Management. All pre-service data reflects both Denials and Approvals during the reporting period. Florida Health Care notifies the member and provider(s) telephonically and in writing, regardless of the determination.

The organizational goal for adherence to timeframes is 100%. This goal was not met for Commercial Urgent Concurrent cases 1.5% of the time in this reporting period. Pre-service Non-behavioral health missed one notification during the reporting period, Pharmacy decision, and notification in both product lines were met at 100%.

The Administrator of Utilization Management, the Manager of Utilization Review and Central Referrals, along with each department's Clinical Supervisors and Non-clinical Supervisors met to perform a barrier analysis and develop a plan to correct the deficits. Medicare members were not included in this report. As of January 1, 2019, FHCP is no longer accredited for this product line.

Date Initiated	Barrier Addressed	Action Implemented	Outcome
November 2017	Lack of systems in Central Referrals to proactively track caseloads and time frames. Central Referrals System remains manual and relied heavily on reviewer to manage and track timeframes. Human error related to manual data entry was the factor.	MCG Care Web QI Interactive Guidelines and dashboard provides management of cases. This was implemented for determinations and time management of caseloads and automatic tracking of time in the queue.	2018, 100% UM timeliness for all concurrent and Urgent reviews, 99.9% compliance for Preservice, Non - behavioral health Notification.
		Electronic Referral Requests through the provider portal is being implemented in May 2019. Central referrals will move to a completely electronic process	Outcome TBD

Committee Reporting

Committee Name	Meeting Date	Committee Actions or Recommendations
H.O.P.E. Committee	May 15, 2019	Approved, send to PIC
Performance Improvement Council	July 17, 2019	Approved as written

Florida Health Care Plans

2019 Utilization Management Program Evaluation

Sandra Sanderson, RN BHCS, MHCA

Contents

Executive Summary	2
UM Structure	2
Scope.....	3
Member Satisfaction with UM	4
Commercial	4
Table 2: Commercial Survey Results	4
Quantitative Analysis Commercial Members	4
Areas for improvement.....	5
Marketplace	5
Quantitative Analysis Marketplace Members	5
Areas for improvement	5
Qualitative Analysis All Populations.....	6
Provider Satisfaction.....	6
Quantitative Analysis	7
Areas for improvement.....	7
Utilization Data	8
Pre-service Requests	8
Methodology	8
Analysis	9
Areas for improvement.....	9
Concurrent Review	9
Methodology	9
Analysis	10
Areas for improvement.....	10
Commercial and Marketplace Appeals	10
Methodology	10
.....	Error! Bookmark not defined.
Areas for improvement.....	13

Executive Summary

Florida Health Care Plans monitors member and practitioner satisfaction with the Utilization Management (UM) process annually. This analysis helps the organization identify whether the UM process is negatively impacting satisfaction. When member or practitioner concerns with UM are identified, FHCP identifies the root cause and initiates actions to improve member and/or practitioner satisfaction with UM. This report describes the monitoring methodology, results, analysis and action.

UM Structure

Utilization Management is overseen by the Chief Medical Officer, a board-certified physician in internal medicine and the Medical Director of Utilization, Quality and Case Management, a board-certified physician in family medicine. Behavioral Health Utilization Management is overseen by the Chief of Psychiatry, a board-certified psychiatrist.

For medical necessity determinations, FHCP utilizes MCG CarewebQI guidelines for Commercial and Marketplace members. If no MCG guideline exists, Local Coverage Determinations Centers for Medicare and Medicaid (CMS) Guidelines may be used. If no guidelines are available from MCG or CMS, Blue Cross Blue Shield of Florida (BCBSFL) medical policy guidelines may be accessed.

UM Physician Participation

Physician participation is an ongoing process in which, physician leaders, consultants and specialists participate in weekly meetings and ad hoc. Medical and Behavioral Health physician participation is conducted in a multidisciplinary setting with current case review. Provider input is designed to look at the individual case, and the use of the Nationally recognized guidelines (MCG), to determine the appropriate guidelines are chosen to make Behavioral Health and Medical necessity determinations. Feedback and discussion between the reviewer and the physician leadership team, drives the Case Management of the member in the current setting. Additionally, physician participation aides in the discharge planning and process of future care and outcomes.

Ongoing review of the medical necessity guidelines are conducted by the Chief Medical Officer (CMO) and the Medical Director of Utilization, Quality and Case Management. When guidelines are in question the CMO, contacts MCG for clarification to share with the review team. In some cases, this participation has provided valuable feedback related to modification of guidelines in future releases of MCG. Additionally, the CMO and Medical Director, participate in mock reviews and internal auditing of previous UM files for verification of compliance and adherence to the NCQA standards.

Physician leadership in the pre-service arena, (Central Referrals), consists of an onsite a family practice provider and part -time physician, who reviews requests for services related to specialty requests, for radiologic procedures, oncology and PET scans. The physician, maintains knowledge of current evidenced-based practices and guidelines. A Pharm D oversees and participates openly with reviewers in relation to medication and

the UM process for approving routine, urgent, formulary exceptions and benefits related to all pre-service requests.

Physician leadership in both family practice and specialty areas, discuss changes to the MCG guidelines when updates and editions are released, to ensure that the current chosen criteria will continue to meet the needs of the membership and are appropriate for the plans intent to provide quality utilization management with the most current evidenced based criteria available.

In conclusion, FHCP has a structured UM program, with a high level of communication and input from its UM Physician team. This high level of involvement has proven to be adequate in maintaining a compliant and effective UM program. Continued review and high-level guidance have improved the UM programs functionality and accuracy in making appropriate determinations related to member requests and inpatient care

Scope

The UM Program encompasses the oversight and review of organizational determinations for the Commercial and Marketplace populations for requests in the pre-service, urgent concurrent, grievances and appeals, as well as, complex case management. The scope also includes, but is not limited to re-openings, reconsiderations and retrospective reviews.

This evaluation provides an opportunity to discuss the UM program, its processes and the satisfaction of all stakeholders in the UM process. Based on feedback from Members, Physicians and statistical claims data, the evaluation identifies whether processes are effective or in need of improvement, it is the foundation of the Utilization Management Program.

Conclusion:

After completing the analysis of FHCP's utilization program, the plan has concluded that our program is satisfactory and effectively meets the needs of our members and our providers. There is no need to modify program structure, scope, processes or information sources used in the program based on this analysis. Despite increase in membership, baseline satisfaction remains steady or has improved. Provider satisfaction with the UM process, and the referrals process has increased significantly with recent modifications and enhancements to internal workflows. The number of employed and contracted servicing providers increased by 27.8% from 2017 to 2018. The satisfaction with the UM process increased by 1.26 percentage points above the goal of 3.5/5. Providers verbalized satisfaction and his satisfaction relays back to the patient and continued satisfaction as evidenced by member feedback. Commercial and Marketplace satisfaction related to the UM process, has remained stable, despite population growth. Enhancement to the Medical Management of requests in all UM areas, has remained stable, as evidenced by the number of appeals and requests for third party review. The Plan attributes the stability and, in some areas, increased satisfaction to the ongoing improvements within the UM processes.

Member Satisfaction with UM

The Commercial, and Marketplace CAHPS member satisfaction surveys are administered annually by an external survey vendor using the survey protocol defined in current HEDIS specifications and the Z test to define statistical significance in differences between years. This report includes results from the last three years for the Commercial and Marketplace product lines.

The survey is conducted using a mixed (mail and phone) survey methodology. Response rate data is below in Table 1. All measures for the Commercial population were compared to the 2018 NCQA Quality Compass benchmark. Measures for the Marketplace population were compared to CMS National Data.

Table 1: CAHPS Survey Response Rates

Product Line	2018	2017	2016
Commercial	25.2%	29.6%	26.1%
Marketplace	25.2%	23.2%	30.6%

Commercial

Table 2: Commercial Survey Results

Survey Questions	2018	2017	2016	2018 Quality Compass Mean	Goal Met ?	Stat. Sign.
Getting Needed Care Composite	87.4%	89.0%	90.4%	86.2%	Yes	No significant difference
Getting the care, you or a doctor believed was necessary	89.2%	91.8%	90.7%	88.5%	Yes	No significant difference
Ease of getting an appointment with a specialist	85.7%	86.2%	90.1 %	84.0%	Yes	No significant difference

The Z test was used for significance testing

Quantitative Analysis Commercial Members

FHCP's goal for Commercial member satisfaction with UM is to meet or exceed the 2018 NCQA Quality Compass "Getting Needed Care" composite mean score of 86.2 percent. The "Getting Needed Care" composite is thought to be one of the key drivers of Rating Health Plan and Rating Health Care. FHCP's 2018 composite score was an 87.4%, 1.2 percentage points above the 2018 Quality Compass composite. FHCP's

composite rate for 2018 is 1.6 percentage points below 2017, and 3.0 percentage points below 2016. This indicates a relatively stable but downward trend over the three-year evaluation period for customer satisfaction. Evaluation of this data concludes there is an opportunity for improvement.

Question 14: Ease of getting care, tests, or treatments necessary.

FHCP's 2018 score of 89.2% is 1.2 percentage points above the 2018 Quality Compass rate, exceeding goal for the year.

Question 25: Getting an appointment with a specialist as soon as needed.

FHCP's 2018 score of 85.7% is 1.7 percentage points above the 2018 Quality Compass rate, exceeding goal for the year.

Areas for improvement.

The results were above average and did not indicate a need for a barrier analysis.

Marketplace

Table 3: Marketplace Survey Results

Trended Marketplace Survey Results						
Survey Questions	2018	2017	2016	2018 CMS National Average	Goal Met?	Stat. Sign.
Getting Needed Care Composite	84.1	84.0	89.7	79.0	Yes	No significant difference
Getting the care you or a doctor believed was necessary	85.4	84.6	93.4	80.1	Yes	No significant difference
Ease of getting appointment with a specialist	82.8	83.3	86.0	77.8	Yes	No significant difference

The Z test was used for significance testing

Quantitative Analysis Marketplace Members

Question 9: Ease of getting care, tests or treatment needed.

FHCP's score of 85.4% exceeded the national average by 5.3 points and did not indicate a need for a barrier analysis.

Question 31: Obtained appointment with specialist as soon as needed.

FHCP's score of 82.8 exceeded the national average by 5 points and did not indicate a need for a barrier analysis.

Areas for improvement

FHCP's goal for Marketplace member satisfaction with the UM process is to meet or exceed the CMS National Average. The "Getting Needed Care" composite of 84.1%

exceeded the National Average by 5.1 points and did not indicate a need for a barrier analysis

Qualitative Analysis All Populations

Performance met the goal for composite and individual questions in “Getting Needed Care” for the Commercial and Marketplace populations. FHCP will continue to promote a Care Transition approach to increase member satisfaction with Utilization Management. In addition, FHCP will work to clarify benefits information and access to care during open enrollment; while continuing efforts to transition new members efficiently and effectively to their plan.

The Customer Satisfaction Committee will continue to analyze all complaints related to these two measures in order to identify opportunities for improvement.

Provider Satisfaction

Florida Health Care Plans monitors practitioner satisfaction with UM through analysis of relevant questions on the annual Practitioner Satisfaction Survey. This survey incorporates provider satisfaction for all lines of business. Provider Surveys were distributed to affiliated FHCP Primary Care Physicians, Specialist Physicians, Ancillary Providers and Facilities. The method for survey administration was via mail with self-addressed pre-paid return envelopes. There were no incentives offered for completing the survey, however, there were reminders in the Provider Newsletter. The survey was distributed 3 times to obtain a sample of 25 percent. However, only 24% response rate was achieved. The executive bodies determined that a 24% response rate was valid given the growth in provider numbers from 2018-2019; therefore, the survey responses were evaluated as a valid representation of the provider population.

“For the 2019 sixty-five percent (65%) of the respondents were specialists, thirty-one percent (31%) were primary care physicians, zero responses were received from facilities and ancillary providers. There were no unknown or anonymous surveys returned.” (Provider Survey, 2018) Table 5 displays provider satisfaction response rates for the past three years.

Table 4: Practitioner Satisfaction Survey Response Rate

	2018	2017	2016
Number of surveys	1525	1,203	688
Number returned	364	381	212
Response rate	24%	32%	31.0%

The following questions related to UM satisfaction:

- Question 5. How would you rate your ability to refer patient to effectively refer to FHCP network physicians and providers?
- Question 8: How would you rate the timeliness of the processing of service

requests for approval by FHCP?

- Question 9: How would you rate the ease of the referral process including the department's access and assistance concerning referral issues?

Response options ranged from 5=Excellent to 1=Poor. The 2018 survey Results are the average of responses from East Volusia, Southeast Volusia, West Volusia, Flagler, Seminole, St John's and Brevard County Networks.

Table 5: Practitioner Satisfaction Survey Results

Trended Practitioner Satisfaction with UM Survey Results					
Survey Questions	2018	2017	2016	Goal Met?	Positive Trend
Ability to refer to provider of your choice	3.96	4.07	3.96	Yes	Stable
Timeliness of processing service requests for approval	3.88	3.89	4.18	Yes	Stable
Ease of use of referral process including department's access and assistance concerning referral issues	4.76	3.89	4.11	Yes	Significant increase

Quantitative Analysis

Florida Health Care Plans performance goal for practitioner satisfaction with UM requires a minimum standard score of 3.5 out of 5 points per question. The Provider Satisfaction Survey scores for 2018 for question 5 and 8 remained stable with a 1/10-point reduction, while question 9 showed a significant increase in satisfaction with the referral process. Current scores indicate an upward trend in satisfaction with the UM process and continued to meet or exceed goal. Since response rates to all questions related to Utilization Management exceeded the benchmark of 3.5, no barrier analysis or intervention was necessary. FHCP will continue to analyze processes and workflows and promote process improvements.

Areas for improvement.

The results were above average and did not indicate a need for a barrier analysis.

Utilization Data

The Florida Health Care Plan's Utilization Management Program is evaluated annually by the Health Outcomes and Patient Engagement (HOPE) Committee and the Performance Improvement Council (PIC) for appropriate utilization of services for members. Pre-service determinations, concurrent determinations, retrospective/post service determinations, and grievances and appeals are the function of the Utilization Management Division. Claims determinations are the function of the Claims Division.

Throughout 2018, all utilization management functions were reviewed and revised as needed in order to improve member satisfaction and quality of care, increase understanding of member specific benefits plans, and clarify reason for approval or denial of services based on medical necessity or benefits. Transition of Care staff were added to compliment the process of onboarding and connecting members with in network providers and facilitate appropriate referrals.

Pre-service Requests

Pre-service review is a function the Central Referrals Department and includes requests for services, medications, Medicare Part D and Part B, and Durable Medical Equipment.

Methodology

Calculations are based on a total membership as of 12/31/18.

- Commercial - 34,018
- Marketplace - 34,951

Table 6: Commercial Pre-service/Prior-Authorization Determinations

Total Processed	Benefit Denials	Medical Necessity Denials	Denial Rate
2018			
7,563 222.33 per 1,000	62	558	8.20% 18.23 per 1,000
2017			
10,475 291.2 per 1000	72	820	8.52% 24.79 per 1,000
2016			
10,581 319.25 per 1,000	83	672	7.26% 21.54 per 1,000

Table 7: Marketplace Preservice/Prior Authorization Determinations

Total Processed	Benefit Denials	Medical Necessity Denials	Denial Rate
2018			
14,858 425.11 per 1,000	180	1301	9.96% 42.37 per 1,000
2017			
8,356 314.81 per 1,000	92	837	11.12% 35.01 per 1,000
2016			
10,581 319.25 per 1,000	83	672	7.26% 21.54 per 1,000

Analysis

The Commercial pre-service requests decreased per 1,000 members, the denial rate remained statistically stable with a slight decrease of 0.32 percentage points. Marketplace pre-service requests increased significantly, however the denial rate decreased by 1.16 percentage points in comparison to the previous year. Therefore; the plan concludes that the process for pre-service review of requests remains consistent year to year.

Areas for improvement.

The results were above average and did not indicate a need for a barrier analysis.

Concurrent Review

Concurrent review for hospital inpatient care is performed by the Case Management Utilization Review Department.

Methodology

Calculations are based on a total membership as of 12/31/18.

- Commercial - 34,018
- Marketplace - 34,951

Table 9: Commercial Concurrent Determinations (Inpatient)*

Total Processed	Benefit Denials	Medical Necessity Denials	Denial Rate
2018			
2,196 62.83 per 1,000	15	100	5.23% 3.29 per 1,000
2017			
1,902	12	95	5.63%

52.87 per 1,000			3.06 per 1,000
2016			
2,277 64.96 per 1,000	24	123	6.46% 4.19 per 1,000

Table 11: Marketplace Concurrent Determinations (Inpatient)*

Total Processed	Benefit Denials	Medical Necessity Denials	Denial Rate
2018			
5,255 154.5 per 1,000	50	411	8.77% 13.55 per 1,000
2017			
2,800 105.49 per 1,000	24	318	12.21% 12.88 per 1,000
2016			
1,401 82.20 per 1,000	13	172	13.2% 10.85 per 1,000

*This data relates to hospital inpatient care only

Analysis

Concurrent determinations and denials showed a decrease from previous years across both product Lines. The significant increase in Marketplace membership drove the number of requested and processed cases up by 46.46% per thousand members. Commercial denials remained statistically stable. Marketplace denial rates decreased by 3.44 percentage points.

Areas for improvement.

The results were above average and did not indicate a need for a barrier analysis

Commercial and Marketplace Appeals

Appeals are handled by the Member Services Grievance and Appeals Department.

Methodology

Calculations are based on a total membership as of 12/31/18.

- Commercial - 34,018
- Marketplace - 34,951

Commercial member appeals include requests for out of network providers citing continuity of care, medications requiring step therapy, medication formulary exceptions, and claims for services where no prior authorization was obtained and appeals of denied co-pay waivers. Members on a Triple Option Plan wanted the highest level of benefits (Option 1) when going out of network, which is not covered under their benefit plan at that level of reimbursement. Appeals that were overturned were due to receiving additional

clinical information submitted, which substantiated approval.

Table 9: Commercial Member Appeals

Number of Appeals	Benefits	Medical Necessity	MAXIMUS / AHCA / SAP
2018			
147 4.32 per 1,000	Upheld – 53 Overturned – 34	Upheld - 30 Overturned - 30	Maximus – 1 Overturned 0 Dismissed- 1
2017			
120 3.34 per 1,000	Upheld- 43 Overturned -11	Upheld - 34 Overturned -32	Maximus – 7 Overturned (AHCA) – 1 Dismissed - 6
2016			
124 3.56 per 1,000	Upheld -42 Overturned -14	Upheld - 36 Overturned - 32	Maximus -14 Overturned – 0 Dismissed -11

Marketplace member appeals primarily included services provided without prior authorization for out of network services for post-service provider visits, processing of claims that resulted in a higher cost sharing for the member (deductible and co-insurance), formulary exceptions, and post-service claims on services that are exclusions to the plan benefit. Appeals for access reasons included requests for out of network providers, exclusions to the member's plan and "doesn't meet established guidelines".

Calculations are based on a total membership as of 12/31/18 of 34,951.

Table 11: Marketplace Member Appeals

Number of Appeals	Benefits	Medical Necessity	MAXIMUS / AHCA / SAP
2018			
168 4.81 per 1000	Upheld – 51 Overturned – 20	Upheld - 59 Overturned – 38	Maximus –9 Overturned 4 Dismissed – 2
2017			
103 3.88 per 1,000	Upheld - 34 Overturned – 5	Upheld - 46 Overturned - 18	Maximus - 12 Overturned - 0 Dismissed - 12
2016			
79 4.58 per 1,000	Upheld - 21 Overturned - 9	Upheld - 28 Overturned -21	Maximus -8 Overturned – 1 Dismissed - 6

Commercial appeals decreased over the three-year period, but Marketplace appeals decreased slightly despite the increase in marketplace membership for 2018.

Analysis

The Utilization Management Team and Member Satisfaction Committee, led by the Chief Medical Officer, reviewed the data, which resulted in discussion of implementation of an interactive Guideline through MCG, enhancing some functions and processes within the Utilization Management Program and Departments.

Utilization Review increased staffing to accommodate the growth of membership. Additionally, a retired physician works side by side with the reviewers in a medical consulting capacity to educate and review cases where the clinical information may not directly fit in the MCG guideline or the correct guideline may be in question. Transition of care remains the function of the Case Management Coordination of Care Department. This position has been instrumental in assisting the onboarding membership with navigation and appropriate utilization of services and benefits, in 2018 a second Transition of Care Nurse Case Manager was added to accommodate continued plan growth. Telehealth services were added in 2016 to improve care coordination and member outreach. In 2018 staffing for telehealth services was assigned to specific staff, to maximize the member benefit and increase expertise in this care area. The increase in Marketplace (ACA) membership resulted in an increase in admissions and denials, as it was found that this population of members were used to utilizing hospital services instead of a primary care. There was also an increase in Marketplace pharmacy requests and behavioral health admissions.

The Interdisciplinary Care team was restructured to review all cases where hospitalization is complex. The team openly discusses, the member's hospital course, and establishes goals for discharge planning to include: referrals for outpatient services and supports. The Team is comprised of the Chief Medical Officer, Medical Director of Utilization, Quality and Case Management, Medical Director of Practice Management, Administrator of Utilization Management, Manager and Supervisor of Utilization Review, The Physician Consultant, Manager of Case Management Coordination of Care, staff from Departments, a Clinical Pharmacist, a Licensed Clinical Social Worker, Risk Manager, and two additional Utilization Management Physicians.

A Behavioral Health Team continues to meet weekly to discuss psychiatric and substance abuse member admissions to inpatient, Residential, Partial Hospital and Intensive Outpatient Programs. This team is comprised of the Director of Psychiatry, two other psychiatrists, two Utilization Management physicians, Licensed Clinical Social Workers, a Licensed Mental Health Therapist, the Behavioral Health Utilization Review nurse, the Administrator of Utilization Management, or designee and the Manager of Utilization Management.

The goal of both teams is to assess level of care and assist with transition of care of

members from the inpatient setting to the most appropriate level of care.

After hospitalization, many members were referred to Home Docs, a company that sends mid-level practitioners to the home, with a goal of engaging the member in medication and care plan compliance. The Behavioral Health Crisis Team, comprised of Licensed Clinical Social Workers are also assigned to some members who are frequently admitted to behavioral health facilities for substance abuse related issues.

FHCP Utilization Management Evaluation Summary 2018

- All Utilization Management reviewers performed interrater reliability testing. All but one met the goal of pass rate 80% or higher. The reviewer that failed 1 case was given targeted review of the cases they did not pass, and additional training.
- Preservice requests for the Marketplace increased per 1,000 members.
- Denial rates for both product lines remained consistent despite membership growth.
- Concurrent determinations for Commercial and Marketplace lines remained stable over the past two years.
- Appeals rates for the Commercial Line remained statistically stable, while the Marketplace appeal requests increased by 83.4% per 1,000 in 2018
- Use of a Physician Consultant and implementation of interactive software for determinations has enhanced the utilization process.
- CAHPS Surveys for all product lines remained stable for UM satisfaction
- 1525 surveys were sent, with a 24% response rate. Provider satisfaction exceeded the goal of a 3.5/5 rating, with a significant increase in satisfaction related to ease of use in the referrals process.

Areas for improvement.

The results were above average and did not indicate a need for a barrier analysis for all areas of the UM Program Evaluation. FHCP will continue to evaluate and strive to improve processes in these areas. Additionally, any areas of stability or marginal increase will be monitored to ensure they do not decrease in the 2019-2020 reporting period.

UM Evaluation 2019 - Committee Action

Committee Name	Meeting Date	Committee Actions or Recommendations
H.O.P.E Committee	10/09/2019	Approved by 10/11 email vote with edits, send to PIC
Performance Improvement	10/16/2019	Approved as written.

Florida Health Care Plan, Inc.

2019 Quality Improvement Work Plan

Overview of Work Plan

The QI Work Plan template is organized in the following sections:

➤ Part I- Development Activities

This section of the work plan identifies **new** activities that need to be developed or enhanced to meet accreditation standards requirements. This work plan template includes the activities required to comply with Health Plan standards requirements that became effective in 2019. If your survey is under the 2019 standards, you must demonstrate a history of implementing the new requirements at least 6 months before your survey. Once a requirement is one year old, then organizations must demonstrate of history of implementation of that requirement for at least 12 months prior to their survey and when a requirement is two years old, then organizations must demonstrate of history of implementation of that requirement for at least 24 months prior to their survey.

Once development activities are implemented, add future activity for that topic to the applicable work plan section.

➤ Part II Annual QI Activities

Activities that must be completed every 12 months are included in this section. This supports efficient coordination of QI activities across the organization. It is also very helpful when there is a staff change; typically new staff are not familiar with all the activities that must occur annually. To complicate matters further, it is difficult for new staff to locate information about the last time an activity occurred without a tracking system.

In addition, the NCQA scoring guidelines specify that certain activities must be completed annually. NCQA defines annual as **at least every 12 months** with a two-month grace period. Annual activities completed within 14 months of the previous review receive a full compliance designation. Work plan activities with an “annual” requirement are denoted with a “Yes” in the Annual Review column of this section of the work plan. Use this section of the work plan to schedule and monitor compliance with NCQA’s “annual” requirements.

➤ Part III-Biennial Activities

This section of the work plan includes activities completed at least every 24 months. Some NCQA scoring guidelines specify an activity must occur at least every two years. All of those requirements are listed in this section of the work plan.

Florida Health Care Plan, Inc.
2019 Quality Improvement Work Plan

Part I- Development Activities

QI Development Activities (New requirements or new processes)	Responsible Person	Start Date	Deadline	Committee Reported to	Completion Date
<i>New 2019 NCQA Standard Requirements</i>					
Compile a report which assesses the impact of population health activities on care process or outcome, cost or utilization and member experience (PHM 6A).	S. Sanderson J. Adams	July 2018	July 2019	HOPE	October 2019
				PIC	
Identify opportunities to improve PHM activities based on the impact report and implement actions to improve one PHM program or activity (PHM 6B).	S. Sanderson J. Adams	July 2018	July 2019	HOPE	October 2019
				PIC	
In addition to the documented process, collect evidence of distribution of materials for four programs that involve interactive contact, demonstrating how members are informed about the programs.	S. Sanderson J. Adams	July 2018	July 2019	HOPE	
				PIC	

Florida Health Care Plan, Inc.
2019 Quality Improvement Work Plan

Part II– Annual QI Activities

Annual QI Activities	Annual Review ¹	Responsible Person	Start Date	Committee and Report Date	Completion Date
QUALITY IMPROVEMENT STANDARDS					
Prepare QI Program Evaluation (QI 1).	Yes	J. Adams	Dec 2018	PIC	February 2019
Prepare QI Program Description (QI 1) and incorporate the recommendations from the QI program evaluation. Process must be completed, but will not be reviewed for survey in 2020	Yes	J. Adams	Dec 2018	PIC	February 2019
Prepare the annual QI work plan (QI 1)	Yes	J. Adams	Feb 2019	PIC	March 2019
Publish annual member newsletter with results of QI activities and effectiveness of actions for improvement (QI 2 B)	Yes	J. Adams	Feb 2019	N/A	February 2019
~~Measure compliance with organization standards for customer service telephone accessibility (QI 4A).~~	Retired for HPA 2020; N/A for 2019; covered by QI 4C Annual Assessment and MEM 3C Quality & Accuracy of Information			N/A	N/A
~~If organization operates behavioral health triage function, measure compliance with standards for behavioral health triage telephone accessibility (QI 4B).~~				N/A	N/A
Complete an analysis of non-behavioral health related member complaints, appeals, and CAHPS satisfaction survey results to identify opportunities to address sources of member dissatisfaction (QI 4C and D).	Yes	D. Siciliano	June 2018	CS	June 2019
				PIC	July 2019
Conduct a separate analysis of member complaints and appeals related to behavioral health services (QI 4E).	Yes	D. Siciliano	Nov 2018	CS	September 2019
				PIC	October 2019
Conduct a separate survey to measure member satisfaction with behavioral health services (QI 4E).	Yes	D. Siciliano	Nov 2018	CS	September 2019
				PIC	October 2019

¹ NCQA's Scoring Guidelines include requirements for completion of a number of activities on an "annual" basis. NCQA defines annual as **at least every 12 months** with a two-month grace period. Annual reviews completed within 14 months of the previous review receive a full compliance designation. Work plan activities with an "annual" requirement are denoted with a "Yes" in the Annual Review Column.

