



Quality Improvement and Utilization Management Evaluation

Current Measurement Year: 2025

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THE STAFFING OUTLINED IN THE 2024 QI PROGRAM DESCRIPTION WAS INADEQUATE, AND ONE FULL TIME EMPLOYEE WAS ADDED TO THE ABH CALL CENTER. THE MEMBERSHIP STEADILY DECLINED IN 2023 AND 2024, ABH WILL CONTINUE TO BE MONITOR ENROLLMENT IN 2025 TO DETERMINE THE NEED FOR ADDITIONAL POSITIONS. ABH WORKED COLLABORATIVELY WITH THE BEHAVIORAL HEALTH HOMES IN 2024 TO IDENTIFY HUMAN RESOURCE NEEDS TO SUPPORT THE EXPECTED CONTRACTUAL REQUIREMENTS RELATED TO THE SIGNIFICANTLY MENTALLY ILL SPECIALTY PRODUCT LINE FOR 2025. 7

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Introduction: The ABH QI/UM Evaluation

The ABH Quality Improvement (QI)/Utilization Management (UM) Evaluation is a report completed annually by the Directors of UM, QI, and Network. It is reviewed and approved by the Quality Management Committee (QMC). This process provides a formal mechanism whereby ABH can systematically and objectively monitor, evaluate, improve, and impact the quality, efficiency, safety, and effectiveness of care to our members. Using these measures, ABH is able to identify and focus on opportunities to improve the quality, accessibility, availability, safety, and clinical outcomes for members. This is accomplished through an internal and external monitoring process of care management, utilization management, the development and maintenance of a provider network, member safety initiatives, and monitoring of clinical services to ensure that all members receive the highest quality care and service.

Executive Summary: Description of Completed and Ongoing QI Activities

ABH has been a Managed Behavioral Healthcare Organizations (MBHO) since 2014. ABH's QI program is modeled after the National Committee for Quality Assurance (NCQA), an organization dedicated to improving health care quality. This model allows ABH to incorporate a comprehensive method of tracking, measuring, and ultimately improving the quality and safety of care to ABH members. Elements of this comprehensive approach ABH takes to Quality Improvement (QI) are Utilization Management (UM), Care Coordination, Provider and Practitioner oversight via the formal Credentialing and Re-Credentialing process, tracking and trending HEDIS and other Performance Measures, and various other QI projects.

ABH works collaboratively with the Provider Network, the Health Plans, and the medical community to ensure continual quality assessment through the tracking and trending of measures, identification of opportunities for improvement, measurement, intervention, and re-measurement of service, utilization, and quality goals.

This document represents a summary of quality activities and accomplishments for the calendar year 2024 and includes quarterly information for 2024. This report was written collaboratively by the Quality Management and Improvement Director and the Director of Utilization Management and reviewed by the Quality Management Committee, which serves as the organization's oversight body.

Key Initiatives 2025

- Actively participate in the re-accreditation process with ABH's accrediting body, the National Committee for Quality Assurance (NCQA) and achieve reaccreditation status for another three (3) years.
- Increase outpatient provider awareness of follow up measures by disseminating quarterly gap reports which specify which members were compliant and non-compliant after behavioral health hospitalization measure.
- Introduce the Follow up after High-Intensity Care for Substance Use Disorder (FUI) to all Behavioral Health Homes and identify barriers to achieving compliance at the 50th percentile as defined by NCQA.
- Obtain data from Behavioral Health Homes regarding services provided by alternate funding sources (i.e. grants) to support follow up measure outcomes.
- Increase inpatient provider awareness of hospital metrics and their related outcomes to each measure via a scorecard.
- QI Department outreach to members discharged from an inpatient behavioral health hospitalization to provide members with appointment information, to assist in rescheduling the appointment if needed, and to gather data on reasons the appointment was missed or rescheduled.
- QI Department outreach to members who had an Emergency Department visit for a substance use or mental health reason to attempt to engage in and schedule follow-up outpatient care.
- QI Department outreach to members referred by the health plans for outpatient behavioral health services.
- Assess for timely access to care for initial outpatient and follow-up behavioral health services.
- Ongoing assessment of the network and single case agreements to determine credentialing needs.
- Increase compliance with 7 and 30 day follow up after behavioral health hospitalization.
- Continue to address barriers to compliance with 7 and 30 day follow up after ER visits.
- Review quality performance measures with the Quality Subcommittee at least twice per year to determine opportunities for improvement and collaborative initiatives.
- Transition the existing ABH website to a new platform/website host.
- Continue Quality Improvement Activities (QIAs) and assess areas for additional study.
- Improve member experience in areas below goal (services and accessibility) identified from results of the 2024-member experience survey.

Accomplishments 2024

- Held quarterly quality meetings with all behavioral health homes to review gap reports and obtain their applicable alternate funding services to support the measures reviewed.
- Held quarterly quality meetings with inpatient providers to review scorecards, identify barriers and develop interventions.
- Outreached to 100% of members discharges from behavioral health hospitalizations, ER visits, and referrals and coordinated follow up care with their preferred providers.
- Assessed 100% of the in-network providers for timely access to initial behavioral health appointments with quarterly improvement noted.
 - All providers met each standard 100% of the time in 2024.
- Assessed timeliness of routine follow-up behavioral health services and improved the methodology for gathering and analyzing this data.
- Met all Provider Network Ratio Standards.
- Met the 50th percentile for FUH 7 and FUH 30 in 2024.
 - Children met the 66th percentile for FUH 7 and 30 in 2024
- Achieved an overall Member Experience Satisfaction Score of 4.6 out of 5 for 2024.
- Completed medical record audits of providers in the network.
 - Providers displayed excellent coordination of care between providers at 100% and between behavioral health and medical providers at 99%.
- Offered spring and fall virtual trainings to all network providers.
- Provided health plans with quarterly evaluations.
- Call center software solution upgrade in October 2023 showing improved abandoned call rates through 2024.
- Collaborated with the health plans during the re-procurement phase of contracting.

Barriers to Achieving Objectives

Hospitals continued to struggle in 2024 with providing ABH discharge clinicals within 2 days of the member's discharge from a behavioral health hospitalization. Hospitals identified low staffing on the weekends and timeliness of physician documentation as primary barriers. ABH provided education on what items could be submitted at a minimum to meet this requirement with the understanding that additional documentation would be received as it was available. This was implemented in late 2024 and will be monitored for effectiveness in 2025.

The FUH 7 and 30 day benchmark goals were both met in 2024. The primary barrier for achieving higher compliance is the inability to contact members. ABH and the health plans are working on accessing additional contact information. ABH completed the necessary training to access the health plan's system and should gain access by Q2.2025.

One barrier to compliance with the follow up after ER visits is the receipt of incomplete data. ABH is reliant upon Encounter Notification Services (ENS) data for notification of ER visits by members for either a substance use or mental health diagnosis. In 2024, ABH identified a potential root cause related to this data gap. In response, ABH expanded its report parameters to ensure that all members who visited the ER were included on the report, where previously if fields were incorrect or blank they were excluded. This allowed ABH to view more entries in late 2024. A new barrier was identified after analyzing the new report. Hospitals are entering incomplete information thus making it difficult for ABH to determine the diagnosis provided, the disposition at discharge, or the date of the ER visit. ABH is working with the health plans on strategies to outreach ERs and provide education about ENS entries.

Analysis and Evaluation of QI Program Effectiveness

ABH developed initiatives with the Health Plans and ABH providers to ensure that ABH goals outlined in the work plan were addressed. The staffing outlined in the 2024 QI Program Description was inadequate and as a result one full time

employee was hired in Q3.24 for the Call Center. The addition of this position led to improved call center metrics. The Quality Management Committee analyzed and evaluated the 2024 QI Program and determined it was effective. ABH consistently evaluated member quality of care when complaints were received. All complaints resulted in agreeable resolutions and there were no quality-of-care concerns for 2024. The results from the 2024 member experience survey supported overall member satisfaction with providers.

The Quality Management Committee (QMC) has four subcommittees: Quality Improvement and Utilization Management (QIUM), Credentialing, Rights and Responsibilities and Quality. Each Subcommittee includes provider representation. Each subcommittee met in 2024 as outlined in the QI Program Description.

The QIUM Subcommittee met quarterly as required and included provider representatives. The evaluation and work plan were reviewed during these meetings to ensure that all activities were on track for completion for the year. Quality metrics were reviewed and analyzed by the committee and opportunities for improvement were identified.

The credentialing committee meets on an as needed basis to review applications for credentialing. All applicants received initial credentialing and recredentialing timely in 2024. There were no credentialing appeals in 2024. There were two modifications to credentialing information in 2024, which complied with the ABH policy of approved modification requests. The committee determined that no monitoring was required. The Quality Management Committee (QMC) also reviewed the 2024 System Controls Report from its credentialing delegate, the Council for Affordable Quality Health Care (CAQH).

The ABH Rights and Responsibilities Subcommittee met once in 2024 (October 2024) and included in network provider representation to review safety of clinical care and quality of services. The committee determined that there was an opportunity for improvement in the Services and Accessibility categories based on the results of the member experience survey. The 2024 member experience survey dissemination occurred in December 2024 and the committee will assess areas of improvement in 2025.

The ABH Quality Subcommittee met twice in 2024. The Subcommittee reviewed the QI Program Description, reviewed provider monitoring results to include recoupment for waste, reviewed behavioral health screening and self-management tools available on the ABH website, and reviewed and continued the existing Clinical Practice Guidelines. The committee discussed the current and ongoing collaborative Quality Improvement Activities and discussed potential service areas for measurement.

Adequacy of QI Resources

The staffing outlined in the 2024 QI Program Description was inadequate, and one full time employee was added to the ABH Call Center. The membership steadily declined in 2023 and 2024, ABH will continue to be monitor enrollment in 2025 to determine the need for additional positions. ABH worked collaboratively with the Behavioral Health Homes in 2024 to identify human resource needs to support the expected contractual requirements related to the Significantly Mentally Ill Specialty Product line for 2025.

QI Committee Structure

ABH is the governing body for all activities as defined by contractual obligations. The Quality Management Committee (QMC) consists of the ABH Director, the ABH Medical Director, the Quality Management and Improvement Director, the Director of Care Management, the Director of Network Management, the Accreditation and Quality Improvement Manager, and the Senior Reporting and Data Analyst.

The existing Quality Management Committee structure is effective. The involvement of the Medical Director in the QMC and the subcommittees as well as the involvement of providers and practitioners in the subcommittees is adequate to ensure quality and safety of clinical care and services to ABH members. There is an ongoing need for four (4) QMC subcommittees: Quality, Credentialing, QI/UM, and Rights, Responsibilities, and Safety. There is currently no need to add additional subcommittees.

Practitioner Participation and Leadership Involvement in the QI Program

Providers and practitioners participate in the Quality Management Committee's (QMC) subcommittees. The following subcommittees include provider and practitioner participation: Credentialing, Quality, QI/UM and Rights, Responsibilities, and Safety. The ABH Medical Director also has an active role in the QMC and its subcommittees.

Summary of Overall Effectiveness

The QI Program oversees both clinical quality outcomes and service utilization measures. The range of clinical activities monitored by the QI Program include access for urgent, emergent, and routine appointment times, Care Coordination between Behavioral Health and Behavioral Health Providers, and Behavioral Health and Medical Providers. Provider and Practitioner credentialing and re-credentialing falls under the QI Program, as well as HEDIS and other performance outcomes, Behavioral Health screening programs, Clinical Practice Guidelines, and medical records documentation audits. The service component of the program includes utilization management, accessibility of care, member/provider satisfaction, member inquiries, member complaints, Member Self-Management Tools, Fraud/Waste/Abuse Prevention, and Coordination of Care.

COVID 19 was a catalyst for change within the network during 2020. The ABH network of providers was successful in implementing telehealth for all members. Telehealth, though used in prior years, was the sole means of outpatient service delivery during COVID in 2020 and continued into 2021 and 2022. Face to face appointments resumed in 2021 with a telehealth option for those members who prefer that delivery method. The 2023 and 2024 member experience surveys reflected that there is not a strong preference for either face to face or telehealth as a service delivery method. Results in 2023 indicated that 46% of respondents preferred face to face service delivery, while 54% preferred telehealth. The preference for telehealth declined by eight percentage points from 2023 to 2024 to 38%.

The QI program was effective in 2024. ABH successfully monitored 100% of in network providers, offered virtual training twice to all network providers, increased the number of providers credentialed in the network, completed the annual member experience survey, improved ER reporting, and resolved data gaps related to call center metrics. The Quality Management Committee (QMC) and its subcommittees met at intervals as outlined within the QI Program Description. The ABH Medical Director had an active role in the QMC and there was an increased provider participation in the QMC Subcommittees this year. The QMC and its subcommittees were successful in discussing topics as outlined in the QIPD, collaboratively making decisions to improve the QI Program, and in determining future goals.

The QMC analyzed the effectiveness of the QI Program on March 26, 2025, and determined that the need for additional human resources in response to the new contracts will be volume dependent. Currently, the member volume is too low to justify the addition of an additional FTE. The volume will be monitored through 2025 and adjustments made accordingly. The committee also discussed the new HEDIS measure Follow up after High Intensity Care for Substance Use Disorder (FUI). The committee unanimously agreed that this measure will be reviewed quarterly with Behavioral Health Homes (BHHs) and will be added to the ABH evaluation for review quarterly with the QIUM subcommittee.

Annual Evaluation of the UM Program

UM Program Structure, Scope and Processes

ABH considers member and practitioner experience data when evaluating the UM Program.

Member experience: There were no member complaints directed toward the UM Program in 2025.

ABH evaluates provider satisfaction through an annual satisfaction survey. In 2025, the health plan assumed responsibility for administering this survey to providers. As a result, there is no updated data for Access Behavioral Health (ABH) post 2024. In 2024, ABH's overall provider satisfaction score was 3.91 out of 5.0, not meeting the established scoring goal of 4.3 set after the analysis of the 2023 survey results.

There were no practitioner complaints directed toward the UM Program in 2025.

In 2025, ABH continued to improve collaboration with the medical delivery system in to following ways:

- Continued participation in clinical case reviews with the Health Plans; and
- Participation in collaborative performance improvement projects

In 2025, ABH documented 126 referrals to behavioral health services from the health plans with which it contracts. This number of referrals was more than 2024 (108 referrals).

In 2025, ABH care coordinators made 82 referrals to health plan medical case management (104 in 2024). This demonstrates continued medical-behavioral health care coordination for plan members.

Both physician and first line clinical reviewer interrater-reliability testing resulted in no scores below 100%. Quarterly reviews were conducted in 2025 of a minimum of 2% of all reviewer decisions made for each contracted health plan.

ABH UM staff excelled in meeting post-hospitalization appointment scheduling metrics as well as meeting both Florida Medicaid and NCQA turnaround times for all types of UM reviews (See QI/UM annual evaluation results). ABH UM staff are trained on UR TAT and Transition of Care requirements upon hire and at least annually thereafter.

The ABH Medical Director and the ABH Quality Management Committee have reviewed the UM Program's structure, scope and process and determined the program as adequate to ensure quality and safety of clinical care and services to ABH members.

UM Program Resources

In 2025, Care Coordinator workloads and assignments were assessed based on recorded utilization management activity metrics (number of initial reviews, continued stay reviews, and discharge reviews). Despite member eligibility decreasing in 2025, Care Coordinator activities remained stable throughout 2025. No adjustments in FTEs were made

Network providers continued to be trained on use of the ABH provider portal for accessing member eligibility, entering claims and claims status (implemented in 2020).

In 2025, ABH continued to utilize Microsoft Teams. This has provided improvement to the efficiency of receiving on call inquires during business hours and after hours. This resulted in fewer missed calls and more information available to callers when reaching voicemail systems.

Physical resources available to staff were evaluated to ensure all staff had the equipment necessary to perform job functions.

Information Sources used to Determine Benefit Coverage

Per Medicaid requirements, ABH follows the Florida Medicaid Coverage and Limitations Handbooks for Behavioral Health (Community Behavioral Health, Behavioral Health Targeted Case Management, Specialized Therapeutic Services and Statewide Inpatient Psychiatric Services); no changes recommended for 2025.

