SMMC Managed Medical Assistance (MMA) Program Issues

Report Period: July, 2016 *Run Date: 8/1/2016*

	# MMA Enrollees as of End of Month - *Source: HealthTrack*	# of Issues Received, last 3 Months	# of Issues Received in July, 2016	# of Issues, per 1,000 enrollees, July, 2016	Difference per 1,000 - Last Month Compared to Last 3 Months (Mthly Avg.)	Median Days for Resolution - Beneficiary Issues, July, 2016 (# Resolved)	Median Days for Resolution - Provider Claims Payment Issues, July, 2016 (# Resolved)	Median Days for Resolution - Provider Non-Claims Payment Issues, July, 2016 (# Resolved)	# of Issues Resolved Incomplete / Informational ****	# of Issues Pending for Resolution
MMA PLANS (Standard Plans)										
Amerigroup Florida, Inc.	360,697	166	57	0.16	+ 0.01	6 (25)	68 (11)	14 (8)	3	49
Better Health, Inc.	103,090	42	11	0.11	-0.09	7 (5)	91 (3)	10 (2)	0	15
Community Care Plan	45,663	20	9	0.20	+ 0.15	9 (3)		3 (3)	1	4
Coventry Health Care of Florida, Inc.	60,065	41	15	0.25	+ 0.07	6 (7)	85 (3)	5 (3)	1	9
First Coast Advantage, LLC	* 0	0	0	*	*				0	0
Humana Medical Plan, Inc.	350,645	248	89	0.25	+ 0.05	7 (47)	131 (11)	7 (9)	5	69
Integral Quality Care	*** 0	15	3	0.03	-0.06	27 (1)			0	6
Molina Healthcare of Florida, Inc.	333,984	201	54	0.16	-0.12	6 (27)	99 (8)	10 (14)	2	54
Preferred Medical Plan, Inc.	** 0	4	0	**	**		53 (1)	53 (1)	0	1
Prestige Health Choice	320,916	206	63	0.20	-0.05	4 (25)	110 (11)	6 (10)	6	52
Simply Healthcare Plans, Inc.	84,898	63	21	0.25	0.00	5 (9)	37 (7)		1	23
Staywell Health Plan of Florida	691,231	452	125	0.18	-0.11	7 (84)	43 (29)	9 (14)	7	76
Sunshine Health Plan, Inc.	485,180	310	105	0.22	+ 0.01	6 (49)	133 (32)	8 (12)	14	72
United Healthcare of Florida, Inc.	286,125	233	83	0.29	+ 0.06	4 (51)	52 (8)	5 (7)	2	66
MMA PLANS (Specialty)										
Children's Medical Services (CMS)	52,657	58	16	0.30	-0.19	20 (14)		35 (11)	0	11
Clear Health Alliance HIV/AIDS Specialty Plan (Simply Healthcare Plans, Inc.)	9,341	29	13	1.39	+ 1.07	5 (6)		6 (2)	0	5
Freedom Health, Inc. Cardiovascular/ CHF/ COPD/ Diabetes Disease Specialty Plans	113	0	0	0.00	0.00				0	0
Magellan Complete Care Serious Mental Illness Specialty Plan (Florida MHS, Inc.)	59,127	104	39	0.66	+ 0.22	6 (23)	46 (7)	4 (5)	5	15
Positive Healthcare Florida HIV/AIDS Specialty Plan (AHF MCO of Florida, Inc.)	1,927	8	3	1.56	+ 0.52	2 (2)	40 (2)		0	3
Sunshine Health Plan, Inc. Child Welfare Specialty Plan	31,469	16	5	0.16	-0.03	6 (3)	75 (4)	15 (2)	0	6
NON-PLAN SPECIFIC										
MMA System (Non-Plan Specific) Issues		1451	514							213