Florida Health Care Plan, Inc.
2019 Quality Improvement Work Plan

Annual QI Activities	Annual Review ¹	Responsible Person	Start Date	Committee and Report Date	Completion Date
Identify opportunities to improve behavioral health services based on QI 4E analyses, implement actions to improve performance and measure the effectiveness of the actions (QI 4F).	Yes	D. Siciliano	Nov 2018	CS	September 2019
				PIC	October 2019
~~Analyze member satisfaction with UM process (QI 4G).~~	Retired for HPA 2020; N/A for 2019; covered by QI 4 analysis of complaint/appeal data			N/A	N/A
~~➤ Identify sources of dissatisfaction with UM process.~~				N/A	N/A
~~Analyze practitioner satisfaction with UM process (QI 4G).~~	Retired for HPA 2020; N/A for 2019; covered by QI 4 analysis of complaint/appeal data			N/A	N/A
~~➤ Identify sources of dissatisfaction with UM process.~~				N/A	N/A
~~Address identified sources of member and practitioner dissatisfaction with the UM process (QI 4G).~~	Retired for HPA 2020; N/A for 2019; covered by QI 4 analysis of non-BH and BH complaint/appeal data			N/A	N/A
~~➤ Implement actions targeting sources of dissatisfaction.~~				N/A	N/A
Monitor at least four aspects of continuity and coordination of care between medical care providers (QI 5A). Data must be collected on both member movement between practitioners and member movement across settings. ➤ Identify four opportunities for improvement, at least one for each aspect measured	Yes	S. Sanderson	Aug 2018	HOPE	October 2019
				PIC	December 2019
Implement actions to improve three aspects of continuity and coordination of care between medical care providers (QI 5B).	Yes	S. Sanderson	Aug 2018	HOPE	October 2019
				PIC	December 2019
Measure the effectiveness of at least three actions implemented to improve continuity and coordination of care between medical care providers (QI 5C).	Yes	S. Sanderson	Aug 2018	HOPE	October 2019
				PIC	December 2019
~~Publish an article in the member newsletter about the availability of assistance for adolescents transitioning from pediatric to adult care (QI 5D factor 2).~~	Retired for HPA 2020; N/A for 2019			N/A	N/A
Monitor the continuity and coordination of medical and behavioral health care, addressing all 6 requirements in this element. Analyze results and implement at least two actions to address opportunities for improvement (QI 6A-B)	Yes	S. Sanderson	Aug 2018	HOPE	October 2019
				PIC	October 2019

Florida Health Care Plan, Inc.
2019 Quality Improvement Work Plan

Annual QI Activities	Annual Review ¹	Responsible Person	Start Date	Committee and Report Date	Completion Date
Measure the effectiveness of at least two actions implemented to improve continuity and coordination of care between medical and behavioral health care providers (QI 6C).	Yes	S. Sanderson	Aug 2018	HOPE	October 2019
				PIC	October 2019
Review and approve the QI program for all QI delegates, regardless of NCQA accreditation or certification status (QI 7E factor 1)	Yes	N/A			
POPULATION HEALTH MANAGEMENT STANDARDS					
Update the Population Health Management Strategy Description to ensure it reflects the current approach used to address member needs across the continuum of care (PHM 1A).	Yes	S. Sanderson J. Adams	July 2018	HOPE	October 2019
				PIC	October 2019
Ensure there is a process to inform all members eligible for PHM programs that include interactive contact with information about how they became eligible to participate, how to use program service and how to opt in or opt out (PHM 1B).	Yes	S. Sanderson J. Adams	July 2018	HOPE	
				PIC	
Conduct an analysis of the needs and characteristics of the entire health plan population. Identify sub-populations that require assistance and determine whether the current population health program services and resources are adequately meeting those needs (PHM 2B).	Yes	S. Sanderson	Aug 2018	HOPE	May 2019
				PIC	July 2019
Implement a process to at least annually segment and stratify the entire enrolled population into subsets for targeted intervention based on their health needs. Compile the report which shows the number of eligible members for each program during the prior measurement year. (PHM 2D).	Yes	S. Sanderson	Aug 2018	HOPE	May 2019
				PIC	July 2019
Compile evidence which shows how the organization supports network practitioners and providers in moving to population-based care during the prior measurement year (PHM 3A).	Yes	S. Sanderson J. Adams	July 2018	HOPE	
				PIC	
~~Measure satisfaction of members participating in complex case management, implement actions as needed to improve performance and measure effectiveness of the actions (PHM 5F).~~				N/A	N/A
				N/A	N/A

Florida Health Care Plan, Inc.
2019 Quality Improvement Work Plan

Annual QI Activities	Annual Review ¹	Responsible Person	Start Date	Committee and Report Date	Completion Date
NET STANDARDS					
Measure PCP, high-volume and high impact specialist, and behavioral health practitioner availability against organization standards (NET 1B-D).	Yes	P. Haedrich	June 2018	CS	July 2019
				PIC	July 2019
Measure compliance with organization standards for PCP appointment and after-hours accessibility (NET 2A).	Yes	P. Haedrich	Aug 2018	CS	August 2019
				PIC	September 2019
Measure compliance with organization standards for behavioral health practitioner appointment accessibility (NET 2B).	Yes	P. Haedrich	Aug 2018	CS	August 2019
				PIC	September 2019
Measure compliance with organization standards for high volume and high impact specialist appointment accessibility (NET 2C).	Yes	P. Haedrich	Aug 2018	CS	August 2019
				PIC	September 2019
Analyze member experience with accessing the network through review of member complaints, appeals and out-of-network utilization for behavioral health and non-behavioral health services to identify network gaps which could impact member ability to access care (NET 3A).	Yes	P. Haedrich	Aug 2018	CS	September 2019
				PIC	September 2019
Identify opportunities to improve access to non-behavioral health services through review of data from NET 1B and C and NET 2A and C analyses plus member complaints, appeals and CAHPS survey results related to non-behavioral health network adequacy. Implement actions to address at least one opportunity and measure the effectiveness of those interventions (NET 3B).	Yes	P. Haedrich	Aug 2018	CS	September 2019
				PIC	September 2019
Identify opportunities to improve access to behavioral health services through review of data from NET 1D and NET 2B analyses plus member complaints, appeals and survey results related to behavioral health network adequacy. Implement actions to address at least one opportunity and measure the effectiveness of those interventions (NET 3C).	Yes	P. Haedrich	Aug 2018	CS	September 2019
				PIC	September 2019

Florida Health Care Plan, Inc.
2019 Quality Improvement Work Plan

Annual QI Activities	Annual Review ¹	Responsible Person	Start Date	Committee and Report Date	Completion Date
Analyze member complaints, appeals, out-of-network requests or utilization and QHP enrollee satisfaction survey results for Marketplace enrollees separately from other enrollees, identify opportunities, and implement actions to address the opportunities (NET 4C and D). INCORPORATED INTO QI 4 Member Experience Analysis	Yes	D. Siciliano	May 2018	CS	June 2019
				PIC	July 2019
Evaluate the accuracy of the online physician directory data on office locations and phone numbers, hospital affiliations, accepting new patients and awareness of physician office staff of practitioner network participation status using valid methodology. Analyze results, identify opportunities to improve the accuracy of information in the directory and implement action to improve performance (NET 6C and D).	Yes	P. Haedrich	Aug 2018	CS	August 2019
				PIC	September 2019
Review and approve the network management procedures for all NET delegates, regardless of NCQA accreditation or certification status (NET 7E factor 1)	Yes	N/A if no delegation			
UTILIZATION MANAGEMENT STANDARDS					
Prepare UM Program Evaluation (UM 1)	Yes	S. Sanderson	Aug 2018	HOPE	October 2019
				PIC	October 2019
Prepare UM Program Description (UM 1) with recommendations from UM Program Evaluation Process must be completed, but will not be reviewed for survey in 2020	Yes	S. Sanderson	Jan 2019	HOPE	September 2019
				PIC	September 2019
Review and update UM criteria (UM 2).	Yes	S. Sanderson	May 2018	N/A Tracking/ Monitoring	April 2019
Evaluate consistency of UM decision-making by all reviewers (UM 2) ➤ Implement actions for improvement based on results	Yes	S. Sanderson	Aug 2018	HOPE	October 2019 (Pharmacy testing pending)

Florida Health Care Plan, Inc.
2019 Quality Improvement Work Plan

Annual QI Activities	Annual Review ¹	Responsible Person	Start Date	Committee and Report Date	Completion Date
				PIC	December 2019 (Pharmacy testing pending)
Analyze the timeliness of all UM decisions and notifications (both approvals and denials). Report data separately for each UM case type (urgent and non-urgent precertification, urgent concurrent and post-service) for non-behavioral, behavioral and pharmacy services (UM 5G).	No	S. Sanderson	June 2018	HOPE	May 2019
				PIC	July 2019
Publish written notice to members in commercial and Marketplace product lines which informs them about the right to external independent review of appeals (UM 8B).	Yes	S. Sanderson	June 2018	N/A Tracking/ Monitoring	February 2019
Distribute formulary information to all existing practitioners and members (UM 11B).	Yes	B. Spitz	April 2018	N/A Tracking/ Monitoring	
Ensure there is a process to notify affected members and their prescribers of negative formulary changes on an ongoing basis (UM 11B).	No	B. Spitz	April 2018	N/A Tracking/ Monitoring	
Review and update pharmacy management procedures (UM 11D).	Yes	B. Spitz	April 2018	N/A Tracking/ Monitoring	
Review and update the formulary (UM 11D)	Yes	B. Spitz	April 2018	N/A Tracking/ Monitoring	
Review and approve the UM program for all UM delegates, regardless of NCQA accreditation or certification status (UM 13E factor 1)	Yes	S. Sanderson	Jan 2019	HOPE	April 2019
CREDENTIALING STANDARDS					
Report data on tracking and trending patterns of complaints and sentinel events/adverse occurrences about individual practitioners at least every 6 months (CR 5)	No- needs semi-annual	C. Gehringer	April 2019	Credentialing/Peer Review Committee	April 2019
Review and approve the CR program for all CR delegates, regardless of NCQA accreditation or certification status (CR 8E factor 1)	Yes	N/A			

Florida Health Care Plan, Inc.
2019 Quality Improvement Work Plan

Annual QI Activities	Annual Review ¹	Responsible Person	Start Date	Committee and Report Date	Completion Date
RIGHTS AND RESPONSIBILITY STANDARDS					
Distribute Member Rights and Responsibility Statement to all practitioners and members (RR 1B).	Yes	J. Adams	May 2018	N/A Tracking/Monitoring	February 2019
Distribute information about how to use benefit plan to all existing members (RR 3A).	Yes	C. Martinez	March 2018	N/A Tracking/Monitoring	February 2019
MEMBER CONNECTION STANDARDS					
Measure the quality and accuracy of pharmacy benefit information communicated via the web, assessing each function required in MEM 2A (MEM 2C).	Yes	B. Spitz	April 2018	P and T PIC	April 2019
Measure the quality and accuracy of pharmacy benefit information communicated via the phone (MEM 2C).	Yes	B. Spitz	April 2018	P and T PIC	April 2019
Measure the quality and accuracy of PCP change and ID card requests submitted via the web (MEM 3C). (ID card factor retired 2020; N/A 2019)	Yes	P. Haedrich C. Martinez	Feb 2019	CS PIC	February 2019
Measure the quality and accuracy of information regarding services requiring referral and authorization on the web (MEM 3C).	Yes	S. Sanderson	June 2018	CS PIC	February 2019
Measure the quality and accuracy of treatment cost estimator information available on the web (MEM 3C).	Yes	S. Berberich	July 2018	CS PIC	August 2019
Measure the quality and accuracy of information communicated via the phone regarding which services require referral and authorization and estimated treatment costs (MEM 3C).	Yes	D. Siciliano	April 2018	CS PIC	April 2019
Measure email inquiry turnaround time and quality of responses (MEM 3D).	Yes	D. Siciliano	May 2018	CS PIC	July 2019
Perform annual delegation site visits to evaluate compliance with Health Plan and NCQA standards (QI 7, PHM 7, NET 7, UM 13, CR 8, RR 5 and MEM 5)	Yes	N/A if no delegation	N/A if no delegation		
Collect HEDIS and CAHPS data for all accredited product lines.	Yes	J. Adams	Oct 2018	PIC	October 2019

Florida Health Care Plan, Inc.
2019 Quality Improvement Work Plan

Part III -Biennial QI Activities

Biennial QI Activities ²	Responsible Person	Start Date	Committee and Report Date	Completion Date
Assess the cultural needs and characteristics of members and determine whether the contracted provider network adequately meets those needs (NET 1A)	P. Haedrich	June 2017 (due June 2019)	CS PIC	July 2019
Publish information about appropriate use of incentives for UM decisions to all members, contracted practitioners and providers and all staff who make UM decisions (including approvals) (UM 4).	S. Sanderson	Dec 2018 (due 2020)	N/A – Tracking/Monitoring	February 2019
Conduct usability testing of the online practitioner directory whenever changes are made to the user interface, but no less than every three years (NET 6K).	P. Haedrich	Aug 2017 (due before Aug 2020)	CS PIC	
Evaluate new member understanding of marketing communications and implement actions to improve (RR 4C).	C. Martinez	Feb 2019 (due 2021)	CS PIC	July 2019
Prepare a report which shows the percent of total payments made during the reporting period that are value-based payments (VBP). Categorize the organization's VBP arrangements into the types outlined in the PHM 3B explanation for reporting (PHM 3B).	R. Barnard S. Berberich M. Ruel	Feb 2018 (due Jan 2020)	HOPE	

² This section lists NCQA requirements that must be performed at least every 2 years. You may perform them annually if desired, but that is not required.



2019 CAHPS Commercial Adult 5.0H Final Report Non-PPO

Florida Health Care Plan, Inc.

Project Number: 1134918



Florida Health Care Plan, Inc.

Contents

- Executive Summary
- Profile of Survey Respondents
- Summary of Trend and Benchmarks
- Global Proportions and Accreditation
- Composite Analyses
- Segmentation Analyses
- Correlation Analyses
- Priority Matrix
- Custom Question Analyses

SPH Analytics (SPH), a National Committee for Quality Assurance (NCQA) certified HEDIS® Survey Vendor, was selected by Florida Health Care Plan, Inc. to conduct its 2019 CAHPS® 5.0H Commercial Adult Member Satisfaction Survey. NCQA requires health plans to submit CAHPS survey results in compliance with HEDIS® accreditation requirements.

Your Sales Director for this project is Sheryl Savage (678-689-0312), and your Project Manager is Miranda Watkins (770-978-3173, ext. 1414). Should you have any questions or comments regarding any aspect of the survey or reporting process, please feel free to call either your Sales Director or your Project Manager.

NCQA made the following change to the survey in 2018:

- NCQA retired the HEDIS® Aspirin Use and Discussion Measure in 2017. The CAHPS 5.0H survey items aligned with this measure have been removed.



Executive Summary

- Florida Health Care Plan, Inc.
- 1134918

SURVEY OBJECTIVE The overall objective of the CAHPS® study is to capture accurate and complete information about consumer-reported experiences with health care. Specifically, the survey aims to measure how well plans are meeting their members' expectations and goals; to determine which areas of service have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement, which could aid plans in increasing the quality of provided care.

SPH Analytics (SPH) has structured this report to provide insightful and actionable information that plans can use to improve quality and performance.

VALID SURVEYS

Using a 4 Wave Mail with Phone survey methodology, per NCQA protocol, SPH Analytics collected **360 valid surveys** from the eligible member population, yielding a response rate of **22.8%**.



Summary Rates are defined by NCQA in its HEDIS 2019 CAHPS® 5.0H guidelines and generally represent the most favorable response percentages. The Summary Rates for *Plan Information on Cost*, Q31, Q33, and Effectiveness of Care Measures (with the exception of the *Flu Vaccinations (Adults 18-64)* measure) are calculated on a two-year rolling average due to anticipated small denominators.

	No	Yes	
Never	Sometimes	Usually	Always

Rating questions are typically displayed with two Summary Rates:

0	1	2	3	4	5	6	7	8	9	10
0	1	2	3	4	5	6	7	8	9	10

Percentile Rankings Your plan's approximate percentile rankings in relation to the Quality Compass® All Plans benchmark were calculated by SPH Analytics using information derived from the NCQA 1-100 Benchmark. Your percentile rank indicates where your plan's Summary Rate falls relative to the NCQA 1-100 Benchmark.

NCQA BENCHMARK INFORMATION

The source for data contained in this publication is Quality Compass® All Plans 2019. It is used with the permission of the National Committee for Quality Assurance (NCQA). Any analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation, or conclusion. Quality Compass® is a registered trademark of NCQA.

The Public Report benchmark is derived from NCQA's Quality Compass® benchmark and is calculated by SPH Analytics. Please note that any analyses, interpretations, or conclusions based upon the Public Report benchmark are solely that of the author (SPH Analytics) and NCQA specifically disclaims responsibility for any such analyses, interpretations, or conclusions. Quality Compass® is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass® is a registered trademark of NCQA.



Health Plan Domain Performance

Your plan's performance on measures that are typically considered to be in the domain of the health plan.

MEASURE	SUMMARY RATE		CHANGE*	2019 Non-PPO SPH ANALYTICS BENCHMARK		2019 Non-PPO QUALITY COMPASS® ALL PLANS BENCHMARK	
	2019	2018		SUMMARY RATE	PERCENTILE RANK	SUMMARY RATE	PERCENTILE RANK
8-10 Rating of Health Plan	71.0%	70.4%	0.6	65.2%	73rd	65.0%	70th
9-10 Rating of Health Plan	47.4%	49.5%	-2.0	43.2%	73rd	42.4%	71st
Getting Needed Care	84.6%	87.4%	-2.9	84.7%	32nd	85.4%	32nd
Customer Service	86.1%	90.2%	-4.1	88.2%	30th	89.1%	22nd
Claims Processing	89.3%	90.9%	-1.6	87.0%	55th	88.7%	51st
Plan Information on Cost	68.1%	73.7%	-5.6	59.5%	91st	61.5%	90th
Providing Needed Information	60.2%	75.4%	-15.2	64.3%	24th	66.2%	18th
Ease of Filling Out Forms	96.5%	95.0%	1.5	95.7%	65th	96.0%	66th

KEY TAKEAWAYS

Your overall Rating of Health Plan (8-10) Summary Rate score was 71.0%, and represents a change of 0.6 from 2018. This measure counts for double points in accreditation scoring.

SPH regression analysis has identified **Claims Processing, Customer Service, and Getting Needed Care** as **Key Drivers** of Rating of Health Plan. Improving scores on these measures can improve the rating score.

* Please note that the "change" comparison may vary slightly due to rounding.

Significance Testing

Green – Current year score significantly higher when compared to trend or benchmark score.

Red – Current year score significantly lower when compared to trend or benchmark score.



Health Care Domain Performance

Your plan's performance on measures that are typically considered to be in the provider health care domain.

MEASURE	SUMMARY RATE		CHANGE*	2019 Non-PPO SPH ANALYTICS BENCHMARK		2019 Non-PPO QUALITY COMPASS® ALL PLANS BENCHMARK	
	2019	2018		SUMMARY RATE	PERCENTILE RANK	SUMMARY RATE	PERCENTILE RANK
8-10 Rating of Health Care	79.1%	80.7%	-1.6	77.2%	63rd	78.1%	56th
9-10 Rating of Health Care	55.0%	57.1%	-2.1	52.8%	63rd	52.9%	61st
Getting Care Quickly	83.7%	89.9%	-6.2	83.5%	32nd	84.4%	36th
How Well Doctors Communicate	95.9%	95.0%	0.8	94.8%	59th	95.1%	60th
Shared Decision Making	79.6%	81.8%	-2.2	81.3%	24th	81.7%	23rd
Health Promotion and Education	77.1%	78.0%	-1.0	73.8%	63rd	75.6%	59th
Coordination of Care	84.8%	85.4%	-0.6	83.9%	48th	83.8%	58th
8-10 Rating of Personal Doctor	87.8%	85.8%	2.0	84.9%	79th	85.3%	76th
9-10 Rating of Personal Doctor	73.8%	72.8%	1.0	67.8%	83rd	68.2%	83rd
8-10 Rating of Specialist	84.1%	84.9%	-0.8	83.3%	48th	84.2%	46th
9-10 Rating of Specialist	65.9%	64.3%	1.7	66.0%	44th	67.0%	39th

KEY TAKEAWAYS

Your overall Rating of Health Care (8-10) Summary Rate score was 79.1%, and represents a change of -1.6 from 2018.

SPH regression analysis has identified **How Well Doctors Communicate** and **Getting Needed Care**, as **Key Drivers** of Rating of Health Care. Improving scores on these measures can improve the rating score.

* Please note that the "change" comparison may vary slightly due to rounding.

Significance Testing

Green – Current year score significantly higher when compared to trend or benchmark score.

Red – Current year score significantly lower when compared to trend or benchmark score.



Effectiveness of Care Performance

Your plan's performance on HEDIS measures collected through the CAHPS 5.0H survey.

MEASURE	SUMMARY RATE		CHANGE*	2019 Non-PPO SPH ANALYTICS BENCHMARK		2019 Non-PPO QUALITY COMPASS® ALL PLANS BENCHMARK	
	2019	2018		SUMMARY RATE	PERCENTILE RANK	SUMMARY RATE	PERCENTILE RANK
Flu Vaccinations (Adults 18-64)	47.6%	43.3%	4.3	52.9%	28th	52.7%	28th
Advising Smokers and Tobacco Users to Quit	80.6%	85.9%	-5.3	75.8%	59th	77.8%	87th
Discussing Cessation Medications	57.5%	62.3%	-4.8	51.6%	61st	55.5%	75th
Discussing Cessation Strategies	52.8%	55.8%	-3.1	44.9%	73rd	48.9%	76th

* Please note that the "change" comparison may vary slightly due to rounding.

Significance Testing

Green – Current year score significantly higher when compared to trend or benchmark score.

Red – Current year score significantly lower when compared to trend or benchmark score.

OVERVIEW: ACCREDITATION FOR 2019 SCORING

Your plan scored at or below the **50th percentile** for the following measures used for accreditation:

MEASURE	PERCENTILE
Getting Needed Care	25th
Getting Care Quickly	25th
Customer Service	50th
Rating of Health Care	50th
Rating of Specialist	50th

MEASURE NAME	2019 HEDIS/CAHPS PERCENTILES				Plan 3-Point Score	Approximate Plan Percentile Threshold	Approximate Points Awarded
	25TH	50TH	75TH	90TH			2019
Getting Needed Care	2.36	2.41	2.45	2.50	2.3753	25th	0.5778
Getting Care Quickly	2.39	2.44	2.49	2.54	2.4270	25th	0.5778
Customer Service	2.44	2.51	2.57	2.63	2.5155	50th	0.9822
Claims Processing	2.36	2.43	2.49	2.55	NA	NA	-
Coordination of Care	2.27	2.33	2.39	2.45	2.3990	75th	1.2711
Rating of Health Care	2.33	2.39	2.45	2.51	2.4437	50th	0.9822
Rating of Personal Doctor	2.47	2.52	2.57	2.61	2.6656	90th	1.4444
Rating of Specialist	2.49	2.53	2.58	2.64	2.5603	50th	0.9822
Rating of Health Plan	2.02	2.13	2.27	2.41	2.2926	75th	2.5422
Approximate Points Earned (13.000 available)							9.3599

Note: If a plan receives an NA (indicating the denominator was less than 100) the points for that measure are redistributed among the remaining required measures. An organization that has more than four CAHPS® NAs, or which exceed ten NA or NB results between HEDIS and CAHPS® for each product line, are scored based on the standards score only and the accreditation status is capped at Commendable.

Top Three Measures

Your plan had the highest NCQA Quality Compass® All Plans percentile rankings for these three measures.

MEASURE	VALID N	2019 SUMMARY RATE SCORE	2018 SUMMARY RATE SCORE	CHANGE*	QC ALL PLANS PERCENTILE RANKING	NCQA QUALITY COMPASS ALL PLANS	GAP
Plan Information on Costs (Rolling Average)	138	68.1%	73.7%	-5.6	90th	61.5%	6.6
Rating of Personal Doctor (8 to 10)	320	87.8%	85.8%	2.0	76th	85.3%	2.5
Rating of Health Plan (8 to 10)	352	71.0%	70.4%	0.6	70th	65.0%	6.0

Bottom Three Measures

Your plan had the lowest NCQA Quality Compass® All Plans percentile rankings for these three measures.

MEASURE	VALID N	2019 SUMMARY RATE SCORE	2018 SUMMARY RATE SCORE	CHANGE*	QC ALL PLANS PERCENTILE RANKING	NCQA QUALITY COMPASS ALL PLANS	GAP
Getting Needed Care	268	84.6%	87.4%	-2.9	32nd	85.4%	-0.9
Shared Decision Making	152	79.6%	81.8%	-2.2	23rd	81.7%	-2.1
Customer Service	108	86.1%	90.2%	-4.1	22nd	89.1%	-3.0

* Please note that the "change" comparison may vary slightly due to rounding.

Significance Testing

Green – Current year score significantly higher when compared to trend or benchmark score.

Red – Current year score significantly lower when compared to trend or benchmark score.

Improving Performance

These measures had the lowest NCQA Quality Compass® All Plans percentile rankings for your plan. While plans should also review which measures have lower scores than last year and which measures perform lower than benchmark, SPH offers these opportunities for improvement based on national percentile rankings.

Getting Needed Care

- Review established appointment scheduling and call back timeline standards by provider type.
- Explore alternative telecommunication technologies to expand access to care: telephone, telehealth/telemedicine
- Revisit and simplify plan requirements/processes (i.e., UM) impacting access to care, tests, or treatment.
- Review and simplify referral policies/procedures for member and provider.
- Ensure Customer Service representatives are able to advise members of available specialists, labs, etc.
- Ensure ease of navigation and accuracy of information about providers (background, contact information, availability, picture, languages, etc.).
- Evaluate number, hours of availability, and overall adequacy of specialty types across the network.
- Establish a specialist referral hotline for providers and members.
- Conduct periodic phone audits of appointment availability (routine, urgent, after-hours) by high-volume specialists.
- Explore open access scheduling opportunities for high volume specialty types (i.e., Cardio).

Shared Decision Making

- Develop video/presentations to help inform patients about chronic illnesses, treatment or medication options, promote health, and teach self-management skills.
- Remind providers of the importance of SDM measure and national focus on use/overuse of prescription drugs.
- Utilize appointment reminder calls to prompt patients to bring their medications (or a list) to review/discuss with the provider.
- Encourage providers to discuss or offer educational materials, videos or on-line tools to help members understand their illness/condition, treatment or medication options, and improving health.

Customer Service

- Emphasize a customer/member services as a high priority across all areas of the organization.
- Involve CSRs in QI discussions and review of internal metrics.
- Identifying QI opportunities via staff observational walkthrough of calls and discussion of the member experience.
- Develop/implement protocols and scripts ("Talking Points") to ensure consistency of information provided to your members and patients.
- Acknowledge and/or reward service performance/behaviors reflective of service excellence.
- Establish measurable CSR performance/service standards (i.e., Call satisfaction, call resolution, Time on hold, etc.).
- Provide on-going/periodic CSR service training, open discussions and refresher programs.
- Engage staff in understanding member/customer basic service expectations.
- Ensure CSRs have immediate access to knowledgeable support staff within key service areas (Claims, Enrollment, etc.).
- Consider value of cross training staff for peak calling seasons or subject matter (i.e., Claims, Drug coverage, etc.).
- Assign subject matter experts to respond to urgent or complex types of calls, questions or issues.

Need Additional Assistance? *For health plans that need additional assistance interpreting survey results and leveraging data to identify appropriate next steps for improvement, SPH offers Performance Improvement Consulting. Contact your Sales Director to learn more or visit our website at*

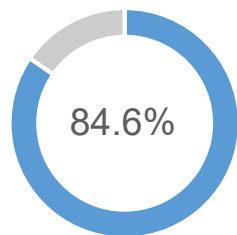
<http://www.sphanalytics.com/consulting>.



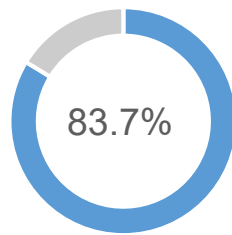
Composite Summary Rate Scores

Florida Health Care Plan, Inc.

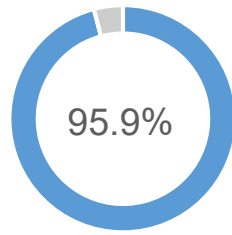
Please see Technical Notes for more information.



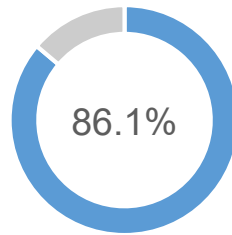
Getting Needed Care



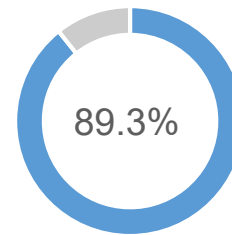
Getting Care Quickly



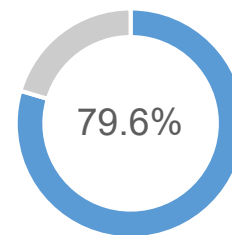
How Well Doctors
Communicate



Customer Service



Claims Processing



Shared Decision Making

2019	84.6%
2018	87.4%
2017	89.0%
SPH	84.7%
NCQA	85.4%

2019	83.7%
2018	89.9%
2017	88.2%
SPH	83.5%
NCQA	84.4%

2019	95.9%
2018	95.0%
2017	95.5%
SPH	94.8%
NCQA	95.1%

2019	86.1%
2018	90.2%
2017	91.5%
SPH	88.2%
NCQA	89.1%

2019	89.3%
2018	90.9%
2017	87.4%
SPH	87.0%
NCQA	88.7%

2019	79.6%
2018	81.8%
2017	86.5%
SPH	81.3%
NCQA	81.7%

Summary Rate Scores

Summary Rates are defined by **NCQA** in its HEDIS 2019 CAHPS® 5.0H guidelines and generally represent the most favorable response percentages.

NCQA refers to the 2019 Quality Compass® All Plans benchmark.

SPH refers to the 2019 SPH Analytics Book of Business benchmark.

Significance Testing

Green – Current year score significantly higher when compared to trend or benchmark score.

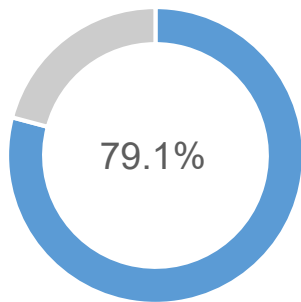
Red – Current year score significantly lower when compared to trend or benchmark score.



Global Rating Summary Rate Scores (8+9+10)

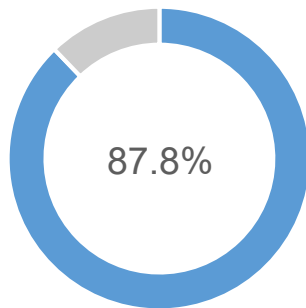
Florida Health Care Plan, Inc.

Please see Technical Notes for more information.



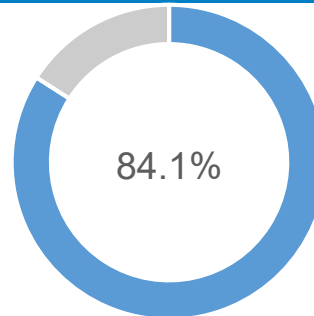
Rating of Health Care

2019	79.1%
2018	80.7%
2017	81.9%
SPH	77.2%
NCQA	78.1%



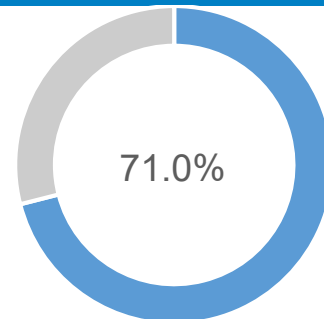
Rating of Personal Doctor

2019	87.8%
2018	85.8%
2017	85.4%
SPH	84.9%
NCQA	85.3%



Rating of Specialist

2019	84.1%
2018	84.9%
2017	80.7%
SPH	83.3%
NCQA	84.2%



Rating of Health Plan

2019	71.0%
2018	70.4%
2017	74.3%
SPH	65.2%
NCQA	65.0%

Summary Rate Scores

Summary Rates are defined by **NCQA** in its HEDIS 2019 CAHPS® 5.0H guidelines and generally represent the most favorable response percentages.

NCQA refers to the 2019 Quality Compass® All Plans benchmark.

SPH refers to the 2019 SPH Analytics Book of Business benchmark.

Significance Testing

Green – Current year score significantly higher when compared to trend or benchmark score.

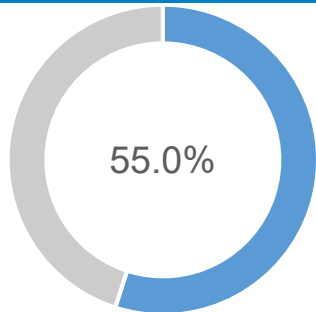
Red – Current year score significantly lower when compared to trend or benchmark score.



Global Rating Summary Rate Scores (9+10)

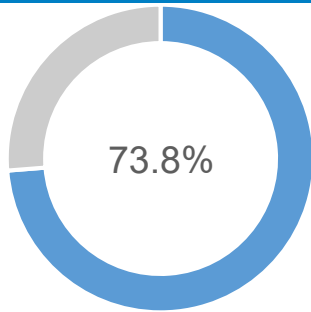
Florida Health Care Plan, Inc.

Please see Technical Notes for more information.



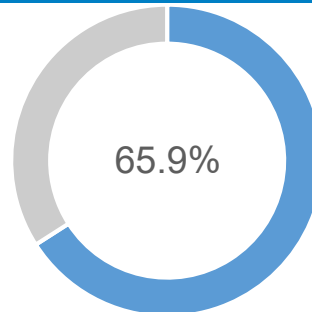
Rating of Health Care

2019	55.0%
2018	57.1%
2017	59.2%
SPH	52.8%
NCQA	52.9%



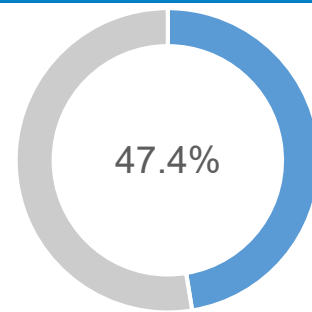
Rating of Personal Doctor

2019	73.8%
2018	72.8%
2017	71.5%
SPH	67.8%
NCQA	68.2%



Rating of Specialist

2019	65.9%
2018	64.3%
2017	64.7%
SPH	66.0%
NCQA	67.0%



Rating of Health Plan

2019	47.4%
2018	49.5%
2017	53.3%
SPH	43.2%
NCQA	42.4%

Summary Rate Scores

Summary Rates are defined by **NCQA** in its HEDIS 2019 CAHPS® 5.0H guidelines and generally represent the most favorable response percentages.

NCQA refers to the 2019 Quality Compass® All Plans benchmark.

SPH refers to the 2019 SPH Analytics Book of Business benchmark.

Significance Testing

Green – Current year score significantly higher when compared to trend or benchmark score.

Red – Current year score significantly lower when compared to trend or benchmark score.

Regression analysis on the SPH Book of Business has identified the following **Key Drivers** of Rating of Health Plan. Performance on these measures may be driving member's overall experience rating.



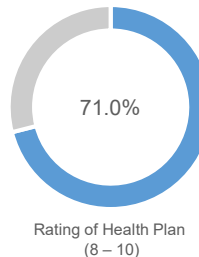
PERFORMANCE ON KEY DRIVERS

Key Driver	SPH BoB %Rank	QC %Rank
Claims Processing	55th	51st
Customer Service	30th	22nd
Getting Needed Care	32nd	32nd

DIFFERENT WAYS TO LOOK AT THE DATA

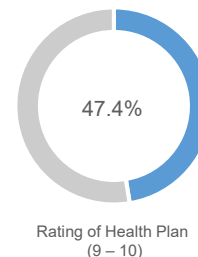
Standard Summary Rate Scoring combines the top 3 responses (8+9+10).

Some health plans prefer to compare to a higher standard of performance and track the top 2 responses (9+10).



Your plan scored in the **70th** percentile when compared to the QC All Plans benchmark.

Compared to last year, your score **increased** by 0.6. This result is not statistically significant.



Your plan scored in the **71st** percentile when compared to the QC All Plans benchmark.

Compared to last year, your score **decreased** by 2. This result is not statistically significant.

PLAN SPECIFIC CORRELATIONS

Correlations show the strength of the linear relationship between the individual attributes and the rating questions for your plan.

These five questions had the **strongest correlation** with your Rating of Health Plan.

Question	Coefficient	2019 SRS	QC AP Rank
Rating of Health Care	0.682	79.1%	56th
33 Able to find out from health plan cost of prescription medicines	0.610	68.6%	90th
41 Claims handled correctly	0.601	89.2%	33rd
36 Treated with courtesy and respect by customer service staff	0.580	91.7%	11th
Providing Needed Information	0.532	60.2%	18th

Demographic Comparisons

Different demographic subgroups can have dissimilar experiences with your health plan.