Information Sources used to Determine Medical Necessity: Level of Care (LOC) Criteria

ABH level of care criteria are objective, based on medical evidence, and are consistent with Florida Medicaid Coverage and Limitations Handbooks for Behavioral Health (Community Behavioral Health, Behavioral Health Targeted Case Management, Specialized Therapeutic Services and Statewide Inpatient Psychiatric Services), and the American Society of Addiction Medicine. The ABH Medical Director and other professionals within the ABH provider network annually review the criteria annually for current clinical and medical evidence. Through the ABH QI/UM Committee, the criteria are made available to other practitioners within the ABH network for review and feedback.

- Criteria are applied based on characteristics of the local delivery system
 - Opportunities identified: None
- Availability of alternative levels of care
 - Opportunities identified:
 - ABH continues to work cooperatively with the health plans and the Agency for Health Care Administration to provide in lieu of services and expanded benefits.
 - Applicable, in-network provider contracts were expanded to include virtual IOP and PHP without prior authorization.
- Benefit coverage for alternative levels of care
 - Opportunities identified: None
- Ability to provide all recommended services within the estimated length of stay
 - Opportunities identified: None

Changes to LOC Criteria for 2025:

- Mental Health Level of Care Criteria: Reviewed by David Josephs, PsyD and Lawrence E. Mobley, MD, FAPA; no updates recommended.
- Statewide Inpatient Psychiatric Program (SIPP) Level of Care Criteria: Reviewed by David Josephs, PsyD and Lawrence E. Mobley, MD, FAPA; no updates recommended.
- Substance Abuse Level of Care Criteria: Reviewed by David Josephs, PsyD and Lawrence E. Mobley, MD, FAPA; no updates recommended.

Level of involvement of the ABH Medical Director in the UM Program

The ABH Medical Director is a board-certified psychiatrist and has been employed by Access Behavioral Health since 2012. He is well versed in medical necessity criteria for behavioral health conditions. The level of involvement of the ABH Medical Director is assessed as adequate to ensure quality and safety of clinical care and services to ABH members.

The ABH Medical Director:

- Is responsible for the overall clinical operations of the ABH UM Program;
- Meets as needed with UM staff to assist with UM decisions;
- Reviews all inpatient readmissions within 7 days and any inpatient admission of a child age five or younger;
- Reviews all cases where medical necessity is questionable;
- Reviews practitioner annual satisfaction survey scores;
- Reviews all member and practitioner complaints related to the UM Program;
- Attends 100% of Quality Management Committee and Quality Improvement/Utilization Management Sub-Committee meetings; and
- Participates in the annual review and update of the ABH UM Program including review of medical necessity criteria and level of care criteria.

Trending of Measures to Assess Performance in the Quality and Safety of Clinical Care and Quality of Service

Quality Improvement

Clinical Performance Measures

This section addresses:

Quality of Clinical Care Safety of Clinical Care Quality of Services

Follow-up After Hospitalization for Mental Illness

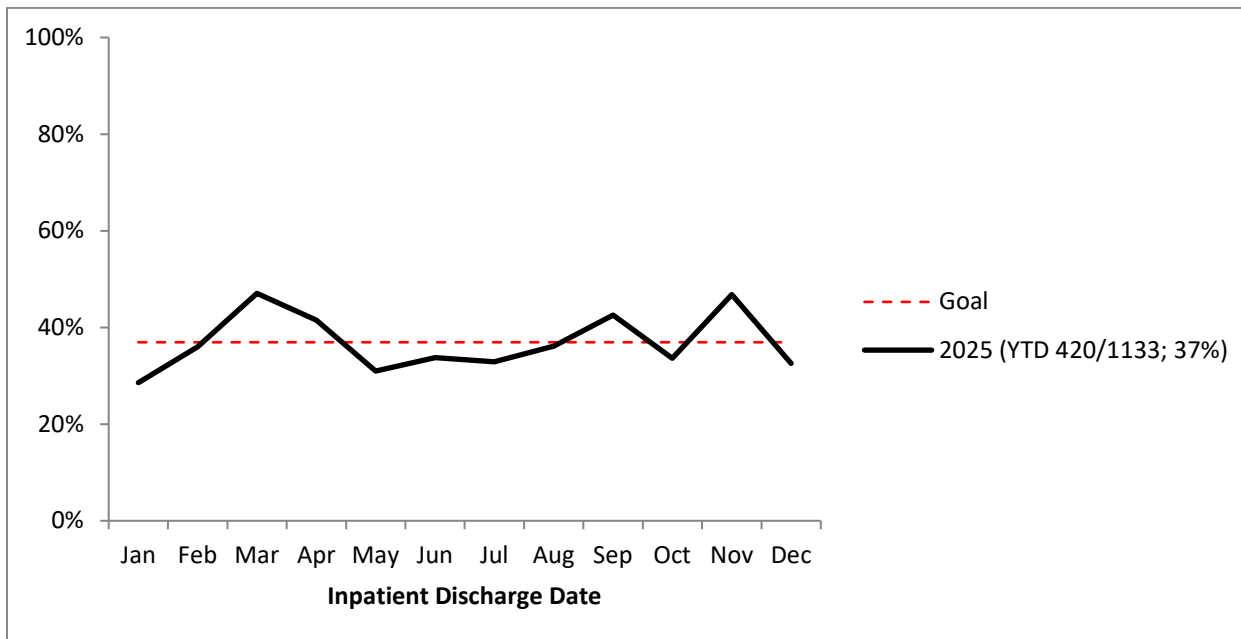
The percentage of discharges for Medicaid enrollees aged 6 and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner.

This is a HEDIS-like measure defined by AHCA. Goals are based on NCQA Quality Compass Medicaid national 50th percentile benchmarks for the FUH HEDIS measure.

7-day Rate

The percentage of discharges with a follow-up service within 7 days.

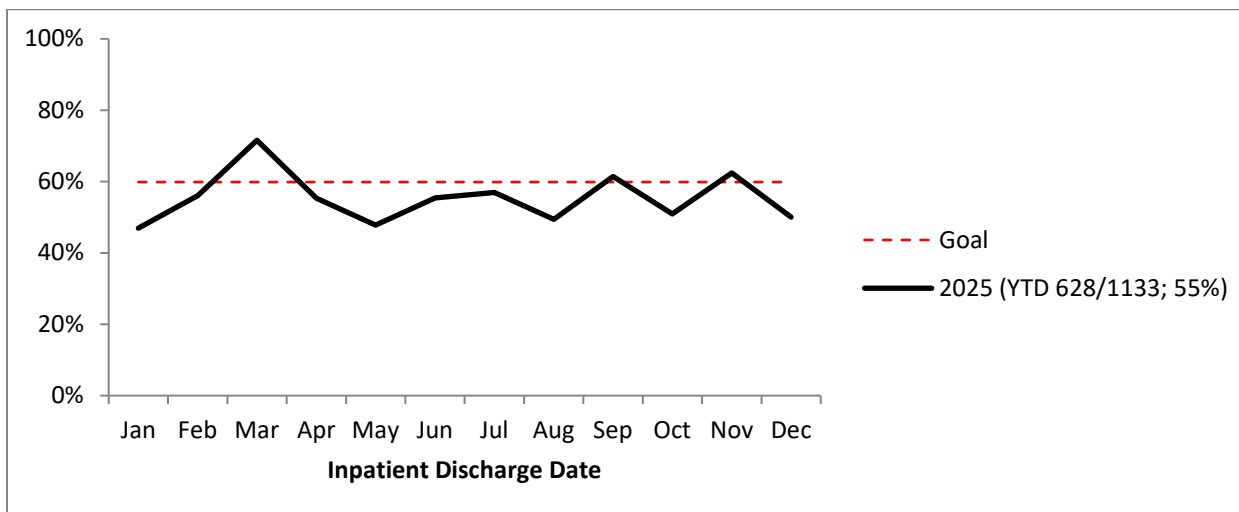
Goal: Above 36.94%



30-day Rate

The percentage of discharges with a follow-up service within 30 days.

Goal: Above 59.85%



	2023	2024	2025
7-Day Follow-Up			
Goal	35.16%	35.16%	40.00%
Rate	39.10%	41.76%	37.07%
30-Day Follow-Up			
Goal	57.69%	57.69%	62.08%
Rate	55.91%	59.62%	55.43%

Qualitative Analysis

Completed February 24, 2026

The goal for both 7 and 30 day follow up is based on the 50th percentile benchmarks as outlined by NCQA. In November 2025, ABH was notified that the 7 day benchmark increased from 36.94% to 40.00% and for 30 days increased from 59.85% to 62.08%. Performance for FUH 7 through Q4 2025 is 37.77%, a rate that is 2.23 percentage points below benchmark. Performance for FUH 30 day through Q4 2025 was 56.38%, a rate that is 5.7 percentage points below benchmark. This is attributed to claims lag, performance is expected to reach benchmark by Q2.2026.

The QI Department continues to attempt to engage with all individuals who were discharged from a psychiatric hospitalization to encourage compliance with the follow up appointment or to determine reasons that the 7 day appointment was missed. The results are summarized in the table below.

The QI Department continues to meet with Behavioral Health Homes (BHHs) quarterly to review provider specific results regarding the 7-day and 30-day FUH measure. ABH also meets with the hospitals quarterly to review metrics associated with the FUH. Barriers and opportunities for improvement as well as interventions are also discussed quarterly with each BHH.

Year to date results for follow up after hospitalization survey calls.

2025	Hospital Survey Call Results			
	Q1	Q2	Q3	Q4
APPOINTMENT RESCHEDULED	37	30	34	40
	10.4%	7.4%	9.4%	10.6%
DECLINED SURVEY	4	6	5	6
	1.1%	1.5%	1.4%	1.6%
DECLINES UPCOMING APPT	9	8	7	4
	2.5%	2.0%	1.9%	1.1%
INVALID NUMBER/ NO CONTACT NUMBER LISTED	33	40	52	46
	9.3%	9.9%	14.4%	12.1%
PLANS TO ATTEND	150	137	134	147
	42.1%	33.9%	37.0%	38.8%
ATTEMPTED, BUT UNABLE TO CONTACT	78	103	76	81
	21.9%	25.5%	21.0%	21.4%
OTHER	45	80	54	55
	12.6%	19.8%	14.9%	14.5%

Barriers and Interventions

Date	Opportunities for Improvement	Barriers	Intervention	Outcome
04/2023	Timeliness of discharges received by ABH from hospitals.	Baptist hospital waiting to send discharge documents until all areas complete.	Review scorecard results with hospitals.	Ongoing
04/2023	Timeliness of discharges received by ABH from hospitals.	Baptist Hospital attempts to schedule appointments with member preferred provider but has difficulty with 2 in network providers.	ABH Quality team worked as liaison to schedule meetings between hospital and the outpatient providers to ensure points of contact for scheduling.	Completed.
4/2023	Timeliness of discharges received by ABH from hospitals.	Weekend discharges are not sent to ABH until Monday at the earliest.	Baptist hospital will now send discharges on the weekend.	Ongoing
4/2023	Increase family engagement during inpatient hospitalization.	Inconsistent reporting in discharge documentation regarding family engagement. Adults consent to family engagement less often than children.	Baptist Hospital created a "collateral note" which will capture this data and will be sent with the discharge clinical information.	Ongoing

09/2023	Timeliness of discharge (FUH) received by BHH.	Automated drop of discharges every Wednesday to one BHH listing FUH discharges from the week prior.	Send real time discharge information every morning to one BHH. One point of contact at the BHH responsible for outreach and engagement.	Ongoing. May expand to all BHHs if positive impact is noted.
06/2024	None at this time- FUH 7 and 30 have been met for 2023 and YTD 2024.			
02/2025	None at this time- FUH 7 and 30 have been met for 2023 and 2024.			
Q2.2025	BHH to make contact with members during inpatient admission to connect to outpatient services prior to discharge.	Hospitals disinclined to allow outside agencies into their facilities.	One BHH permitted to send peer specialists in twice per week to offer an educational group about the programs/services provided by the BHH.	Ongoing.

Mental Health Readmission Rate

The percentage of acute care facility discharges for enrollees who were hospitalized for a mental health diagnosis that resulted in a readmission for a mental health diagnosis.

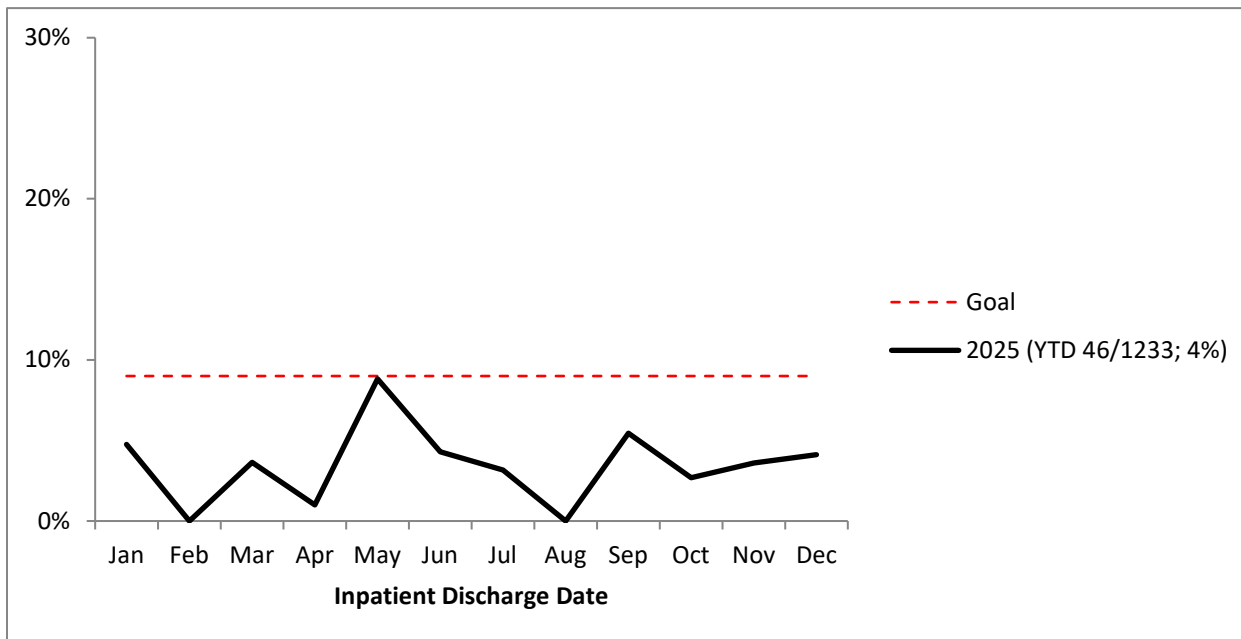
This is a HEDIS-like measure defined by AHCA. There is no statewide benchmark for this measure, therefore the goals are calculated by ABH's historical average.

This measure has been retired by AHCA in 2021. ABH continues to track readmission rates for quality improvement purposes.

7-day Rate

The percentage of discharges with a readmission within 7 days.

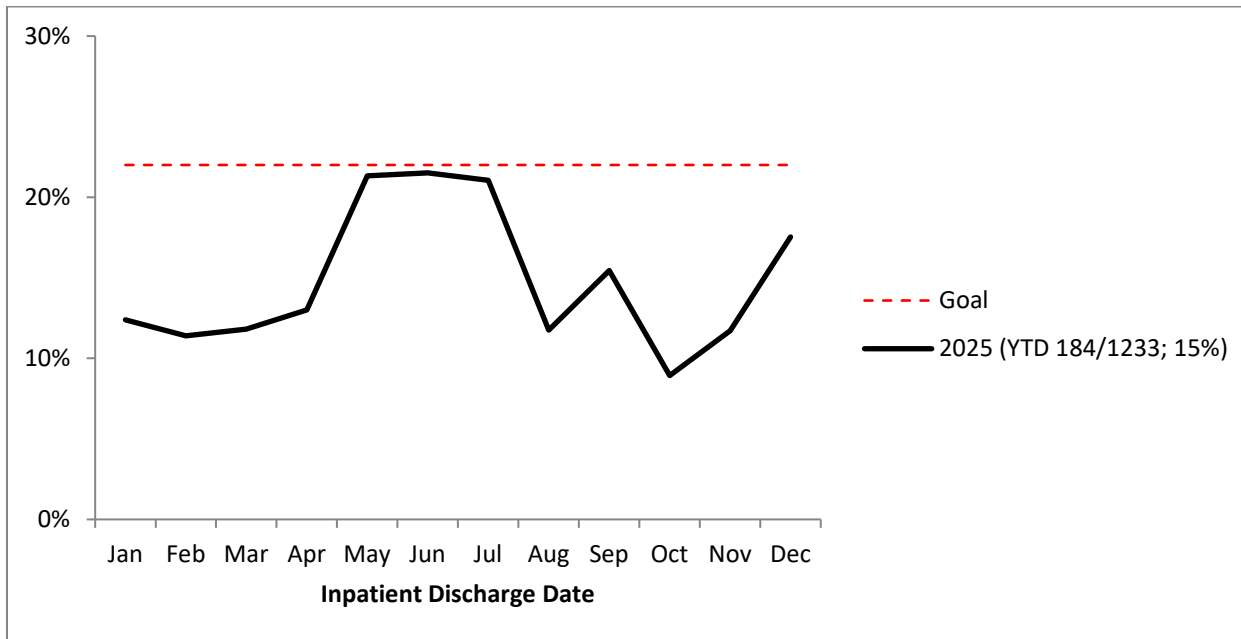
Goal: Below 9%



30-day Rate

The percentage of discharges with a readmission within 30 days.