SMMC MMA Issues Reported to the Complaint Operations Center - July, 2016

Standard Plans | Specialty Plans

ISSUE CATEGORY / SUBCATEGORY:	Amerigroup Florida, Inc.	Better Health, LLC	Community Care Plan	Coventry Health Care of Florida, Inc.	First Coast Advantage, LLC	Humana Medical Plan, Inc.	Integral Health Plan, Inc.	Molina Healthcare of Florida, Inc.	Preferred Medical Plan, Inc.	Prestige Health Choice	Simply Healthcare Plans, Inc.	Staywell Health Plan of Florida	Sunshine Health Plan, Inc.	United Healthcare of Florida, Inc.	Clear Health Alliance (HIV/AIDS)	Children's Medical Services Network	Freedom Health, Inc. (Cardiovascular, CHF, Diabetes, COPD)	Magellan Complete Care (Serious Mental Illness)	Positive Healthcare Florida (HIV/AIDS)	Sunshine Health Plan, Inc. (Child Welfare)	Non-Plan Specific	Total
Customer Service	**7**	**3**	**4**	**3**		**15**	**1**	**8**		**7**	**1**	**17**	**17**	**12**		**3**		**3**			**2**		**103**
GENERAL	3	2	2	1		7	1	2		4	1	7	5	5		1		1					42
INCORRECT INFORMATION PROVIDED	2		2			1		3				2		1		1							12
INFORMATION VERIFICATION	2	1		2		5		3		3		7	10	5				2			1		41
UNABLE TO OBTAIN MEMBER MATERIALS						2						1	2	1		1					1		8
Fraud Allegation	**1**	**1**						**1**			**2**	**3**	**1**							**1**			**10**
FRAUD ALLEGATION	1	1						1			2	3	1							1			10
General				**1**						**1**			**1**	**1**									**518**
GENERAL				1						1			1	1									4
SYSTEM																						514	514
HIPAA																							**0**
HIPAA																							0
Marketing Violation																							**0**
MARKETING VIOLATION																							0
Network Access	**6**		**1**	**1**		**6**		**6**		**3**	**4**	**10**	**8**	**10**	**1**	**1**		**3**					**60**
APPOINTMENTS ARE NOT TIMELY								1		1		1		2									5
NO PROVIDERS OF A SPECIFIC TYPE	4					1		3			4	3	2	3									20
NOT ENOUGH PROVIDERS OF A SPECIFIC TYPE	1			1		2				2		5	5	2		1		3					22
PROVIDERS TOO FAR AWAY	1		1			3		2				1	1	3	1								13
Payment	**20**	**3**	**1**	**1**		**26**	**2**	**17**		**17**	**9**	**34**	**35**	**33**	**3**	**1**		**11**	**2**				**215**
PAYMENT	20	3	1	1		26	2	17		17	9	34	35	33	3	1		11	2				215
Pharmacy	**6**			**1**		**6**		**4**		**4**	**2**	**6**	**1**	**3**	**4**	**1**		**1**					**39**
PHARMACY	6			1		6		4		4	2	6	1	3	4	1		1					39
Services	**17**	**4**	**3**	**8**		**36**		**18**		**31**	**3**	**55**	**42**	**24**	**5**	**10**		**21**			**3**		**280**
DENIED	5			2		17		8		9	2	26	10	8		1		6					94
GAINING PRIOR AUTHORIZATION	4			2		5		4		7	1	7	4	3		1		4					42
LIMITATIONS		1		1		3						1	2	1		4							13
NOT PROVIDED, MISSED, OR DELAYED	4	2	2	1		7		2		10		14	15	9	3	3		8			2		82
QUALITY	2		1	2		2						2		3	1	1		1					15
SCHEDULING (IN-HOME)																							0
SCHEDULING (PROVIDER)		1				1		2		2		1	3					2					12
SCHEDULING (TRANSPORT)	2					1		2		3		4	8		1						1		22
NOT SPECIFIED (Complainant accepted referral to Plan)																							0
Total:	57	11	9	15	0	89	3	54	0	63	21	125	105	83	13	16	0	39	3	5	0		

GRAND TOTAL **1225**

NEW Issue Category Definitions (*as of April 1, 2015*)

Customer Service- Complainant alleges poor customer service

- **General**-Caller alleges poor customer service from the Health Plan. Also includes complaints about member verification.
- **Information Verification**- Caller alleges that Health Plan was unable to provide eligibility or plan related information such as plan enrollment, Medicaid eligibility, open enrollment dates, receipt of faxed information, etc.
- **Incorrect information provided**- Caller alleges that Health Plan provided incorrect information.
- **Unable to receive Materials** - Caller alleges that the Health Plan didn't provide materials (e.g. member handbook, ID card, provider directory, etc.)

Fraud Allegation – Caller alleges that Provider or Health Plan is committing Medicaid fraud.

General- Caller reports a specific incident that occurred with the Health Plan and the issue being reported does not fit any other Issue Category.

- **System Issues** – Issue requires a system/file correction. Includes file errors, county code corrections, segment updates and newborn coverage. (Note: Plans are not responsible for resolving System Issues. These numbers are reflected for Agency use only)

HIPAA- Caller reports a Medicaid related HIPAA violation that occurred with the Health Plan or Provider. This includes unauthorized disclosing of medical and personal health information to unauthorized people.

Marketing Violation- Caller alleges that they were convinced to join a specific plan or they were promised a gift to enroll. Also, caller may indicate that a plan is improperly marketing.

Network Access- Caller alleges they are having difficulties with network providers.

- Not enough of a specific provider type
- The providers in the network are too far away
- Appointments with providers are not timely
- The plan does not have a specific type of provider

Pharmacy- Caller states the Health Plan is denying their medications.

Services – Caller states they are having difficulty receiving services through the plan.

- Denial of Services
- Gaining Prior Authorization
- Limitations
- Not provided, missed, or delayed services
- Scheduling appointments for In Home visits, Provider Appointments, or Transportation
- Quality of services

Please note - The Agency encourages all stakeholders to surface any potential issue, concern, or complaint regarding the SMMC Program to the SMMC Complaint Operations Center. All allegations and issues are recorded, regardless of whether they are found to be accurate or substantiated.

Median Days for Resolution of Issues -

Current resolution protocol direct staff to close all non-claims payment Issues within one business day of receiving the resolution from the plan.

Current resolution protocol for provider claims payment issues include days for Agency staff research and provider document collection and response. As such, median days to resolve for provider claims payment issues cannot be exclusively attributed to plan activity.

* - First Coast Advantage ceased operations effective November 30, 2014.

** - Preferred Medical Plan ceased operations effective July 31, 2015.

*** - Integral ceased operations effective October 31, 2015.

**** - Issues Resolved Incomplete / Informational are issues that did not require follow-up action by the Plan. These issues are not included in the Median Day for Resolution columns. Examples include; Complainant referred to his/her Plan Member Services to answer general questions, Complainant did not provide enough information to proceed with complaint and was nonresponsive to follow-up attempts to contact.