Gender

	8 - 10	9 - 10
MEN	67.0%	44.7%
WOMEN	72.5%	48.6%



Age

	8 - 10	9 - 10
18 - 34	58.1%	38.7%
35 - 44	61.9%	33.3%
45 - 54	68.2%	36.5%
55 or older	76.6%	56.8%



Education

	8 - 10	9 - 10
HS GRAD OR LESS	83.6%	57.5%
SOME COLLEGE OR MORE	67.6%	44.6%



Health Status

	8 - 10	9 - 10
EXCELLENT/VERY GOOD	72.9%	53.2%
GOOD	66.1%	38.6%
FAIR/POOR	79.4%	50.0%



Mental/Emotional Health Status

	8 - 10	9 - 10
EXCELLENT/VERY GOOD	72.4%	52.3%
GOOD	67.4%	37.1%
FAIR/POOR	72.2%	33.3%



Data Collection

	8 - 10	9 - 10
MAIL	73.5%	49.5%
PHONE	53.5%	32.6%
INTERNET	NA	NA



Ethnicity & Race

	8 - 10	9 - 10
HISPANIC/LATINO	64.0%	44.0%
NOT HISPANIC/LATINO	72.1%	47.6%

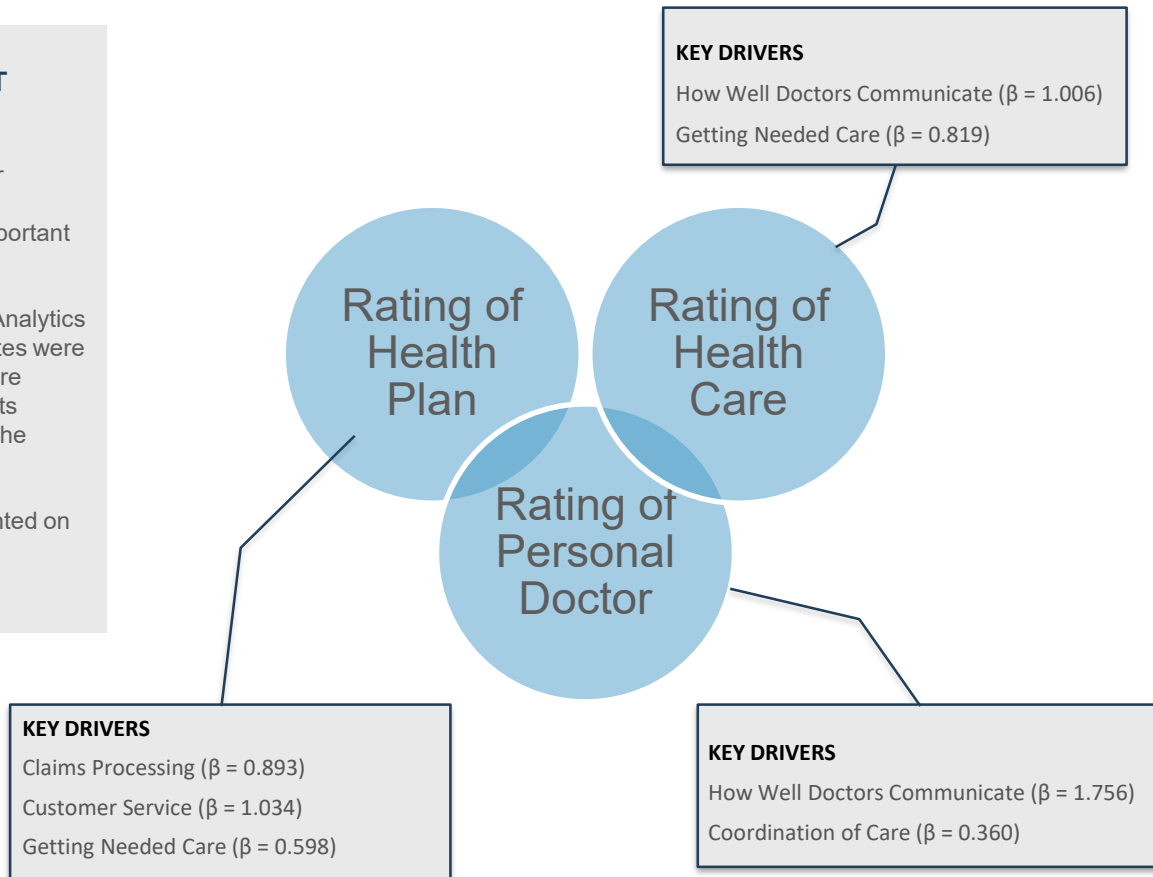
	8 - 10	9 - 10
WHITE	70.9%	46.8%
BLACK/AFRICAN AMERICAN	77.4%	58.1%
OTHER	51.9%	29.6%

KEY DRIVERS: WHERE TO FOCUS IMPROVEMENT EFFORTS

Members set standards for performance whether consciously or subconsciously. Standards are usually set higher for those plan services that are deemed important to each member. These important services are the Key Drivers of Experience.

Multiple linear regression analyses were run on the 2019 SPH Analytics Commercial Adult Book of Business to discover which composites were Key Drivers of Rating of Health Plan (Q42), Rating of Health Care (Q13), and Rating of Personal Doctor (Q23). Improvement efforts focused on these measures can also result in improvement on the global rating questions.

Your **Opportunity Analysis** based on this information is presented on the next page.



This Opportunity Analysis displays both high performing measures and measures that are opportunities for improvement.

STRENGTH – Summary Rates **at or above the 75th percentile** when compared to the 2019 SPH Analytics Book of Business.

MONITOR – Summary Rates **at or above the 50th percentile and below the 75th percentile** when compared to the 2019 SPH Analytics Book of Business should be monitored, as they do have a significant impact on members' overall ratings.

OPPORTUNITY – Summary Rates that fall **below the 50th percentile** when compared to the 2019 SPH Analytics Book of Business should be investigated and improved upon.



Rating of Health Plan

These Composites have been identified by SPH as Key Drivers of Rating of Health Plan.

Claims Processing

Monitor

Customer Service

Opportunity

Getting Needed Care

Opportunity

Rating of Health Care

These Composites have been identified by SPH as Key Drivers of Rating of Health Care.

How Well Doctors Communicate

Monitor

Getting Needed Care

Opportunity

Rating of Personal Doctor

These Composites have been identified by SPH as Key Drivers of Rating of Personal Doctor.

How Well Doctors Communicate

Monitor

Coordination of Care

Opportunity

VALID SURVEYS

	Total Number of Phone Completes =	47
	Total Number of Mail Completes =	313
	Total Number of Internet Completes =	NA

2019 RESPONSE RATE

Ineligible members are subtracted from the sample size when computing a **response rate** as shown below.

$$\frac{\text{Completed Surveys}}{\text{Sample Size - Ineligible Members}} = \text{Response Rate}$$

Using the final figures from the survey, the numerator and denominator used to compute your **response rate** are presented below.

$$\frac{313 \text{ (Mail)} + 47 \text{ (Phone)}}{1595 \text{ (Sample)} - 15 \text{ (Ineligibles)}} = 22.8\%$$

RESPONSE RATE COMPARISONS

Your plan's response rate in 2018 was **25.2%**.

The SPH Analytics 2019 Book of Business average response rate is **22.7%**.

Ineligible	Does not Meet Eligibility Criteria (01)	12
	Language Barrier (03)	1
	Mentally/Physically Incapacitated (04)	1
	Deceased (05)	1
	SUBTOTAL	15
Non-Response	Break-off/Incomplete (02)	23
	Refusal (06)	19
	Maximum Attempts Made (07)	1169
	Added to DNC List (08)	9
	SUBTOTAL	1220
TOTAL		1235



Profile of Survey Respondents

Demographic Composition

- Florida Health Care Plan, Inc.
- 1134918



Demographic Profile The demographic characteristics of respondents surveyed should be representative of your member population. SPH Analytics follows NCQA protocol to help achieve a representative sample of your plan's member population.

The percentages of respondents are displayed by demographic category (Health Status, Mental/Emotional Health Status, Age, Gender, Education, Ethnicity, and Race) from your current survey, compared to trend data (if applicable), the 2019 Non-PPO SPH Analytics Commercial Adult Book of Business benchmark, and the 2019 Non-PPO Commercial Adult Public Report benchmark.

The demographic makeup of your plan's member base may not mirror the "average" plan; therefore, caution is recommended when making comparisons to benchmark data. To help you identify how your plan's population compares to other plans and to previous data, statistically significant differences are highlighted with green or red text. Refer to the Technical Notes for more information on this topic.

Significance Testing

Green – Current year score significantly higher when compared to trend or benchmark score.

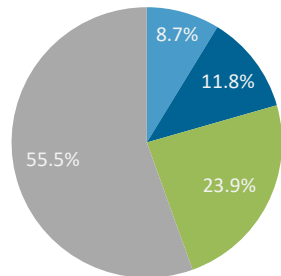
Red – Current year score significantly lower when compared to trend or benchmark score.

No color denotes that there was no significant difference between the percentages or that there was insufficient sample size to conduct the statistical test. All significance testing is performed at the 95% significance level.

Survey Demographics

The demographic characteristics of respondents surveyed should be representative of your member population. SPH Analytics follows NCQA protocol to help achieve a representative sample of your plan's member population.

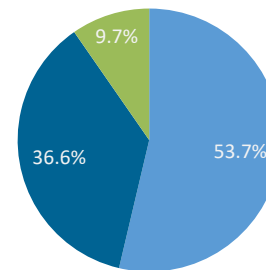
Age



■ 18 - 34 ■ 35 - 44 ■ 45 - 54 ■ 55 or older

	18 - 34	35 - 44	45 - 54	55 or older
2019	8.7%	11.8%	23.9%	55.5%
2018	9.6%	15.3%	23.3%	51.8%
2017	9.1%	13.8%	25.8%	51.3%
SPH	14.3%	13.8%	19.3%	52.6%
NCQA	13.6%	13.5%	20.1%	52.7%

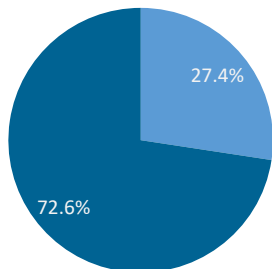
Health Status



■ Excellent/ Very Good ■ Good ■ Fair/Poor

	Excellent/ Very Good	Good	Fair/Poor
2019	53.7%	36.6%	9.7%
2018	60.5%	29.5%	10.1%
2017	60.6%	31.9%	7.5%
SPH	55.7%	34.7%	9.6%
NCQA	56.2%	34.6%	9.2%

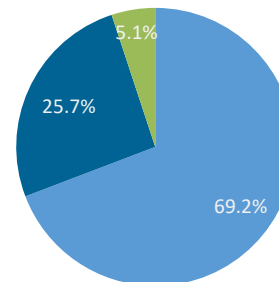
Gender



■ Male ■ Female

	Male	Female
2019	27.4%	72.6%
2018	32.0%	68.0%
2017	33.3%	66.7%
SPH	41.3%	58.7%
NCQA	41.3%	58.7%

Mental/Emotional Health Status



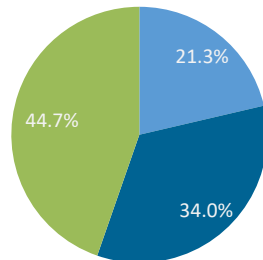
■ Excellent/ Very Good ■ Good ■ Fair/Poor

	Excellent/ Very Good	Good	Fair/Poor
2019	69.2%	25.7%	5.1%
2018	71.7%	22.3%	6.0%
2017	75.9%	18.2%	6.0%
SPH	68.1%	24.7%	7.2%
NCQA	69.5%	23.7%	6.8%

Survey Demographics

The demographic characteristics of respondents surveyed should be representative of your member population. SPH Analytics follows NCQA protocol to help achieve a representative sample of your plan's member population.

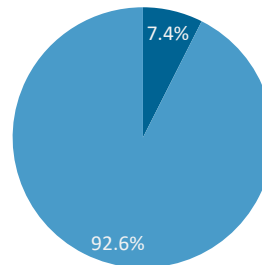
Education



■ HS Graduate or Less ■ Some College ■ College Graduate or More

	HS Graduate or Less	Some College	College Graduate or More
2019	21.3%	34.0%	44.7%
2018	22.0%	31.5%	46.5%
2017	23.2%	37.1%	39.7%
SPH	28.5%	30.5%	41.0%
NCQA	25.5%	31.8%	42.7%

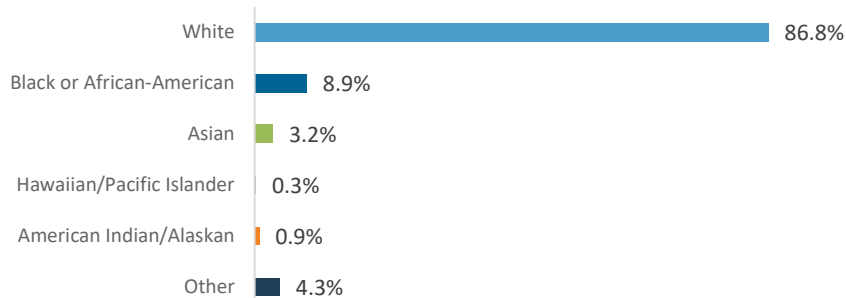
Ethnicity



■ Hispanic/Latino ■ Not Hispanic/Latino

	Hispanic/Latino	Not Hispanic/Latino
2019	7.4%	92.6%
2018	5.0%	95.0%
2017	6.4%	93.6%
SPH	9.9%	90.1%
NCQA	10.1%	89.9%

Race



	White	Black or African-American	Asian	Hawaiian/Pacific Islander	American Indian/Alaskan	Other
2019	86.8%	8.9%	3.2%	0.3%	0.9%	4.3%
2018	84.3%	11.5%	1.8%	0.3%	1.6%	5.0%
2017	87.2%	9.3%	1.6%	0.6%	1.9%	5.1%
SPH	76.2%	9.5%	9.4%	2.3%	1.7%	7.5%
NCQA	75.6%	9.8%	6.0%	1.1%	1.7%	6.1%



Summary of Trend and Benchmarks

Summary Rate Scores

Percentile Rankings

- Florida Health Care Plan, Inc.
- 1134918



Trend and Benchmark Comparisons The CAHPS® 5.0H survey is designed to use composite scores to facilitate the aggregation of information and the communication of results. Questions are combined into composite categories comprising a particular service area managed by your plan. These composites, the questions that make up composites (attributes), additional measures, and rating questions are shown on the following pages.

Summary Rate Scores: Shows how your plan's composite and key question Summary Rates compare to scores from the previous years' results (if applicable) and scores from the 2019 Non-PPO SPH Analytics Commercial Adult Book of Business, 2019 Non-PPO Commercial Adult Public Report, and the 2019 Non-PPO Commercial Adult Quality Compass® All Plans benchmarks. To help you identify how your plan's population compares to other plans and to previous data, statistically significant differences are highlighted.

Plan Percentile Rankings: Shows your plan's Summary Rates and percentile rankings in relation to the three benchmarks. Benchmark percentile scores (25th, 50th, 75th, and 90th) are available in the Technical Notes.

Significance Testing

Green – Current year score significantly higher when compared to trend or benchmark score.

Red – Current year score significantly lower when compared to trend or benchmark score.

No color denotes that there was no significant difference between the percentages or that there was insufficient sample size to conduct the statistical test. All significance testing is performed at the 95% significance level.

Available Benchmarks

The following benchmarks are used throughout the report.

	2019 NCQA Public Report	2019 Quality Compass® All Plans	2019 NCQA 1-100 Benchmark	2019 SPH Analytics Book of Business
	Derived from NCQA's Quality Compass® benchmark and is calculated by SPH Analytics. The benchmark is a collection of commercial, Non-PPO, adult samples that submitted data to NCQA in 2019 and allowed their data to be publicly reported.	Includes all commercial Non-PPO adult samples that submitted data to NCQA in 2019.	A percentile benchmark (with values ranging from the first through the one hundredth percentile) calculated by NCQA and derived from commercial Non-PPO adult data collected by NCQA in 2019.	Includes all commercial Non-PPO samples that contracted with SPH Analytics to administer the 2019 CAHPS 5.0H survey and submitted data to NCQA.
PROS	- Provides the most up-to-date benchmark reflecting the 2018 survey results - Provides a benchmark for each question from the survey - Permits precise percentile ranking of plan compared to benchmark	- Contains more plans than Public Report - Is presented in NCQA's The State of Health Care Quality	Utilized by SPH Analytics to calculate approximate percentile ranking of plan scores in relation to the Quality Compass® All Plans benchmark	- Provides a benchmark for each question from the survey - Permits precise percentile ranking of plan compared to benchmark - Historically, the SPH BoB has varied by less than 1% from the Public Report benchmark.
CONS	Contains fewer plans than All Plans benchmark	Only contains benchmarks for certain key questions, composites, and rating questions	Only contains benchmarks for certain key questions, composites, and rating questions	Contains fewer plans than the Public Report and the Quality Compass® All Plans Benchmarks
# OF PLANS	176	186	186	50



Summary Rate Scores

Florida Health Care Plan, Inc.

Please see Technical Notes for more information.

COMPOSITES, ATTRIBUTES, AND KEY QUESTIONS

	Valid n	2019	2018	2017	2019 SPH Book of Business Non-PPO	2019 Public Report Non-PPO	2019 Quality Compass® All Plans, Non-PPO
Getting Needed Care		84.6%	87.4%	89.0%	84.7%	85.7%	85.4%
14 Getting care, tests, or treatments necessary	302	87.4%	89.2%	91.8%	87.4%	88.7%	88.5%
25 Obtained appointment with specialist as soon as needed	235	81.7%	85.7%	86.2%	82.1%	82.8%	82.8%
Getting Care Quickly		83.7%	89.9%	88.2%	83.5%	84.5%	84.4%
4 Obtaining needed care right away	153	85.0%	92.3%	89.4%	85.9%	87.6%	87.6%
6 Obtained appointment for care as soon as needed	290	82.4%	87.5%	87.0%	81.2%	82.1%	82.0%
How Well Doctors Communicate		95.9%	95.0%	95.5%	94.8%	95.2%	95.1%
17 Doctors explained things in an understandable way	284	97.5%	96.6%	96.4%	95.4%	96.3%	96.1%
18 Doctors listened carefully to you	284	95.1%	94.8%	94.8%	94.6%	94.9%	94.8%
19 Doctors showed respect for what you had to say	285	95.4%	95.7%	96.4%	96.2%	96.2%	96.2%
20 Doctors spent enough time with you	284	95.4%	92.9%	94.4%	93.2%	93.5%	93.3%
Health Plan Customer Service		86.1%	90.2%	91.5%	88.2%	88.9%	89.1%
35 Getting information/help from customer service	108	80.6%	86.2%	87.0%	81.4%	82.7%	83.0%
36 Treated with courtesy and respect by customer service staff	109	91.7%	94.3%	96.0%	94.9%	95.1%	95.2%
Claims Processing		89.3%	90.9%	87.4%	87.0%	88.7%	88.7%
40 Claims handled quickly	76	89.5%	88.9%	86.4%	85.6%	87.1%	87.2%
41 Claims handled correctly	83	89.2%	92.9%	88.3%	88.3%	90.3%	90.4%



Summary Rate Scores

Florida Health Care Plan, Inc.

Please see Technical Notes for more information.

COMPOSITES, ATTRIBUTES, AND KEY QUESTIONS (continued)

	Valid n	2019	2018	2017	2019 SPH Book of Business Non-PPO	2019 Public Report Non-PPO	2019 Quality Compass® All Plans, Non-PPO
Shared Decision Making		79.6%	81.8%	86.5%	81.3%	81.7%	81.7%
10 Doctor/health care provider talked about reasons you might want to take a medicine	153	94.1%	92.6%	95.3%	93.8%	94.5%	94.5%
11 Doctor/health care provider talked about reasons you might not want to take a medicine	153	69.9%	75.5%	79.5%	71.9%	73.2%	73.1%
12 Doctor/health care provider asked you what you thought was best when talking about starting or stopping a prescription	150	74.7%	77.2%	84.7%	78.3%	77.5%	77.6%
Plan Information on Costs		68.1%	73.7%	69.9%	59.5%	61.3%	61.5%
31 Able to find out from health plan cost of health care service or equipment	108	67.6%	73.1%	70.7%	59.1%	61.0%	61.2%
33 Able to find out from health plan cost of prescription medicines	169	68.6%	74.4%	69.1%	59.6%	62.4%	62.4%
Other Measures							
8 Health Promotion and Education	301	77.1%	78.0%	83.3%	73.8%	75.6%	75.6%
22 Coordination of Care	198	84.8%	85.4%	81.3%	83.9%	83.8%	83.8%
29 Providing Needed Information	118	60.2%	75.4%	77.5%	64.3%	65.9%	66.2%
38 Ease of Filling Out Forms	346	96.5%	95.0%	93.6%	95.7%	96.1%	96.0%

RATING ITEMS

	Valid n	2019	2018	2017	2019 SPH Book of Business Non-PPO	2019 Public Report Non-PPO	2019 Quality Compass® All Plans, Non-PPO
Rating Questions (8+9+10)							
13 Rating of Health Care	302	79.1%	80.7%	81.9%	77.2%	78.1%	78.1%
23 Rating of Personal Doctor	320	87.8%	85.8%	85.4%	84.9%	85.2%	85.3%
27 Rating of Specialist	232	84.1%	84.9%	80.7%	83.3%	84.1%	84.2%
42 Rating of Health Plan	352	71.0%	70.4%	74.3%	65.2%	65.0%	65.0%
Rating Questions (9+10)							
13 Rating of Health Care	302	55.0%	57.1%	59.2%	52.8%	52.8%	52.9%
23 Rating of Personal Doctor	320	73.8%	72.8%	71.5%	67.8%	68.2%	68.2%
27 Rating of Specialist	232	65.9%	64.3%	64.7%	66.0%	67.0%	67.0%
42 Rating of Health Plan	352	47.4%	49.5%	53.3%	43.2%	42.2%	42.4%

EFFECTIVENESS OF CARE MEASURES

	Valid n	2019	2018	2017	2019 SPH Book of Business Non-PPO	2019 Public Report Non-PPO	2019 Quality Compass® All Plans, Non-PPO
Effectiveness of Care Measures							
Flu Vaccinations (Adults 18-64)	336	47.6%	43.3%	36.0%	52.9%	NA	52.7%
Advising Smokers and Tobacco Users to Quit	72	80.6%	85.9%	86.4%	75.8%	74.5%	77.8%
Discussing Cessation Medications	73	57.5%	62.3%	58.8%	51.6%	49.9%	55.5%
Discussing Cessation Strategies	72	52.8%	55.8%	55.6%	44.9%	46.1%	48.9%

COMPOSITES, ATTRIBUTES, AND KEY QUESTIONS

	Plan Summary Rate	2019 SPH Book of Business Non-PPO	2019 Public Report Non-PPO	2019 Quality Compass® All Plans, Non-PPO
Getting Needed Care	84.6%	32nd	31st	32nd
14 Getting care, tests, or treatments necessary	87.4%	36th	35th	35th
25 Obtained appointment with specialist as soon as needed	81.7%	28th	33rd	32nd
Getting Care Quickly	83.7%	32nd	35th	36th
4 Obtaining needed care right away	85.0%	26th	21st	21st
6 Obtained appointment for care as soon as needed	82.4%	40th	45th	45th
How Well Doctors Communicate	95.9%	59th	59th	60th
17 Doctors explained things in an understandable way	97.5%	75th	71st	72nd
18 Doctors listened carefully to you	95.1%	51st	49th	50th
19 Doctors showed respect for what you had to say	95.4%	28th	30th	30th
20 Doctors spent enough time with you	95.4%	81st	81st	82nd
Health Plan Customer Service	86.1%	30th	21st	22nd
35 Getting information/help from customer service	80.6%	38th	33rd	32nd
36 Treated with courtesy and respect by customer service staff	91.7%	16th	12th	11th
Claims Processing	89.3%	55th	50th	51st
40 Claims handled quickly	89.5%	65th	68th	68th
41 Claims handled correctly	89.2%	36th	33rd	33rd

COMPOSITES, ATTRIBUTES, AND KEY QUESTIONS (continued)

	Plan Summary Rate	2019 SPH Book of Business Non-PPO	2019 Public Report Non-PPO	2019 Quality Compass® All Plans, Non-PPO
Shared Decision Making	79.6%	24th	22nd	23rd
10 Doctor/health care provider talked about reasons you might want to take a medicine	94.1%	36th	34th	34th
11 Doctor/health care provider talked about reasons you might not want to take a medicine	69.9%	32nd	24th	24th
12 Doctor/health care provider asked you what you thought was best when talking about starting or stopping a prescription	74.7%	20th	27th	27th
Plan Information on Costs	68.1%	91st	<10th	90th
31 Able to find out from health plan cost of health care service or equipment	67.6%	87th	<10th	86th
33 Able to find out from health plan cost of prescription medicines	68.6%	87th	<10th	90th
Other Measures				
Health Promotion and Education	77.1%	63rd	60th	59th
Coordination of Care	84.8%	48th	58th	58th
Providing Needed Information	60.2%	24th	18th	18th
Ease of Filling Out Forms	96.5%	65th	66th	66th

RATING ITEMS

	Plan Summary Rate	2019 SPH Book of Business Non-PPO	2019 Public Report Non-PPO	2019 Quality Compass® All Plans, Non-PPO
Rating Questions (8+9+10)				
13 Rating of Health Care	79.1%	63rd	55th	56th
23 Rating of Personal Doctor	87.8%	79th	76th	76th
27 Rating of Specialist	84.1%	48th	46th	46th
42 Rating of Health Plan	71.0%	73rd	70th	70th
Rating Questions (9+10)				
13 Rating of Health Care	55.0%	63rd	61st	61st
23 Rating of Personal Doctor	73.8%	83rd	82nd	83rd
27 Rating of Specialist	65.9%	44th	38th	39th
42 Rating of Health Plan	47.4%	73rd	72nd	71st

EFFECTIVENESS OF CARE MEASURES

	Plan Summary Rate	2019 SPH Book of Business Non-PPO	2019 Public Report Non-PPO	2019 Quality Compass® All Plans, Non-PPO
Effectiveness of Care Measures				
Flu Vaccinations (Adults 18-64)	47.6%	28th	NA	28th
Advising Smokers and Tobacco Users to Quit	80.6%	59th	<10th	87th
Discussing Cessation Medications	57.5%	61st	<10th	75th
Discussing Cessation Strategies	52.8%	73rd	<10th	76th



Global Proportions and Accreditation

Three Point Scores and Accreditation Scoring

- Florida Health Care Plan, Inc.
- 1134918

ACCREDITATION FOR 2019 SCORING

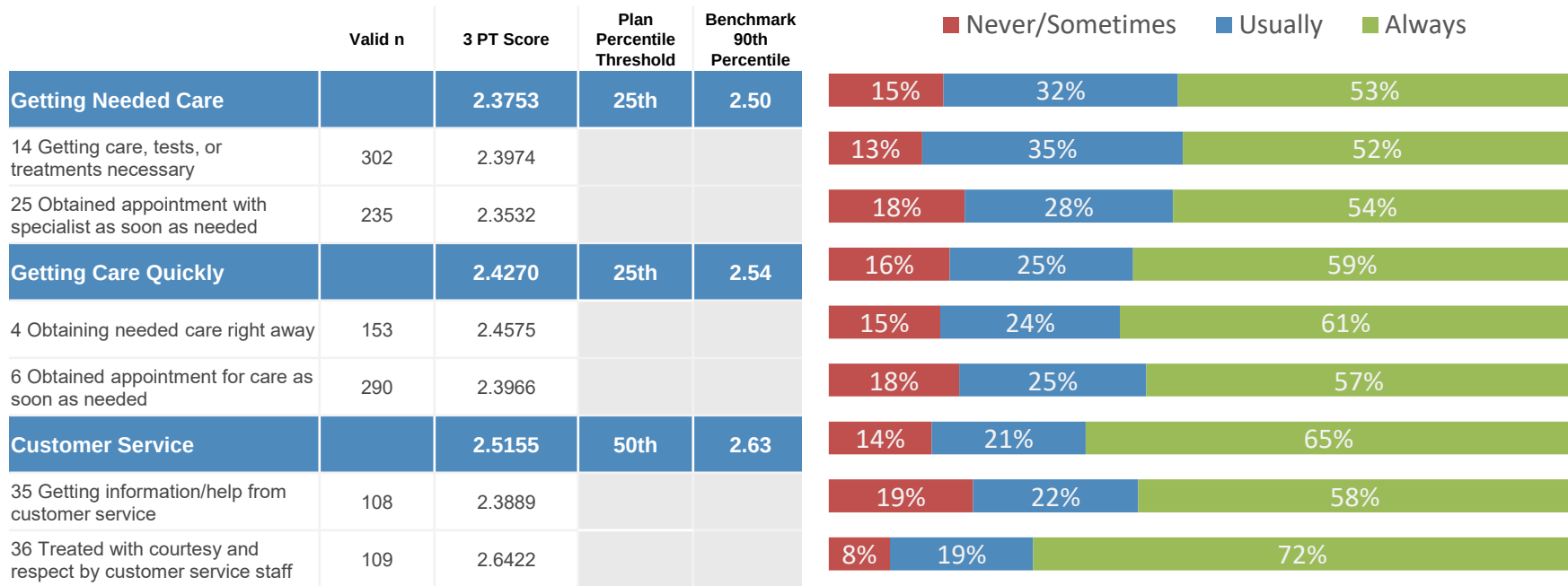
NCQA requires health plans seeking accreditation to submit specified HEDIS measures and HEDIS/CAHPS 5.0H survey results. NCQA determines the CAHPS 5.0H portion of the score by comparing the plan's results to a national benchmark (the 90th percentile) and to national thresholds (the 75th, 50th, and 25th percentiles). The HEDIS measure portion of the score is ascertained by comparing the plan's results to a national benchmark (the 90th percentile) and to regional and national thresholds (the 75th, 50th, and 25th percentiles).

MEASURE NAME	2019 HEDIS/CAHPS PERCENTILES				Plan 3-Point Score	Approximate Plan Percentile Threshold	Approximate Points Awarded
	25 TH	50 TH	75 TH	90 TH			2019
Getting Needed Care	2.36	2.41	2.45	2.50	2.3753	25th	0.5778
Getting Care Quickly	2.39	2.44	2.49	2.54	2.4270	25th	0.5778
Customer Service	2.44	2.51	2.57	2.63	2.5155	50th	0.9822
Claims Processing	2.36	2.43	2.49	2.55	NA	NA	-
Coordination of Care	2.27	2.33	2.39	2.45	2.3990	75th	1.2711
Rating of Health Care	2.33	2.39	2.45	2.51	2.4437	50th	0.9822
Rating of Personal Doctor	2.47	2.52	2.57	2.61	2.6656	90th	1.4444
Rating of Specialist	2.49	2.53	2.58	2.64	2.5603	50th	0.9822
Rating of Health Plan	2.02	2.13	2.27	2.41	2.2926	75th	2.5422
Approximate Points Earned (13.000 available)							9.3599

Note: If a plan receives an NA (indicating the denominator was less than 100) the points for that measure are redistributed among the remaining required measures. An organization that has more than four CAHPS® NAs, or which exceed ten NA or NB results between HEDIS and CAHPS® for each product line, are scored based on the standards score only and the accreditation status is capped at Commendable.

GLOBAL PROPORTIONS SCORING AND ACCREDITATION

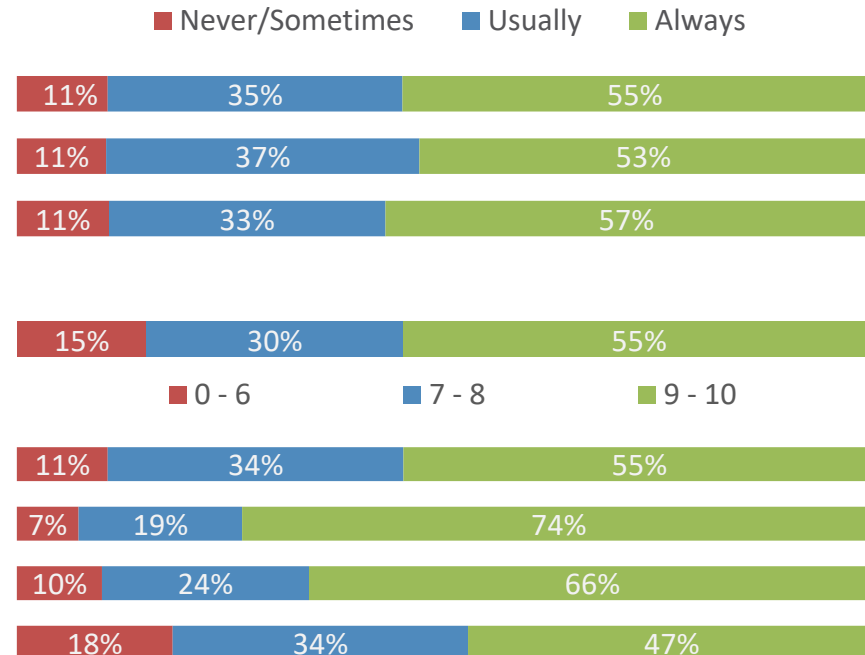
The graphical presentation and Three-Point Score for composites and rating questions are shown on these pages. In addition, the measure's percentile threshold when compared to the accreditation benchmark and the 90th percentile benchmark is shown. The 90th percentile is the standard for achieving the maximum points possible for a particular CAHPS accreditation measure. Please see Technical Notes for more information on Three-Point Scores.



GLOBAL PROPORTIONS SCORING AND ACCREDITATION

The graphical presentation and Three-Point Score for composites and rating questions are shown on these pages. In addition, the measure's percentile threshold when compared to the accreditation benchmark and the 90th percentile benchmark is shown. The 90th percentile is the standard for achieving the maximum points possible for a particular CAHPS accreditation measure. Please see Technical Notes for more information on Three-Point Scores.