Goal: Below 22%



	Goal	2023	2024	2025
7-day	<9%	4.08%	3.93%	3.73%
30-day	<22%	16.43%	14.91%	14.92%

Qualitative Analysis

Completed February 24, 2026

Readmission rates continue to meet goals.

ABH sends Daily Census Inpatient Reports to providers which indicate which members have been readmitted within 30 days of discharge from initial hospitalization. A monthly High Utilizer report identifying those members who frequently penetrate inpatient services, to include SIPP is sent to the BHHs. This creates increased awareness for providers regarding re-admissions and which members may need additional monitoring. ABH discussed auditing the high utilizer report and Significantly Mentally Ill (SMI) Specialty Plan members for their readmissions rates to determine root cause and potential interventions. Reporting on this is not available but continues to be an initiative.

Barriers and Interventions

Date	Opportunities for Improvement	Barriers	Intervention	Outcome
January 2023	None: Readmission rates are low and remain within standard.			
January 2024	None: Readmission rates are low and remain within standard.			
January 2024	None: Readmission rates are low and remain within standard.			
January 2025	None: Readmission rates are low and remain within standard.			

Availability of Practitioners and Providers

This section addresses:

Quality of Clinical Care Safety of Clinical Care Quality of Services

Cultural Needs and Preferences/Cultural Competence

Cultural competence is the ability to work effectively within the context of the cultural beliefs, behaviors and needs of a Behavioral Healthcare Organization's membership. It requires the ongoing practice of integrating knowledge, information, and data from and about individuals, families, communities and groups. This information is transformed into specific standards, practices, skills, service approaches, techniques and marketing strategies that match the service population and increase the quality and appropriateness of services.

Language needs and ethnic backgrounds of members, including prevalent languages and cultural groups, are identified using:

- U.S. Census data,
- County specific data,
- Enrollment data when available,
- Member Complaints,
- Member Satisfaction Survey Questions 7, 8, and 9

Data regarding language and ethnic backgrounds of members is compared to language and ethnic backgrounds of the ABH provider network for analysis. ABH operates from a Cultural Competence plan based on a multi-measure analysis of network adequacy. Languages spoken by Providers and Practitioners in the ABH Network include:

- English
- French
- Spanish
- Italian
- Vietnamese
- Swahili
- ASL

To address the needs of members who speak English as a second language, ABH offers the following:

- Free language assistance services;
- Free interpretation services for all languages via a Language Line;
- Spanish versions of ABH's website and member materials;
- Translation of ABH's website in most languages, as available by Google Translation services online;
- TTY/TDD services;
- Members may request a written translation of documents mailed to them by calling the ABH Quality Director.

This section is updated annually in the ABH evaluation.

Member Experience Survey scores regarding practitioner fit.

Survey Question	2023	2024	2025
7. My counselor is a good match for me.	4.6	4.6	4.6
8. Information is given to me in a language I understand.	4.8	4.7	4.7
9. The staff are sensitive to my cultural/ethnic background.	4.5	4.5	4.5

Number of member complaints regarding practitioner availability.

	2023	2024	2025
Number of Complaints	1	0	0

Percentage of languages spoken in ABH membership.

Language	2023	2024	2025+
English	96.4%	96.0%	95.8%
Spanish	3.4%	3.8%	3.9%
Other	0.2%	0.2%	0.1%
Unspecified/Not Provided			0.2%

+ Data source: Health plan eligibility/enrollment data

Percentage of languages spoken in ABH provider network.

Language	2023	2024	2025
English	100%	100%	100%
Spanish	6%	5%	4%
Other	4%	5%	3%

Ethnicity distribution of ABH membership (formerly region A population).

Ethnicity	2023*	2024*	2025+
African-American	15%	15%	7.7%
American Indian/Alaskan Native			0.1%
Asian/Pacific Islander			0.3%
Hispanic	26%	26%	1.4%
White (Non-Hispanic)	52%	52%	11.5%
Other	4%	4%	1.4%
Unspecified/Not Provided			75.3%

* Data source: US Census 2021 US Census with 5-year projection

+ Data source: Health plan eligibility/enrollment data

Ethnicity distribution of ABH provider network.

Ethnicity	2023	2024	2025
African-American	17%	17%	15%
Hispanic	7%	8%	9%
White (Non-Hispanic)	62%	57%	57%
Other	14%	18%	19%

Gender distribution of ABH membership.

Gender	2023	2024	2025
Male	56%	55%	55.8%
Female	44%	45%	44.2%

Gender distribution of ABH provider network.

Gender	2023	2024	2025
Male	24%	23%	22%
Female	76%	77%	78%

ABH membership age group distribution.

Ages	2023	2024	2025
00-11 Months	3%	3%	3.8%
01-05 Years	16%	18%	18.0%
06-13 Years	23%	25%	25.9%
14-20 Years	18%	18%	18.8%
21-54 Years	32%	27%	24.4%
55+ Years	8%	9%	9.0%

Network Adjustment	2023	2024	2025
Q1	N	N	N
Q2	N	N	N
Q3	N	N	N
Q4	N	N	N

Qualitative Analysis

Completed April 13, 2026

ABH Network provider organizations’ practitioners are routinely compared to a member’s gender, ethnicity, and language preference. ABH has been presented with no complaints or issues regarding availability for any member seeking service from a provider of requested gender, ethnicity or language spoken.

Results for 2025 regarding cultural needs and preferences were reviewed and analyzed by the Director of Provider Network Management and Contracting as well as the Quality Management Committee. Results reflect that the ABH membership consists of 3.9% individuals who speak Spanish while the ABH network includes 4% of providers who are available to provide services directly in Spanish. The language line is also available for use by network providers across Region A, at no cost to members. The Quality Management Committee discussed the distribution of primary languages across the ABH membership and provider network. The distribution is well balanced and there is no need to adjust the network based on language at this time.

Those members who identify as Hispanic account for 1.4% of the ABH membership. 9% of providers in the ABH network identify as Hispanic. ABH continues to stress the importance of accurate roster submissions during provider trainings and will continue to do so in 2026. Members have not filed complaints about ethnic distribution/cultural disparities in 2025. Members also scored the three questions related to cultural competence on the member experience survey at or

above the goal of 4.5. These factors support the network remaining as it is atg this time. ABH continues to monitor the ethnic distribution to assess for necessary adjustments.

Ensuring Availability

ABH continuously monitors its network to ensure that the needs of members in Regions I and II are met. ABH members can receive Behavioral Healthcare services through any of these service delivery methods:

- **High Volume Provider:** Any provider that renders services to more than 50% of the total members served in a county.
- **Provider:** A provider that renders services to less than 50% of the total members served in a county.
- **Practitioner:** A licensed mental health counselor, social worker, psychologist, psychiatrist, or APRN.
- **Practitioner Group:** A licensed practitioner who operates within a group setting, credentialed by ABH but contracted as a group.

Network Ratios

ABH monitors the ratio of member to providers to ensure contractual standards are met. MMA plan ratios reported below were formerly measured against 120% of Medicaid enrollment totals for the regions we serve. The 2025 standard is based on 100%. Humana has the largest membership among plans whose behavioral health is managed by ABH. Network ratios for each health plan exceeds the measures reported below.

This section is updated annually in the ABH evaluation.

Goal: 100% compliance

Required Providers	Regional Provider Ratios Standard	2023	2024	2025
Board Certified or Board Eligible Adult Psychiatrists	1: 1,500**	Yes	Yes	Yes
Board Certified or Board Eligible Pediatric Psychiatrists	1: 7,100 1:1,350*	Yes	Yes	Yes
Licensed Practitioners of the Healing Arts	1: 1,500 1:1,000*	Yes	Yes	Yes
Licensed Community SA Treatment Centers	2: county	Yes	Yes	Yes
Inpatient SA Détoxification Units	1 bed: 4,000 1 bed: 1,000*	Yes	Yes	Yes
Accredited Psychiatric Community Hospital (Adult) or CSU/Free Standing Psychiatric Specialty Hospital	1 bed: 2,000	Yes	Yes	Yes

*Standard effective 2025

**An error was found in state published adult psychiatrist standard for 2025. Awaiting state correction.

Geographic Access

ABH analyses Geospatial Access (drive time and distance), which is the use of geographic data to analyze the accessibility of health care networks. The goal is to locate geographic gaps in board certified or board eligible adult psychiatrists, board certified or board eligible child psychiatrists, and licensed practitioners of the healing arts. ABH geo-codes member addresses taken from enrollment files for the last month of each quarter and provider service location addresses in the ABH provider directory. For each provider type, the distance to the closest provider is calculated for each member relevant to the provider type (e.g., adult only for adult psychiatrists, children only for child psychiatrists) and assessed against the urban (20 mile) and rural (45 mile) standards. The percentage of members meeting each standard is reported.

This section is updated annually in the ABH evaluation.

Goal: 95% compliance with urban and rural distance standards

Percentage of specialists within 20 miles (Urban Standard)

Specialists	2023	2024	2025
Adult Psychiatrist	99%	100%	99%
Child Psychiatrist	99%	100%	99%
Licensed Practitioner	99%	100%	100%

Percentage of specialists within 45 miles (Rural Standard)

Specialists	2023	2024	2025
Adult Psychiatrist	100%	100%	99%
Child Psychiatrist	100%	100%	98%
Licensed Practitioner	100%	100%	99%

Qualitative Analysis

Network standards have been met. ABH monitors network adequacy using eSpatial to report ongoing to continue to meet provider ratios and network adequacy standards.

Single-Case Agreements

These are single case agreements entered into with non-participating outpatient behavioral health providers within Region A. Single case contracting experience with providers has led to network provider contracting when indicated.

In-Region Outpatient Single Case Agreements						
Facilities	2023	2024	Q1/2025	Q2/2025	Q3/2025	Q4/2025
Adult & Child Mental Health Care	1	0	0	0	0	0
Adult Children & Family Counseling	0	0	0	0	0	0
Aldda Medical – Mindful Care	0	0	14	11	0	0
AMIKids Behavioral Health	0	1	0	0	0	0
Ascension Sacred Heart	8	1	0	0	0	0
Baycare Behavioral Health	1	0	0	0	0	0
Brave Health	0	0	0	0	0	0
Beyond Expectations	1	0	2	0	0	9
Camelot	1	0	0	0	0	0
Center for Alcohol and Drug Studies	1	0	0	0	0	0
Charlie Health	2	0	0	7	16	38
Circles of Care	1	0	0	0	0	0
Community Wellness Counseling and Support	4	0	0	0	0	0
Chrysalis Health	17	93	21	27	17	14
Cotler Healthcare	0	0	0	0	0	6
DNA Comprehensive Therapy	100	0	0	0	0	1
Drake Gunning	1	0	0	0	0	0
Empathy Behavioral Health	0	0	0	0	0	1
ERMC Counseling	0	0	0	0	0	0
Florida Medical Practice Plan	0	0	1	1	0	0
Florida Therapy	0	0	0	0	0	0
Gary Wylin, LCSW	0	0	0	0	0	0
The Healing Impact	0	0	0	0	0	0
Horse Healing	0	2	0	0	0	0
Hughley’s Mental Health	0	2	0	0	0	0
IBIS / Gracepoint / MHC Inc	0	0	0	0	0	1
Impact Behavioral Health	0	0	0	0	0	0
Kristina Sykes, LMHC	1	1	0	0	0	0
Lucas Counseling	1	0	0	0	9	0
Marriage and Family Services, Inc.	0	1	0	0	0	0
Metro Treatment of Florida	9	0	0	0	0	0
Morning Light Wellness Center	6	0	0	0	0	0
Osana	1	0	0	0	0	0
Panhandle Comprehensive Treatment Center	31	0	0	0	0	0
Panhandle Therapy	11	0	0	0	0	0
Partners Family Medicine & Recovery Center	0	0	0	0	0	0
Peter Oas, PhD	1	1	0	0	0	0
Railey and Associates	1	0	0	0	0	0
Refresh Canopy Cove	1	0	0	0	0	0
Resolution Health Alliance	2	2	0	0	0	0
United Hands	0	0	0	0	0	0
Wiregrass Wellness	0	1	0	0	2	0

**Qualitative Analysis:
Completed 2/27/2026:**

Single case contracting with an out-of-network provider can identify a network expansion need and demonstrate a provider's suitability to address the need. ABH adjusts its provider network to ensure that plan members will have all required access to behavioral health specialty provider services. Chrysalis Health is a credentialed provider, SCAs were for services not included in their network provider agreement with ABH.

ABH is contracting with Charlie Health due to the increased referrals and requests for single-case agreements for the Intensive Outpatient virtual and after-hours services Charlie Health provides to Medicaid recipients.

Accessibility of Services

Timely Access to Services

To ensure availability of services in a timely manner appropriate to a plan member’s level of need. Monitor and measure to ensure that network providers are meeting and exceeding Medicaid standards for timely access to services according to AHCA categories of access times. This is measured by network provider monitoring telephone surveys (secret shopper calls) and by review of utilization and claims data.

ABH uses valid methodology to collect and analyze data to evaluate access to appointments for behavioral healthcare.

Access to BH appointments

Updated May 25, 2023

ABH providers are required to meet the following access times:

1. Within fourteen (14) days for initial outpatient behavioral health treatment;
2. Within sixty (60) days of a request for an appointment with a prescribing practitioner;
3. Within seven (7) days post discharge from an inpatient behavioral health admission for follow up behavioral health treatment.
4. Within six (6) hours for a non-life threatening emergency from an ABH high volume provider
5. Within 48 hours for urgent care from an ABH high volume provider
6. *Follow up routine care for prescribers is received within six (6) months of the initial appointment and at least every six (6) months thereafter.
7. *Follow up routine care for non – prescribers is received at least once per month (every 30 days)

* These appointments were assessed via claims/utilization data, not secret shopper calls.

Data Collection Methods:

Secret Shopper

ABH staff assessed appointment wait times through secret shopper calls conducted by the ABH Quality Specialist, utilizing the AHCA-approved phone script. Providers not meeting appointment wait time standards submitted root cause analyses and corrective action plans and were reassessed in subsequent quarters. Appointment access is evaluated separately for adults and children; providers serving both populations are counted in each category to facilitate targeted analysis of deficiencies.

As of 2019, ABH is not delegated member complaints by any health plan. However, ABH will continue to review member complaints to determine if access becomes an issue.

For follow up routine care data collection methodology see the “Timely Access to Services Follow Up Care” section below.

2025 Provider Type	Number of Secret Shopper Survey				Number of Member Complaints			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Prescribing Practitioners	39	30	27	21	0	0	0	0
Prescribing Practitioners	28	33	14	2	0	0	0	0

*Numbers are year-to-date and updated on a quarterly basis

Access Times for Providers/Practitioners

2025	Post Inpatient Discharge Follow-up				Initial Outpatient Treatment				Request for Specialist Appt (Psychiatry)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
% meeting standard	100%	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%	100%
Num/Denom	34/34	32/32	12/12	2/2	36/36	30/30	25/27	21/21	26/26	33/33	14/14	2/2
Average (days)	7	7	7	7	10	14	13	10	9	55	33	60
Goal (days)	7	7	7	7	14	14	14	14	60	60	60	60

Qualitative Analysis

Completed February 24, 2026

Secret shopper calls were made to providers, using the AHCA approved script, during Q4.25. As a result, 100% of providers were identified as proficient in meeting appointment standards for follow-up after hospitalization and for prescribers. Lakeview Center, Walton County, was assessed for access times for adults and children and failed to meet initial therapy standards during Q3.25. They received secret shopper calls in Q4.25 and demonstrated that the interventions implemented during Q3.25 were effective at improving performance.

ABH is not delegated member complaints therefore the table reflects zero through Q4.25. ABH does assist the health plans at their request to resolve member complaints. That data is submitted to the health plans separately.

Barriers and Interventions

Date	Opportunities for Improvement	Barriers	Intervention	Outcome
05/2023	Collect data for access to services: follow up routine care	Relying on claims data for appointments may not show all services received by a member when a claim is not submitted.	Quarterly assessment of claims data to determine access to services for routine follow up care for prescribers and therapy. Follow up with providers who do not meet standard.	Ongoing
08/2023	Increase the sample size	Q1.23 being done manually by QI staff.	Data team developed a report to capture this data	Increased sample size and more specific reporting methodology.
02/2025	None-100% of providers met all standards in 2024.			
07/2025	Improve timeliness of complaint resolution.	Health Plan awareness of ABH providers and access to outpatient services.	ABH and a Health Plan Representative from the Complaints department met to provide education regarding the process to initiate outpatient services.	Reduction in complaints sent to ABH in Q3.25 suggesting the Health Plan representatives assist the member immediately by connecting them to an ABH in network provider.

Timely Access to Services: Follow Up Care

The purpose of this assessment is to ensure that follow-up appointments for individual/family therapy (IFT) and medication management (MM) are regularly scheduled and attended for ABH members. QMC reviewed best practices for these services and determined that IFT should occur at a minimum of every 30 days, and MM should occur at a minimum of every 6 months (180 days).

Methodology

For Q1.23 utilization data was reviewed for 20 randomly selected members. Data was analyzed to determine the number of days between prescriber appointments (Medication Management) and between individual/family therapy appointments. These services are the most utilized by our members. One (1) out of the 20 members receiving medication management services fell outside of the 6-month (180 day) standard, at 182 days. When this member is removed, the average number of days for a follow up prescriber appointment is 55 days. The range of days was 18-182 with an average of 61.3 and modes of 56 and 42 days.

The average number of days between therapy appointments was 34 days. When the outlier of 135 days between appointments is removed, the average becomes 28 days.

Beginning Q2.23, ABH Quality and Data departments met to improve the methodology and efficiency for this assessment. For each service, a random 25% of members who'd received services within the reporting quarter was selected. Then a year's lookback of claims history for IFT or MM was pulled for each member, with their most recent service in the reporting quarter as the lookback date. The number of days between each service for each member was calculated using the following criteria:

1. If the only recorded service was on the last day of the measurement quarter, then the Days Between (DaysBT) was NULL;
2. If the only recorded service was not on the last day of the measurement quarter, then the DaysBT was recorded a zero;
3. If it was not the first service and had no subsequent services following (most recent service), then the DaysBT was NULL;
4. Otherwise, calculate the day between each subsequent service, ascending by service date.

From the base group, the total records of services were grouped by the DaysBT. All NULL DaysBT were removed from the dataset. To control for outliers, the top 10% of days was combined as "999" days. The data was then analyzed using a percent (%) running total and a % grand total.

This change in methodology from Q1.23 was intended to improve timeliness and accuracy of the report.

In Q1.25, the selection was modified to align with the secret shopper calls and provider monitoring for each quarter. 100% of services rendered in the reporting quarter will be pulled.

Goal: 180 days for Medication Management
30 days for Individual/Family Therapy

Utilization Outcomes

2025 Follow-Up Service Type	Percent of appointments that are within follow-up standards				
	Goal	Q1	Q2	Q3	Q4
Individual/Family Therapy	30 days	82.7%	81.4%	94.2%	77.9%
Medication Management	180 days	94.7%	97.2%	98.8%	97.9%

2025 Providers Monitored per Quarter			
Q1	Q2	Q3	Q4
Adult and Child Mental Health Care Apalachee Center, Inc. Bridgeway Center, Inc. Santa Rosa Counseling Center The Healing Impact, Inc. Lakeview Center, Inc.	Life Management Center Neighborhood Medical Center PanCare of Florida Panhandle Therapy Partners Family Medicine Psychological Associates Lakeview Center, Inc. Community Wellness Counseling and Support Services	Lakeview Center, Inc. Beach Counseling Services Chemical Addictions Recovery Effort, Inc. Camelot Community Care Children's Home Society of Florida Chrysalis Health Community Health NW Florida	Families First of FL Christine Brownfield Chemical Addictions Recovery Effort, Inc. Bond Community Health Center Lakeview Center, Inc. Community Health NW Florida DISC Village

	Goal	2023	2024	2025
Individual/Family Therapy	30 days	87.9%	88.9%	86.9%
Medication Management	180 days	96.2%	94.4%	97.4%

Q4.25 Results

Completed February 20, 2026

For Individual and Family Therapy (IFT), 77.9% of services occurred within 30 days, with 49.1% occurring within 19 days of each other and 90.0% of services occurring within 52 days of each other. Most services occurred within fourteen days of each other (15.6%).

For Medication Management (MM), 97.9% of services occurred within 180 days of each other, with 50.5% occurring within 34 days of each other and 90.2% occurring within 105 days of each other. Most services occurred within 28 days of each other (15.1%).

Date	Opportunities for Improvement	Barriers	Intervention	Outcome
03/2023	Collect data for ongoing therapy and medication management appointments to ensure timely follow up/engagement appointments.	Data collection is cumbersome with room for human error.	Data team developed automated report for Quality review.	Larger sample, more accurate outcomes.
02/2024	Align providers who receive secret shopper calls each quarter with those providers assessed during routine follow up care.	No existing report, ABH data will create a new report	ABH Data team created a scheduled data pull to include only those providers who are simultaneously being assessed for routine initial care.	The same providers assessed for initial care are assessed for follow up care each quarter.

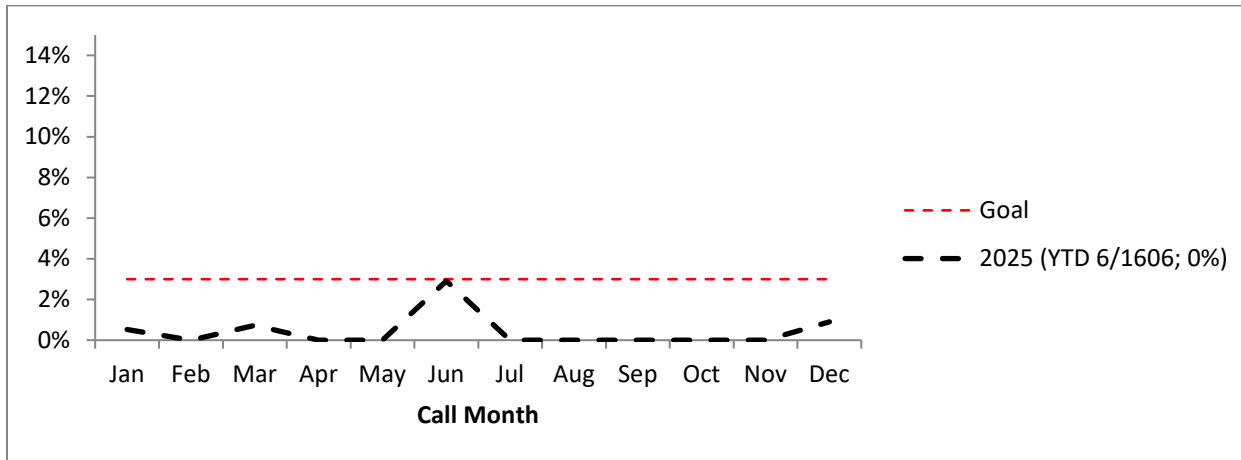
04/2024	Collect data to ensure timely follow up care and share results with ABH and network providers.	Providers unaware of ABH expectations regarding routine follow up care.	Share results with QI_UM Subcommittee and providers during annual provider training sessions.	Sharing of information across ABH and provider network.
Q1.2025	Align sampling of follow up care for initial care.	Timeframes for reporting out results to providers. Initial access to care scorecards are sent out immediately following secret shopper calls. Follow up care is determined by evaluating claims data thus there is a delay in reporting out.	Quality Specialist will provide the data team with the list of providers scheduled for secret shopper calls each quarter and this will be the provider sample also used for follow up care. All results will be reported on the scorecard and given to providers.	Ongoing.

Telephone Standards

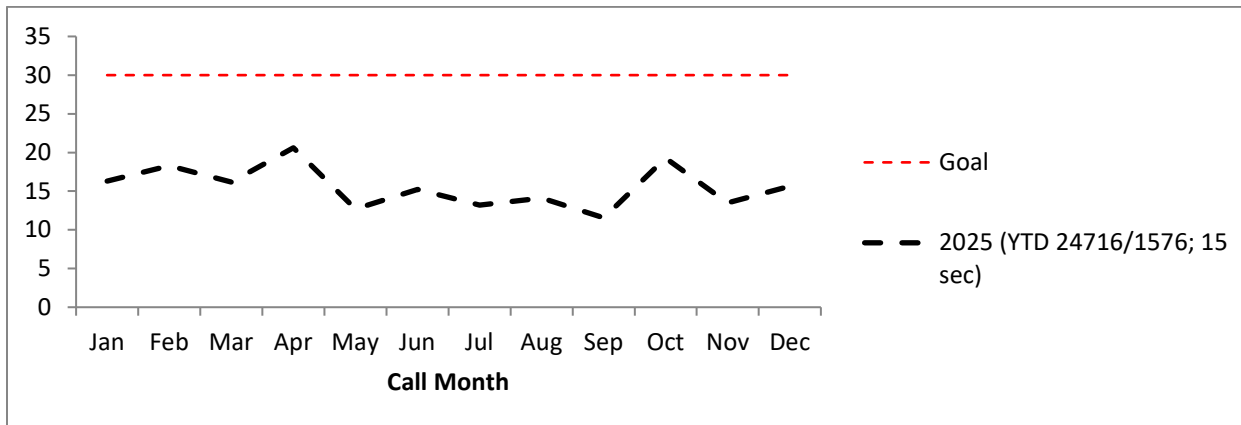
Call abandonment rates, call quality, and the average time it takes for call center staff to answer calls (ASA).

Goal: Abandonment rate below 3%; ASA below 30 seconds

Call Abandonment



Call ASA



	Goal	2023	2024	2025
Avg. Speed of Answer	30 seconds	11.4	22.4	15.7
Abandonment Rate	3.0%	4.7%	0.6%	0.4%

Qualitative Analysis

Completed November 20, 2025

Average speed of answer: Average Speed of Answer (ASA) metrics in Q4.25 continue to meet targets (30 seconds) with an average of 15 seconds.

Abandonment rate: ABH met the call abandonment rate through Q4.25 with an average abandonment rate of zero per cent. There was an increase of abandoned calls in June, this was attributed to staffing levels. The rate has since improved and been maintained since July.

Barriers and Interventions

Date	Opportunities for Improvement	Barriers	Intervention	Outcome
January 2023	None: Abandoned calls and time to answer rates are within standards.			
October 2023	More detailed results regarding abandonment rates.	Call Center Solution limitations regarding abandonment rates	Upgraded call center solution from TASKE to NICE on 10/20/23	Ongoing. Preliminary results for November 2023 show <3% abandonment rate. This continued through Q1.2024.
July 2024	Staff shortages led to missed SLAs	Low call volume to support hiring new staff	One FTE Call Center Employee hired/onboarded in July/August 2024.	Ongoing-performance through Q2.25 shows this intervention was effective.

Provider Satisfaction Survey

ABH evaluates provider satisfaction through an annual comprehensive health plan provider satisfaction survey.

In 2025, the health plan assumed responsibility for administering this survey to providers. As a result, there will be no updated data for ABH post-2024. The tables below will remain due to the presence of historical data.

Goal: 4.3 out of 5

Domains		2023		2024	
		Score	N	Score	N
<i>How satisfied are you with ABH?</i>		4.26	44	4.43	48
<i>How would you rate ABH compared to all other Medicaid health plans with which you contract?</i>		4.24	38	4.45	48
<i>How satisfied are you with your ability to obtain member-level information (e.g., eligibility, benefit coverage, recent admissions and discharges) from ABH?</i>		4.33	43	4.47	47
<i>How satisfied are you with the care management services (e.g., planning, directing, and coordinating health care and utilization of medical and allied services) at ABH?</i>		4.38	43	4.51	47
<i>How satisfied are you with ABH's materials (e.g., manuals/handbooks, newsletters, policies)?</i>		4.16	43	4.23	47
<i>How satisfied are you with your provider relations representative (e.g., representative's ability to answer questions and resolve problems, timeliness)?</i>		4.49	43	4.62	47
<i>How satisfied are you with the offered network of medical specialists (e.g., number, availability, quality)?</i>		3.91	43	NA	.
<i>How satisfied are you with the network of behavioral health specialists (e.g., number, availability, quality) at ABH?</i>		4.18	43	4.32	47
<i>How satisfied were you with the credentialing process at ABH?</i>		4.18	43	4.39	47
How would you rate your level of agreement with the following statements for	<i>Rules and procedures for service authorizations and referrals are clear in provider handbook</i>	4.25	5	4.43	11
	<i>Standard service authorization denial notifications are sent within 7 calendar days</i>	4.46	7	4.38	10
	<i>Expedited service authorization denial notifications are sent within 2 business days</i>	4.58	6	4.38	10

ABH?	<i>I am satisfied with the authorization process</i>	4.64	7	4.43	11
	<i>I am satisfied with the authorization appeal process</i>	4.58	6	NA	
How satisfied are you with ABH's performance in the following areas?	<i>Claims submission process</i>	3.57	14	3.37	13
	<i>Assistance with claims process</i>	3.84	14	2.92	3
	<i>Timeliness of claims payment</i>	3.48	14	2.5	3
	<i>Accuracy of claims payment</i>	3.75	14	2.5	3
	<i>Resolution of claims payment problems or disputes</i>	3.75	14	2.92	3
	<i>Timeliness of the claims appeal process</i>	3.75	14	3.33	3
	<i>Claims denial reasons</i>	3.85	13	3.33	3
<i>How satisfied are you with the complaint resolution process related to grievances and appeals at ABH?</i>		4.32	22	4.38	47
OVERALL SCORE		4.13		3.91	

What has been the impact of Florida Medicaid's Medication Formulary on your ability to provide quality care for your patients?		
	2023	2024
Strong positive impact	19%	NA
Positive impact	38%	NA
Little to no impact	44%	NA
Negative impact	NA	NA
Strong negative impact	NA	NA

What has been the impact of ABH's Behavioral Health Screening Program(s) [e.g., Metabolic Syndrome, Co- Occurring Disorders] on your patients' health status relative to their condition(s)?		
	2023	2024
Very positive	13%	26%
Positive	87%	74%
Negative	NA	NA
Very negative	NA	NA

Qualitative Analysis
Completed June 28th, 2024

2024 was the third remeasurement year for this provider survey. The survey format, domains, and questions were designed by the Agency for Healthcare Administration (AHCA). The survey was delivered by the Access Behavioral Health (ABH) Quality Department via Survey Monkey to ABH's participating provider network and included both clinical and administrative professionals. The survey was sent out on May 23rd, 2024, with responses due by June 21st, 2024. Those who received the survey were encouraged to forward the survey to other individuals within their organization. Forty-eight participants completed the survey, a slight increase from 2023 (n=43). All survey responses were anonymous. Enough returned surveys were returned to count as a valid response.

Survey results were reviewed and discussed with the ABH Quality Management Committee and the ABH Care Management team on 09/10/2024, and with the ABH Claims team on 08/21/2024.

Access Behavioral Health's (ABH) overall provider satisfaction score for 2024 was 3.91 out of 5.0, not meeting the established scoring goal of 4.3, set after the analysis of the 2023 survey results. In 2024, performance improved in 10 out of 12 areas. Claims continues to be a low scoring area in the annual provider survey. This year, for the seven questions regarding claims, the denominator was significantly low (n=3). When the claims results are removed from the analysis, the average score increases to 4.42 points out of five, exceeding the goal of 4.3 points. ABH believes these lower averages are due to one outlying provider. ABH is currently working one-on-one with this provider to address their concerns and improve their overall billing experience.

Three questions were removed from the 2024 survey after being determined by QMC that they were no longer applicable. The first question is regarding medical specialists. The ABH network is composed of behavioral health providers, so this question did not seem appropriate for ABH providers. The second question regarding appeals was removed due to ABH not being delegated appeals by the health plans. The last question was removed due to ABH not having a Medicaid Medication Formulary.