	Valid n	3 PT Score	Plan Percentile Threshold	Benchmark 90th Percentile
Claims Processing		2.4394	50th	2.55
40 Claims handled quickly	76	2.4211		
41 Claims handled correctly	83	2.4578		
Other Measures				
Coordination of Care	198	2.3990	75th	2.45
Rating Questions				
Rating of Health Care	302	2.4437	50th	2.51
Rating of Personal Doctor	320	2.6656	90th	2.61
Rating of Specialist	232	2.5603	50th	2.64
Rating of Health Plan	352	2.2926	75th	2.41





Composite Analyses

Composite Details and Scoring

- Florida Health Care Plan, Inc.
- 1134918

Drilling Down Into Composites and Ratings

This section is designed to give plans a detailed report on the performance of each composite and rating measure used in accreditation.

The Composite Analysis typically consists of two pages. The first page displays composite level details and the second displays results for the attributes contained within the composite. It is critical to look at these attribute questions to determine if there is a particular aspect of care that is driving your composite score.

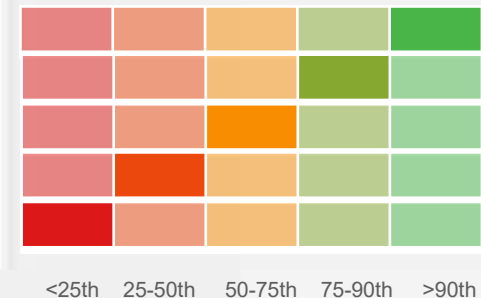


Analyses included in this section include: Plan Summary Rate Scores with comparisons to trending (if available), benchmarks, percentile rankings, accreditation scoring, and correlations.

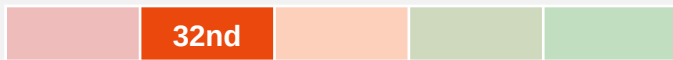
Measures Included in Composite Analyses

- Getting Needed Care
- Getting Care Quickly
- Customer Service
- Claims Processing
- Coordination of Care
- Rating of Health Care
- Rating of Personal Doctor
- Rating of Specialist
- Rating of Health Plan

Percentile Rankings



PERCENTILE RANKING 2019 QC ALL PLANS

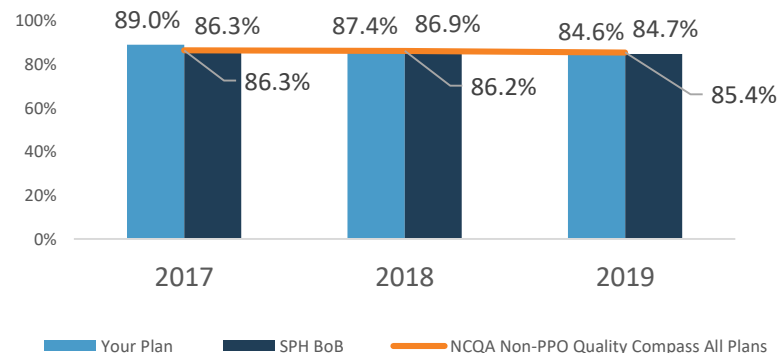


NATIONAL TRENDS

The Non-PPO Quality Compass score for Getting Needed Care decreased by 0.7% from 2018 to 2019.

The Non-PPO SPH Book of Business decreased by 2.1% since 2018.

GETTING NEEDED CARE – TRENDING AND BENCHMARKS



COMPARISON TO TRENDING

	Summary Rate	Change*	Sig Test
2018	87.4%	-2.9	↔
2017	89.0%	-4.5	↔

COMPARISON TO BENCHMARKS

	Summary Rate	Gap*	Sig Test
2019 SPH Non-PPO BoB	84.7%	-0.2	↔
2019 QC All Plans	85.4%	-0.9	↔

ACCREDITATION SCORING

	2019	2018	2017
3 Pt Score	2.3753	2.4412	2.4450
Plan Percentile Threshold	25th	50th	50th

* Please note that the "change" or "gap" comparison may vary slightly due to rounding.

GETTING NEEDED CARE QUESTIONS

The Getting Needed Care composite score is calculated by taking the average of two questions:

- Q14. In the last 12 months, how often was it easy to get the care, tests, or treatment you needed?
- Q25. In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed?

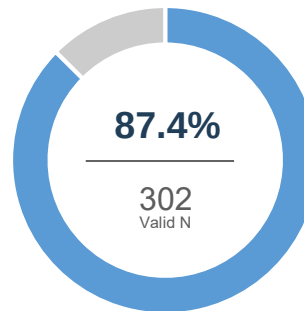
2019 GNC COMPOSITE SUMMARY RATE SCORE

84.6%

CORRELATION WITH RATING QUESTIONS

	With Health Plan	With Health Care	With Personal Doctor
Q14	0.412	0.570	0.340
Q25	0.331	0.403	0.183

Q14. GETTING CARE, TESTS, OR TREATMENTS NEEDED

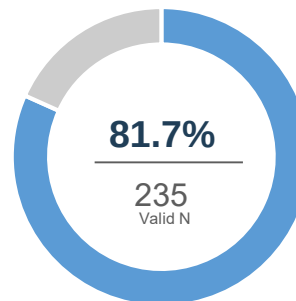


2019	87.4%
2018	89.2%
2017	91.8%
SPH	87.4%
NCQA	88.5%

Percentile Ranking 2019 QC All Plans



Q25. EASE OF GETTING APPOINTMENT WITH A SPECIALIST

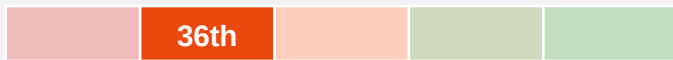


2019	81.7%
2018	85.7%
2017	86.2%
SPH	82.1%
NCQA	82.8%

Percentile Ranking 2019 QC All Plans



PERCENTILE RANKING 2019 QC ALL PLANS

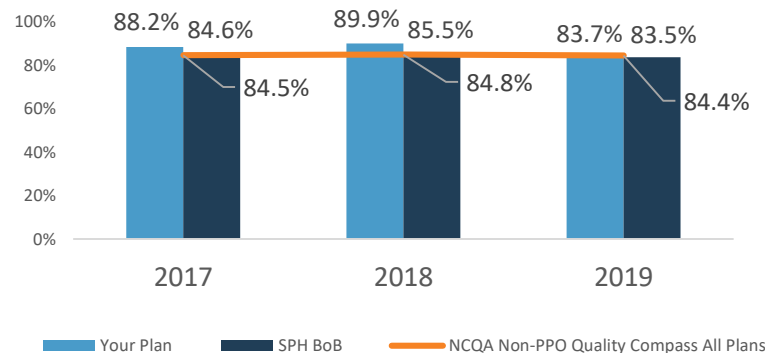


NATIONAL TRENDS

The Non-PPO Quality Compass score for Getting Care Quickly decreased by 0.4% from 2018 to 2019.

The Non-PPO SPH Book of Business decreased by 2.0% since 2018.

GETTING CARE QUICKLY – TRENDING AND BENCHMARKS



COMPARISON TO TRENDING

	Summary Rate	Change*	Sig Test
2018	89.9%	-6.2	↓
2017	88.2%	-4.5	↔

COMPARISON TO BENCHMARKS

	Summary Rate	Gap*	Sig Test
2019 SPH Non-PPO BoB	83.5%	0.2	↔
2019 QC All Plans	84.4%	-0.7	↔

ACCREDITATION SCORING

	2019	2018	2017
3 Pt Score	2.4270	2.5660	2.4838
Plan Percentile Threshold	25th	90th	50th

* Please note that the "change" or "gap" comparison may vary slightly due to rounding.

GETTING CARE QUICKLY QUESTIONS

The Getting Care Quickly composite score is calculated by taking the average of two questions:

- Q4. In the last 12 months, when you needed care right away, how often did you get care as soon as you needed?
- Q6. In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

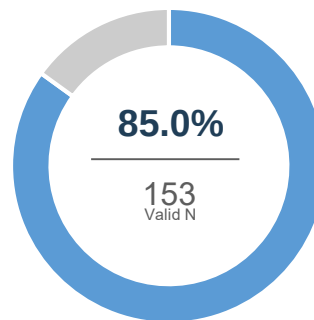
2019 GCQ COMPOSITE SUMMARY RATE SCORE

83.7%

CORRELATION WITH RATING QUESTIONS

	With Health Plan	With Health Care	With Personal Doctor
Q4	0.446	0.497	0.285
Q6	0.290	0.354	0.186

Q4. OBTAINED NEEDED CARE RIGHT AWAY



2019 85.0%

2018 92.3%

2017 89.4%

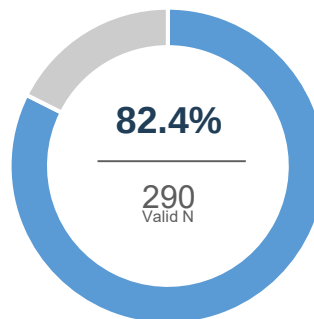
SPH 85.9%

NCQA 87.6%

Percentile Ranking 2019 QC All Plans



Q6. OBTAINED APPOINTMENT FOR CARE AS SOON AS NEEDED



2019 82.4%

2018 87.5%

2017 87.0%

SPH 81.2%

NCQA 82.0%

Percentile Ranking 2019 QC All Plans



PERCENTILE RANKING 2019 QC ALL PLANS

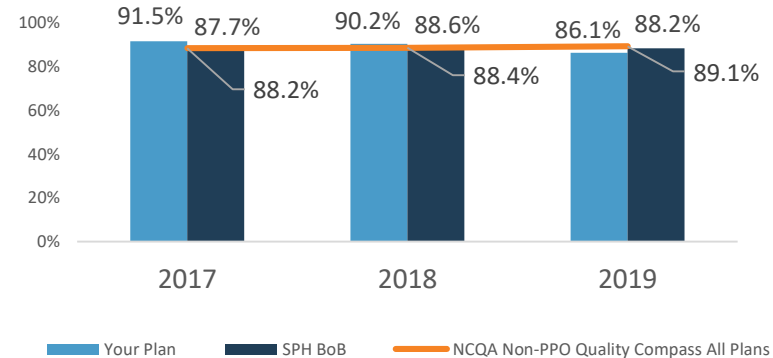
22nd

NATIONAL TRENDS

The Non-PPO Quality Compass score for Customer Service increased by 0.7% from 2018 to 2019.

The Non-PPO SPH Book of Business increased by 1.4% since 2018.

CUSTOMER SERVICE – TRENDING AND BENCHMARKS



COMPARISON TO TRENDING

	Summary Rate	Change*	Sig Test
2018	90.2%	-4.1	↔
2017	91.5%	-5.4	↔

COMPARISON TO BENCHMARKS

	Summary Rate	Gap*	Sig Test
2019 SPH Non-PPO BoB	88.2%	-2.0	↔
2019 QC All Plans	89.1%	-3.0	↔

ACCREDITATION SCORING

	2019	2018	2017
3 Pt Score	2.5155	2.5638	2.5950
Plan Percentile Threshold	50th	50th	75th

* Please note that the "change" or "gap" comparison may vary slightly due to rounding.

CUSTOMER SERVICE QUESTIONS

The Customer Service composite score is calculated by taking the average of two questions:

- Q35. In the last 12 months, how often did your health plan's customer service give you the information or help you needed?
- Q36. In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect?

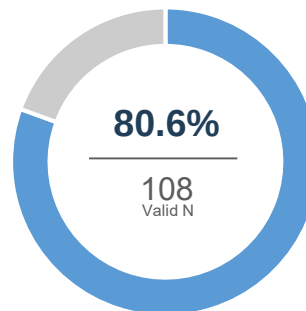
2019 CS COMPOSITE SUMMARY RATE SCORE

86.1%

CORRELATION WITH RATING QUESTIONS

	With Health Plan	With Health Care	With Personal Doctor
Q35	0.492	0.489	0.326
Q36	0.580	0.502	0.560

Q35. GETTING INFORMATION/HELP FROM CUSTOMER SERVICE



2019 80.6%

2018 86.2%

2017 87.0%

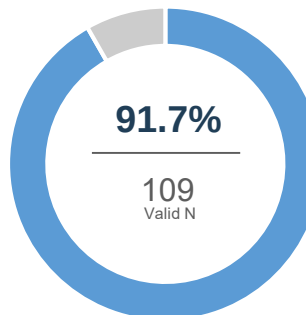
SPH 81.4%

NCQA 83.0%

Percentile Ranking 2019 QC All Plans



Q36. TREATED WITH COURTESY AND RESPECT BY CUSTOMER SERVICE STAFF



2019 91.7%

2018 94.3%

2017 96.0%

SPH 94.9%

NCQA 95.2%

Percentile Ranking 2019 QC All Plans



PERCENTILE RANKING 2019 QC ALL PLANS

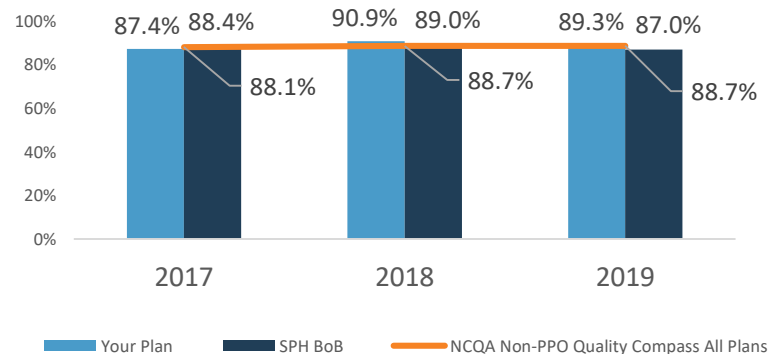


NATIONAL TRENDS

The Non-PPO Quality Compass score for Claims Processing saw no change between 2018 and 2019.

The Non-PPO SPH Book of Business decreased by 2.1% since 2018.

CLAIMS PROCESSING – TRENDING AND BENCHMARKS



COMPARISON TO TRENDING

	Summary Rate	Change*	Sig Test
2018	90.9%	-1.6	↔
2017	87.4%	1.9	↔

COMPARISON TO BENCHMARKS

	Summary Rate	Gap*	Sig Test
2019 SPH Non-PPO BoB	87.0%	2.3	↔
2019 QC All Plans	88.7%	0.6	↔

ACCREDITATION SCORING

	2019	2018	2017
3 Pt Score	2.4394	2.5730	2.4612
Plan Percentile Threshold	50th	90th	75th

* Please note that the "change" or "gap" comparison may vary slightly due to rounding.

CLAIMS PROCESSING QUESTIONS

The Claims Processing composite score is calculated by taking the average of two questions:

- Q40. In the last 12 months, how often did your health plan handle your claims quickly?
- Q41. In the last 12 months, how often did your health plan handle your claims correctly?

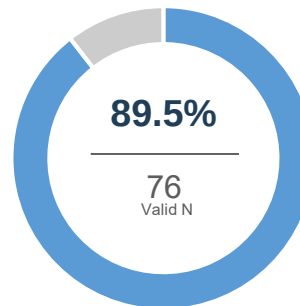
2019 CP COMPOSITE SUMMARY RATE SCORE

89.3%

CORRELATION WITH RATING QUESTIONS

	With Health Plan	With Health Care	With Personal Doctor
Q40	0.404	0.419	0.164
Q41	0.601	0.626	0.411

Q40. HANDLED CLAIMS QUICKLY



2019 89.5%

2018 88.9%

2017 86.4%

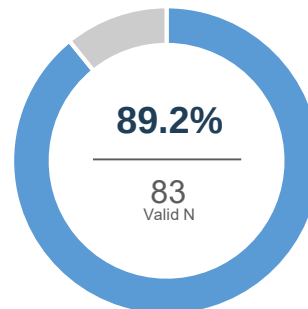
SPH 85.6%

NCQA 87.2%

Percentile Ranking 2019 QC All Plans



Q41. HANDLED CLAIMS CORRECTLY



2019 89.2%

2018 92.9%

2017 88.3%

SPH 88.3%

NCQA 90.4%

Percentile Ranking 2019 QC All Plans



PERCENTILE RANKING 2019 QC ALL PLANS

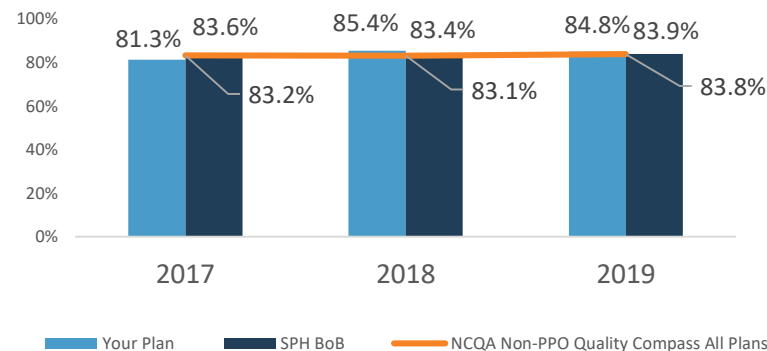


NATIONAL TRENDS

The Non-PPO Quality Compass score for Coordination of Care increased by 0.7% from 2018 to 2019.

The Non-PPO SPH Book of Business increased by 0.4% since 2018.

COORDINATION OF CARE – TRENDING AND BENCHMARKS



COMPARISON TO TRENDING

	Summary Rate	Change*	Sig Test
2018	85.4%	-0.6	↔
2017	81.3%	3.6	↔

COMPARISON TO BENCHMARKS

	Summary Rate	Gap*	Sig Test
2019 SPH Non-PPO BoB	83.9%	0.9	↔
2019 QC All Plans	83.8%	1.0	↔

ACCREDITATION SCORING

	2019	2018	2017
3 Pt Score	2.3990	2.4206	2.3226
Plan Percentile Threshold	75th	75th	25th

* Please note that the "change" or "gap" comparison may vary slightly due to rounding.

PERCENTILE RANKING 2019 QC ALL PLANS

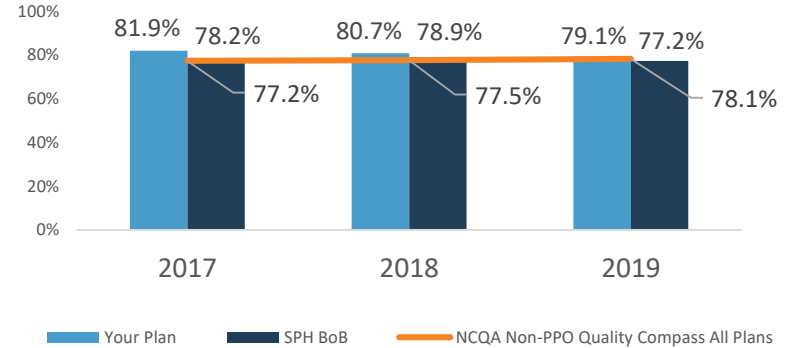


NATIONAL TRENDS

The Non-PPO Quality Compass score for Rating of Health Care increased by 0.6% from 2018 to 2019.

The Non-PPO SPH Book of Business decreased by 1.8% since 2018.

RATING OF HEALTH CARE – TRENDING AND BENCHMARKS



COMPARISON TO TRENDING

	Summary Rate	Change*	Sig Test
2018	80.7%	-1.6	↔
2017	81.9%	-2.8	↔

COMPARISON TO BENCHMARKS

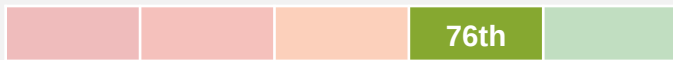
	Summary Rate	Gap*	Sig Test
2019 SPH Non-PPO BoB	77.2%	2.0	↔
2019 QC All Plans	78.1%	1.0	↔

ACCREDITATION SCORING

	2019	2018	2017
3 Pt Score	2.4437	2.4755	2.5177
Plan Percentile Threshold	50th	75th	90th

* Please note that the "change" or "gap" comparison may vary slightly due to rounding.

PERCENTILE RANKING 2019 QC ALL PLANS

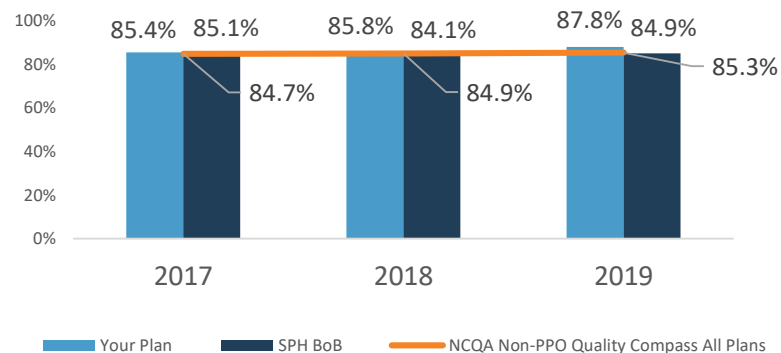


NATIONAL TRENDS

The Non-PPO Quality Compass score for Rating of Personal Doctor increased by 0.4% from 2018 to 2019.

The Non-PPO SPH Book of Business increased by 0.9% since 2018.

RATING OF PERSONAL DOCTOR – TRENDING AND BENCHMARKS



COMPARISON TO TRENDING

	Summary Rate	Change*	Sig Test
2018	85.8%	2.0	↔
2017	85.4%	2.4	↔

COMPARISON TO BENCHMARKS

	Summary Rate	Gap*	Sig Test
2019 SPH Non-PPO BoB	84.9%	2.9	↔
2019 QC All Plans	85.3%	2.5	↔

ACCREDITATION SCORING

	2019	2018	2017
3 Pt Score	2.6656	2.6500	2.6424
Plan Percentile Threshold	90th	90th	90th

* Please note that the "change" or "gap" comparison may vary slightly due to rounding.

PERCENTILE RANKING 2019 QC ALL PLANS

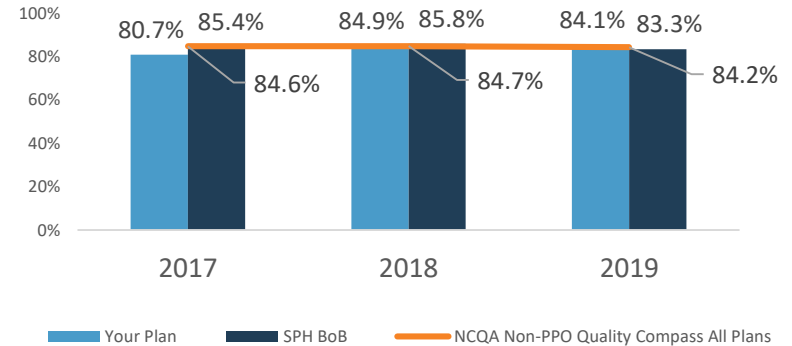


NATIONAL TRENDS

The Non-PPO Quality Compass score for Rating of Specialist decreased by 0.5% from 2018 to 2019.

The Non-PPO SPH Book of Business decreased by 2.6% since 2018.

RATING OF SPECIALIST– TRENDING AND BENCHMARKS



COMPARISON TO TRENDING

	Summary Rate	Change*	Sig Test
2018	84.9%	-0.8	↔
2017	80.7%	3.3	↔

COMPARISON TO BENCHMARKS

	Summary Rate	Gap*	Sig Test
2019 SPH Non-PPO BoB	83.3%	0.8	↔
2019 QC All Plans	84.2%	-0.2	↔

ACCREDITATION SCORING

	2019	2018	2017
3 Pt Score	2.5603	2.5462	2.5294
Plan Percentile Threshold	50th	50th	25th

* Please note that the "change" or "gap" comparison may vary slightly due to rounding.

PERCENTILE RANKING 2019 QC ALL PLANS

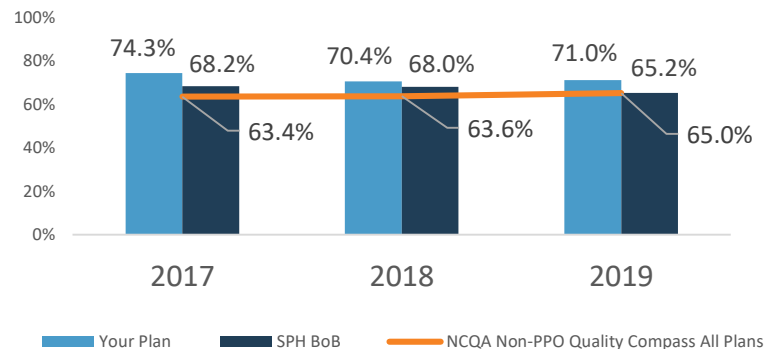


NATIONAL TRENDS

The Non-PPO Quality Compass score for Rating of Health Plan increased by 1.4% from 2018 to 2019.

The Non-PPO SPH Book of Business decreased by 2.8% since 2018.

RATING OF HEALTH PLAN – TRENDING AND BENCHMARKS



COMPARISON TO TRENDING

	Summary Rate	Change*	Sig Test
2018	70.4%	0.6	↔
2017	74.3%	-3.3	↔

COMPARISON TO BENCHMARKS

	Summary Rate	Gap*	Sig Test
2019 SPH Non-PPO BoB	65.2%	5.9	↑
2019 QC All Plans	65.0%	6.0	↑

ACCREDITATION SCORING

	2019	2018	2017
3 Pt Score	2.2926	2.3141	2.3950
Plan Percentile Threshold	75th	75th	90th

* Please note that the "change" or "gap" comparison may vary slightly due to rounding.



Segmentation Analyses

Subgroup Analysis

- Florida Health Care Plan, Inc.
- 1134918



Segmenting Responses The CAHPS® 5.0H survey asks demographic questions about the respondent. This information allows for a market segmentation of your members. Reviewing the set of measures across the assortment of demographic categories may indicate a health plan's overall ability to meet the needs of a varied population.

The percentages represent the Summary Rate for each segment. For example, in the table below, the Summary Rate for the *Rating of Health Plan* is the percentage of respondents who rated their health plan an 8, 9 or 10. The interpretation of this example would be, "Of the respondents with a high school education or less, 63% gave their health plan a rating of 8, 9 or 10. And, of the respondents with some college education or more, 58% gave their health plan a rating of 8, 9 or 10."

	High School or Less	Some College or More
Rating of Health Plan (8-10)	63%	58%

Segment Groups

- Respondent's Age (Q54)
- Respondent's Education (Q56)
- Respondent's Ethnicity (Q57)
- Respondent's Race (Q58)
- Respondent's Health Status (Q43)
- Respondent's Mental/Emotional Health Status (Q44)
- Number of Doctor/Clinic Visits (Q7)
- Data Collection Mode

Refer to "Summary Rate" in the *Technical Notes* for the Summary Rate definition for each composite.



By Respondent's Age (Q54)

Florida Health Care Plan, Inc.

Please see Technical Notes for more information.

	18 - 34	35 - 44	45 - 54	55 or older	Range*
Getting Needed Care	80.6%	84.1%	81.2%	87.1%	5.9%
Getting Care Quickly	85.8%	73.9%	80.0%	87.8%	7.8%
How Well Doctors Communicate	90.5%	98.0%	95.5%	96.4%	0.9%
Customer Service	90.0%	67.9%	85.5%	89.1%	3.6%
Claims Processing	100.0%	74.6%	90.7%	89.8%	0.9%
Shared Decision Making	80.0%	83.4%	76.9%	80.2%	3.3%
Plan Information on Cost	41.4%	41.4%	55.4%	71.2%	15.8%
Health Promotion and Education	63.0%	78.1%	78.9%	78.3%	0.6%
Coordination of Care	78.6%	93.8%	83.0%	84.6%	1.6%
Providing Needed Information	58.3%	50.0%	53.8%	66.2%	12.3%
Ease of Filling Out Forms	96.8%	95.2%	93.8%	98.4%	4.6%
Rating of Health Care (8 - 10)	70.4%	64.5%	81.9%	81.4%	0.5%
Rating of Personal Doctor (8 - 10)	80.0%	91.4%	87.7%	88.5%	0.8%
Rating of Specialist (8 - 10)	76.5%	75.0%	86.8%	85.6%	1.2%
Rating of Health Plan (8 - 10)	58.1%	61.9%	68.2%	76.6%	8.3%
Rating of Health Care (9 - 10)	44.4%	38.7%	52.8%	60.5%	7.7%
Rating of Personal Doctor (9 - 10)	72.0%	65.7%	74.0%	75.8%	1.9%
Rating of Specialist (9 - 10)	58.8%	50.0%	64.2%	69.8%	5.6%
Rating of Health Plan (9 - 10)	38.7%	33.3%	36.5%	56.8%	20.3%

* Range is the difference between Summary Rates shown. Due to the small number of respondents aged 18-34 or 35-44, these segments are not included in range calculations.



By Respondent's Education (Q56)

Florida Health Care Plan, Inc.

Please see Technical Notes for more information.

	High School Graduate or Less	Some College or More	Range*
Getting Needed Care	87.6%	83.9%	3.7%
Getting Care Quickly	84.4%	84.1%	0.3%
How Well Doctors Communicate	97.5%	95.5%	2.0%
Customer Service	94.4%	84.3%	10.1%
Claims Processing	100.0%	88.1%	11.9%
Shared Decision Making	83.1%	79.4%	3.7%
Plan Information on Cost	48.4%	63.4%	15.1%
Health Promotion and Education	65.5%	79.8%	14.3%
Coordination of Care	89.7%	83.6%	6.0%
Providing Needed Information	54.5%	61.3%	6.8%
Ease of Filling Out Forms	97.2%	96.4%	0.9%
Rating of Health Care (8 - 10)	91.1%	76.0%	15.0%
Rating of Personal Doctor (8 - 10)	90.9%	86.8%	4.1%
Rating of Specialist (8 - 10)	89.2%	83.3%	5.9%
Rating of Health Plan (8 - 10)	83.6%	67.6%	15.9%
Rating of Health Care (9 - 10)	62.5%	52.9%	9.6%
Rating of Personal Doctor (9 - 10)	74.2%	73.6%	0.6%
Rating of Specialist (9 - 10)	75.7%	64.1%	11.6%
Rating of Health Plan (9 - 10)	57.5%	44.6%	12.9%

* Range is the difference between Summary Rates shown. The larger the number, the greater the difference in Summary Rates between segment groups for any given question/composite.



By Respondent's Ethnicity (Q57)

Florida Health Care Plan, Inc.

Please see Technical Notes for more information.

	Hispanic/Latino	Not Hispanic/Latino	Range*
Getting Needed Care	73.8%	85.7%	NA
Getting Care Quickly	67.9%	85.7%	NA
How Well Doctors Communicate	97.5%	95.8%	NA
Customer Service	78.6%	87.4%	NA
Claims Processing	75.0%	89.7%	NA
Shared Decision Making	74.1%	80.3%	NA
Plan Information on Cost	36.7%	63.7%	NA
Health Promotion and Education	90.5%	76.0%	NA
Coordination of Care	87.5%	84.6%	NA
Providing Needed Information	57.1%	60.7%	NA
Ease of Filling Out Forms	100.0%	96.5%	NA
Rating of Health Care (8 - 10)	66.7%	80.5%	NA
Rating of Personal Doctor (8 - 10)	82.6%	88.5%	NA
Rating of Specialist (8 - 10)	86.7%	84.8%	NA
Rating of Health Plan (8 - 10)	64.0%	72.1%	NA
Rating of Health Care (9 - 10)	47.6%	55.9%	NA
Rating of Personal Doctor (9 - 10)	73.9%	74.3%	NA
Rating of Specialist (9 - 10)	73.3%	65.7%	NA
Rating of Health Plan (9 - 10)	44.0%	47.6%	NA

* Range is the difference between Summary Rates shown. Due to the small number of Hispanic/Latino respondents, range calculations are not included.



By Respondent's Race (Q58)

Florida Health Care Plan, Inc.

Please see Technical Notes for more information.

	White	Black or African American	Other	Range*
Getting Needed Care	85.5%	82.1%	83.6%	NA
Getting Care Quickly	84.8%	90.5%	67.3%	NA
How Well Doctors Communicate	96.3%	98.9%	96.1%	NA
Customer Service	87.0%	71.4%	58.9%	NA
Claims Processing	90.2%	78.6%	84.5%	NA
Shared Decision Making	80.6%	65.6%	76.2%	NA
Plan Information on Cost	64.5%	45.0%	17.1%	NA
Health Promotion and Education	76.8%	80.0%	91.3%	NA
Coordination of Care	84.9%	93.3%	80.0%	NA
Providing Needed Information	61.4%	50.0%	38.5%	NA
Ease of Filling Out Forms	96.3%	96.7%	100.0%	NA
Rating of Health Care (8 - 10)	81.2%	64.0%	56.5%	NA
Rating of Personal Doctor (8 - 10)	88.3%	83.3%	78.3%	NA
Rating of Specialist (8 - 10)	82.6%	93.8%	84.6%	NA
Rating of Health Plan (8 - 10)	70.9%	77.4%	51.9%	NA
Rating of Health Care (9 - 10)	55.7%	48.0%	47.8%	NA
Rating of Personal Doctor (9 - 10)	74.0%	70.8%	69.6%	NA
Rating of Specialist (9 - 10)	65.7%	62.5%	69.2%	NA
Rating of Health Plan (9 - 10)	46.8%	58.1%	29.6%	NA

* Range is the difference between Summary Rates shown. Due to the small number of respondents falling into the "Other" race category or indicating their race is Black or African American, range calculations are not included.