- "How satisfied are you with the offered network of medical specialists (e.g., number, availability, quality)?"
- "I am satisfied with the authorization appeal process"
- "What has been the impact of Florida Medicaid's Medication Formulary on your ability to provide quality care for your patients?"

The ABH QMC Committee unanimously decided to continue the current goal of 4.3 out of 5 for the 2025 survey year, as it was not met in 2024. To achieve this goal, ABH has developed an action plan targeting the five lowest scoring questions (claims submission process, timeliness of claims payment, accuracy of claims payment, resolution of claims payment problems or disputes & timeliness of the claims appeal process) and all survey comments. ABH will use the

following primary interventions to improve provider satisfaction with ABH: Provider education through initial provider onboarding training, bi-annual provider training, and ad hoc provider training; using ad hoc polls throughout provider trainings to gain more insight into provider concerns and how to address them, communication and addressing of current concerns at quarterly Quality Improvement meetings with ABH's sub-capitated Community Behavioral Health Home (BHH) providers; and communication to providers using the ABH website, abhfl.org. In 2025 ABH will attempt to begin implementation of functions that will scan and read paper claims and automate electronic entry into the claims payment system, thereby reducing common claims data entry keying errors.

Barriers and Interventions

Date	Opportunities for Improvement	Barriers	Intervention	Outcome
July 2024	Claims submissions	Continued claim submission concerns	Electronic portal for submissions	Ongoing

Member Experience

This section addresses:

Quality of Clinical Care Safety of Clinical Care Quality of Services

Member Experience Survey

The ABH Member Experience survey is a tested, reliable, and NCQA-approved tool for gaining information directly from members regarding their experience with ABH providers. The survey addresses Member Experience in the following categories:

- **Services:** The scope of services offered by the organization.
- **Accessibility:** The members’ ability to easily obtain services when needed.
- **Availability:** The presence of the appropriate types of practitioners, providers and services in locations convenient for the members.
- **Acceptability:** The “fit” of the practitioner, program and services with the member receiving care, representing an organization’s “cultural competence”, or its capacity to assess and meet the special, cultural, ethnic, communication and linguistic needs and preferences expressed by its members.

Methodology

The 2025 survey was sent by mail to all in-network providers on November 10th, 2025. A sample of the population was not used for this survey; the entire population was surveyed. ABH distributed a total of 710 paper surveys to Region A in Florida. These providers and practitioners in turn distributed the paper copies to members. A QR code flyer was also distributed, so members could complete the survey electronically.

This section is updated annually in the ABH evaluation.

Goal: Rating of 4.5 or higher across all categories.

2025 Results

Category	Question	N	Average
Services	<i>Q01: The services available meet my needs.</i>	412	4.6
	<i>Q02: I can get as much help as I want for my mental health needs.</i>	355	4.4
	<i>Q03: I am able to get in touch with someone when I need help.</i>	411	4.4
	<i>Q04: I receive help when I need it.</i>	412	4.5
Accessibility	<i>Q05: I can easily get to my appointments.</i>	412	4.5
Availability	<i>Q06: The people who I see are skilled at helping me.</i>	415	4.6
	<i>Q07: My counselor is a good match for me.</i>	402	4.6
	<i>Q08: Information is given to me in a language I understand.</i>	414	4.7
Acceptability	<i>Q09: The staff is sensitive to my cultural/ethnic background.</i>	386	4.5
	<i>Q10: The staff involved me in deciding my treatment plan and goals.</i>	405	4.5
Overall Satisfaction	<i>Q11: Overall, I am satisfied with my services.</i>	408	4.6
	<i>Q12: I would tell other people to come here if they needed help.</i>	407	4.6

Category	Goal	2023	2024	2025
Services	4.5	4.4	4.5	4.5
Accessibility	4.5	4.4	4.5	4.5
Availability	4.5	4.7	4.6	4.7
Acceptability	4.5	4.5	4.5	4.6
Overall Satisfaction	4.5	4.6	4.6	4.7

Qualitative Analysis

Completed November 20, 2025

ABH mailed surveys out to providers on November 10, 2025. ABH is hosting a provider training on December 4 & 5, 2025 and will review instructions with providers at that time. Responses are due no later than December 30, 2025. Results and analyses of the member experience survey will be included in the next ABH evaluation.

Completed February 23, 2026

ABH met or exceeded the stated goals across all survey categories for 2025, thus a qualitative analysis identifying specific barriers and developing targeted interventions was not conducted. Qualitative analysis is traditionally used to explore areas where performance falls below expectations or where trends indicate a need for corrective action. Since results demonstrated strong performance and consistent satisfaction with services, accessibility, availability, acceptability, and overall experience, no systemic barriers were identified that warranted additional investigation. As such, no interventions were recommended for 2025, and ABH will continue routine monitoring to ensure performance remains at or above established benchmarks.

Member Complaints

To provide the best experience possible for members by assisting the member’s Health Plan, when requested, in resolving member complaints, grievances, and appeals.

This section is updated annually in the ABH evaluation. **As of February 2019, ABH is not delegated member complaints by any contracted Health Plans. However, ABH does assist the health plans at their request to resolve member complaints.**

Methodology

Members are given the opportunity to contact the ABH staff to receive assistance in accessing services or resolving concerns relating to network providers and practitioners. If a complaint is received, ABH directs the member to the appropriate health plan for resolution. ABH is not delegated member complaints, but does assist the Health Plans, when requested.

2025 Member Complaints				
Category	Q1	Q2	Q3	Q4
Quality of Care	0	0	0	0
Access	4	4	2	2
Attitude and Service	0	0	0	0
Billing and Financial	0	2	1	1
Quality of Provider Office Site	0	0	0	0

Category	2023	2024	2025
Quality of Care	0	0	0
Access	15	11	12
Attitude and Service	4	0	0
Billing and Financial	0	0	4
Quality of Provider Office Site	0	0	0

Qualitative Analysis

Completed February 24, 2026

ABH is not delegated member complaints, grievances, or appeals but supports the Health Plan in resolving them upon request. Of the three cases that required ABH assistance, one was related to claims or billing issues. In this instance, the member filed a general complaint with the State but did not offer any provider information. ABH assisted the health plan by providing a full account of all previous contact with the member.

Two complaints were received regarding members who needed assistance finding network providers. In both instances the members were provided appropriate assistance finding network providers who met their needs.

All complaints were resolved successfully, resulting in zero appeals in Q4.2025.

Member Inquiries

To provide the best experience possible for members by offering members the opportunity to speak with ABH staff to get assistance with accessing services, or with resolving concerns related to treatment provided by an ABH network provider.

2025 Inquiries				
Category	Q1	Q2	Q3	Q4
Services	4	5	4	5
Accessibility	1	2	0	0
Availability	0	0	1	0
Acceptability	0	0	0	0
Other Quality	0	0	1	0

Category	2023	2024	2025
Services	37	39	18
Accessibility	3	0	3
Availability	1	0	1
Acceptability	7	0	0
Other Quality	5	0	1

Qualitative Analysis

Completed February 24, 2026

During Q4.2025 ABH received five (5) routine inquiries. ABH assists members who make contact for information or request assistance in meeting their needs. "Services" has historically been the most common category of inquiries. This continues to be the case for Q4.2025. In each of these cases the member was either agreeably connected to an appropriate network provider for care or referred to the ABH Director of Network/Contracting for assistance regarding a single case agreement request for an out-of-network provider. ABH continues to educate providers and community partners regarding the website network directory located at ABHFL.org.

Member Safety

Critical Incidents

Manage care monitoring and ensure the safety of its members via Incident Reporting. ABH strives to record, categorize, and trend 100% of incidents and report them to the health plan, when required, within 24 hours of notification.

2025 Behavioral Health Critical Incidents				
Category	Q1	Q2	Q3	Q4
Quality of Care	0	2	0	1
Enrollee Death	1	1	0	3
Elopement	3	11	5	1
LEO Involvement	0	4	1	2
Enrollee Homicide	0	0	0	0
Other Reportable Incident	13	5	4	4

Category	2023	2024	2025
Quality of Care	0	0	3
Enrollee Death	8	3	5
Enrollee Homicide	0	0	0
Elopement	38	10	20
LEO Involvement	14	11	7
Other Reportable Incident	13	12	26

Qualitative Analysis

Completed February 24, 2026

During Q4 2025, one (1) member elopement, one (1) member death and four (4) incidents of child-on-child sexual misconduct were reported as occurring in facilities that are required to independently enter incident reports into the DCF IRAS, DCF Incident Reporting and Analysis System, as a result these incidents were not reported to the assigned health plans. Although no further action was required, ABH continues to track and monitor such incidents for possible quality improvement opportunities.

One (1) quality of care incident was received from the ABH utilization management team for a member who was discharged from an inpatient hospitalization. Upon discharge the facility failed to provide discharge information as it was mistakenly given to the member. The ABH Quality Department met with the director of the hospital who indicated they were making attempts to reach the member to request the return of the documents.

The two (2) deaths reported during Q4 were unrelated to behavioral health but were reported to the Health Plans as both members were receiving outpatient behavioral health care at the time of their deaths. ABH continues to request guidance from the Health Plans as to whether deaths unrelated to BH should continue to be reported.

Additionally, there were two (2) reports of member involvement with law enforcement. While one (1) of the arrests occurred while a member was in a group home with several witnesses, the other occurred in the community and the event remains under investigation. Currently, no additional information is available.

All applicable incidents were reported to the appropriate health plan within 24 hours of receipt.

ABH continues to train providers on critical incident reporting during annual trainings. In addition, all new providers receive this training during a formal onboarding. Internally tracked incidents include behavioral health related incidents such as suicide attempts and other significant events such as abuse, neglect, or human trafficking.

Quality of Care Referrals

Assure that members receive appropriate care to meet their needs, improve outcomes, and maintain safety during treatment. ABH strives to record, categorize, and trend 100% of referrals received.

2025 Quality of Care Referrals				
Quality of Care Referrals	Q1	Q2	Q3	Q4
Access	0	0	0	0
Clinical	0	0	0	1
Environment of Care	0	0	0	0
Member Safety	0	2	0	0
Member Experience	0	0	0	0

Category	2023	2024	2025
Access	0	0	0
Clinical	0	0	1
Environment of Care	1	0	0
Member Safety	0	0	2
Member Experience	0	0	0

Qualitative Analysis

Completed February 24, 2026

See Qualitative Analysis under Critical Incidents (page 43) for details related to the Quality of Care Referrals.

Quality Audits

This section addresses:

Quality of Clinical Care Safety of Clinical Care Quality of Services

The following audits are conducted by the ABH Quality Improvement Department:

- Provider Medical Records
- Claims Procedural and Financial Accuracy
- Call Center Monitoring

Provider Medical Records Audits

ABH Quality staff conduct annual audits of network providers' and practitioners' medical records to ensure adherence to AHCA requirements and other applicable regulatory standards. The Quality Department performs these audits through comprehensive medical record reviews and utilization reviews.

New providers and practitioners typically undergo documentation reviews during their first year in-network to confirm the presence of required consents, evidence of medical necessity, proper Medicaid documentation, and coordination of care.

Once providers are established, an overall utilization review of paid claims is conducted to verify accuracy and compliance. This process includes confirming that claims are billed under the correct service descriptions, reviewing the number of units billed, and identifying potential instances of fraud, waste, or abuse.

Both documentation and utilization reviews are employed to ensure that proper processes are consistently followed across multiple areas. This section is updated annually upon completion of all medical record audits.

Qualitative Analysis

Completed November 25, 2025

This section is updated annually, following the completion of all audits. Audits of ABH in-network providers began in March 2025 and continued through November 2025. In 2021, the ABH Quality Management Committee determined that if a provider had an overall score of 90% or higher for their documentation score for two consecutive years, they would be exempt from an audit during the 3rd year. Thirteen providers qualified for this exemption in 2025. Due to the focus of provider audits shifting from documentation requirements to appropriate billing practices in 2025, ABH policy was also updated. QMC approved policy changes that practitioners and providers not listed on the Health Plan waste report could be exempt from the upcoming audits, with the caveat that all in-network practitioners and providers are audited every 3 years.

Five providers (Psychological Associates, Beach Counseling & Psychological Services, BOND, Chemical Addictions Recovery Effort, & Neighborhood Medical Center) weren't audited due to low utilization or not accepting new patients. These were reviewed on an individual basis and approved by QMC.

In lieu of traditional audits, each in network hospital attended quarterly meetings to review performance in 4 categories: timeliness of receipt of admission notification, discharge notification, family engagement, and scheduling the outpatient appointment. An opportunity for improvement was noted across all providers with timeliness of notification of discharges. Performance improvement in this area will continue to be a focus in 2026.

In 2025, provider audits extended beyond reviewing documentation for Medicaid requirements. Utilization reviews of paid claims were also conducted to identify potential instances of fraud, waste, or abuse, with any findings reported to the Health Plans on a monthly and quarterly basis. The review process ensured that services requiring justification, such

as In-Depth Assessments, were properly supported, that units billed for therapy were accurate, and that all paid claims had active treatment plans during the lookback period to substantiate the services provided.

While the table displaying documentation scores by specific service descriptions has been removed to align with the updated process, new providers and practitioners joining the ABH network will continue to undergo documentation reviews during their first year in network. For instance, Eric Lamb, LMHC, completed his provider audit in April 2025, which primarily focused on documentation compliance. The Quality Department will also maintain its commitment to offering Medicaid documentation training upon request to any practitioner or provider.

In 2025, two providers, Partners Family Medical Practice & Recovery Center and Railey & Associates, LLC were placed on Corrective Action Plans following utilization reviews. These reviews revealed incorrect service codes being billed, missing justification for higher-compensation services, and other excessive billing issues. ABH will continue to monitor these providers until all corrective actions have been fully implemented and verified.

New guidelines ensuring appropriate documentation and handling of consents to psychotropic medications for minors under the age of 13 were introduced. While this new measure doesn't officially go into effect until 2026, the Health Plans asked ABH to start monitoring and reporting on it for applicable providers. This will be elaborated on in the next section, in addition to care coordination for both medical to behavioral health, and behavioral health to behavioral health.

BH-BH CoC: Medical Record Audit

Access Behavioral Health Providers and Practitioners provide for continuity of care and communication between all Behavioral Health Providers involved with members' care.

This section is updated annually in the ABH evaluation.

Goal: 97% Coordination between Behavioral Health Providers and Behavioral Health Providers.

	Goal	2023	2024	2025
Records Reviewed	N/A	50	38	20
BH/BH	97%	100%	100%	100%

Qualitative Analysis

Completed November 25, 2025

ABH Quality Staff annually audit network providers' and practitioners' medical records for documentation adherence to AHCA requirements and other regulatory standards.

The total amount of provider records monitored for BH-BH Care Coordination was 193 in 2025. However, only 20 were applicable for BH-BH care coordination, with all of them receiving a score of 100%.

Barriers and Interventions

Date	Opportunities for Improvement	Barriers	Intervention	Outcome
January 2023	None identified.	None identified.	Continue annual provider record monitoring for BH-BH care coordination.	100% of the 50 records monitored in 2023 met the requirements for BH-BH care coordination.
February 2024	None identified.	None identified.	Continue annual provider record monitoring for BH-BH care coordination.	100% of the 38 records monitored in 2024 met the requirements for BH-BH care coordination.
November 2025	None identified.	None identified.	Continue annual provider record monitoring for BH-BH care coordination.	100% of the 20 records monitored in 2025 met the requirements for BH-BH care coordination.

BH-MC CoC: Medical Record Audit

Collaboration between Behavioral Health Care Providers and Medical Providers (MC): Access Behavioral Health Providers and Practitioners provide for continuity of care and communication between Behavioral Health Providers and members' Medical Care providers. This measure is monitored with two areas of focus, coordination of care utilizing release of information, as well as appropriate psychotropic medication consents for minors under the age of 13.

This section is updated annually in the ABH evaluation.

Coordination of Care Record Review

Goal: 97% Coordination between Behavioral Health Providers and Medical Health Providers.

	Goal	2023	2024	2025
Records Reviewed	N/A	122	94	66
BH/MC	97%	99%	99%	100%

Qualitative Analysis

Completed November 25, 2025

ABH Quality Staff annually audit network providers' and practitioners' medical records for documentation adherence to AHCA requirements and other regulatory standards.

The total amount of provider records monitored for BH-MC Care Coordination was 193 in 2025. However, only 66 charts were applicable for BH-MC care coordination, with all receiving a score of 100%.

Barriers and Interventions

Date	Opportunities for Improvement	Barriers	Intervention	Outcome
Jan 2023	None identified.	None identified.	Continue annual provider record monitoring for BH-MC care coordination.	99% of the 122 records monitored in 2023 met the requirements for BH-MC care coordination.
Feb 2024	None identified.	None identified.	Continue annual provider record monitoring for BH-MC care coordination.	99% of the 94 records monitored in 2024 met the requirements for BH-MC care coordination.
Nov 2025	None identified.	None identified.	Continue annual provider record monitoring for BH-MC care coordination.	100% of the 66 records monitored in 2025 met the requirements for BH-MC care coordination.

Psychotropic Medication Consent for Minors Aged <13

Goal: 90% Coordination between Behavioral Health Providers and Medical Health Providers.

This is a new measure being implemented by the Health Plan in 2026. ABH was asked to gather information in 2025 to develop a baseline for providers who meet the measure and begin to educate providers about the consent requirements.

ABH will audit a minimum of five (5) charts for nine (9) providers each year. Charts for members under the age of 13 who are prescribed psychotropic medications are reviewed for the following:

- Documentation of the express written and informed consent of the enrollee’s authorized representative prescriptions for psychotropic medication (i.e. antipsychotics, antidepressants, antianxiety medications, and mood stabilizers).
- The prescriber must document the consent in the child’s medical record and provide the pharmacy with a signed attestation of the consent with the prescription.
- The prescriber must ensure completion of an appropriate attestation form.

Consent for Psychotropics: Presence of Informed Consent				
	Q1.25	Q2.25	Q3.25	Q4.25
Goal	90%	90%	90%	90%
Rate	N/A	25%	80%	75%
Numerator/Denominator	0/0	2/8	4/5	6/8
Consent for Psychotropics: Presence of Attestation to Pharmacy				
Goal	90%	90%	90%	90%
Rate	N/A	25%	80%	75%
Numerator/Denominator	0/0	2/8	4/5	6/8

Qualitative Analysis

Will be completed following completion of audits in Q4 2025.

Date	Opportunities for Improvement	Barriers	Intervention	Outcome
April & Dec 2025	A new audit requirement was a result of reprocurement with the health plans in February 2025.	Provider awareness of requirements for consents.	Annual Provider training conducted in April 2025 and planned for December 2025. Materials distributed to providers in April and December 2025.	Completed training with providers in April and December 2025.
November 2025	Ability to identify type of medication prescribed to members as audits result in random selection and the majority were for excluded medications. This limits the ability to assess provider performance accurately.	ABH does not have access to pharmacy data.	ABH presents to Humana QIC about this measure and has identified it as a barrier. Humana and ABH will develop potential interventions.	Presented to Humana QIC 12/11/25.

Claims Procedural and Financial Accuracy Audit

ABH audits a random sample of 30 non-capitated paper claims for procedural (adjudication errors, common keying errors) and financial (payment rate) accuracy. Patterns of inaccuracy are noted and corrected immediately. A score of less than 98% for procedural accuracy or 99% for financial accuracy for three consecutive months requires corrective action. In 2025, the ABH Quality Improvement Department assumed the role of auditing claims for financial and procedural accuracy.

During the third quarter of 2025, a revised methodology was implemented to enhance the integrity of the claim audit sampling process. Previously, the ABH Billing Department was responsible for selecting and submitting 30 random claims to the Quality Department for keying accuracy review. Under the new approach, the Senior Reporting & Data Analyst generates a randomized sample of claims based on predefined parameters. The Quality team then locates each claim in Milner and evaluates it according to established scoring metrics.

This updated process ensures that the sample selection is both statistically random and free from potential bias introduced by manual selection. There is a delay in data collection using this new process.

Claims Procedural and Financial Accuracy													
2025	Goal	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Procedural Accuracy	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Financial Accuracy	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

	Goal	2023	2024	2025
Procedural Accuracy	98%	100%	100%	100%
Financial Accuracy	99%	100%	100%	100%

Call Monitoring Audit

The ABH Accreditation and Quality Improvement Manager audits a random sample of 10 calls per month. The calls are assessed for greeting, handling of contact, solution information, telephony skills, end call, and soft skills. The results are reflected in the tables below. Call monitoring audits are completed to ensure the highest level of customer service is provided to members and providers.

During Q3 2025, the ABH Quality Department gained access to recordings of calls routed to the call center. This was a change to prior audits where the Call Center Manager supplied the ABH Quality team with self-assessment ratings. During the September 2025 Quality Management Committee meeting, committee members unanimously voted to continue using the existing audit tool. The ABH Accreditation and Quality Improvement Manager randomly selects 5 member, and 5 provider calls to listen to from the NICE CXONE call center platform and completes the audit tool. Results are entered in the tables above.

Goal: 95%

MEMBER	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Call 01	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Call 02	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Call 03	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Call 04	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Call 05	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
PROVIDER	Jan	Feb	Mar	Apr	May	Jun	Jun	Jun	Sep	Oct	Nov	Dec
Call 01	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Call 02	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Call 03	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Call 04	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Call 05	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

	Goal	2023	2024	2025
Member Line	95%	100%	100%	100%
Provider Line	95%	100%	100%	100%

Credentialing

ABH Quality Management Department has maintained the Network to meet the contractual obligations set forth by the Health Plans.

Credentialing Actions Taken for 2025				
Activity	Q1	Q2	Q3	Q4
No. of Providers Credentialed	1	0	0	0
No. of Providers Re-Credentialed	5	0	2	1
No. of Practitioners Credentialed	0	0	0	0
No. of Practitioners Re-Credentialed	0	0	0	0
No. of Credentialing Applications Denied	0	0	0	0
No. of Credentialing Applications Appealed	0	0	0	0
No. of Providers or Practitioners Terminated due to Fraud, Waste, and/or Abuse	0	0	0	0
No. of Practitioners Leaving Network	6	1	1	0
	Date	Date	Date	Date
	1/23/25	5/16/25	9/11/25	N/A
No. of Members notified of Practitioners Leaving Network	0	0	0	0
	Date	Date	Date	Date
	N/A	N/A	N/A	N/A
No. of Modifications to Credentialing Information	0	0	0	N/A
	Date	Date	Date	Date
	N/A	N/A	N/A	N/A
No. of Deletions to Credentialing Information	0	0	0	N/A
	Date	Date	Date	Date
	N/A	N/A	N/A	N/A

Quantitative Analysis:

Completed February 24, 2026

ABH continues to analyze the network to identify areas of need. During Q4.25, one provider was recredentialed. This provider was recredentialed within the 36-month standard.

There were no denied applications or grievances/appeals associated with the credentialing process during Q4.25.

There were no modifications or deletions made to any credentialing information in Q4.25.

Number of Events	2023	2024	2025
Providers Credentialed	4	3	1
Providers Re-Credentialed	1	8	8
Practitioners Credentialed	11	5	0
Practitioners Re-Credentialed	11	17	0
Credentialing Applications Denied	1	0	0
Credentialing Applications Appealed	0	0	0
Providers/Practitioners Terminated	0	0	0
Practitioners Leaving Network	7	3	8
Members notified of Practitioners Leaving Network	0	0	0

Rights and Responsibilities

Practitioner & Provider Directory Updates

ABH updates the information contained in the provider/practitioner directory within 30 days of notification to ensure that members, practitioners, and providers have access to accurate information.

2025 Provider/Practitioner/Hospital Directory Information Updates				
	Q1	Q2	Q3	Q4
Practitioner Directory Information Updates for All Credentialed Practitioners				
Name	0/0	0/0	0/0	0/0
Gender	0/0	0/0	0/0	0/0
Discipline/provider type	0/0	0/0	0/0	0/0
Specialty	0/0	0/0	0/0	0/0
Organizational affiliations	0/0	0/0	0/0	0/0
Board Certification	0/0	0/0	0/0	0/0
Accepting New patients	0/0	0/0	0/0	0/0
Languages spoken by practitioner or staff	0/0	0/0	0/0	0/0
Office Locations and phone numbers	0/0	0/0	0/0	0/0
Initial Credentialing	0/0	0/0	0/0	0/0
Left the network	6/6	1/1	0/0	0/0
Provider Directory Information Updates for all Credentialed Providers				
Facility Name	0/0	0/0	0/0	0/0
Facility location and phone number	0/0	2/2	4/4	0/0
Accepting new patients	0/0	0/0	0/0	0/0
Modality of services	0/0	0/0	0/0	0/0
Languages spoken by provider or staff	0/0	2/2	0/0	0/0
Provider specialties	0/0	2/2	4/4	0/0
Facility accreditation status	0/0	0/0	8/8	0/0
Initial Credentialing	1/1	0/0	0/0	0/0
Left the network	0/0	0/0	0/0	0/0
Hospital Directory Information Updates for all Credentialed Hospitals				
Hospital Name	0/0	0/0	0/0	0/0
Hospital location and phone number	0/0	0/0	0/0	0/0
Hospital accreditation status	0/0	0/0	0/0	0/0
Initial credentialing	0/0	0/0	0/0	0/0
Left the network	0/0	0/0	0/0	0/0

	2023	2024	2025
Providers updated in directory	100%	100%	100%
Practitioners updated in directory	100%	100%	100%
Hospitals updated in the directory	100%	100%	100%

Qualitative Analysis

Completed November 20, 2025

Effective Q2.25 (with retrospective data added to Q1.25), the above table shows a numerator and denominator for each line. The denominator reflects the total number of requests made for each category and the numerator reflects the number of completed updates within the 30-day timeframe. This includes credentialing of new applicants, modifications listed on the provider roster and changes found during the annual directory review.

During Q4.25, zero (0) updates to the provider directory were requested or required.

ABH continues to meet the goal of updating the provider directory within 30 days 100% of the time as new providers or practitioners join or leave the network. This ensures that the ABH provider network remains 100% accurate.

Access Behavioral Health monitors the practitioner directory for accuracy. Verification of directory accuracy is completed during the annual ABH website review and quarterly during secret shopper survey calls. Practitioner availability, location, phone number, network participation, and whether the provider is accepting new patients is verified for accuracy.

Assessment of Practitioner & Provider Directory Accuracy

Access Behavioral Health monitors the online directory for accuracy in several ways. One method used to verify directory information is done by secret shopper calls. These calls are made monthly by the QI Specialist, to all credentialed providers and practitioners. Another method utilized is the directory accuracy survey that is distributed annually to all in-network providers. This survey asks that practitioners and providers review the directory information listed themselves, and report any errors noticed. In both measures, accuracy for address, phone number, network participation, and whether the provider is accepting new patients is verified.

This section is updated annually in the ABH evaluation.

Secret Shopper Calls:

	2023			2024			2025		
	Num	Denom	Score	Num	Denom	Score	Num	Denom	Score
Office Location/Phone Number	119	119	100%	125	125	100%	123	123	100%
Accepting New Members	119	119	100%	125	125	100%	123	123	100%
Aware of Network Participation	119	119	100%	125	125	100%	123	123	100%

Num: Accuracy of information

Denom: Number of secret shopper calls

Assessment Criteria	2023	2024	2025
Office Location/Phone Number	100%	100%	100%
Accepting New Members	100%	100%	100%
Aware of Network Participation	100%	100%	100%

Qualitative Analysis

Completed on February 24, 2026:

Provider assessment on their knowledge of network participation occurs quarterly during secret shopper calls made by the ABH Quality Specialist. During these calls, accuracy of provider phone numbers, addresses, and ability to accept new members is also assessed. Annually since 2023, 100% of providers accurately reported information during the secret shopper calls.

Annual Practitioner & Provider Directory Accuracy Survey:

	2024			2025		
	Num	Denom	Rate	Num	Denom	Rate
Office Address	23	27	81%	25	26	96%
Phone Number	24	27	89%	25	26	96%
Participation Awareness	27	27	100%	26	26	100%
Accepting New Patients	26	26	100%	26	26	100%
Languages Spoken by Staff & Providers	24	25	96%	22	24	92%
Specialties	22	25	88%	23	25	88%

Num: Number of respondents with correct information listed on the directory

Denom: Total number of practitioner/provider responses

Assessment Criteria	2023	2024	2025
Office Location/Phone Number	91%	81%	96%
Phone Number	91%	89%	96%
Aware of Network Participation	100%	100%	100%
Accepting New Members	100%	100%	100%
Languages Spoken by Staff & Providers	NA	96%	92%
Specialties	NA	88%	88%

Qualitative Analysis:

Completed on May 16, 2025

In 2025, ABH conducted a directory accuracy survey amongst all current practitioners and providers. An email was sent out on May 5th, 2025, to all 34 in-network providers, asking them to access the ABH website and attempt to find the provider directory. Once located, they were asked to search for their practice and review the current information listed (including office location, phone number, awareness of participation, languages spoken, specialties, new patient acceptance, etc.). After reviewing the information, providers were asked to complete the survey stating whether the information was accurate or if any changes needed to be made. ABH received 26 responses, resulting in a 76% response rate for survey participation.

A review of the responses showed that the majority of providers who did not participate in the survey were providers with low utilization of services. ABH implemented education during the spring annual provider training to emphasize the importance of participation in the directory accuracy survey prior to the survey being distributed. The importance of monthly roster report submissions was also reviewed. The results of the survey will be discussed during the fall provider training.

One provider reported that a location in Wakulla County was missing from the directory. This error is reflected in the numerator of 'Office address' data. Another provider reported that phone number for offices in the former area identified as region 2, was incorrect and should be listed as the same as all other locations. Two providers stated that

languages spoken by providers needed to be updated with Spanish also being available. Another two providers reported that their ‘Specialty’ listed on the directory was inaccurate. All reported errors have been submitted to the responsible party, for updates to be made immediately.

Opportunities for Improvement/Interventions:

To better improve ABH’s directory accuracy, a large emphasis was placed on the importance of monthly roster reports during the biannual provider trainings.

Another intervention that continues is on-boarding training with all new providers coming into the ABH network. During these meetings the quality team reviews the importance of reporting any changes of directory information immediately. Providers are reminded that members look at the directory for services available to them, and it is imperative that this information be accurate. The ABH quality team also uses the directory almost daily when making Health Plan referrals and other required member appointments.

The Quality Improvement Specialist continues to be granted access to all incoming monthly roster reports in 2025. This helps ensure that any changes sent in by providers are made to the ABH website. In 2024 it was stated that providers would be asked to review both the searchable and the PDF directory. This was not done due to the PDF version being removed from the ABH website. It was decided by the Quality Management Committee in March 2025 that if anyone needed a print friendly version, it could be done by rick clicking and requesting the print feature.

Date	Opportunities for Improvement	Barriers	Intervention	Outcome
Jan 2023	Gather real time changes to provider information to reflect in the ABH directory.	Inconsistent and/or incomplete roster submission by providers.	Increase provider awareness of the importance of correct and timely submission of rosters during ABH provider training.	Providers continue to submit rosters inconsistently and with incomplete data.
Feb 2024	New network providers understand the importance of directory accuracy.	Ensuring the new provider responsible for the submission of the roster attends onboarding.	ABH presents this information during initial onboarding training with new providers.	Ongoing.
Aug 2024	New website platform that allows more control over updates to directory.	Under existing contract through July 2025 and cost.	Investigate alternate website hosting platforms for 2025 contract renewal.	Ongoing.
Jan 2025	Gather real time changes to provider information to reflect in the ABH directory.	Inconsistent and/or incomplete roster submission by providers.	ABH Director and Director of Network Management and Contracting created a table to feed roster information into. An automated report sent to quality will be the next step to ensure updates made timely.	Ongoing.
Q2.2025	Improve tables to reflect clearly defined	Prior table reflected 100% for each category	Update the table in the evaluation to reflect	Completed with data retroactive to Q1.25 so

	opportunities for changes to the directory.	but did not define the number of opportunities for completion or the number of those completed within 30 days (a numerator and denominator).	clearly defined numerator and denominators.	that all of 2025 will have the same format.
Sep 2025	Increase independent access to make changes to the directory.	Website host does not allow ABH to make changes to the directory. All change requests must be made to the host. All requests are cumbersome and require numerous email exchanges before accurate changes are made.	Website host contract terminated and new host (Moore Company) contracted.	ABH has direct access to the platform to make changes live.