By Respondent's Health Status (Q43)

Florida Health Care Plan, Inc.

Please see Technical Notes for more information.

	Excellent/ Very Good	Good	Fair/Poor	Range*
Getting Needed Care	87.9%	80.9%	81.6%	7.0%
Getting Care Quickly	83.6%	81.7%	90.7%	1.9%
How Well Doctors Communicate	96.7%	94.2%	98.0%	2.5%
Customer Service	90.9%	81.5%	83.3%	9.4%
Claims Processing	87.0%	93.4%	78.6%	6.5%
Shared Decision Making	80.4%	78.9%	81.3%	1.5%
Plan Information on Cost	70.9%	54.1%	66.7%	16.9%
Health Promotion and Education	70.4%	82.5%	89.7%	12.1%
Coordination of Care	89.8%	77.1%	90.5%	12.7%
Providing Needed Information	61.2%	56.6%	71.4%	4.6%
Ease of Filling Out Forms	98.4%	95.2%	94.1%	3.2%
Rating of Health Care (8 - 10)	84.3%	71.1%	80.0%	13.3%
Rating of Personal Doctor (8 - 10)	89.7%	83.8%	93.3%	5.9%
Rating of Specialist (8 - 10)	87.3%	81.3%	84.0%	6.0%
Rating of Health Plan (8 - 10)	72.9%	66.1%	79.4%	6.7%
Rating of Health Care (9 - 10)	65.4%	41.2%	50.0%	24.1%
Rating of Personal Doctor (9 - 10)	78.8%	66.7%	76.7%	12.1%
Rating of Specialist (9 - 10)	71.8%	58.2%	68.0%	13.6%
Rating of Health Plan (9 - 10)	53.2%	38.6%	50.0%	14.6%

* Range is the difference between Summary Rates shown. Due to the small number of respondents indicating their health is "Fair" or "Poor," this segment is not included in range calculations.



By Respondent's Mental/Emotional Health Status (Q44)

Florida Health Care Plan, Inc.

Please see Technical Notes for more information.

	Excellent/ Very Good	Good	Fair/Poor	Range*
Getting Needed Care	84.5%	85.1%	81.0%	0.6%
Getting Care Quickly	85.8%	82.6%	73.0%	3.2%
How Well Doctors Communicate	96.4%	94.9%	93.8%	1.4%
Customer Service	87.2%	83.3%	83.3%	3.9%
Claims Processing	87.7%	93.2%	100.0%	5.4%
Shared Decision Making	78.1%	81.1%	88.9%	3.0%
Plan Information on Cost	65.1%	56.8%	50.0%	8.2%
Health Promotion and Education	73.6%	85.0%	78.6%	11.4%
Coordination of Care	88.5%	75.5%	75.0%	13.1%
Providing Needed Information	64.9%	55.3%	40.0%	9.6%
Ease of Filling Out Forms	98.3%	95.6%	83.3%	2.8%
Rating of Health Care (8 - 10)	80.2%	77.2%	66.7%	3.0%
Rating of Personal Doctor (8 - 10)	88.1%	87.5%	87.5%	0.6%
Rating of Specialist (8 - 10)	84.9%	87.9%	63.6%	3.0%
Rating of Health Plan (8 - 10)	72.4%	67.4%	72.2%	5.0%
Rating of Health Care (9 - 10)	61.4%	41.8%	33.3%	19.6%
Rating of Personal Doctor (9 - 10)	74.8%	71.3%	75.0%	3.5%
Rating of Specialist (9 - 10)	69.8%	58.6%	54.5%	11.2%
Rating of Health Plan (9 - 10)	52.3%	37.1%	33.3%	15.2%

* Range is the difference between Summary Rates shown. Due to the small number of respondents indicating their mental/emotional health is "Fair" or "Poor," this segment is not included in range calculations.



By Number of Doctor or Clinic Visits (Q7)

Florida Health Care Plan, Inc.

Please see Technical Notes for more information.

	Less Than Three Visits	Three or More Visits	Range*
Getting Needed Care	83.0%	85.4%	2.4%
Getting Care Quickly	85.4%	83.2%	2.2%
How Well Doctors Communicate	94.1%	97.2%	3.1%
Customer Service	84.7%	86.6%	1.8%
Claims Processing	94.3%	86.9%	7.4%
Shared Decision Making	74.7%	81.7%	7.0%
Plan Information on Cost	53.0%	65.0%	12.0%
Health Promotion and Education	68.9%	83.7%	14.8%
Coordination of Care	85.0%	85.9%	0.9%
Providing Needed Information	57.5%	61.8%	4.3%
Ease of Filling Out Forms	96.6%	96.3%	0.2%
Rating of Health Care (8 - 10)	78.8%	79.4%	0.6%
Rating of Personal Doctor (8 - 10)	86.5%	88.7%	2.1%
Rating of Specialist (8 - 10)	83.3%	84.2%	0.8%
Rating of Health Plan (8 - 10)	67.8%	73.9%	6.2%
Rating of Health Care (9 - 10)	59.9%	50.9%	8.9%
Rating of Personal Doctor (9 - 10)	72.4%	74.2%	1.8%
Rating of Specialist (9 - 10)	68.9%	63.3%	5.6%
Rating of Health Plan (9 - 10)	43.3%	50.3%	7.0%

* Range is the difference between Summary Rates shown. The larger the number, the greater the difference in Summary Rates between segment groups for any given question/composite.

	Mail	Phone	Internet	Range*
Getting Needed Care	85.8%	76.2%	NA	9.6%
Getting Care Quickly	85.2%	72.6%	NA	12.7%
How Well Doctors Communicate	96.2%	93.6%	NA	2.6%
Customer Service	85.9%	87.5%	NA	1.6%
Claims Processing	90.9%	82.1%	NA	8.8%
Shared Decision Making	79.6%	79.6%	NA	0.0%
Plan Information on Cost	63.3%	46.4%	NA	16.8%
Health Promotion and Education	77.1%	76.9%	NA	0.2%
Coordination of Care	84.5%	87.5%	NA	3.0%
Providing Needed Information	60.4%	58.8%	NA	1.6%
Ease of Filling Out Forms	97.4%	89.5%	NA	7.9%
Rating of Health Care (8 - 10)	82.1%	59.0%	NA	23.2%
Rating of Personal Doctor (8 - 10)	88.1%	85.7%	NA	2.4%
Rating of Specialist (8 - 10)	85.6%	74.2%	NA	11.4%
Rating of Health Plan (8 - 10)	73.5%	53.5%	NA	20.0%
Rating of Health Care (9 - 10)	57.8%	35.9%	NA	21.9%
Rating of Personal Doctor (9 - 10)	74.8%	66.7%	NA	8.2%
Rating of Specialist (9 - 10)	67.2%	58.1%	NA	9.1%
Rating of Health Plan (9 - 10)	49.5%	32.6%	NA	17.0%

* Range is the difference between Summary Rates shown. This survey wasn't administered using an Internet data collection methodology. In keeping, the Internet segment is not included in range calculations.



Correlation Analyses

Plan Specific Correlations

- Florida Health Care Plan, Inc.
- 1134918

Correlations This section provides attribute correlations with *Rating of Health Plan* (Q42), *Rating of Health Care* (Q13), and *Rating of Personal Doctor* (Q23). The correlations show the strength of the linear relationship between the individual attribute and the rating question. The correlation value can range from -1 to $+1$ with values close to $+1$ indicating a strong positive relationship. For example, a question that is highly correlated with *Rating of Health Plan* indicates that a low Summary Rate for that question is associated with a low Summary Rate for *Rating of Health Plan*, and a high Summary Rate for that question is associated with a high Summary Rate for *Rating of Health Plan*.

Attributes considered to be highly correlated with the rating measures are shaded blue ($r > 0.400$). Comparisons to the 2019 Non-PPO Commercial Adult Quality Compass® All Plans benchmark are also shown with significance testing.

Significance Testing

Green – Current year score significantly higher when compared to trend or benchmark score.

Red – Current year score significantly lower when compared to trend or benchmark score.

No color denotes that there was no significant difference between the percentages or that there was insufficient sample size to conduct the statistical test. All significance testing is performed at the 95% significance level.



	With Health Plan Rating	With Health Care Rating	With Personal Doctor Rating	Plan Summary Rate	2019 Quality Compass® All Plans, Non-PPO
Getting Needed Care					
14 Getting care, tests, or treatments necessary	0.412	0.570	0.340	87.4%	88.5%
25 Obtained appointment with specialist as soon as needed	0.331	0.403	0.183	81.7%	82.8%
Getting Care Quickly					
4 Obtaining needed care right away	0.446	0.497	0.285	85.0%	87.6%
6 Obtained appointment for care as soon as needed	0.290	0.354	0.186	82.4%	82.0%
How Well Doctors Communicate					
17 Doctors explained things in an understandable way	0.373	0.514	0.719	97.5%	96.1%
18 Doctors listened carefully to you	0.421	0.532	0.704	95.1%	94.8%
19 Doctors showed respect for what you had to say	0.360	0.480	0.649	95.4%	96.2%
20 Doctors spent enough time with you	0.396	0.468	0.663	95.4%	93.3%
Customer Service					
35 Getting information/help from customer service	0.492	0.489	0.326	80.6%	83.0%
36 Treated with courtesy and respect by customer service staff	0.580	0.502	0.560	91.7%	95.2%
Claims Processing					
40 Claims handled quickly	0.404	0.419	0.164	89.5%	87.2%
41 Claims handled correctly	0.601	0.626	0.411	89.2%	90.4%

	With Health Plan Rating	With Health Care Rating	With Personal Doctor Rating	Plan Summary Rate	2019 Quality Compass® All Plans, Non-PPO
Plan Information on Costs					
31 Able to find out from health plan cost of health care service or equipment	0.405	0.163	0.323	67.6%	61.2%
33 Able to find out from health plan cost of prescription medicines	0.610	0.447	0.417	68.6%	62.4%
Other Measures					
Coordination of Care	0.387	0.412	0.532	84.8%	83.8%
Providing Needed Information	0.532	0.418	0.279	60.2%	66.2%
Ease of Filling Out Forms	0.122	0.175	0.134	96.5%	96.0%
Rating Questions					
Rating of Health Care	0.682	NA	0.632	79.1%	78.1%
Rating of Personal Doctor	0.506	0.632	NA	87.8%	85.3%
Rating of Specialist	0.364	0.407	0.371	84.1%	84.2%
Rating of Health Plan	NA	0.682	0.506	71.0%	65.0%



Priority Matrix

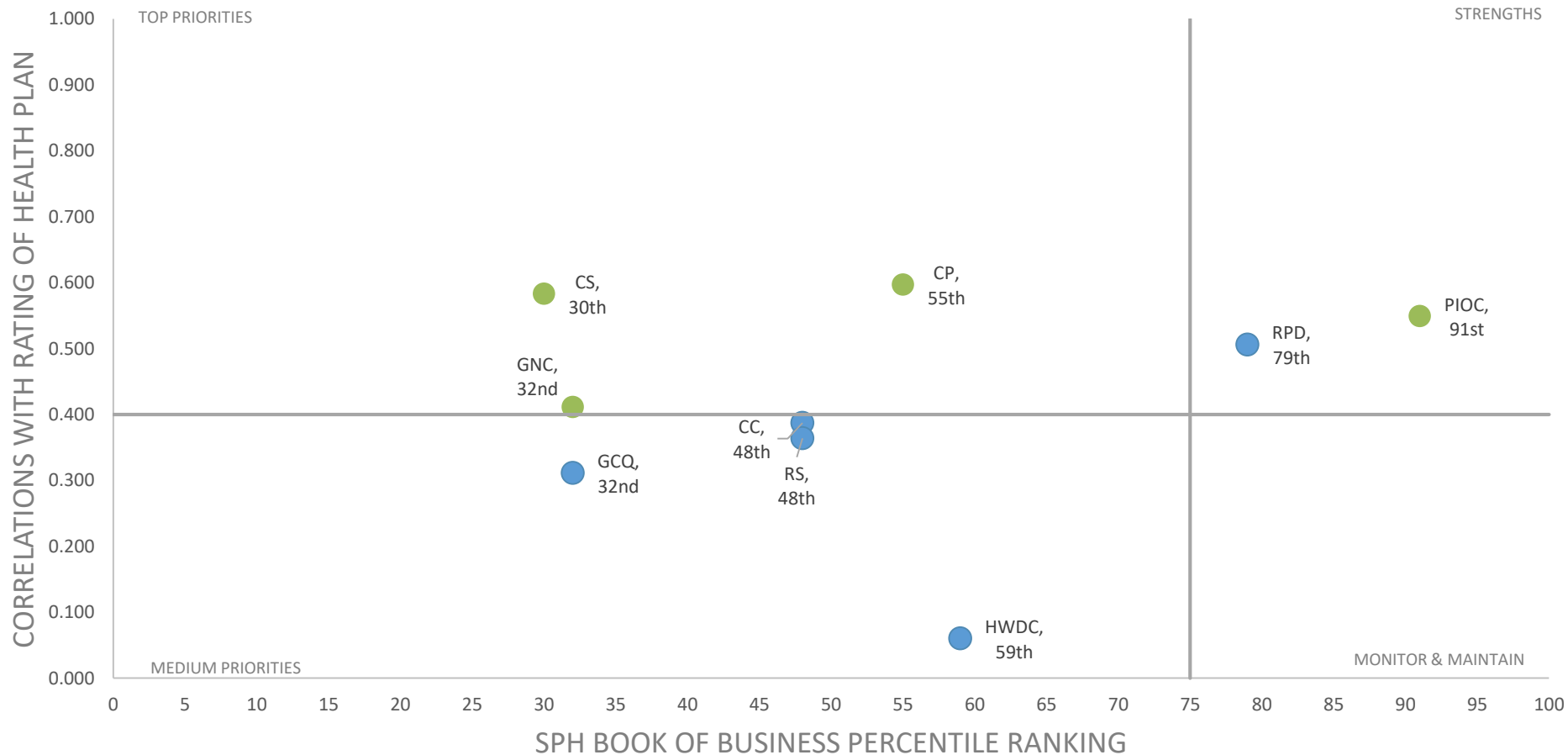
Display of Measure Performance

- Florida Health Care Plan, Inc.
- 1134918

Priority Matrix This section provides a graphical display of performance of survey composites and key measures, along with their relative ‘importance’ as it relates to *Rating of Health Plan* (Q42). Composites and key measures are placed on the Priority Matrix according to the interaction between their correlation coefficient and percentile ranking within the 2019 SPH Analytics Book of Business.

Composites and measures with moderate to strong correlations (0.400 and higher) with *Rating of Health Plan* (Q42) and ranking at or above the 75th percentile are considered plan *Strengths* and are placed in the top right quadrant. Composites with moderate to strong correlations (0.400 and higher) with *Rating of Health Plan* but ranking below the 75th percentile are considered *Top Priorities* and are placed in the top left quadrant. The *Monitor and Maintain* quadrant includes those composites and measures that are weakly correlated (below 0.400) with *Rating of Health Plan* but rank at or above the 75th percentile. Composites that are weakly correlated (below 0.400) with *Rating of Health Plan* and rank below the 75th percentile are considered *Medium Priorities* and are placed in the bottom left quadrant.

 HEALTH PLAN DOMAIN	 HEALTH CARE DOMAIN
Getting Needed Care (GNC)	Getting Care Quickly (GCQ)
Customer Service (CS)	How Well Doctors Communicate (HWDC)
Claims Processing (CP)	Coordination of Care (CC)
Plan Information on Costs (PIOC)	Rating of Personal Doctor (RPD)
	Rating of Specialist (RS)





Custom Question Analyses

- Florida Health Care Plan, Inc.
- 1134918

Your plan asked the following supplemental questions on the 2019 survey tool.

Q#	Survey Item	Valid n	Category Responses (Summary Rate responses in grey)	Plan's Summary Rate		2018 SPH Book of Business*	
				2019	2018	Summary Rate	Corr. with Q42
61	Would you recommend your health plan to your family or friends?	349	<u>Definitely yes</u> <u>Probably yes</u> <u>Uncertain</u> <u>Probably not</u> <u>Definitely not</u>	80.5%	93.4%	93.0%	0.028
			40.7% 39.8% 11.7% 4.6% 3.2%				
62	How would you rate the number of doctors you had to choose from?	331	<u>Excellent</u> <u>Very Good</u> <u>Good</u> <u>Fair</u> <u>Poor</u> <u>No Experience</u>	62.5%	62.8%	67.1%	0.049
			24.8% 37.8% 24.8% 7.6% 5.1% n = 15				
63	If today you could select any health plan company in your area, would you select your current plan again?	349	<u>Definitely yes</u> <u>Probably yes</u> <u>Uncertain</u> <u>Probably not</u> <u>Definitely not</u>	75.6%	77.0%	NA	NA
			39.8% 35.8% 15.5% 4.6% 4.3%				

* The 2018 SPH Analytics Book of Business consists of the results of 28 commercial adult samples surveyed by SPH Analytics in 2018 that submitted data to NCQA.

Significance Testing

Green – Current year score significantly higher when compared to trend or benchmark score.

Red – Current year score significantly lower when compared to trend or benchmark score.

SPH understands CAHPS is only one component of your performance improvement program. We invite you to partner with us for ongoing quality improvement.

Performance Improvement Consulting

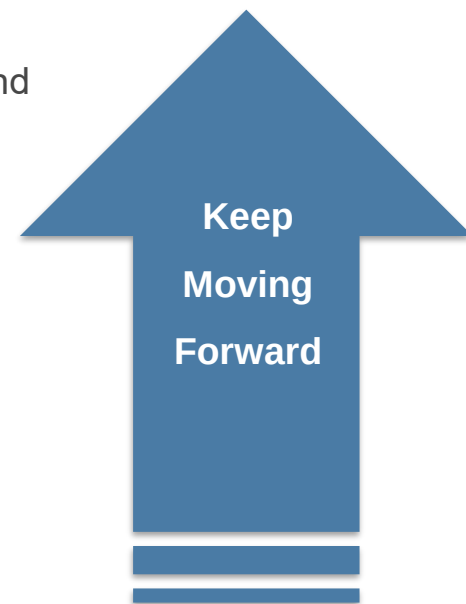
SPH's consulting services help plans understand their CAHPS results and develop improvement initiatives based on survey data.

Simulation and Drill-Down Surveys

Understand the why behind your members' responses and develop targeted initiatives to improve scores, performance, and member satisfaction.

Continuous Member Engagement and Outreach

Connect with members throughout the year with SPH's multi-channel member engagement and targeted outreach programs. Increase satisfaction/loyalty, close care gaps, and improve scores and ratings.





2019 QHP Enrollee Experience Survey Final Report

Florida Health Care Plan, Inc.

Project Number: 80134923



Florida Health Care Plan, Inc.

Contents

- Executive Summary
- Profile of Survey Respondents
- Summary of Trend and Benchmarks
- Composite Analyses
- Segmentation Analyses
- Correlation Analyses

SPH Analytics (SPH), a Centers for Medicare and Medicaid Services (CMS) certified Survey Vendor, was selected by Florida Health Care Plan, Inc. to conduct its 2019 QHP Enrollee Experience Survey.

Your Sales Director for this project is Sheryl Savage (678-689-0312), and your Project Manager is Miranda Watkins (770-978-3173, ext. 1414). Should you have any questions or comments regarding any aspect of the survey or reporting process, please feel free to call either your Sales Director or your Project Manager.

New in 2019 – Survey Tool Changes

The number of survey questions has been reduced from 82 questions in 2018 to 68 questions in 2019.

- Added “Not Applicable” option for Questions 3, 4, 5, 6, 9, 12, 20, 21, 24, 26, 32, 34, 39, and 41.
- Moved up the “Your Health Plan” question set to follow Question 2.
- Transferred the health literacy questions (Questions 17 and 18) from the “About You” section to the “Your Health Plan” section.
- Moved all global rating items to the end of their relevant sections.



Executive Summary

Florida Health Care Plan, Inc.

Project Number: 80134923



SURVEY OBJECTIVE The overall objective of the Qualified Health Plan Enrollee Experience Survey is to capture accurate and reliable information about consumer-reported experiences with health care. The survey includes all of the questions in the core CAHPS® Health Plan (Adult Medicaid) survey plus additional questions added to collect needed data specific to this population.

Section 1311(c)(4) of the Affordable Care Act (ACA) requires the development of a system to rate QHPs offered through a Marketplace based on quality and price. This mandate required the development and implementation of a survey to assess the consumer experience. The goal of the **Quality Rating System** (QRS) is to provide information for consumers to use when they select a health plan in the Marketplace and to facilitate regulatory oversight by states, CMS, and accreditation authorities. Results will be displayed using a 5-star rating scale. The QHP Enrollee Experience Survey supplies data to the QRS regarding patient experiences with their health care.

SPH Analytics (SPH) has structured this report to provide insightful and actionable information that plans can use to improve quality and performance. However, it is important to note as you are reviewing these results that your SPH Analytics report should be used for **quality improvement purposes only**. It is not a source from which you can determine your Quality Rating System scores that CMS ultimately provides.

VALID SURVEYS

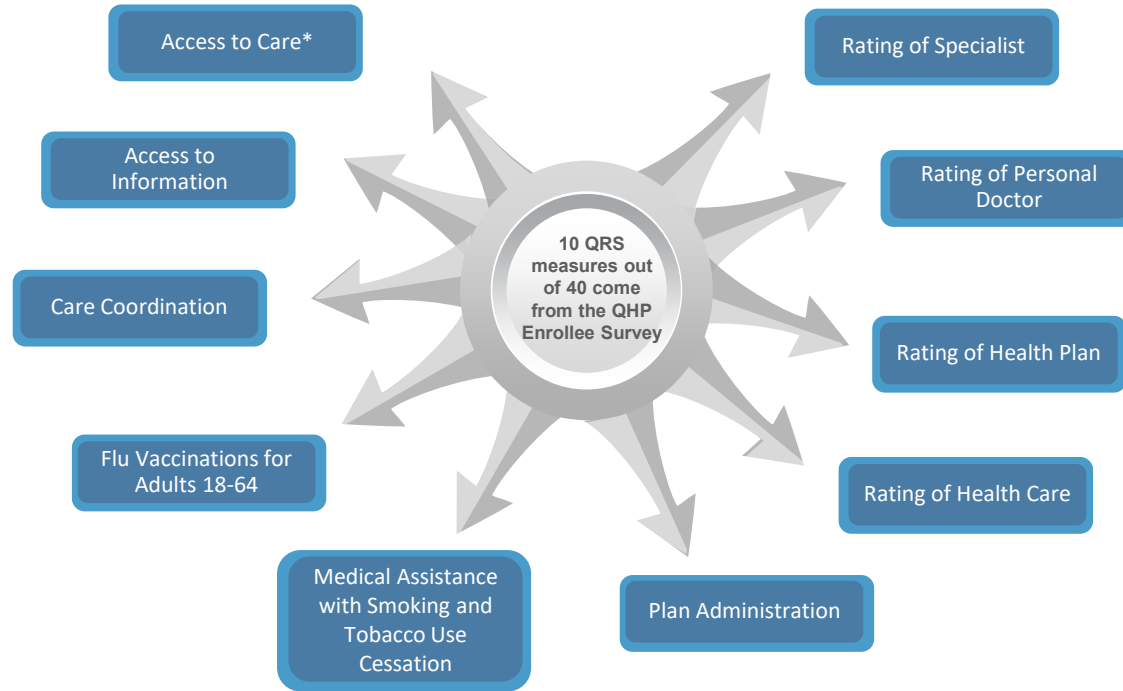
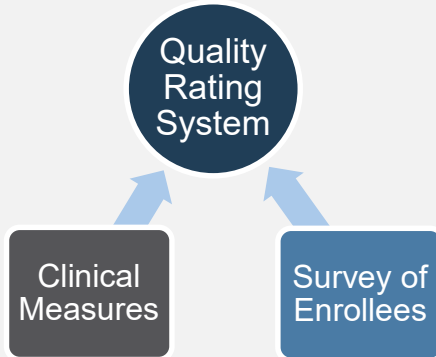
Using a 4 Wave Mail with Phone/Internet survey methodology, per CMS protocol, SPH Analytics collected **254 valid surveys** from the eligible member population, yielding a response rate of **25.6%**

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

Results in SPH reporting are unofficial and do not represent official results provided by CMS.

QHP Quality Rating System

The data that is used in the QRS comes from two categories of data sources. The measures that come from the QHP Enrollee Survey are listed to the right.



*The Access to Care composite contains the questions from Getting Needed Care and Getting Care Quickly

NOTE: The Cultural Competence QRS Composite was removed as a CMS QRS measure in 2019.

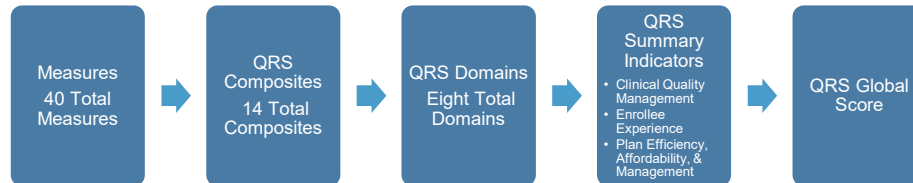


The QRS and National Trends for Survey Measures

Please see Technical Notes for more information.

Measured Improvement It is critical to have continuous member experience quality improvement strategies in place to keep pace with national trends.

Quality Rating System Weighting The global score is an average of weighted summary indicator scores. The Clinical Quality Management summary indicator has a weight of two-thirds (66.67%), while the Enrollee Experience and Plan Efficiency, Affordability, & Management summary indicators will each have a weight of one sixth (16.67%).



	2017 CMS National Average	2018 CMS National Average	Change
Getting Care Quickly**	77.76	78.43	0.67
Getting Needed Care**	78.95	78.60	-0.35
Cultural Competence*	71.48	69.52	-1.96
How Well Doctors Communicate*	90.01	89.76	-0.25
Care Coordination	83.69	83.41	-0.28
Access to Information	57.64	57.82	0.18
Health Plan Customer Service*	78.73	80.26	1.53
Cost*	79.07	78.80	-0.27
Rating of Health Care	82.27	82.31	0.04
Rating of Personal Doctor	88.69	88.38	-0.31
Rating of Specialist	87.44	86.85	-0.59
Rating of Health Plan	73.17	74.47	1.30

*Not a QRS Measure. Getting Care Quickly and Getting Needed Care composites are combined to form the Access to Care measure for QRS ratings.

Scaled Mean Scores are used by CMS to calculate the scores for the Quality Rating System. The plan's scaled mean score is the mean score converted to a 100-point scale. An exception to this scoring is for the *Annual Flu Vaccine* and *Medical Assistance with Smoking and Tobacco Use Cessation* measures.

Case-Mix Adjustment Please be aware that all results throughout this report are not based on case-mix adjusted data. Case-mix adjustment is a method by which CMS accounts for demographic trends in satisfaction (e.g., the fact that older, healthier, less-educated members and members with lower socio-economic status tend to respond more favorably to survey questions). Factors to be used in the case-mix adjustment will be determined by CMS once the 2019 data have been analyzed. Please be aware that **all numbers throughout this report are unadjusted and will not match the report provided by CMS.**

Please note that survey composite and key question calculations are based upon preliminary guidelines and are subject to change during or after the regulatory reporting period.

Cell Size Suppression

Throughout this report, an 'NA' is displayed in place of any percentage that is representative of **10 or fewer respondents** in accordance with CMS cell size suppression guidelines.

QHP Enrollee Experience Summary Indicator

Your plan's performance on QRS Enrollee Experience measures that are collected from the survey.

MEASURE	2019 SCALED MEAN SCORE	2018 SCALED MEAN SCORE	CHANGE**	2019 SPH ANALYTICS BENCHMARK		2018 CMS NATIONAL DATA
				SCALED MEAN	PERCENTILE RANK	SCALED MEAN
Access to Care*	76.7	82.8	-6.1	75.7	57th	X
Getting Care Quickly	77.0	81.6	-4.6	76.9	47th	78.4
Getting Needed Care	76.4	84.1	-7.7	74.6	64th	78.6
Care Coordination	80.1	85.9	-5.8	82.7	18th	83.4
Rating of All Health Care	81.4	86.1	-4.6	77.8	92nd	82.3
Rating of Personal Doctor	86.4	89.1	-2.8	87.7	25th	88.4
Rating of Specialist	81.3	86.1	-4.8	85.4	<10th	86.9

*The Access to Care composite contains the questions from Getting Needed Care and Getting Care Quickly. Note that the single item measure about after hours care was removed in 2018. As such, please use caution when making comparisons to trend data. Getting Needed Care and Getting Care Quickly are not included separately in the QRS; only Access to Care is a QRS measure.

**Please note that the "Change" comparison may vary slightly due to rounding.

KEY TAKEAWAYS

SPH regression analysis has identified **How Well Doctors Communicate**, and **Getting Needed Care** as **Key Drivers** of Rating of Health Care. Improving scores on these measure can improve the rating score.

SCORING CHANGE

CMS removed the question about after hours care from the **Access to Care** composite. As such, please use caution when making comparisons to trend data.

QHP Plan Efficiency, Affordability, & Management Summary Indicator

Your plan's performance on QRS Efficiency, Affordability, & Management measures that are collected from the survey.

MEASURE	2019 SCALED MEAN SCORE	2018 SCALED MEAN SCORE	CHANGE*	2019 SPH ANALYTICS BENCHMARK		2018 CMS NATIONAL DATA
				SCALED MEAN	PERCENTILE RANK	SCALED MEAN
Access to Information	54.0	66.3	-12.3	48.0	94th	57.8
Plan Administration	73.8	81.6	-7.8	70.2	76th	X
Rating of Health Plan	74.0	80.9	-6.9	68.8	83rd	74.5

*Please note that the "Change" comparison may vary slightly due to rounding.

KEY TAKEAWAYS

Your 2019 overall **Rating of Health Plan** Scaled Mean Score was 74.0. This was a change of **-6.9** from 2018.

SPH regression analysis has identified **Getting Needed Care, Plan Administration, and Cost** as **Key Drivers** of Rating of Health Plan. Improving scores on these measure can improve the rating score.

QHP Clinical Quality Management Summary Indicator

Your plan's performance on QRS Clinical Quality Management measures that are collected from the survey.

MEASURE	2019 SUMMARY RATE SCORE	2018 SUMMARY RATE SCORE	CHANGE*	2019 SPH ANALYTICS BENCHMARK		2018 CMS NATIONAL DATA
				SUMMARY RATE	PERCENTILE RANK	SUMMARY RATE
Flu Vaccinations for Adults 18-64	41.1%	38.8%	2.4	47.3%	22nd	X
Medical Assistance with Smoking and Tobacco Use Cessation - Rolling Average	66.8%	61.0%	5.7	52.9%	90th	X

*Please note that the "Change" comparison may vary slightly due to rounding.

Top Three Measures

Your plan had the highest SPH Book of Business percentile rankings for these three QRS measures.

MEASURE	VALID N	2019 SCALED MEAN SCORE	2018 SCALED MEAN SCORE	CHANGE*	SPH BoB PERCENTILE RANKING	SPH BOOK OF BUSINESS	GAP*
Access to Information	168	54.0	66.3	-12.3	94th	48.0	6.0
Rating of All Health Care	197	81.4	86.1	-4.6	92nd	77.8	3.6
Medical Assistance with Smoking and Tobacco Use Cessation (Rolling Average)	62	66.8%	61%	5.7	90th	52.9%	13.9

Bottom Three Measures

Your plan had the lowest SPH Book of Business percentile rankings for these three QRS measures.

MEASURE	VALID N	2019 SCALED MEAN SCORE	2018 SCALED MEAN SCORE	CHANGE*	SPH BoB PERCENTILE RANKING	SPH BOOK OF BUSINESS	GAP*
Flu Vaccinations (18-64)	236	41.1%	38.8%	2.4	22nd	47.3%	-6.2
Care Coordination	190	80.1	85.9	-5.8	18th	82.7	-2.6
Rating of Specialist	126	81.3	86.1	-4.8	<10th	85.4	-4.1

*Please note that the "Change" and "Gap" comparisons may vary slightly due to rounding.

Results in SPH reporting are unofficial and do not represent official results provided by CMS.

Improving Performance

These QRS measures had the lowest performing scores for your plan.

Flu Vaccinations (18-64)

- Review provider processes and tools used (i.e., EHRs) to identify and follow up with members needing flu shots.
- Collaborate with providers across the network to improve rate of flu shots.
- Review clinical documentation policies and procedures regarding administration of the vaccines.
- Expand access and availability via contracting with retail pharmacies.
- Consider benefits of member reminders (via calls, text, website, clinical staff, patient portal, mail) to improve flu shot rates.
- Promote clinical documentation, research and/or FAQ about advantages of getting a flu shot.
- Determine sub-groups of member population whose culture or religion prohibits vaccinations.