Care Coordination

This section addresses:

Quality of Clinical Care

Safety of Clinical Care

Quality of Services

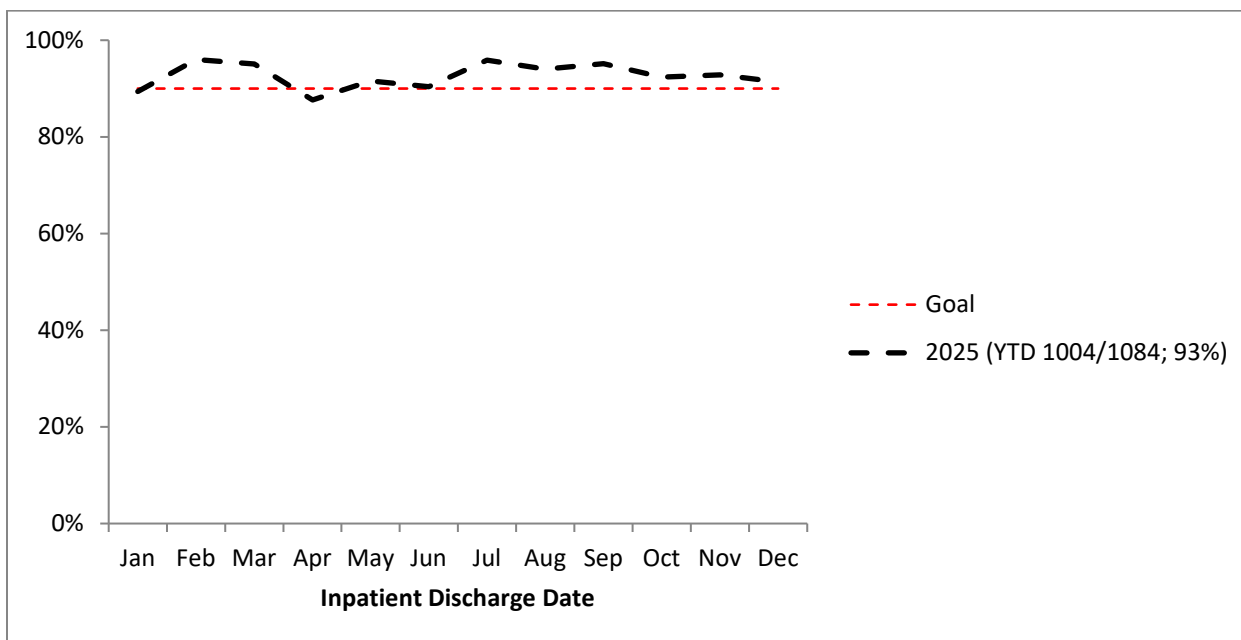
Coordination of Care between Behavioral Health Care Providers (BH) and Behavioral Health Care Providers

Access Behavioral Health monitors the continuity and coordination of care that members receive across the behavioral healthcare network and takes action, as necessary, to improve and measure the effectiveness of these actions.

Appointments scheduled within 7 days of inpatient discharge

Percentage of discharges with an appointment scheduled within 7 days.

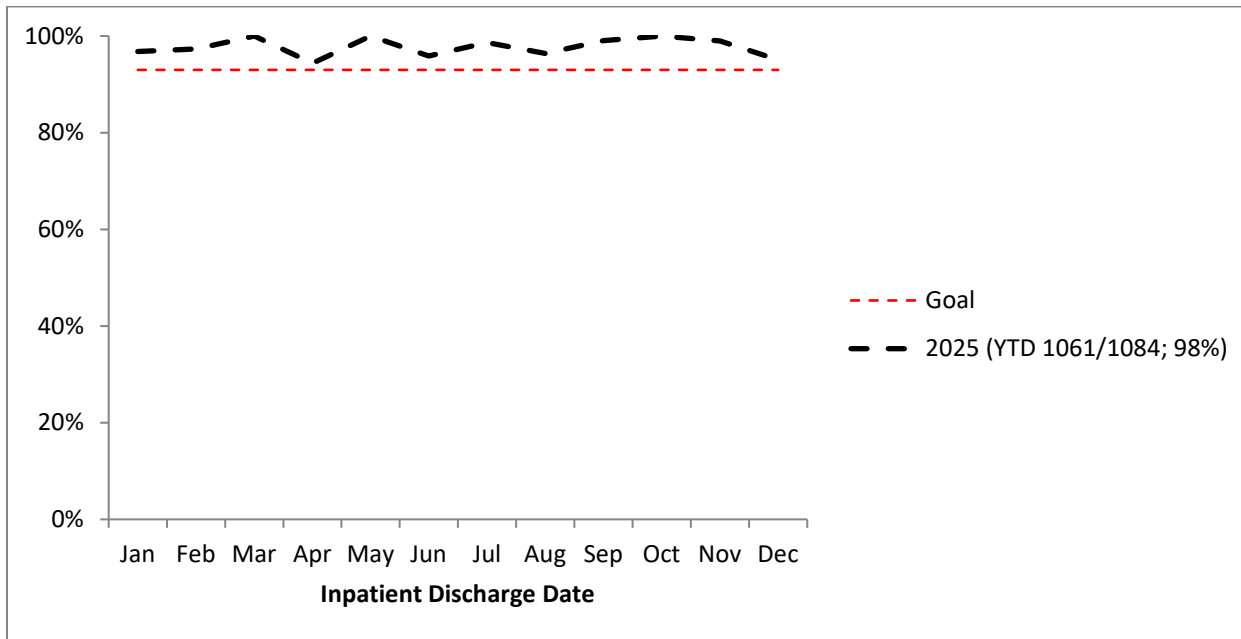
Goal: Above 90%



Appointments scheduled within 30 days of inpatient discharge

Percentage of discharges with an appointment scheduled within 30 days.

Goal: Above 93%



Appointments	Goal	2023	2024	2025
7-day	90%	95%	95%	93%
30-day	93%	99%	99%	98%

Qualitative Analysis

In 2024, the rate of post-hospitalization follow-up appointments scheduled within 7- and 30-days maintained from the previous year, at 95% and 99%, respectively. ABH continues to meet the goal for both rates, and no barriers were identified.

Utilization Management

Interrater Reviewer Reliability

ABH evaluates interrater reliability for physician and care management staff involved in the clinical review process. Staff involved in UM decisions (both physician and non-physician) have a random sampling of their case files reviewed quarterly during the year (2% of all UM decisions per reviewer, per quarter). Reviews are conducted by a reviewer of the same qualifications as the original decision maker. (i.e. UM staff initial clinical reviewers review other UM initial clinical reviewer decisions, UM physicians review other UM physician decisions)

Goal: Each clinical reviewer must maintain a 90% accuracy rate.

2025		Reviewer Accuracy Rate			
Reviewer Name	Reviewer Profession	Q1	Q2	Q3	Q4
Mobley, Ed	Physician		100%	100%	100%
Conrad, Michael	Physician				
Dillon, Vincence	Physician				
King, Katie	Nurse	100%	100%	100%	100%
DeGraaf, Ruth	Nurse	100%	100%	100%	100%
Greenway, Rochelle	Nurse	100%	100%	100%	100%
Raulston, Tara	LMHC	100%	100%	100%	100%
Beach, Rebecca	LMHC	100%	100%	100%	100%

Reviewer Profession	Goal	2023	2024	2025
Physician	90%	100%	100%	100%
Nurse/LMHC	90%	100%	100%	100%

Qualitative Analysis

All review criteria exceeded the goal of 90% or greater through the current quarter. No interventions are needed regarding inter-rater reliability.

Referrals and Authorizations

Number of Referrals and Authorizations received.

2025	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Referrals	149	127	146	139	193	146	150	134	158	160	149	137
Urgent Concurrent	146	125	145	136	190	137	143	130	154	156	143	133
Urgent Preservice	0	0	0	0	0	0	0	0	0	0	0	0
Nonurgent Preservice	0	0	0	0	0	1	0	1	2	0	0	0
Postservice	3	2	1	3	3	8	7	3	2	4	6	4
Authorizations	149	127	146	139	193	146	150	134	158	160	149	137
Standard	3	2	1	3	3	9	6	3	3	2	6	4
Expedited	146	125	145	136	190	137	144	131	155	158	143	133

	2023	2024	2025
Referrals	2163	1725	1788
Urgent Concurrent	2095	1676	1738
Urgent Preservice	0	2	0
Nonurgent Preservice	3	4	4
Postservice	65	43	46
Authorizations	2165	1725	1788
Standard	65	49	45
Expedited	2100	1676	1743

Decision Making Timeliness

Percentage of Referrals reviews meeting NCQA timeliness standards and Authorizations meeting MMA timeliness standards.

Goal: 90% for Referrals, 95% for Authorizations

2025	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Referrals	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Urgent Concurrent	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Urgent Preservice												
Nonurgent Preservice						100%		100%	100%			
Postservice	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Authorizations	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Expedited	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

	Goal	2023	2024	2025
Referrals (NCQA Standard)		100%	100%	100%
Urgent Concurrent	90%	100%	100%	100%
Urgent Preservice	90%	.	100%	
Nonurgent Preservice	90%	100%	100%	100%
Postservice	90%	100%	100%	100%
Authorizations (MMA Standard)		100%	100%	100%
Standard	95%	100%	100%	100%
Expedited	95%	100%	100%	100%

Denials

Number of denials and compliance with denial timeline process standards. Appeals are not delegated to ABH.

Goal: 100% Denial Timeline Compliance

2025	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Medical Necessity Denials	0	0	0	0	0	0	0	0	0	0	0	0
(Inpatient) Urgent Concurrent	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Preservice	0	0	0	0	0	0	0	0	0	0	0	0
Nonurgent Preservice	0	0	0	0	0	0	0	0	0	0	0	0
Postservice	0	0	0	0	0	0	0	0	0	0	0	0
Denial Timeline Compliance	0	0	0	0	0	0	0	0	0	0	0	0
Administrative Denials	0	0	0	0	0	0	0	0	0	0	0	0
(Inpatient) Urgent Concurrent	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Preservice	0	0	0	0	0	0	0	0	0	0	0	0
Nonurgent Preservice	0	0	0	0	0	0	0	0	0	0	0	0
Postservice	0	0	0	0	0	0	0	0	0	0	0	0

	2023	2024	2025
Medical Necessity Denials	1	0	0
(Inpatient) Urgent Concurrent	1	0	0
Urgent Preservice	0	0	0
Nonurgent Preservice	0	0	0
Postservice	0	0	0
Denial Timeline Compliance	100%	.	.
Administrative Denials	0	0	0
(Inpatient) Urgent Concurrent	0	0	0
Urgent Preservice	0	0	0
Nonurgent Preservice	0	0	0
Postservice	0	0	0

Inpatient Utilization

Inpatient Admissions

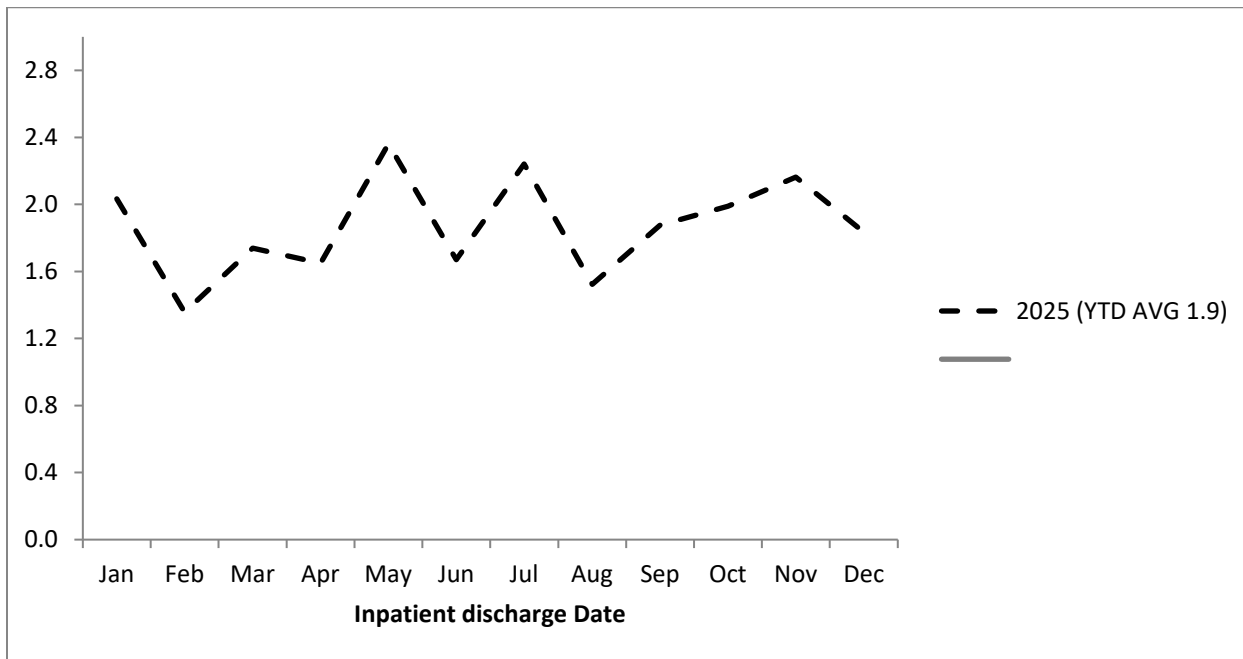
Number of IP discharges

2025	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
ABH	127	103	132	130	168	123	130	109	144	133	133	117
Adults	67	43	50	64	102	75	70	57	75	64	60	62
Children	60	60	82	66	66	48	60	52	69	69	73	55

	2023		2024		2025	
	Discharges	YoY %	Discharges	YoY %	Discharges	YoY%
Overall	2123	-8.21%	1550	-26.99%	1549	-0.06%
Adults	1281	-13.03%	824	-35.58%	789	-4.25%
Children	842	0.24%	726	-13.78%	760	4.68%

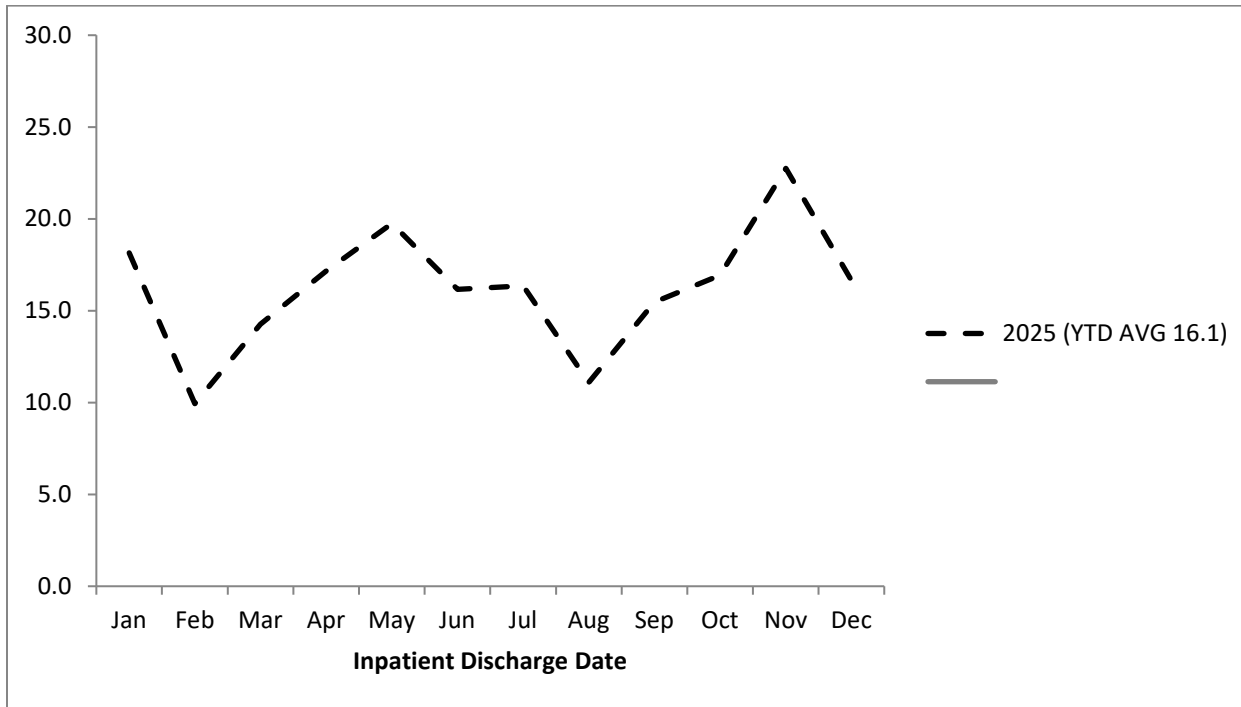
Admissions per 1000 Members

Number of IP discharges per 1,000 members.