Care Coordination

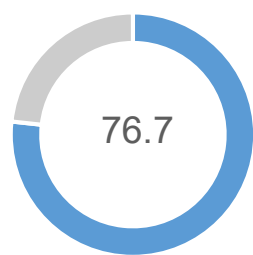
- Assess status and consistency of coordination of patient care and information across provider network.
- Inform/remind providers about coordination of care expectations or time standards for post-visit follow up to PCPs.
- Develop on-going reminders/messaging to promote and improve communication and reporting between providers.
- Expand/Encourage a practice-wide patient-centered commitment or program. Make the commitment a reality by setting program goals, establishing standards, and tracking progress.
- Explore potential of EHRs to integrate/facilitate distribution of patient information among providers.
- Prompt patients to bring all medications (or list) to their appointments.
- Encourage a strengthening of the member/patient-personal doctor relationship through better patient understanding of their health conditions and treatment choices they can take to improve their health.
- Prompt patients to share care, tests or treatments involving other providers.
- Prior to appointments, speak with patients' specialists to review the care they have provided.
- Promote a patient-centered care management approach across the network.
- Educate personal doctor offices about Care Coordination standards – awareness of history, other care, medications, test results, etc.

Rating of Specialist

- Analyze, investigate, probe for weakness or QI needs those composite measures highly correlated with rating of doctor or specialist. (i.e., GNC, HWDC, Coord. Of Care).
- Review QI recommendations for related QHP measures: How Well Doctors Communicate and Coordination of Care.
- Stress with providers members' concerns and importance of coordination of care.
- Determine systems (i.e., EHRs) processes or procedures used to gather or facilitate distribution of patient information.
- Share and discuss QHP feedback, scores and reporting with providers.
- Suggest providers/practices periodically analyze appointment scheduling timeframes versus types of office visits.
- Gather and analyze patient feedback on their recent office visit (i.e., patient "comment cards," follow up call/text/email, etc.).
- Provide on-line tools or training sessions to include improving physician-patient communication, patient-centered interviewing.
- Develop videos which provides insights into the patient office visit experience versus their expectations.
- Promote use of a secure online patient portal which allows access to their medical record and a health care information of particular interest to their needs.

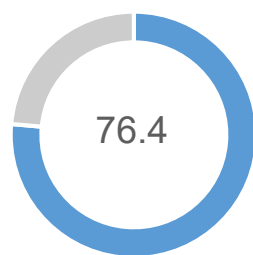
Need Additional Assistance? For health plans that need additional assistance interpreting survey results and leveraging data to identify appropriate next steps for improvement, SPH offers Performance Improvement Consulting. Contact your Sales Executive to learn more or visit our website at <http://www.sphanalytics.com/consulting>.

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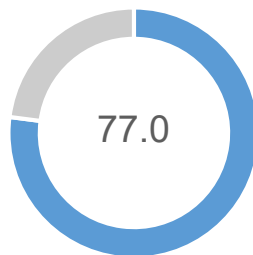
Access To Care*

2019	76.7
2018	82.8
SPH	75.7
CMS	X



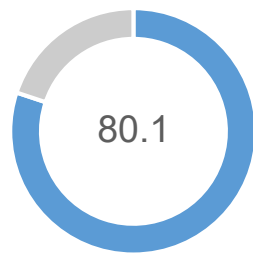
Getting Needed Care**

2019	76.4
2018	84.1
SPH	74.6
CMS	78.6



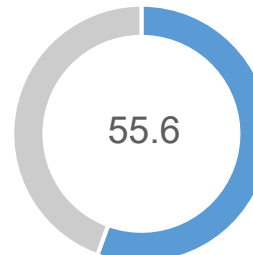
Getting Care Quickly**

2019	77.0
2018	81.6
SPH	76.9
CMS	78.4



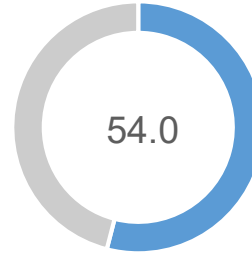
Care Coordination

2019	80.1
2018	85.9
SPH	82.7
CMS	83.4



Cultural Competence**

2019	55.6
2018	NA
SPH	60.7
CMS	69.5



Access To Information

2019	54.0
2018	66.3
SPH	48.0
CMS	57.8

*The Access to Care composite contains the questions from Getting Needed Care and Getting Care Quickly. Getting Needed Care and Getting Care Quickly are not included separately in the QRS; only Access to Care is a QRS measure.

**Not a QRS Measure.

Scaled Mean Scores

The plan's scaled mean score is the mean score converted to a **100 - Point Scale**.

These scores are unadjusted.

Significance Testing

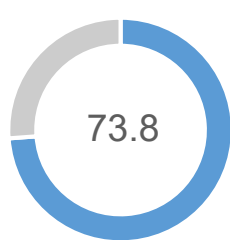
Green – Current year score significantly higher when compared to trend or benchmark score.

Red – Current year score significantly lower when compared to trend or benchmark score.

SPH refers to the 2019 SPH Analytics Book of Business benchmark.

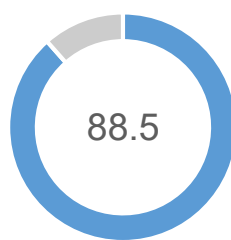
CMS refers to the 2018 CMS National Data benchmark.

Results in SPH reporting are unofficial and do not represent official results provided by CMS.



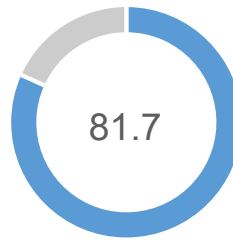
Plan Administration

2019	73.8
2018	81.6
SPH	70.2
CMS	X



How Well Doctors
Communicate*

2019	88.5
2018	90.5
SPH	89.7
CMS	89.8



Cost*

2019	81.7
2018	82.7
SPH	78.9
CMS	78.8

*Not a QRS Measure.

Scaled Mean Scores

The plan's scaled mean score is the mean score converted to a **100 - Point Scale**.

These scores are unadjusted.

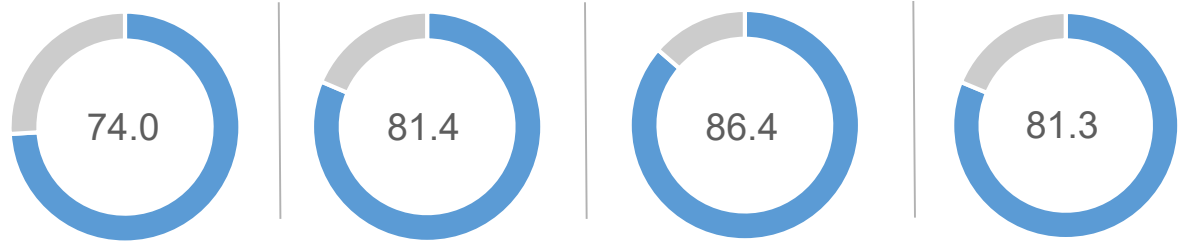
Significance Testing

Green – Significantly higher percentage when compared to current year data.

Red – Significantly lower percentage when compared to current year data.

SPH refers to the 2019 SPH Analytics Book of Business benchmark.

CMS refers to the 2018 CMS National Data benchmark.



Rating of Health Plan		Rating Of Health Care		Rating of Personal Doctor		Rating of Specialist	
2019	74.0	2019	81.4	2019	86.4	2019	81.3
2018	80.9	2018	86.1	2018	89.1	2018	86.1
SPH	68.8	SPH	77.8	SPH	87.7	SPH	85.4
CMS	74.5	CMS	82.3	CMS	88.4	CMS	86.9

Scaled Mean Scores

The plan's scaled mean score is the mean score converted to a **100 - Point Scale**.

These scores are unadjusted.

Significance Testing

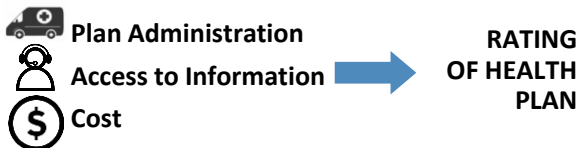
Green – Significantly higher percentage when compared to current year data.

Red – Significantly lower percentage when compared to current year data.

SPH refers to the 2019 SPH Analytics Book of Business benchmark.

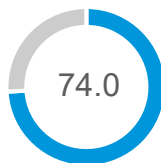
CMS refers to the 2018 CMS National Data benchmark.

Multiple regression analyses run on the SPH Book Of Business has identified the following **Key Drivers** of Rating of Health Plan. Performance on these measures may be driving member's overall experience rating.



PERFORMANCE ON KEY DRIVERS

Key Driver	2019 Scaled Mean Score	SPH %Rank
Plan Administration	73.8	76th
Access to Information	54.0	94th
Cost	81.7	81st



Rating Of Health Plan

SCALED MEAN SCORE

Your plan scored in the **83rd percentile** when compared to the SPH Book of Business benchmark.

Compared to last year, your score decreased by -6.9. This result is not statistically significant.

PLAN SPECIFIC CORRELATIONS

Correlations show the strength of the linear relationship between the individual attributes and the rating questions for your plan.

These five questions had the **strongest correlation** with your Rating of Health Plan.

QUESTION	Coefficient	2019 Scaled Mean Score	SPH %Rank
25 Rating of All Health Care	0.777	81.4	92nd
23 Ease of getting care, tests, or treatment needed	0.521	82.9	81st
7 Treated with courtesy and respect by customer service staff	0.486	87.4	66th
15 Delayed or did not visit doctor because you were worried about cost	0.463	77.4	69th
20 Obtained needed care right away	0.441	76.5	36th

Demographic Comparisons

Different demographic subgroups can have dissimilar experiences with your health plan.



Gender

	8-10	9-10
MEN	47.3%	28.4%
WOMEN	61.5%	45.0%



Age

	8-10	9-10
18-34	37.9%	NA
35-44	NA	NA
45-54	47.8%	34.8%
55 or older	63.9%	44.4%



Education

	8-10	9-10
HS GRAD OR LESS	71.6%	55.4%
SOME COLLEGE OR MORE	50.3%	33.7%



Health Status

	8-10	9-10
EXCELLENT /VERY GOOD	58.3%	41.7%
GOOD	53.0%	37.3%
FAIR/POOR	58.5%	39.0%



Mental/Emotional Health Status

	8-10	9-10
EXCELLENT /VERY GOOD	60.3%	41.1%
GOOD	43.9%	31.8%
FAIR/POOR	63.6%	48.5%



Data Collection

	8-10	9-10
MAIL	59.5%	39.6%
PHONE	63.1%	47.7%
INTERNET	47.9%	32.4%



Ethnicity & Race

	8-10	9-10
HISPANIC/LATINO	50.0%	50.0%
NOT HISPANIC/LATINO	57.8%	38.9%

	8-10	9-10
WHITE	56.6%	39.4%
BLACK/AFRICAN-AMERICAN	77.3%	59.1%
OTHER	NA	NA

Results in SPH reporting are unofficial and do not represent official results provided by CMS.

KEY DRIVERS: WHERE TO FOCUS IMPROVEMENT EFFORTS

Members set standards for performance whether consciously or subconsciously. Standards are usually set higher for those plan services that are deemed important to each member. These important services are the Key Drivers of Experience.

Multiple linear regression analyses were run on the 2019 SPH Analytics QHP Book of Business to discover which composites were Key Drivers of Rating of Health Plan (Q19), Rating of Health Care (Q25), and Rating of Personal Doctor (Q38). Improvement efforts focused on these measures can also result in improvement on the global rating questions.

Your **Opportunity Analysis** based on this information is presented on the next page.

KEY DRIVERS

Cost ($\beta = 1.477$)
Plan Administration ($\beta = 0.651$)
Access to Information ($\beta = 0.442$)

Rating of
Health
Plan

KEY DRIVERS

Cost ($\beta = 0.991$)
Getting Needed Care ($\beta = 1.006$)

Rating of
Health
Care

Rating of
Personal
Doctor

KEY DRIVERS

How Well Doctors Communicate ($\beta = 1.832$)
Coordination of Care ($\beta = 0.615$)

This Opportunity Analysis displays both high performing measures and measures that are opportunities for improvement.

STRENGTH - Mean Scores **at or above the 75th percentile** when compared to the 2019 SPH Analytics Book of Business.

MONITOR - Mean Scores **above the 50th percentile and below the 75th percentile** when compared to the 2019 SPH Analytics Book of Business should be monitored, as they do have a significant impact on members' overall ratings.

OPPORTUNITY - Mean Scores that fall **at or below the 50th percentile** when compared to the 2019 SPH Analytics Book of Business should be investigated and improved upon.

≥75th

50-75th

≤50th

Rating of Health Plan

These Composites have been identified by SPH as Key Drivers of Rating of Health Plan.

Access to Information

STRENGTH

Plan Administration

STRENGTH

Cost

STRENGTH

Rating of Health Care

These Composites have been identified by SPH as Key Drivers of Rating of Health Care.

Getting Needed Care

MONITOR

Cost

STRENGTH

Rating of Personal Doctor

These Composites have been identified by SPH as Key Drivers of Rating of Personal Doctor.

How Well Doctors Communicate

OPPORTUNITY

Coordination of Care

OPPORTUNITY

VALID SURVEYS

 Total Number of Internet Completes = **73**
 Total Number of Phone Completes = **66**
 Total Number of Mail Completes = **115**

2019 RESPONSE RATE

The response rate is the total number of completed surveys divided by the total number of respondents selected. For analysis and reports, this rate is calculated as shown in the following formula:

C

$$\frac{C}{(C+E)+(R+O)+(X*U)} = \text{Response Rate}$$

C = Completed Surveys (Disposition code 10)

E = Partial Completed Surveys (Disposition code 31)

U = Cases with unknown eligibility (Disposition codes 33, 34, 35)

O = Other disposition (Disposition codes 22 and 24)

R = Refusal (Disposition code 32)

I = Ineligible (Disposition codes 20, 40, 43)

X = The proportion of cases that were eligible for this survey, which is calculated as $X = (C+E)/(C+E+I+O+R)$

Your plan's 2019 response rate is **25.6%**

Your plan had **5** surveys completed in Spanish for 2019.

The 2019 SPH Book of Business average response rate is **23.6%**.

2018 RESPONSE RATE

Your plan's response rate in 2018 was **25.2%**

		Code	Group	
Completed	Completed Survey	M, I, or T10	C	254
	SUBTOTAL			254
Ineligible	Deceased	X20	I	1
	Not Eligible	X40	I	24
	"Do Not Survey" list	X43	I	0
	SUBTOTAL			25
Non-response	Partially Completed Survey	M, I or T31	E	29
	Language Barrier	X22	O	5
	Mentally/Physically Incapacitated	X24	O	1
	Refusal	X32	R	101
	Blank Survey Returned	X34	U	0
	No Response after Maximum Attempts	X33	U	881
	Bad Address/Phone	X35	U	4
	SUBTOTAL			1021

1,300



Profile of Survey Respondents

Demographic Composition

- Florida Health Care Plan, Inc.
- Project Number: 80134923



Demographic Profile The demographic characteristics of respondents surveyed should be representative of your member population. SPH Analytics follows CMS protocol to help achieve a representative sample of your plan's member population.

The percentages of respondents are displayed by demographic category (Age, Gender, Health Status, Mental/Emotional Health Status, Education, Ethnicity, Race, Metal Level, and Employment Status) from your current survey, compared to trend data (if applicable) and the 2019 SPH Analytics Book of Business benchmark.

The demographic makeup of your plan's member base may not mirror the "average" plan; therefore, caution is recommended when making comparisons to benchmark data. To help you identify how your plan's population compares to other plans and to previous data, statistically significant differences are highlighted with green or red text.

Significance Testing

Green – Current year score significantly higher when compared to trend or benchmark score.

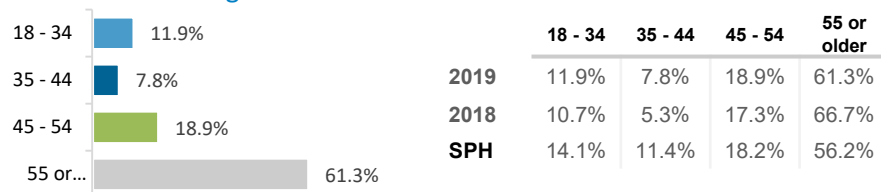
Red – Current year score significantly lower when compared to trend or benchmark score.

No color denotes that there was no significant difference between the percentages or that there was insufficient sample size to conduct the statistical test. All significance testing is performed at the 95% significance level.

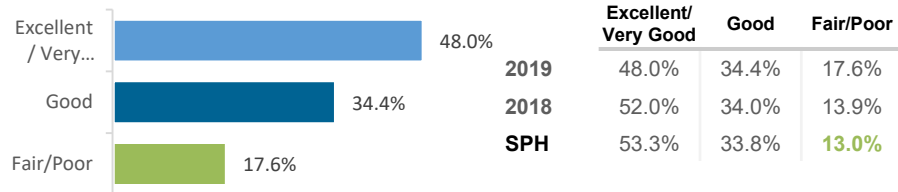
Survey Demographics

The demographic characteristics of respondents surveyed should be representative of your member population. SPH Analytics follows CMS protocol to help achieve a representative sample of your plan's member population.

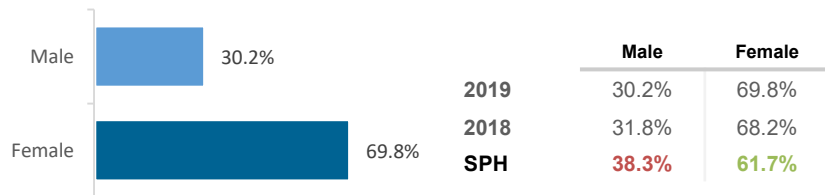
Age



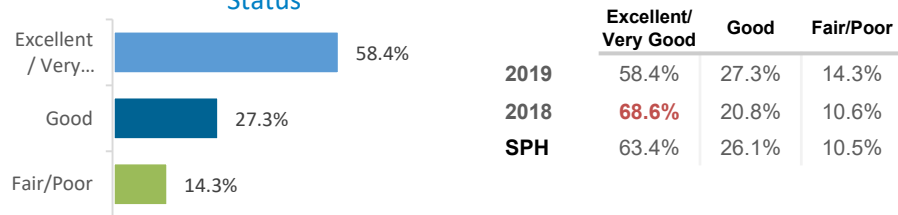
Health Status



Gender



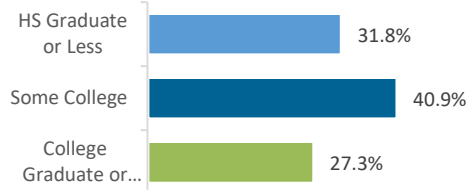
Mental/Emotional Health Status



Survey Demographics

The demographic characteristics of respondents surveyed should be representative of your member population. SPH Analytics follows CMS protocol to help achieve a representative sample of your plan's member population.

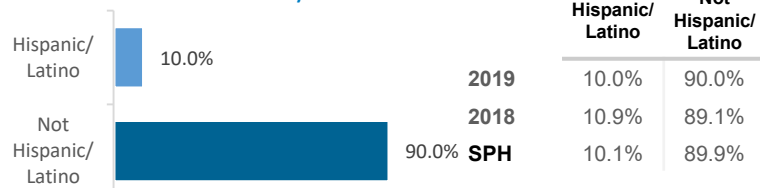
Education



2019
2018
SPH

HS Graduate or Less	Some College	College Graduate or More
31.8%	40.9%	27.3%
32.8%	47.1%	20.1%
31.8%	29.5%	38.7%

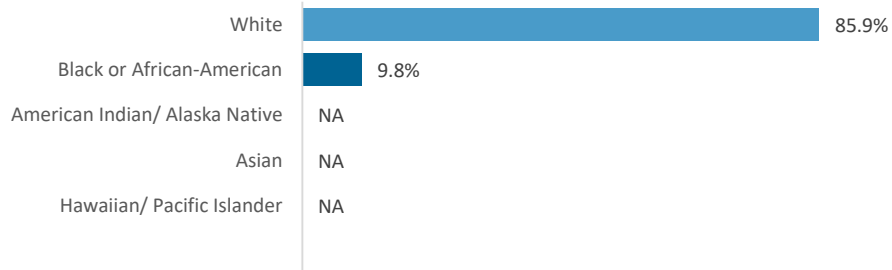
Ethnicity



2019
2018
SPH

Hispanic/Latino	Not Hispanic/Latino
10.0%	90.0%
10.9%	89.1%
10.1%	89.9%

Race

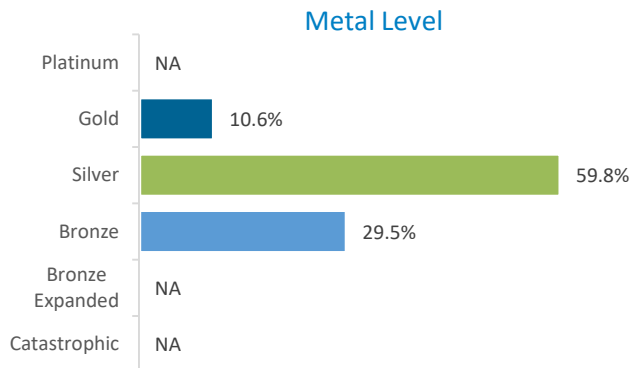


2019
2018
SPH

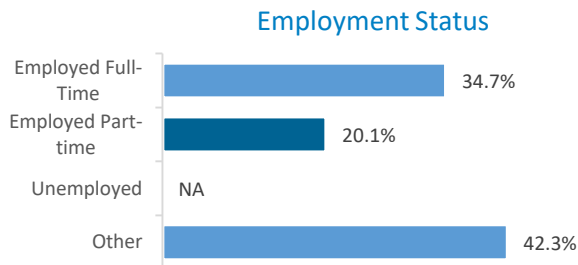
White	Black or African-American	American Indian/Alaska Native	Asian	Hawaiian/Pacific Islander
85.9%	9.8%	NA	NA	NA
87.0%	6.1%	NA	6.1%	NA
86.0%	7.8%	2.2%	6.6%	0.8%

Survey Demographics

The demographic characteristics of respondents surveyed should be representative of your member population. SPH Analytics follows CMS protocol to help achieve a representative sample of your plan's member population.



	Platinum	Gold	Silver	Bronze	Bronze Expanded	Catastrophic
2019	NA	10.6%	59.8%	29.5%	NA	NA
2018	NA	NA	NA	95.5%	NA	NA
SPH	3.1%	15.9%	52.7%	27.3%	0.1%	0.6%



	Employed Full-Time	Employed Part-time	Unemployed	Other
2019	34.7%	20.1%	NA	42.3%
2018	38.4%	17.4%	5.0%	39.3%
SPH	43.3%	17.7%	3.7%	35.2%



Summary of Trend and Benchmarks

Scaled Mean Scores

Summary Rate Scores

Top Box Scores

Percentile Rankings

- Florida Health Care Plan, Inc.
- Project Number: 80134923



Trend and Benchmark Comparisons The QHP Enrollee Experience survey is designed to use composite scores to facilitate the aggregation of information and the communication of results. Questions are combined into composite categories comprising a particular service area managed by your plan. These composites, the questions that make up composites (attributes), additional measures, and rating questions are shown on the following pages.

Scaled Mean Scores show how your plan's 2019 composite and key question Scaled Mean Scores compare to your scores from the previous year's results (if applicable), as well as to Scaled Mean Scores in the 2019 SPH Analytics Book of Business and the 2018 CMS National Data. Significant differences are highlighted.

Summary Rate Scores show how your plan's composite and key question Summary Rates compare to scores from the previous year's results (if applicable) and scores from the 2019 SPH Analytics Book of Business. Significant differences are highlighted. The *Annual Flu Vaccine* and *Medical Assistance with Smoking and Tobacco Use Cessation* measures are only displayed in this section.

Top Box Scores show how your plan's 2019 composite and key question Top Box Scores compare to your scores from the previous year's results (if applicable), as well as to Top Box Scores in 2019 SPH Analytics Book of Business. Significant differences are highlighted.

Significance Testing

Green – Current year score significantly higher when compared to trend or benchmark score.

Red – Current year score significantly lower when compared to trend or benchmark score.

No color denotes that there was no significant difference between the percentages or that there was insufficient sample size to conduct the statistical test. All significance testing is performed at the 95% significance level.

Available Benchmarks

The following benchmarks are used throughout the report.

	2018 CMS National Data	2019 SPH Analytics Book of Business
	Includes all QHP plans that conducted a survey in 2018. Calculated on the respondent level.	Includes all QHP plans that conducted a survey with SPH Analytics in 2019. Calculated on the plan level.
PROS	Provides national scores from 2018	Includes unadjusted current year data
CONS	- Percentile thresholds are not available for comparisons - Data is from 2018 - Will not match CMS benchmark reporting for 2019 - Does not provide benchmark data for Summary Rate and Top Box scores.	- Limited to plans conducting surveys with SPH Analytics - Will not match CMS benchmark reporting for 2018
CONTAINS DATA FROM	All plans that meet the minimum criteria for scoring.	84 plans

SUMMARY INDICATOR: ENROLLEE EXPERIENCE

	Valid n	2019	2018	2019 SPH Book of Business	2019 SPH Scaled Mean Percentile Rank	2018 CMS National Data
Access to Care*		76.7	82.8	75.7	57th	X
Getting Care Quickly		77.0	81.6	76.9	47th	78.4
20 Obtained needed care right away	126	76.5	84.4	77.3	36th	81.1
21 Obtained appointment for care as soon as needed	213	77.6	78.8	76.5	57th	75.8
Getting Needed Care		76.4	84.1	74.6	64th	78.6
23 Ease of getting care, tests, or treatment needed	199	82.9	85.4	79.4	81st	79.8
39 Obtained appointment with specialist as soon as needed	155	69.9	82.8	69.7	40th	77.4
Care Coordination		80.1	85.9	82.7	18th	83.4
31 Doctors had medical records or care information	190	89.5	94.0	91.5	17th	91.6
32 Doctor's office followed up with test results	175	78.5	80.2	82.3	17th	X
33 Obtained test results as soon as needed	175	82.5	86.8	85.1	19th	X
32 + 33 Combined Item - Test Results	175	80.5	83.5	83.7	17th	86.7
41 Doctors were informed and up-to-date about specialist care	121	69.7	82.3	73.7	17th	76.2
34 Discussed prescription medicines	169	84.8	85.9	86.1	31st	82.5
37 Obtained help needed from doctor's office to manage care	32	76.0	84.0	78.6	36th	79.4

10

Total QRS Measures

6

Above 2019 SPH Book Of Business Benchmark

4

Below 2019 SPH Book Of Business Benchmark

*The Access to Care composite contains the questions from Getting Needed Care and Getting Care Quickly.

Results in SPH reporting are unofficial and do not represent official results provided by CMS.

SUMMARY INDICATOR: ENROLLEE EXPERIENCE *(continued)*

	Valid n	2019	2018	2019 SPH Book of Business	2019 SPH Scaled Mean Percentile Rank	2018 CMS National Data
Rating of All Health Care	197	81.4	86.1	77.8	92nd	82.3
Rating of Personal Doctor	190	86.4	89.1	87.7	25th	88.4
Rating of Specialist	126	81.3	86.1	85.4	<10th	86.9

10

Total QRS Measures

SUMMARY INDICATOR: PLAN EFFICIENCY, AFFORDABILITY, AND MANAGEMENT

	Valid n	2019	2018	2019 SPH Book of Business	2019 SPH Scaled Mean Percentile Rank	2018 CMS National Data
Access to Information		54.0	66.3	48.0	94th	57.8
3 Providing Needed Information	168	52.2	63.0	54.4	40th	60.9
4 Able to find out from health plan cost of health care service or equipment	159	53.2	61.8	45.5	93rd	53.8
5 Able to find out from health plan cost of prescription medicines	153	56.6	74.1	44.2	96th	58.9
Plan Administration		73.8	81.6	70.2	76th	X
6 Getting information/help from customer service	168	69.2	82.5	65.5	77th	72.9
7 Treated with courtesy and respect by customer service staff	167	87.4	93.1	85.4	66th	87.6
8 Longer than expected wait time to speak with customer service staff	165	81.4	73.7	71.5	93rd	62.0
9 Ease of Filling Out Forms	124	72.6	80.7	65.6	94th	67.6
10 Explanation of Forms	125	58.4	78.0	62.9	16th	70.9
Rating of Health Plan	247	74.0	80.9	68.8	83rd	74.5

6

Above 2019 SPH Book Of Business Benchmark

4

Below 2019 SPH Book Of Business Benchmark

OTHER MEASURES

	Valid n	2019	2018	2019 SPH Book of Business	2019 SPH Scaled Mean Percentile Rank	2018 CMS National Data
How Well Doctors Communicate		88.5	90.5	89.7	30th	89.8
27 Doctors explained things in an understandable way	189	88.7	91.0	90.1	29th	90.0
28 Doctors listened carefully to you	190	88.4	92.1	89.8	29th	89.9
29 Doctors showed respect for what you had to say	191	90.4	92.1	92.0	22nd	92.1
30 Doctors spent enough time with you	191	86.4	86.9	87.0	43rd	87.1
Cost		81.7	82.7	78.9	81st	78.8
13 Health plan did not pay for needed care	241	79.9	80.8	78.2	64th	77.1
14 Paid out of own pocket for care you thought would be covered	248	82.0	80.4	75.8	92nd	75.8
15 Delayed or did not visit doctor because you were worried about cost	252	77.4	79.0	74.8	69th	76.0
16 Delayed or did not fill prescriptions because you were worried about cost	251	87.6	90.5	86.7	64th	86.3
Cultural Competence		55.6	NA	60.7	19th	69.5
24 Obtained interpreter when needed	22	15.2	NA	23.8	31st	64.6
11 Forms available in preferred language	123	84.3	83.7	87.4	24th	89.4
12 Forms available in needed format	57	67.3	NA	70.6	40th	60.3

10

Total QRS Measures

6

Above 2019 SPH Book Of Business Benchmark

4

Below 2019 SPH Book Of Business Benchmark

SUMMARY INDICATOR: ENROLLEE EXPERIENCE

	Valid n	2019	2018	2019 SPH Book of Business	2019 SPH Summary Rate Percentile Rank
Access to Care*		80.8%	85.7%	80.0%	49th
Getting Care Quickly		80.3%	82.6%	80.9%	39th
20 Obtained needed care right away	126	79.4%	85.7%	81.4%	34th
21 Obtained appointment for care as soon as needed	213	81.2%	79.5%	80.3%	54th
Getting Needed Care		81.3%	88.8%	79.2%	63rd
23 Ease of getting care, tests, or treatment needed	199	88.4%	90.9%	85.6%	70th
39 Obtained appointment with specialist as soon as needed	155	74.2%	86.7%	72.7%	51st
Care Coordination		83.3%	88.8%	85.7%	31st
31 Doctors had medical records or care information	190	93.7%	97.7%	94.8%	30th
32 Doctor's office followed up with test results	175	80.6%	81.3%	84.8%	19th
33 Obtained test results as soon as needed	175	86.9%	90.1%	89.8%	18th
32 + 33 Combined Item - Test Results	175	83.7%	85.4%	87.3%	18th
41 Doctors were informed and up-to-date about specialist care	121	74.4%	85.4%	77.4%	29th
34 Discussed prescription medicines	169	86.4%	87.7%	88.4%	24th
37 Obtained help needed from doctor's office to manage care	32	78.1%	88.0%	80.6%	37th

*The Access to Care composite contains the questions from Getting Needed Care and Getting Care Quickly.

Results in SPH reporting are unofficial and do not represent official results provided by CMS.

SUMMARY INDICATOR: ENROLLEE EXPERIENCE *(continued)*

	Valid n	2019	2018	2019 SPH Book of Business	2019 SPH Summary Rate Percentile Rank
Rating of All Health Care	197	70.6%	81.4%	65.2%	80th
Rating of Personal Doctor	190	83.2%	87.2%	84.6%	40th
Rating of Specialist	126	70.6%	82.5%	80.3%	<10th

SUMMARY INDICATOR: CLINICAL QUALITY MANAGEMENT

	Valid n	2019	2018	2019 SPH Book of Business	2019 SPH Summary Rate Percentile Rank
Medical Assistance with Smoking and Tobacco Use Cessation (Current Year)		66.1%	67.3%	52.9%	83rd
47 Advising Smokers and Tobacco Users to Quit	28	82.1%	88.2%	69.5%	86th
48 Discussing Cessation Medications	28	64.3%	60.6%	46.3%	89th
49 Discussing Cessation Strategies	27	51.9%	53.1%	42.8%	69th
Medical Assistance with Smoking and Tobacco Use Cessation (Rolling Average)		66.8%	61.0%	52.9%	90th
47 Advising Smokers and Tobacco Users to Quit	62	85.5%	81.4%	69.5%	91st
48 Discussing Cessation Medications	61	62.3%	54.4%	46.3%	83rd
49 Discussing Cessation Strategies	59	52.5%	47.4%	42.8%	71st
Flu Vaccinations (18-64)	236	41.1%	38.8%	47.3%	22nd

Results in SPH reporting are unofficial and do not represent official results provided by CMS.

SUMMARY INDICATOR: PLAN EFFICIENCY, AFFORDABILITY, AND MANAGEMENT

	Valid n	2019	2018	2019 SPH Book of Business	2019 SPH Summary Rate Percentile Rank
Access to Information		50.3%	69.4%	45.5%	80th
3 Providing Needed Information	168	46.4%	69.5%	51.5%	25th
4 Able to find out from health plan cost of health care service or equipment	159	51.6%	61.0%	43.0%	90th
5 Able to find out from health plan cost of prescription medicines	153	52.9%	77.8%	42.2%	93rd
Plan Administration		77.4%	87.1%	73.9%	72nd
6 Getting information/help from customer service	168	71.4%	85.4%	64.3%	82nd
7 Treated with courtesy and respect by customer service staff	167	91.6%	97.6%	88.7%	70th
8 Longer than expected wait time to speak with customer service staff	165	89.1%	84.0%	79.8%	90th
9 Ease of Filling Out Forms	124	75.0%	84.4%	70.7%	75th
10 Explanation of Forms	125	60.0%	84.1%	66.2%	16th
Rating of Health Plan	247	57.1%	70.5%	47.0%	84th

OTHER MEASURES

	Valid n	2019	2018	2019 SPH Book of Business	2019 SPH Summary Rate Percentile Rank
How Well Doctors Communicate		91.3%	93.4%	93.6%	17th
27 Doctors explained things in an understandable way	189	92.1%	93.7%	94.4%	19th
28 Doctors listened carefully to you	190	90.0%	96.0%	93.6%	<10th
29 Doctors showed respect for what you had to say	191	92.1%	94.3%	94.9%	12th
30 Doctors spent enough time with you	191	91.1%	89.6%	91.4%	40th
Cost		87.9%	88.2%	85.1%	78th
13 Health plan did not pay for needed care	241	84.6%	83.9%	84.3%	47th
14 Paid out of own pocket for care you thought would be covered	248	89.1%	88.0%	84.2%	89th
15 Delayed or did not visit doctor because you were worried about cost	252	84.9%	84.8%	80.3%	76th
16 Delayed or did not fill prescriptions because you were worried about cost	251	92.8%	95.9%	91.7%	65th
Cultural Competence		NA	NA	61.2%	NA
24 Obtained interpreter when needed	22	NA	NA	22.2%	NA
11 Forms available in preferred language	123	85.4%	84.4%	88.2%	28th
12 Forms available in needed format	57	70.2%	NA	72.6%	42nd

SUMMARY INDICATOR: ENROLLEE EXPERIENCE

	Valid n	2019	2018	2019 SPH Book of Business	2019 SPH Top Box Percentile Rank
Access to Care*		56.4%	65.1%	54.1%	71st
Getting Care Quickly		58.3%	65.5%	56.2%	67th
20 Obtained needed care right away	126	60.3%	70.1%	57.8%	69th
21 Obtained appointment for care as soon as needed	213	56.3%	60.8%	54.7%	60th
Getting Needed Care		54.5%	64.7%	51.9%	72nd
23 Ease of getting care, tests, or treatment needed	199	61.3%	65.2%	54.7%	89th
39 Obtained appointment with specialist as soon as needed	155	47.7%	64.2%	49.2%	36th
Care Coordination		62.4%	72.6%	67.1%	18th
31 Doctors had medical records or care information	190	75.8%	84.4%	81.1%	14th
32 Doctor's office followed up with test results	175	62.3%	68.0%	68.0%	16th
33 Obtained test results as soon as needed	175	64.0%	72.8%	68.2%	25th
32 + 33 Combined Item - Test Results	175	63.1%	70.2%	68.1%	17th
41 Doctors were informed and up-to-date about specialist care	121	50.4%	65.6%	53.7%	28th
34 Discussed prescription medicines	169	72.8%	74.7%	73.3%	39th
37 Obtained help needed from doctor's office to manage care	32	50.0%	68.0%	59.5%	18th

*The Access to Care composite contains the questions from Getting Needed Care and Getting Care Quickly.

Results in SPH reporting are unofficial and do not represent official results provided by CMS.

SUMMARY INDICATOR: ENROLLEE EXPERIENCE *(continued)*

	Valid n	2019	2018	2019 SPH Book of Business	2019 SPH Top Box Percentile Rank
Rating of All Health Care	197	51.8%	63.3%	41.6%	93rd
Rating of Personal Doctor	190	66.8%	69.2%	68.3%	39th
Rating of Specialist	126	54.8%	65.8%	62.5%	<10th

SUMMARY INDICATOR: PLAN EFFICIENCY, AFFORDABILITY, AND MANAGEMENT

	Valid n	2019	2018	2019 SPH Book of Business	2019 SPH Top Box Percentile Rank
Access to Information		31.2%	35.6%	25.3%	89th
3 Providing Needed Information	168	26.2%	24.4%	25.9%	48th
4 Able to find out from health plan cost of health care service or equipment	159	30.8%	34.1%	24.6%	87th
5 Able to find out from health plan cost of prescription medicines	153	36.6%	48.1%	25.3%	94th
Plan Administration		53.3%	62.0%	47.7%	82nd
6 Getting information/help from customer service	168	47.6%	64.6%	43.9%	70th
7 Treated with courtesy and respect by customer service staff	167	75.4%	82.9%	72.5%	72nd
8 Longer than expected wait time to speak with customer service staff	165	58.2%	45.7%	44.3%	92nd
9 Ease of Filling Out Forms	124	50.8%	60.0%	37.4%	94th
10 Explanation of Forms	125	34.4%	56.8%	40.1%	17th
Rating of Health Plan	247	39.7%	53.3%	28.5%	93rd

Results in SPH reporting are unofficial and do not represent official results provided by CMS.

OTHER MEASURES

	Valid n	2019	2018	2019 SPH Book of Business	2019 SPH Top Box Percentile Rank
How Well Doctors Communicate		76.0%	79.4%	76.8%	41st
27 Doctors explained things in an understandable way	189	75.7%	81.0%	76.9%	40th
28 Doctors listened carefully to you	190	76.8%	80.9%	77.0%	48th
29 Doctors showed respect for what you had to say	191	80.6%	82.2%	81.8%	35th
30 Doctors spent enough time with you	191	70.7%	73.4%	71.6%	46th
Cost		64.4%	66.3%	59.3%	81st
13 Health plan did not pay for needed care	241	65.6%	67.4%	58.7%	83rd
14 Paid out of own pocket for care you thought would be covered	248	61.7%	59.5%	51.0%	92nd
15 Delayed or did not visit doctor because you were worried about cost	252	56.7%	60.2%	54.9%	64th
16 Delayed or did not fill prescriptions because you were worried about cost	251	73.7%	78.1%	72.7%	61st
Cultural Competence		NA	NA	52.1%	NA
24 Obtained interpreter when needed	22	NA	NA	16.5%	NA
11 Forms available in preferred language	123	78.0%	77.8%	81.7%	25th
12 Forms available in needed format	57	54.4%	NA	58.1%	36th



Composite Analyses

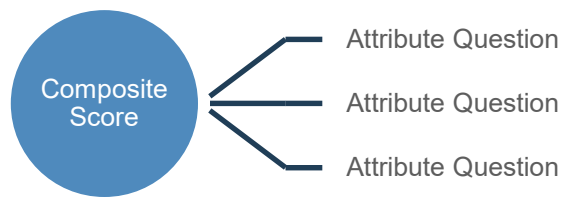
Composite Details and Scoring

- Florida Health Care Plan, Inc.
- Project Number: 80134923

Drilling Down Into Composites and Ratings

This section is designed to give plans a detailed report on the performance of each composite and rating measure.

The Composite Analyses typically consists of two pages. The first page displays composite level details and the second displays results for the questions contained within the composite. It is critical to look at these attribute questions to determine is there is a particular aspect of care that is driving your composite score.



Analyses included in this section include: Plan Scaled Mean Scores with comparisons to benchmarks, trending (if available), percentile rankings, and correlations.

Note: The CMS National Data Benchmark represents values calculated using data from the previous year's survey administration.

Measures Included in Composite Analyses

- Getting Needed Care
- Getting Care Quickly
- Cultural Competence
- Care Coordination
- Plan Administration
- Access to Information
- Rating of Health Plan
- Rating of Health Care
- Rating of Personal Doctor
- Rating of Specialist

Percentile Rankings

	<25	25-50	50-75	75-90	>90
Measure 1	Red	Orange	Yellow	Light Green	Dark Green
Measure 2	Red	Orange	Yellow	Dark Green	Light Green
Measure 3	Red	Orange	Yellow	Light Green	Dark Green
Measure 4	Red	Dark Orange	Yellow	Light Green	Dark Green
Measure 5	Dark Red	Orange	Yellow	Light Green	Dark Green

PERCENTILE RANKING 2019 SPH BOOK OF BUSINESS

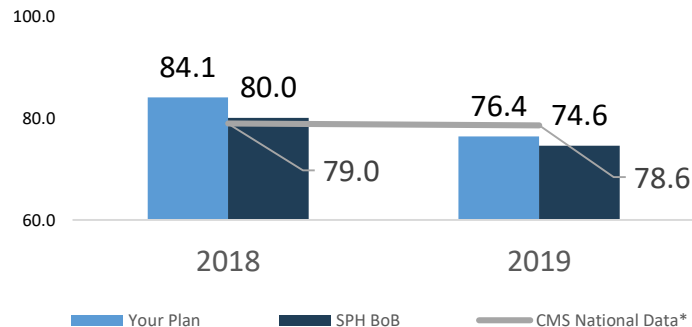


NATIONAL TRENDS

CMS Scaled Mean scores for Getting Needed Care **decreased** by 0.4 to 78.6 from 2017.

The SPH BoB has **decreased** by 5.4 since 2018.

GETTING NEEDED CARE – TRENDING AND BENCHMARKS



*Please note that the CMS National Benchmark represents the previous years measurement period.

COMPARISON TO TRENDING

2019 Scaled Mean Score	2018 Trend	Change**	Sig. Test
76.4	84.1	-7.7	↔

COMPARISON TO BENCHMARKS

	Scaled Mean Score	Gap**	Sig. Test
2019 SPH BoB	74.6	1.8	↔
2018 CMS National Benchmark	78.6	-2.2	↔

**Please note that the "Change" and "Gap" comparison may vary slightly due to rounding.

Results in SPH reporting are unofficial and do not represent official results provided by CMS.

GETTING NEEDED CARE QUESTIONS

The Getting Needed Care composite score is calculated by taking the average of two questions:

- Q23. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
- Q39. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

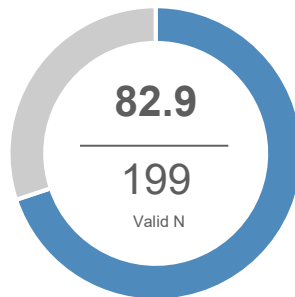
2019 GNC COMPOSITE SCALED MEAN SCORE

76.4

CORRELATION WITH RATING QUESTIONS

	With Health Plan	With Health Care	With Personal Doctor	With Specialist
Q23	0.521	0.608	0.304	0.328
Q39	0.300	0.216	0.236	0.191

Q23. Ease of getting care, tests, or treatment needed

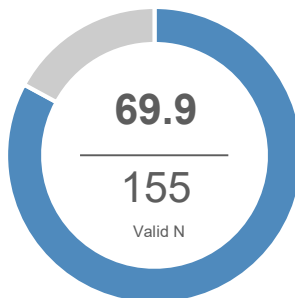


2019	82.9
2018	85.4
SPH	79.4
CMS	79.8

Percentile Ranking 2019 SPH BoB



Q39. Obtained appointment with specialist as soon as needed

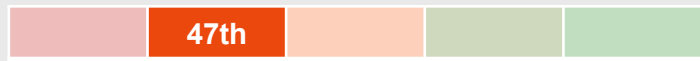


2019	69.9
2018	82.8
SPH	69.7
CMS	77.4

Percentile Ranking 2019 SPH BoB



PERCENTILE RANKING 2019 SPH BOOK OF BUSINESS

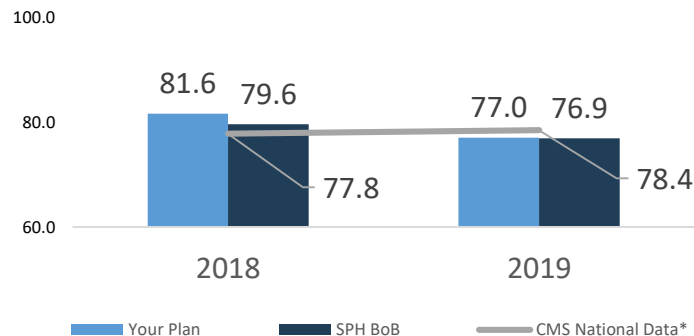


NATIONAL TRENDS

CMS Scaled Mean scores for Getting Care Quickly **increased** by 0.7 to 78.4 from 2017.

The SPH BoB has **decreased** by 2.7 since 2018.

GETTING CARE QUICKLY – TRENDING AND BENCHMARKS



*Please note that the CMS National Benchmark represents the previous years measurement period.

COMPARISON TO TRENDING

2019 Scaled Mean Score	2018 Trend	Change**	Sig. Test
77.0	81.6	-4.6	↔

COMPARISON TO BENCHMARKS

	Scaled Mean Score	Gap**	Sig. Test
2019 SPH BoB	76.9	0.1	↔
2018 CMS National Benchmark	78.4	-1.4	↔

**Please note that the "Change" and "Gap" comparison may vary slightly due to rounding.

Results in SPH reporting are unofficial and do not represent official results provided by CMS.

GETTING CARE QUICKLY QUESTIONS

The Getting Care Quickly composite score is calculated by taking the average of two questions:

- Q20. In the last 6 months, when you needed care right away, in an emergency room, doctor's office, or clinic, how often did you get care as soon as you needed?
- Q21. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

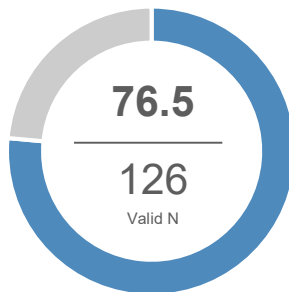
2019 GCQ COMPOSITE SCALED MEAN SCORE

77.0

CORRELATION WITH RATING QUESTIONS

	With Health Plan	With Health Care	With Personal Doctor	With Specialist
Q20	0.441	0.386	0.125	0.261
Q21	0.414	0.362	0.270	0.211

Q20. Obtained needed care right away

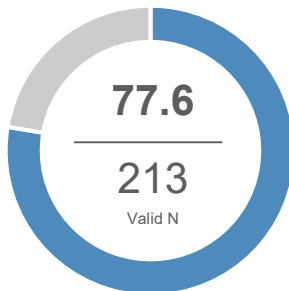


2019	76.5
2018	84.4
SPH	77.3
CMS	81.1

Percentile Ranking 2019 SPH BoB



Q21. Obtained appointment for care as soon as needed



2019	77.6
2018	78.8
SPH	76.5
CMS	75.8

Percentile Ranking 2019 SPH BoB



PERCENTILE RANKING 2019 SPH BOOK OF BUSINESS

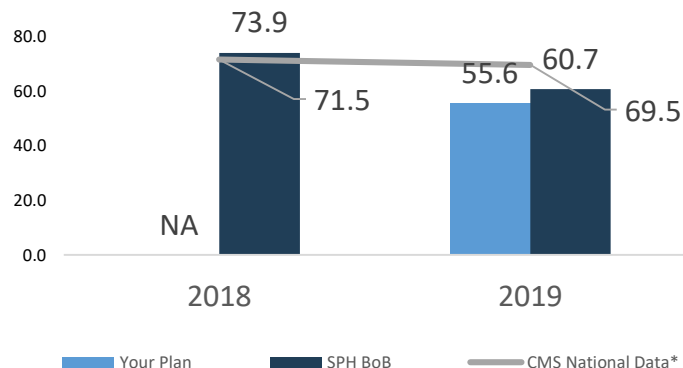
19th

NATIONAL TRENDS

CMS Scaled Mean scores for Cultural Competence **decreased** by 2.0 to 69.5 from 2017.

The SPH BoB has **decreased** by 13.2 since 2018.

CULTURAL COMPETENCE – TRENDING AND BENCHMARKS



*Please note that the CMS National Benchmark represents the previous years measurement period.

COMPARISON TO TRENDING

2019 Scaled Mean Score	2018 Trend	Change**	Sig. Test
55.6	NA	NA	↔

COMPARISON TO BENCHMARKS

	Scaled Mean Score	Gap**	Sig. Test
2019 SPH BoB	60.7	-5.1	↔
2018 CMS National Benchmark	69.5	-14.0	↓

**Please note that the "Change" and "Gap" comparison may vary slightly due to rounding.

Results in SPH reporting are unofficial and do not represent official results provided by CMS.

CULTURAL COMPETENCE QUESTIONS

The Cultural Competence composite score is calculated by taking the average of three questions:

- Q24. In the last 6 months, when you needed an interpreter at your doctor's office or clinic, how often did you get one?
- Q11. In the last 6 months, how often were the forms that you had to fill out available in the language you prefer?
- Q12. In the last 6 months, how often were the forms that you had to fill out available in the format you needed, such as large print or braille?

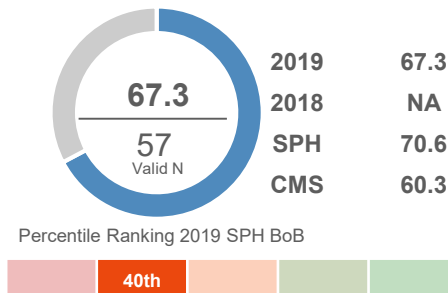
2019 CULTURAL COMPETENCE COMPOSITE SCALED MEAN SCORE

55.6

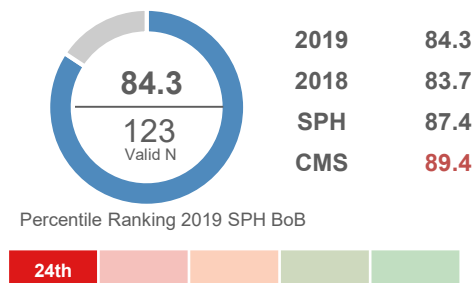
CORRELATION WITH RATING QUESTIONS

	With Health Plan	With Health Care	With Personal Doctor	With Specialist
Q11	0.185	0.087	0.185	0.047
Q12	0.391	0.141	0.430	0.106
Q24	0.196	0.123	0.131	0.207

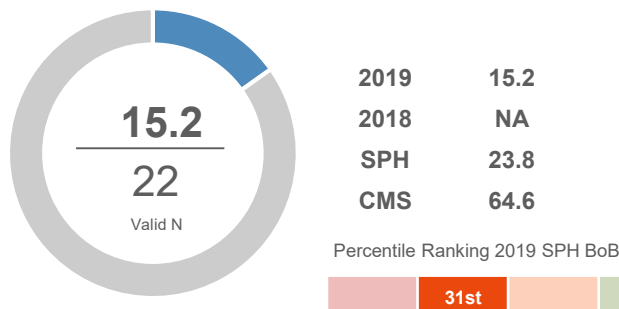
Q12. Forms available in needed format



Q11. Forms available in preferred language



Q24. Obtained interpreter when needed



PERCENTILE RANKING 2019 SPH BOOK OF BUSINESS

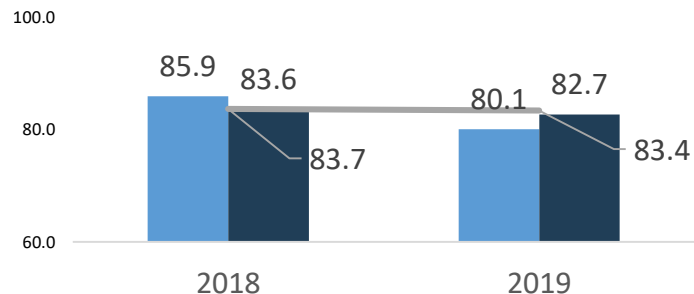
18th

NATIONAL TRENDS

CMS Scaled Mean scores for Care Coordination **decreased** by 0.3 to 83.4 from 2017.

The SPH BoB has **decreased** by 0.9 since 2018.

CARE COORDINATION – TRENDING AND BENCHMARKS



*Please note that the CMS National Benchmark represents the previous years measurement period.

COMPARISON TO TRENDING

2019 Scaled Mean Score	2018 Trend	Change**	Sig. Test
80.1	85.9	-5.8	↔

COMPARISON TO BENCHMARKS

	Scaled Mean Score	Gap**	Sig. Test
2019 SPH BoB	82.7	-2.6	↔
2018 CMS National Benchmark	83.4	-3.3	↔

**Please note that the "Change" and "Gap" comparison may vary slightly due to rounding.

Results in SPH reporting are unofficial and do not represent official results provided by CMS.

CARE COORDINATION QUESTIONS

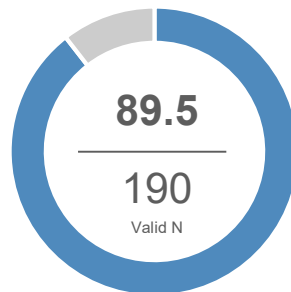
The Care Coordination composite comprises of 6 questions. The average of Q32 and Q33 is calculated to generate the Test Results combined item. The average of Q31, Q34, Q37, Q41, and the Test Results combined item is then calculated to obtain the Care Coordination composite score.

- Q31. When you visited your personal doctor for a scheduled appointment in the last 6 months, how often did he or she have your medical records or other information about your care?
- Q32. In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
- Q33. In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did you get those results as soon as you needed them?
- Q34. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?
- Q37. In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
- Q41. In the last 6 months, how often did you get the help that you needed from your personal doctor's office to manage your care among these different providers and services?

**2019 CARE COORDINATION
COMPOSITE SCALED MEAN SCORE**

80.1

Q31. Doctors had medical records or care information

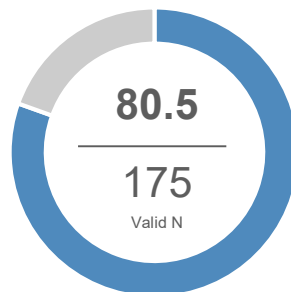


2019	89.5
2018	94.0
SPH	91.5
CMS	91.6

Percentile Ranking 2019 SPH BoB



Q32 + Q33. Combined Item – Test Results



2019	80.5
2018	83.5
SPH	83.7
CMS	86.7

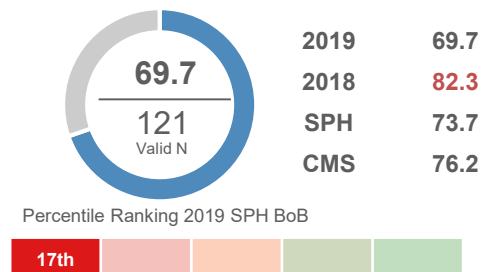
Percentile Ranking 2019 SPH BoB



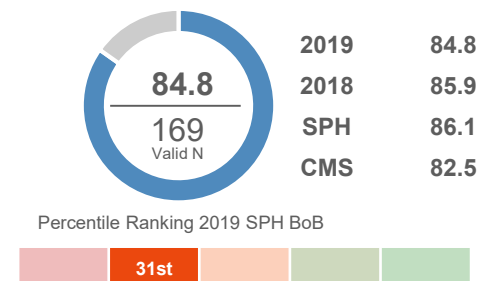
CORRELATION WITH RATING QUESTIONS

	With Health Plan	With Health Care	With Personal Doctor	With Specialist
Q31	0.299	0.323	0.516	0.123
Q32	0.108	0.198	0.415	0.107
Q33	0.242	0.248	0.426	0.153
Q34	0.204	0.097	0.469	0.191
Q37	0.304	0.403	0.430	0.288
Q41	0.170	0.193	0.508	0.181

Q41. Doctors were informed and up-to-date about specialist care



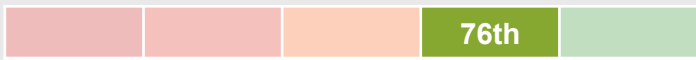
Q34. Discussed prescription medicines



Q37. Obtained help needed from doctor's office to manage care



PERCENTILE RANKING 2019 SPH BOOK OF BUSINESS

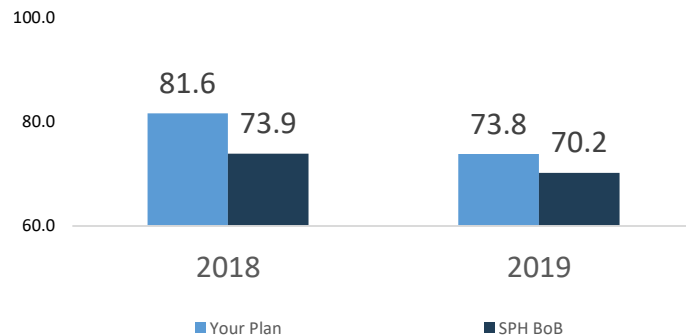


NATIONAL TRENDS

Due to additional questions being included in the Plan Administration composite, CMS National Data Benchmarks are not shown.

The SPH BoB has **decreased** by 3.7 since 2018.

PLAN ADMINISTRATION – TRENDING AND BENCHMARKS



COMPARISON TO TRENDING

2019 Scaled Mean Score	2018 Trend	Change**	Sig. Test
73.8	81.6	-7.8	↔

COMPARISON TO BENCHMARKS

	Scaled Mean Score	Gap**	Sig. Test
2019 SPH BoB	70.2	3.6	↔
2018 CMS National Benchmark	X	X	↔

**Please note that the "Change" and "Gap" comparison may vary slightly due to rounding.

Results in SPH reporting are unofficial and do not represent official results provided by CMS.

PLAN ADMINISTRATION QUESTIONS

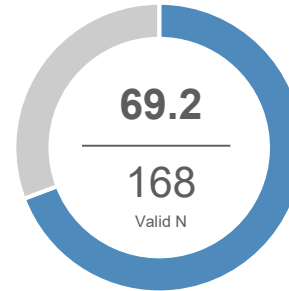
The Plan Administration composite score is calculated by taking the average of five questions:

- Q6. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?
- Q7. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?
- Q8. In the last 6 months, how often did the time that you waited to talk to your health plan's customer service staff take longer than you expected?
- Q9. In the last 6 months, how often were the forms from your health plan easy to fill out?
- Q10. In the last 6 months, how often did the health plan explain the purpose of a form before you filled it out?

**2019 PLAN ADMINISTRATION
COMPOSITE SCALED MEAN SCORE**

73.8

Q6. Getting information/help from customer service

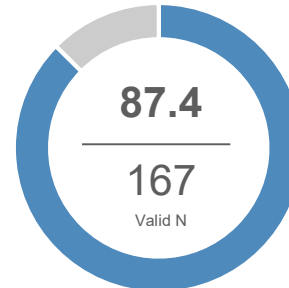


2019	69.2
2018	82.5
SPH	65.5
CMS	72.9

Percentile Ranking 2019 SPH BoB



Q7. Treated with courtesy and respect by customer service staff



2019	87.4
2018	93.1
SPH	85.4
CMS	87.6

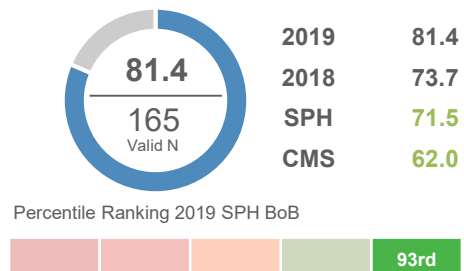
Percentile Ranking 2019 SPH BoB



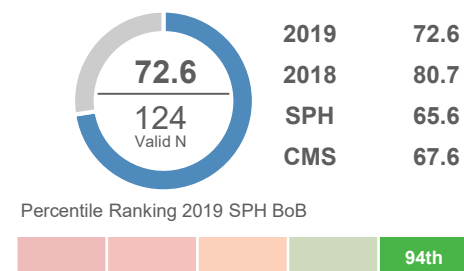
CORRELATION WITH RATING QUESTIONS

	With Health Plan	With Health Care	With Personal Doctor	With Specialist
Q6	0.440	0.367	0.195	0.223
Q7	0.486	0.362	0.181	0.383
Q8	0.214	0.308	0.107	0.359
Q9	0.433	0.476	0.318	0.429
Q10	0.396	0.347	0.216	0.258

Q8. Longer than expected wait time to speak with customer service staff



Q9. Ease of filling out forms



Q10. Explanation of forms



PERCENTILE RANKING 2019 SPH BOOK OF BUSINESS

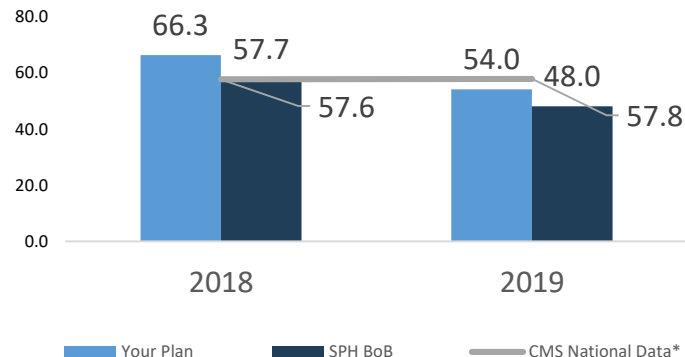


NATIONAL TRENDS

CMS Scaled Mean scores for Access to Information **increased** by 0.2 to 57.8 from 2017.

The SPH BoB has **decreased** by 9.7 since 2018.

ACCESS TO INFORMATION – TRENDING AND BENCHMARKS



*Please note that the CMS National Benchmark represents the previous years measurement period.

COMPARISON TO TRENDING

2019 Scaled Mean Score	2018 Trend	Change**	Sig. Test
54.0	66.3	-12.3	↔

COMPARISON TO BENCHMARKS

	Scaled Mean Score	Gap**	Sig. Test
2019 SPH BoB	48.0	6.0	↔
2018 CMS National Benchmark	57.8	-3.8	↔

**Please note that the "Change" and "Gap" comparison may vary slightly due to rounding.

Results in SPH reporting are unofficial and do not represent official results provided by CMS.

ACCESS TO INFORMATION QUESTIONS

The Access To Information composite score is calculated by taking the average of three questions:

- Q3. In the last 6 months, how often did written materials or the Internet provide the information you needed about how your health plan works?
- Q4. In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment before you got it?
- Q5. In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines?

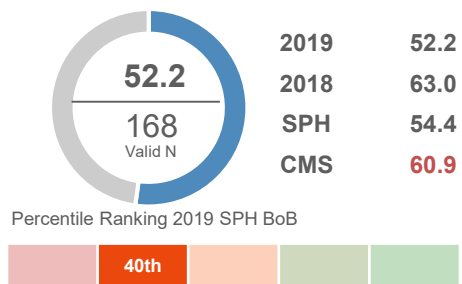
2019 ACCESS TO INFORMATION COMPOSITE SCALED MEAN SCORE

54.0

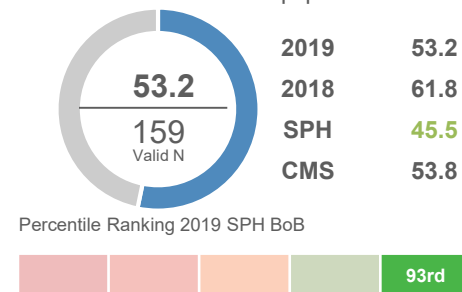
CORRELATION WITH RATING QUESTIONS

	With Health Plan	With Health Care	With Personal Doctor	With Specialist
Q3	0.227	0.226	0.251	0.265
Q4	0.210	0.247	0.088	0.204
Q5	0.338	0.440	0.089	0.334

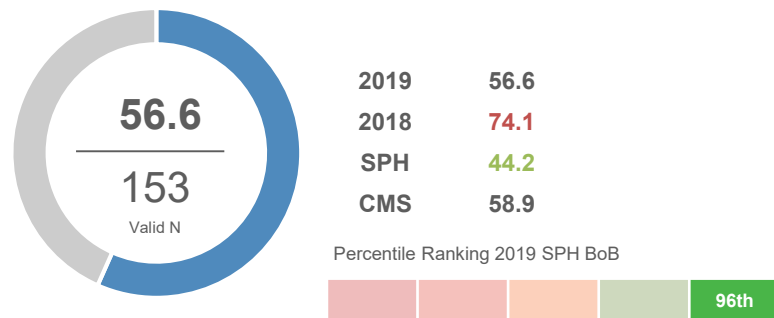
Q3. Providing needed information



Q4. Able to find out from health plan cost of health care service or equipment



Q5. Able to find out from health plan cost of prescription medicines



PERCENTILE RANKING 2019 SPH BOOK OF BUSINESS

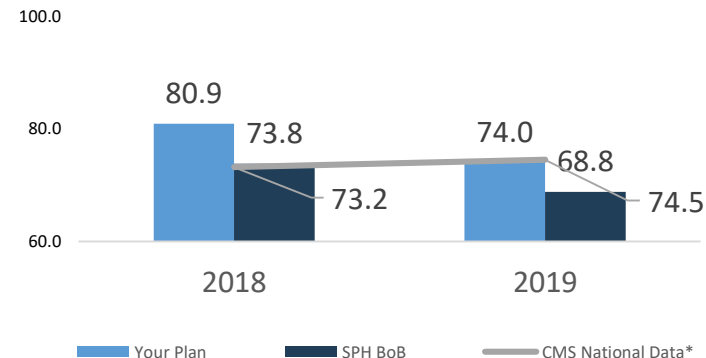


NATIONAL TRENDS

CMS Scaled Mean scores for Rating of Health Plan **increased** by 1.3 to 74.5 from 2017.

The SPH BoB has **decreased** by 5.0 since 2018.

RATING OF HEALTH PLAN – TRENDING AND BENCHMARKS



*Please note that the CMS National Benchmark represents the previous years measurement period.

COMPARISON TO TRENDING

2019 Scaled Mean Score	2018 Trend	Change**	Sig. Test
74.0	80.9	-6.9	↔

COMPARISON TO BENCHMARKS

	Scaled Mean Score	Gap**	Sig. Test
2019 SPH BoB	68.8	5.2	↔
2018 CMS National Benchmark	74.5	-0.4	↔

**Please note that the "Change" and "Gap" comparison may vary slightly due to rounding.

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PERCENTILE RANKING 2019 SPH BOOK OF BUSINESS

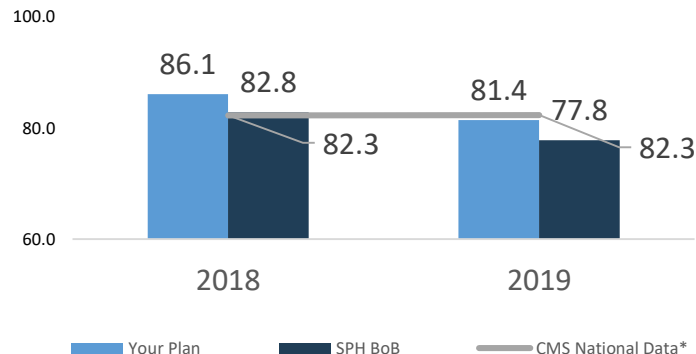


NATIONAL TRENDS

CMS Scaled Mean scores for Rating of Health Care **remained constant** at 82 for 2017 and 2018.

The SPH BoB has **decreased** by 5.0 since 2018.

RATING OF HEALTH CARE – TRENDING AND BENCHMARKS



*Please note that the CMS National Benchmark represents the previous years measurement period.

COMPARISON TO TRENDING

2019 Scaled Mean Score	2018 Trend	Change**	Sig. Test
81.4	86.1	-4.6	↔

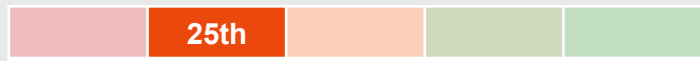
COMPARISON TO BENCHMARKS

	Scaled Mean Score	Gap**	Sig. Test
2019 SPH BoB	77.8	3.6	↔
2018 CMS National Benchmark	82.3	-0.9	↔

**Please note that the "Change" and "Gap" comparison may vary slightly due to rounding.

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PERCENTILE RANKING 2019 SPH BOOK OF BUSINESS

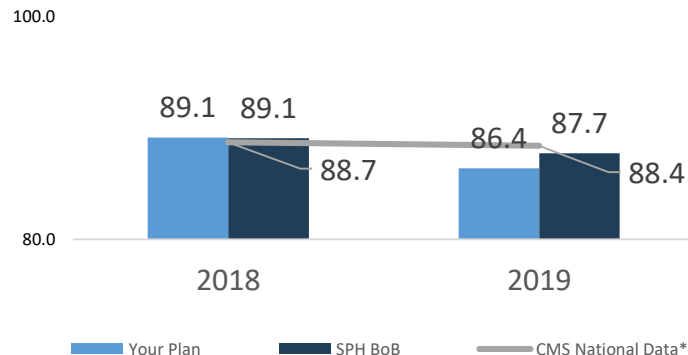


NATIONAL TRENDS

CMS Scaled Mean scores for Rating of Personal Doctor **decreased** by 0.3 to 88.4 from 2017.

The SPH BoB has **decreased** by 1.4 since 2018.

RATING OF PERSONAL DOCTOR – TRENDING AND BENCHMARKS



*Please note that the CMS National Benchmark represents the previous years measurement period.

COMPARISON TO TRENDING

2019 Scaled Mean Score	2018 Trend	Change**	Sig. Test
86.4	89.1	-2.8	↔

COMPARISON TO BENCHMARKS

	Scaled Mean Score	Gap**	Sig. Test
2019 SPH BoB	87.7	-1.3	↔
2018 CMS National Benchmark	88.4	-2.0	↔

**Please note that the "Change" and "Gap" comparison may vary slightly due to rounding.

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PERCENTILE RANKING 2019 SPH BOOK OF BUSINESS

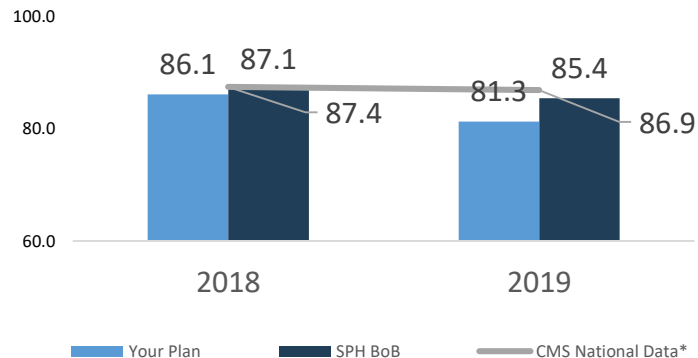


NATIONAL TRENDS

CMS Scaled Mean scores for Rating of Specialist **decreased** by 0.6 to 86.9 from 2017.

The SPH BoB has **decreased** by 1.6 since 2018.

RATING OF SPECIALIST – TRENDING AND BENCHMARKS



*Please note that the CMS National Benchmark represents the previous years measurement period.

COMPARISON TO TRENDING

2019 Scaled Mean Score	2018 Trend	Change**	Sig. Test
81.3	86.1	-4.8	↔

COMPARISON TO BENCHMARKS

	Scaled Mean Score	Gap**	Sig. Test
2019 SPH BoB	85.4	-4.1	↔
2018 CMS National Benchmark	86.9	-5.6	↔

**Please note that the "Change" and "Gap" comparison may vary slightly due to rounding.

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Segmentation Analyses

Subgroup Analysis

- Florida Health Care Plan, Inc.
- Project Number: 80134923

Segmenting Responses

The QHP Enrollee Experience survey asks demographic questions about the respondent. This information along with other variables in your database allows for a market segmentation of your members. Reviewing the set of measures across the assortment of demographic categories may indicate a health plan's overall ability to meet the needs of a varied population.

The percentages represent the Summary Rate for each segment. For example, in the table below, the Summary Rate for the *Rating of Health Plan* is the percentage of respondents who rated their health plan an 8, 9 or 10. The interpretation of this example would be, "Of the respondents with a high school education or less, 63% gave their health plan a rating of 8, 9 or 10. And, of the respondents with some college education or more, 58% gave their health plan a rating of 8, 9 or 10."

	High School or Less	Some College or More
Rating of Health Plan	63%	58%

Segment Groups

- Respondent's Age (Q60)
- Respondent's Gender (Q61)
- Respondent's Health Status (Q43)
- Respondent's Mental/Emotional Health Status (Q44)
- Respondent's Race (Q66)
- Respondent's Ethnicity (Q64)
- Respondent's Education (Q62)
- Respondent's Metal Level (Database)

Note: An 'NA' is displayed in place of any percentage that is representative of 10 or fewer respondents. An "NA" displayed in the range column indicates that a segment was too small for valid comparisons or there were not enough segments for which to calculate a range due to CMS cell size suppression guidelines.

Refer to "Summary Rate" in the *Technical Notes* for the Summary Rate definition for each composite.

Results in SPH reporting are unofficial and do not represent official results provided by CMS.

	18 - 34	35 - 44	45 - 54	55 or older	Range*
Getting Care Quickly	74.0%	92.9%	71.1%	83.6%	NA
Getting Needed Care	72.5%	70.9%	81.9%	83.4%	NA
Cultural Competence	79.4%	NA	70.7%	52.1%	NA
How Well Doctors Communicate	93.3%	85.2%	98.5%	90.0%	NA
Care Coordination	81.3%	58.8%	76.8%	85.9%	NA
Access to Information	53.3%	NA	50.0%	49.5%	NA
Plan Administration	82.4%	NA	74.4%	77.1%	NA
Cost	78.7%	85.6%	91.8%	88.7%	NA
Annual Flu Vaccine (All Respondents)	NA	NA	27.3%	50.3%	NA
Rating of Health Care (8-10)	59.1%	NA	59.5%	75.8%	NA
Rating of Health Plan (8-10)	37.9%	NA	47.8%	63.9%	NA
Rating of Personal Doctor (8-10)	73.7%	NA	87.9%	83.7%	NA
Rating of Specialist (8-10)	NA	NA	70.8%	75.6%	NA
Rating of Health Care (9-10)	NA	NA	40.5%	58.3%	NA
Rating of Health Plan (9-10)	NA	NA	34.8%	44.4%	NA
Rating of Personal Doctor (9-10)	NA	NA	69.7%	69.1%	NA
Rating of Specialist (9-10)	NA	NA	58.3%	59.3%	NA

* Range is the difference between Summary Rates shown. Due to the small number of respondents aged 18-34 or 45-54, these segments are not included in range calculations.

	Male	Female	Range
Getting Care Quickly	70.4%	84.5%	14.1%
Getting Needed Care	80.3%	81.9%	1.5%
Cultural Competence	45.2%	66.7%	21.5%
How Well Doctors Communicate	93.0%	90.4%	2.6%
Care Coordination	76.1%	85.2%	9.1%
Access to Information	40.5%	54.3%	13.8%
Plan Administration	67.7%	81.1%	13.5%
Cost	86.2%	88.6%	2.4%
Annual Flu Vaccine (All Respondents)	36.5%	43.2%	6.7%
Rating of Health Care (8-10)	60.0%	74.6%	14.6%
Rating of Health Plan (8-10)	47.3%	61.5%	14.2%
Rating of Personal Doctor (8-10)	79.2%	84.3%	5.1%
Rating of Specialist (8-10)	66.7%	73.3%	6.7%
Rating of Health Care (9-10)	41.8%	55.1%	13.3%
Rating of Health Plan (9-10)	28.4%	45.0%	16.6%
Rating of Personal Doctor (9-10)	60.4%	68.7%	8.3%
Rating of Specialist (9-10)	51.5%	56.7%	5.2%

* Range is the difference between Summary Rates shown. The larger the number, the greater the difference in Summary Rates between segment groups for any given question/composite.



By Respondent's Health Status (Q43)

	Excellent/Very Good	Good	Fair/Poor	Range
Getting Care Quickly	87.0%	78.5%	71.2%	8.4%
Getting Needed Care	83.4%	80.9%	76.7%	2.5%
Cultural Competence	53.0%	63.3%	64.9%	10.4%
How Well Doctors Communicate	90.1%	93.4%	95.1%	3.3%
Care Coordination	85.8%	83.0%	81.6%	2.9%
Access to Information	46.9%	57.5%	46.7%	10.6%
Plan Administration	79.2%	77.1%	74.4%	2.1%
Cost	90.4%	85.2%	86.4%	5.2%
Annual Flu Vaccine (All Respondents)	37.7%	42.0%	50.0%	4.3%
Rating of Health Care (8-10)	73.1%	74.2%	56.8%	1.1%
Rating of Health Plan (8-10)	58.3%	53.0%	58.5%	5.2%
Rating of Personal Doctor (8-10)	83.3%	86.7%	83.8%	3.3%
Rating of Specialist (8-10)	73.1%	70.0%	68.8%	3.1%
Rating of Health Care (9-10)	52.7%	54.8%	45.9%	2.2%
Rating of Health Plan (9-10)	41.7%	37.3%	39.0%	4.4%
Rating of Personal Doctor (9-10)	71.1%	70.0%	56.8%	1.1%
Rating of Specialist (9-10)	57.7%	52.5%	53.1%	5.2%

* Range is the difference between Summary Rates shown. Due to the small number of respondents indicating their health is "Fair" or "Poor," this segment is not included in range calculations.



By Respondent's Mental/Emotional Health Status (Q44)

Florida Health Care Plan, Inc.

Please see Technical Notes for more information.

	Excellent/Very Good	Good	Fair/Poor	Range
Getting Care Quickly	85.8%	71.7%	77.8%	14.1%
Getting Needed Care	84.7%	74.0%	81.7%	10.6%
Cultural Competence	55.8%	64.9%	67.7%	9.2%
How Well Doctors Communicate	91.3%	90.1%	95.5%	1.2%
Care Coordination	85.8%	77.0%	87.6%	8.8%
Access to Information	54.7%	43.4%	50.0%	11.2%
Plan Administration	80.1%	71.3%	82.6%	8.9%
Cost	88.7%	85.9%	88.4%	2.9%
Annual Flu Vaccine (All Respondents)	42.9%	32.8%	50.0%	10.0%
Rating of Health Care (8-10)	79.3%	50.9%	71.4%	28.4%
Rating of Health Plan (8-10)	60.3%	43.9%	63.6%	16.3%
Rating of Personal Doctor (8-10)	88.6%	74.1%	82.8%	14.5%
Rating of Specialist (8-10)	74.2%	62.2%	73.9%	12.1%
Rating of Health Care (9-10)	60.4%	30.9%	57.1%	29.5%
Rating of Health Plan (9-10)	41.1%	31.8%	48.5%	9.3%
Rating of Personal Doctor (9-10)	76.2%	48.1%	69.0%	28.0%
Rating of Specialist (9-10)	60.6%	43.2%	56.5%	17.4%

* Range is the difference between Summary Rates shown. Due to the small number of respondents indicating their mental/emotional health is "Fair" or "Poor," this segment is not included in range calculations.

Results in SPH reporting are unofficial and do not represent official results provided by CMS.



By Respondent's Race (Q66)

	White	Black or African American	Other	Range
Getting Care Quickly	81.5%	91.2%	53.6%	NA
Getting Needed Care	82.5%	85.1%	73.2%	NA
Cultural Competence	57.7%	83.3%	NA	NA
How Well Doctors Communicate	91.7%	93.3%	90.7%	NA
Care Coordination	85.0%	85.4%	42.0%	NA
Access to Information	52.7%	NA	40.3%	NA
Plan Administration	80.3%	81.5%	54.3%	NA
Cost	87.7%	92.1%	85.4%	NA
Annual Flu Vaccine (All Respondents)	41.9%	52.4%	NA	NA
Rating of Health Care (8-10)	69.9%	76.2%	NA	NA
Rating of Health Plan (8-10)	56.6%	77.3%	NA	NA
Rating of Personal Doctor (8-10)	83.8%	94.7%	NA	NA
Rating of Specialist (8-10)	70.2%	84.6%	NA	NA
Rating of Health Care (9-10)	50.0%	71.4%	NA	NA
Rating of Health Plan (9-10)	39.4%	59.1%	NA	NA
Rating of Personal Doctor (9-10)	67.5%	84.2%	NA	NA
Rating of Specialist (9-10)	56.7%	NA	NA	NA

* Range is the difference between Summary Rates shown. Due to the small number of respondents falling into the "Other" race category or indicating their race is Black or African American, range calculations are not included.

By Respondent's Ethnicity (Q64)

	Hispanic/Latino	Not Hispanic/Latino	Range
Getting Care Quickly	75.3%	81.3%	NA
Getting Needed Care	63.3%	83.8%	NA
Cultural Competence	72.2%	57.5%	NA
How Well Doctors Communicate	87.5%	91.9%	NA
Care Coordination	81.1%	84.7%	NA
Access to Information	NA	51.8%	NA
Plan Administration	78.2%	77.9%	NA
Cost	89.3%	88.4%	NA
Annual Flu Vaccine (All Respondents)	47.8%	41.0%	NA
Rating of Health Care (8-10)	68.4%	70.8%	NA
Rating of Health Plan (8-10)	50.0%	57.8%	NA
Rating of Personal Doctor (8-10)	85.0%	83.4%	NA
Rating of Specialist (8-10)	NA	71.6%	NA
Rating of Health Care (9-10)	NA	51.5%	NA
Rating of Health Plan (9-10)	50.0%	38.9%	NA
Rating of Personal Doctor (9-10)	NA	69.3%	NA
Rating of Specialist (9-10)	NA	56.9%	NA

* Range is the difference between Summary Rates shown. Due to the small number of Hispanic/Latino respondents, range calculations are not included.

	High School Graduate or less	Some College or more	Range
Getting Care Quickly	82.6%	79.1%	3.5%
Getting Needed Care	81.0%	81.1%	0.2%
Cultural Competence	49.0%	67.1%	18.1%
How Well Doctors Communicate	94.1%	90.2%	3.9%
Care Coordination	84.1%	82.8%	1.3%
Access to Information	50.5%	51.5%	1.0%
Plan Administration	74.9%	79.5%	4.6%
Cost	88.6%	88.2%	0.4%
Annual Flu Vaccine (All Respondents)	42.5%	41.4%	1.1%
Rating of Health Care (8-10)	83.9%	63.6%	20.3%
Rating of Health Plan (8-10)	71.6%	50.3%	21.3%
Rating of Personal Doctor (8-10)	85.2%	82.3%	3.0%
Rating of Specialist (8-10)	70.6%	71.1%	0.5%
Rating of Health Care (9-10)	62.9%	46.5%	16.4%
Rating of Health Plan (9-10)	55.4%	33.7%	21.7%
Rating of Personal Doctor (9-10)	72.1%	64.5%	7.6%
Rating of Specialist (9-10)	61.8%	52.2%	9.5%

* Range is the difference between Summary Rates shown. The larger the number, the greater the difference in Summary Rates between segment groups for any given question/composite.



By Respondent's Metal Level (Database)

	Platinum	Gold	Silver	Bronze	Bronze Expanded	Catastrophic	Range
Getting Care Quickly	NA	79.8%	80.1%	81.1%	NA	NA	1.0%
Getting Needed Care	NA	78.8%	81.9%	81.8%	NA	NA	0.1%
Cultural Competence	NA	NA	54.1%	72.4%	NA	NA	18.3%
How Well Doctors Communicate	NA	94.4%	90.2%	92.5%	NA	NA	2.2%
Care Coordination	NA	87.5%	81.2%	86.7%	NA	NA	5.5%
Access to Information	NA	NA	51.7%	47.1%	NA	NA	4.6%
Plan Administration	NA	79.7%	75.9%	80.5%	NA	NA	4.6%
Cost	NA	87.7%	90.9%	81.8%	NA	NA	9.1%
Annual Flu Vaccine (All Respondents)	NA	40.7%	44.9%	35.1%	NA	NA	9.8%
Rating of Health Care (8-10)	NA	63.6%	78.2%	57.1%	NA	NA	21.0%
Rating of Health Plan (8-10)	NA	44.4%	69.6%	36.1%	NA	NA	33.5%
Rating of Personal Doctor (8-10)	NA	87.0%	83.5%	80.8%	NA	NA	2.7%
Rating of Specialist (8-10)	NA	75.0%	69.0%	73.1%	NA	NA	4.0%
Rating of Health Care (9-10)	NA	NA	58.8%	39.3%	NA	NA	19.5%
Rating of Health Plan (9-10)	NA	NA	50.0%	22.2%	NA	NA	27.8%
Rating of Personal Doctor (9-10)	NA	65.2%	68.7%	63.5%	NA	NA	5.2%
Rating of Specialist (9-10)	NA	NA	54.8%	53.8%	NA	NA	0.9%

* Range is the difference between Summary Rates shown. Due to the small number of Platinum, Gold, Bronze-Expanded, and Catastrophic respondents, these segments are not included in range calculations.

Results in SPH reporting are unofficial and do not represent official results provided by CMS.



Correlation Analyses

Plan Specific Correlations

- Florida Health Care Plan, Inc.
- Project Number: 80134923

Correlations This section provides attribute correlations with *Rating of Health Plan* (Q19) *Rating of Health Care* (Q25), *Rating of Personal Doctor* (Q38), and *Rating of Specialist* (Q42). The correlations show the strength of the linear relationship between the individual attribute and the rating question. The correlation value can range from -1 to $+1$ with values close to $+1$ indicating a strong positive relationship. For example, a question that is highly correlated with *Rating of Health Plan* indicates that a low Summary Rate for that question is associated with a low Summary Rate for *Rating of Health Plan*, and a high Summary Rate for that question is associated with a high Summary Rate for *Rating of Health Plan*.

Attributes considered to be highly correlated with the rating measures are shaded blue ($r > 0.400$). Comparisons to the 2019 SPH Book Of Business benchmark are also shown with significance testing.

Significance Testing

Green – Current year score significantly higher when compared to trend or benchmark score.

Red – Current year score significantly lower when compared to trend or benchmark score.

No color denotes that there was no significant difference between the percentages or that there was insufficient sample size to conduct the statistical test. All significance testing is performed at the 95% significance level.

	With Health Plan Rating	With Health Care Rating	With Personal Doctor Rating	With Specialist Rating	Plan Summary Rate	2019 SPH Book Of Business
Getting Care Quickly						
20 Obtained needed care right away	0.441	0.386	0.125	0.261	79.4%	81.4%
21 Obtained appointment for care as soon as needed	0.414	0.362	0.270	0.211	81.2%	80.3%
Getting Needed Care						
23 Ease of getting care, tests, or treatment needed	0.521	0.608	0.304	0.328	88.4%	85.6%
39 Obtained appointment with specialist as soon as needed	0.300	0.216	0.236	0.191	74.2%	72.7%
Cultural Competence						
24 Obtained interpreter when needed	NA	NA	NA	NA	NA	22.2%
11 Forms available in preferred language	0.185	0.087	0.185	0.047	85.4%	88.2%
12 Forms available in needed format	0.391	0.141	0.430	0.106	70.2%	72.6%
Care Coordination						
31 Doctors had medical records or care information	0.299	0.323	0.516	0.123	93.7%	94.8%
32 Doctor's office followed up with test results	0.108	0.198	0.415	0.107	80.6%	84.8%
33 Obtained test results as soon as needed	0.242	0.248	0.426	0.153	86.9%	89.8%
41 Doctors were informed and up-to-date about specialist care	0.170	0.193	0.508	0.181	74.4%	77.4%
34 Discussed prescription medicines	0.204	0.097	0.469	0.191	86.4%	88.4%
37 Obtained help needed from doctor's office to manage care	0.304	0.403	0.430	0.288	78.1%	80.6%

Results in SPH reporting are unofficial and do not represent official results provided by CMS.

	With Health Plan Rating	With Health Care Rating	With Personal Doctor Rating	With Specialist Rating	Plan Summary Rate	2019 SPH Book Of Business
Access to Information						
3 Providing Needed Information	0.227	0.226	0.251	0.265	46.4%	51.5%
4 Able to find out from health plan cost of health care service or equipment	0.210	0.247	0.088	0.204	51.6%	43.0%
5 Able to find out from health plan cost of prescription medicines	0.338	0.440	0.089	0.334	52.9%	42.2%
Plan Administration						
6 Getting information/help from customer service	0.440	0.367	0.195	0.223	71.4%	64.3%
7 Treated with courtesy and respect by customer service staff	0.486	0.362	0.181	0.383	91.6%	88.7%
8 Longer than expected wait time to speak with customer service staff	0.214	0.308	0.107	0.359	89.1%	79.8%
9 Ease of Filling Out Forms	0.433	0.476	0.318	0.429	75.0%	70.7%
10 Explanation of Forms	0.396	0.347	0.216	0.258	60.0%	66.2%
Rating Questions						
Rating of Health Plan	NA	0.777	0.226	0.356	57.1%	47.0%
Rating of All Health Care	0.777	NA	0.284	0.380	70.6%	65.2%
Rating of Personal Doctor	0.226	0.284	NA	0.170	83.2%	84.6%
Rating of Specialist	0.356	0.380	0.170	NA	70.6%	80.3%

	With Health Plan Rating	With Health Care Rating	With Personal Doctor Rating	With Specialist Rating	Plan Summary Rate	2019 SPH Book Of Business
How Well Doctors Communicate						
27 Doctors explained things in an understandable way	0.034	0.120	0.606	0.125	92.1%	94.4%
28 Doctors listened carefully to you	0.028	0.089	0.695	0.103	90.0%	93.6%
29 Doctors showed respect for what you had to say	0.069	0.143	0.669	0.235	92.1%	94.9%
30 Doctors spent enough time with you	0.180	0.225	0.692	0.171	91.1%	91.4%
Cost						
13 Health plan did not pay for needed care	0.243	0.201	0.045	0.242	84.6%	84.3%
14 Paid out of own pocket for care you thought would be covered	0.355	0.327	0.061	0.251	89.1%	84.2%
15 Delayed or did not visit doctor because you were worried about cost	0.463	0.512	0.239	0.312	84.9%	80.3%
16 Delayed or did not fill prescriptions because you were worried about cost	0.373	0.381	0.022	0.167	92.8%	91.7%

SPH understands QHP is only one component of your performance improvement program. We invite you to partner with us for ongoing quality improvement.

Performance Improvement Consulting

SPH's consulting services help plans understand their QHP results and develop improvement initiatives based on survey data.

Simulation and Drill-Down Surveys

Understand the why behind your members' responses and develop targeted initiatives to improve scores, performance, and member satisfaction.

Continuous Member Engagement and Outreach

Connect with members throughout the year with SPH's multi-channel member engagement and targeted outreach programs. Increase satisfaction/loyalty, close care gaps, and improve scores and ratings.



HEDIS® Score Sheet

Org Name : Florida Health Care Plan, Inc.

Last HEDIS® Review based on HEDIS 2019

Accreditation Code: 1233H-18

**Product Line/Reporting Product : Commercial HMO/POS
Combined
CAHPS Used: (Adult)**

HHS Region: 4

Effectiveness of Care	Reported Rate (Adjusted)	National Threshold Meets or Exceeds	Points	Regional Threshold Meets or Exceeds	Points	Score
Adult BMI Assessment	94.40%	90th Percentile which was 94%	1.3214	75th Percentile which was 90%	1.1629	1.3214
Antidepressant - Continuation	43.78%	Less than 25th Percentile	0.2643	Less than 25th Percentile	0.2643	0.2643
Appropriate Testing for Children with Pharyngitis	75.76%	Less than 25th Percentile	0.2643	Less than 25th Percentile	0.2643	0.2643
Appropriate Treatment for Children with Upper Respiratory Infection	87.58%	25th Percentile which was 85%	0.5286	50th Percentile which was 86%	1.1629	0.8457
Asthma Medication Ratio	77.17%	25th Percentile which was 77%	0.5286	Less than 25th Percentile	0.2643	0.5286
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	56.17%	90th Percentile which was 49%	1.3214	75th Percentile which was 34%	1.1629	1.3214
Breast Cancer Screening	79.78%	90th Percentile which was 79%	1.3214	75th Percentile which was 74%	1.1629	1.3214
Cervical Cancer Screening	79.32%	75th Percentile which was 78%	1.1629	75th Percentile which was 76%	1.1629	1.1629
Childhood Immunization Status (Combo 10)	32.45%	Less than 25th Percentile	0.2643	Less than 25th Percentile	0.2643	0.2643
Chlamydia Screening in Women (Total Rate)	48.77%	50th Percentile which was 46%	0.8986	50th Percentile which was 47%	0.8986	0.8986
Colorectal Cancer Screening	69.83%	75th Percentile which was 68%	1.1629	75th Percentile which was 64%	1.1629	1.1629
Controlling High Blood Pressure (overall rate)	65.45%	50th Percentile which was 60%	0.8986	75th Percentile which was 65%	1.1629	1.0307
Emergency Department Utilization (Commercial)	93.87%	O/E <0.9 and 95% upper confidence interval <1.0 (100%)	1.3214	NA	NA	1.3214
Flu Vaccinations for Adults Ages 18-64	47.62%	25th Percentile which was 45%	0.5286	25th Percentile which was 41%	0.5286	0.5286
Follow-Up After Hospitalization for Mental Illness (7-day rate only)	57.35%	75th Percentile which was 51%	1.1629	75th Percentile which was 41%	1.1629	1.1629
Follow-up for Children Prescribed ADHD Medication – Continuation	NA	No Benchmark Available	NA	No Benchmark Available	NA	NA
Immunizations for Adolescents (Combo 2)	24.63%	50th Percentile which was 21%	0.8986	75th Percentile which was 20%	1.1629	1.0307
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement of AOD Treatment Rate Only)	8.63%	Less than 25th Percentile	0.2643	Less than 25th Percentile	0.2643	0.2643
Medication Management for People with Asthma (75% Rate Only)	43.14%	Less than 25th Percentile	0.2643	Less than 25th Percentile	0.2643	0.2643
Metabolic Monitoring for Children and Adolescents on Antipsychotics	41.94%	75th Percentile which was 41%	1.1629	75th Percentile which was 36%	1.1629	1.1629
Plan All-Cause Readmissions	66.29%	O/E not meaningfully and significantly different from 1.0 (i.e., $0.9 \leq O/E \leq 1.1$ or 95% confidence interval includes 1.0) (68%)	0.8986	NA	NA	0.8986
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NA	No Benchmark Available	NA	No Benchmark Available	NA	NA
Use of Imaging Studies for Low Back Pain	77.06%	50th Percentile which was 76%	0.8986	75th Percentile which was 74%	1.1629	1.0307
WCC Weight Assessment and Counseling for Nutrition and Physical Activity for Children (Rate - BMI Percentile - Total)	90.51%	90th Percentile which was 89%	1.3214	75th Percentile which was 81%	1.1629	1.3214

HEDIS® Score Sheet

Org Name : Florida Health Care Plan, Inc.

Last HEDIS® Review based on HEDIS 2019

Accreditation Code: 1233H-18

**Product Line/Reporting Product : Commercial HMO/POS
Combined
CAHPS Used: (Adult)**

HHS Region: 4

Comprehensive Diabetes Care Averaged Rate						2.3433
Comprehensive Diabetes Care - Eye Exams	54.01%	50th Percentile which was 52%	0.8986	75th Percentile which was 50%	1.1629	1.0307
Comprehensive Diabetes Care - BP Control <140/90	73.97%	75th Percentile which was 72%	1.1629	75th Percentile which was 67%	1.1629	1.1629
Comprehensive Diabetes Care - HbA1c Control <8.0%	67.40%	90th Percentile which was 66%	1.3214	75th Percentile which was 63%	1.1629	1.3214
PCE Pharmacotherapy Mgmt COPD Exacerbation - Averaged Rate						0.3304
PCE Pharmacotherapy Mgmt COPD Exacerbation (Rate - Systemic corticosteroid)	66.67%	Less than 25th Percentile	0.2643	Less than 25th Percentile	0.2643	0.2643
PCE Pharmacotherapy Mgmt COPD Exacerbation (Rate - Bronchodilator)	73.33%	Less than 25th Percentile	0.2643	25th Percentile which was 72%	0.5286	0.3964
Prenatal/Postpartum Averaged Rate						0.9646
Prenatal & Postpartum Care - Timeliness of Prenatal Care Rate	86.31%	50th Percentile which was 85%	0.8986	50th Percentile which was 85%	0.8986	0.8986
Prenatal & Postpartum Care - Postpartum Care	81.56%	50th Percentile which was 75%	0.8986	75th Percentile which was 81%	1.1629	1.0307
Statin Therapy for Patients With Cardiovascular Disease - Averaged Rate						0.2643
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy	73.65%	Less than 25th Percentile	0.2643	Less than 25th Percentile	0.2643	0.2643
Statin Therapy for Patients With Cardiovascular Disease - Statin 80% Adherence	63.41%	Less than 25th Percentile	0.2643	Less than 25th Percentile	0.2643	0.2643
Statin Therapy for Patients With Diabetes - Averaged Rate						0.2643
Statin Therapy for Patients With Diabetes - Received Statin Therapy	56.52%	Less than 25th Percentile	0.2643	Less than 25th Percentile	0.2643	0.2643
Statin Therapy for Patients With Diabetes - Statin 80% Adherence	58.06%	Less than 25th Percentile	0.2643	Less than 25th Percentile	0.2643	0.2643
Total EOC Score*						23.539 out of 37

HEDIS® Score Sheet

Org Name : Florida Health Care Plan, Inc.

Last HEDIS® Review based on HEDIS 2019

Accreditation Code: 1233H-18

**Product Line/Reporting Product : Commercial HMO/POS
Combined
CAHPS Used: (Adult)**

HHS Region: 4

CAHPS®	Reported Rate (Adjusted)	National Threshold Meets or Exceeds	Score
Claims Processing	NA	No Benchmark Available	NA
Coordination of Care	2.3990	75th Percentile which was 2.39	1.2711
Customer Service	2.5156	50th Percentile which was 2.51	0.9822
Getting Care Quickly	2.4270	25th Percentile which was 2.39	0.5778
Getting Needed Care	2.3753	25th Percentile which was 2.36	0.5778
Rating of All Health Care	2.4437	50th Percentile which was 2.39	0.9822
Rating of Health Plan	2.2926	75th Percentile which was 2.27	2.5422
Rating of Personal Doctor	2.6656	90th Percentile which was 2.61	1.4444
Rating of Specialist Seen Most Often	2.5603	50th Percentile which was 2.53	0.9822
Total CAHPS® Score*			9.36 out of 13
			Total HEDIS® Score* 32.899 of 50

* Total scores may not appear to total as all numbers are truncated for display purposes only. All total scores and star calculations are based on actual, not truncated, numbers.

** The separate rates for these measures are scored against thresholds or benchmarks and then averaged to determine the overall score.

Next HEDIS® Review based on HEDIS 2020