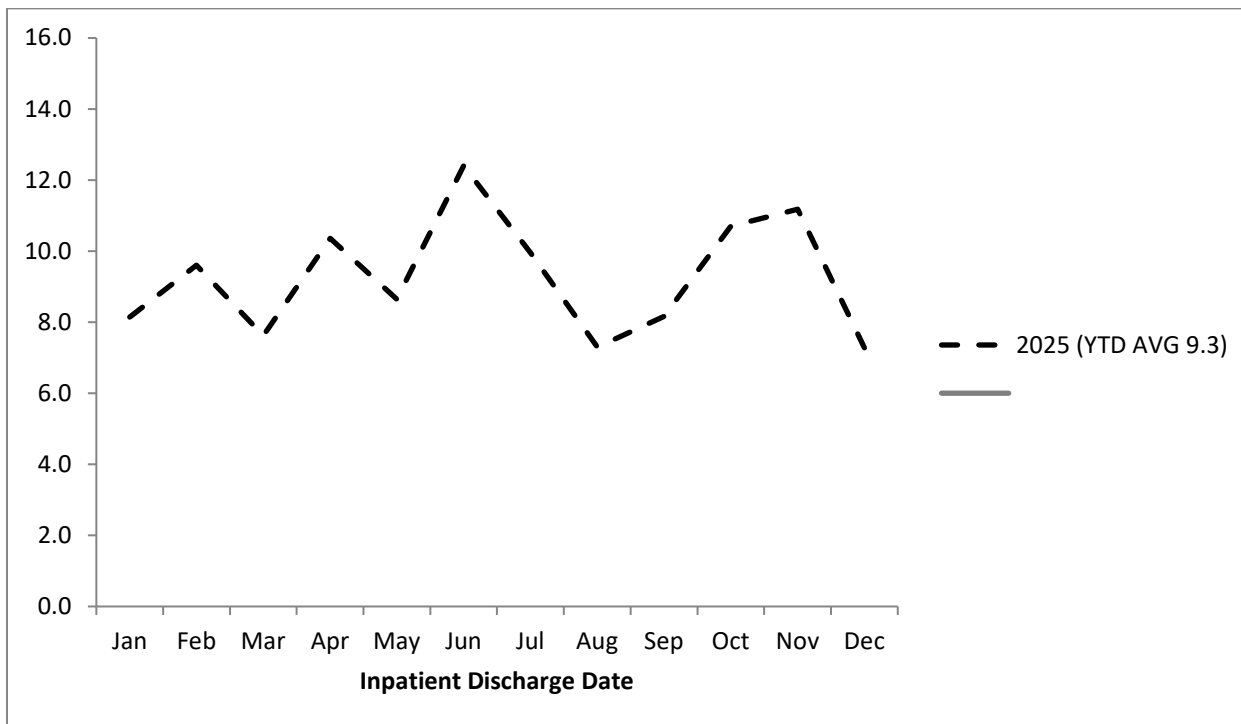
Inpatient days per 1000 Members

Number of IP days per 1,000 members



Average Length of Stay per Admission

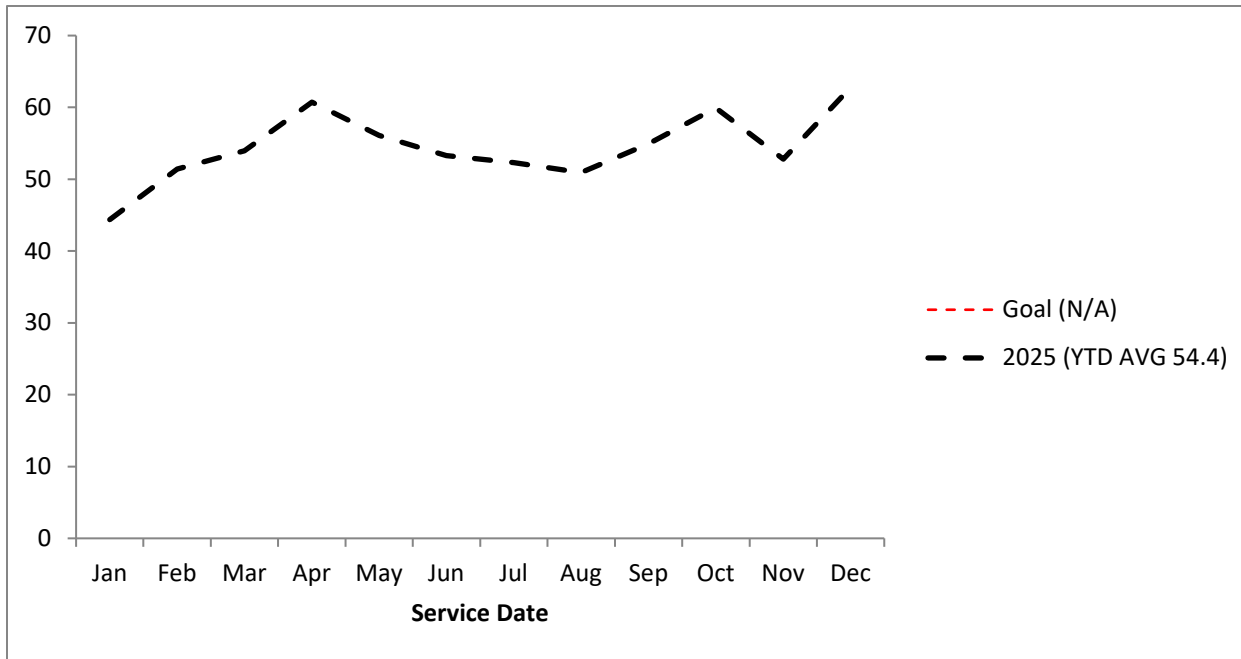
Average Length of stay (in days) per admission



Outpatient Utilization

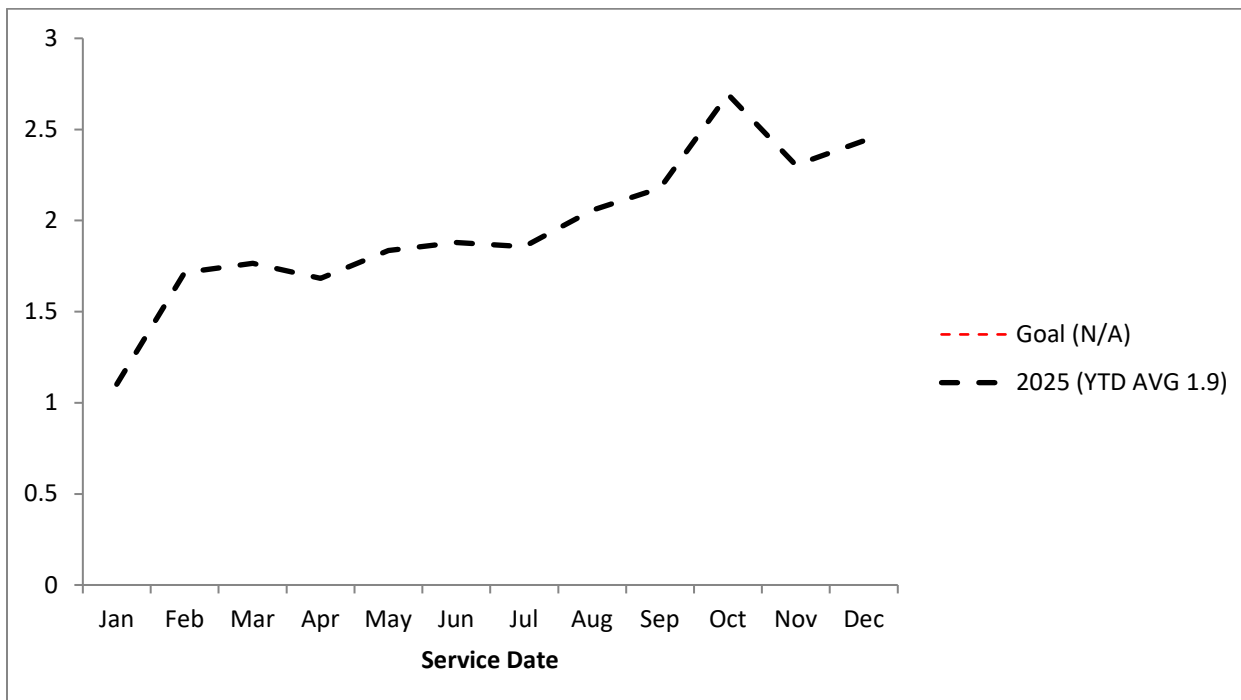
Outpatient Therapy and Evaluation Services per 1000 Members

Members receiving outpatient therapy and evaluation services per 1,000 members (HCPCS codes: H0001xx, H0020, H0031xx, H0032xx, H2000xx, H2012xx, H2017, H2019xx, H2020xx, T1007xx, and T1023xx).



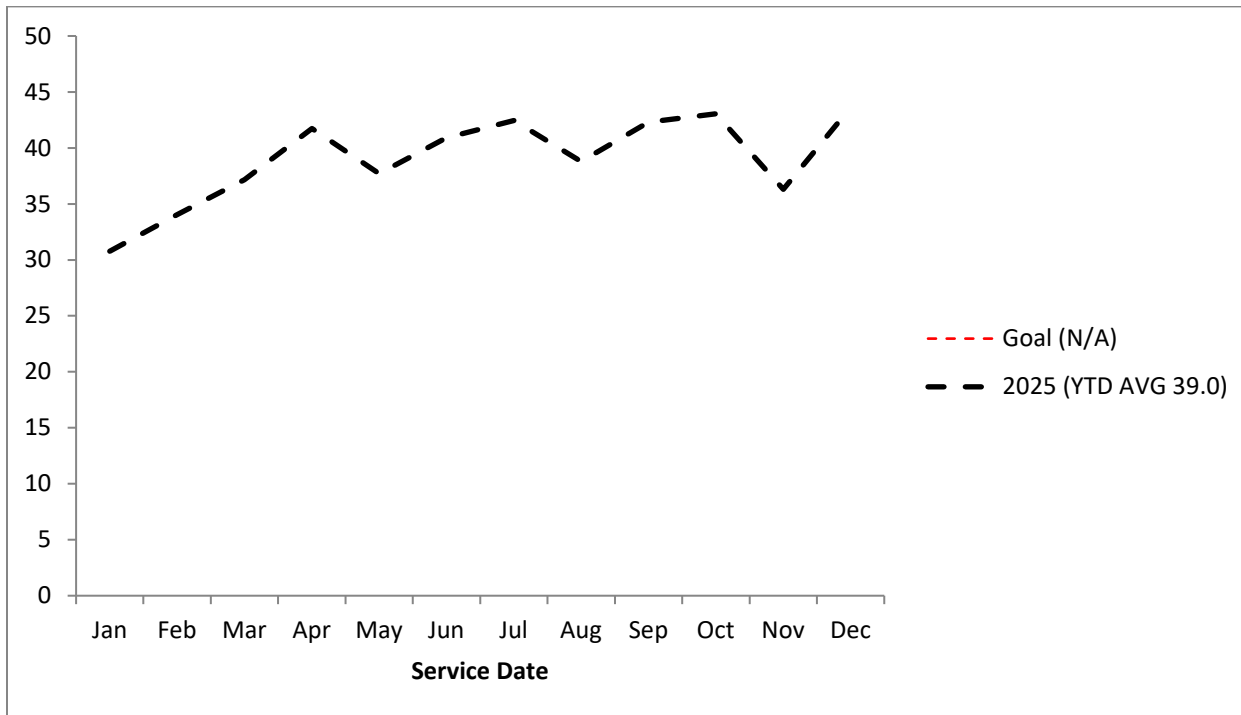
Case Management Services per 1000 Members

Members receiving case management services per 1,000 members (HCPCS codes: T1017xx).



Outpatient MD Services per 1000 Members

Members receiving medication management services in an outpatient setting per 1,000 members (HCPCS code T1015).



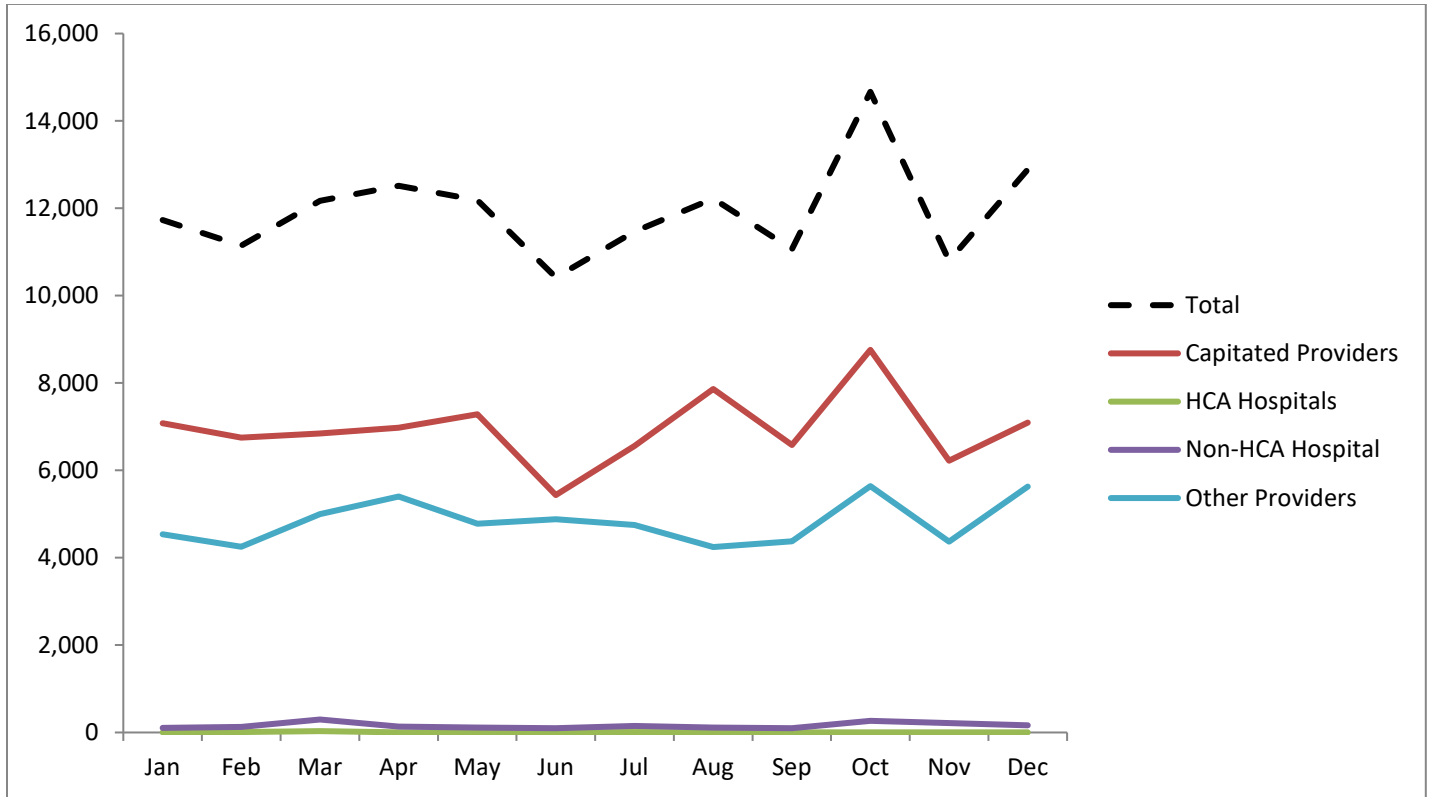
Telehealth Usage

Claims received for telehealth utilization and year-over-year variance.

	2023		2024		2025	
	# Claims	YoY %	# Claims	YoY %	# Claims	YoY %
Overall	22,535	-33.86%	23,713	5.23%	22,545	-4.93%
Adults	14,721	-30.55%	14,746	0.17%	13,434	-8.90%
Children	7,814	-39.32%	8,967	14.76%	9,111	1.61%

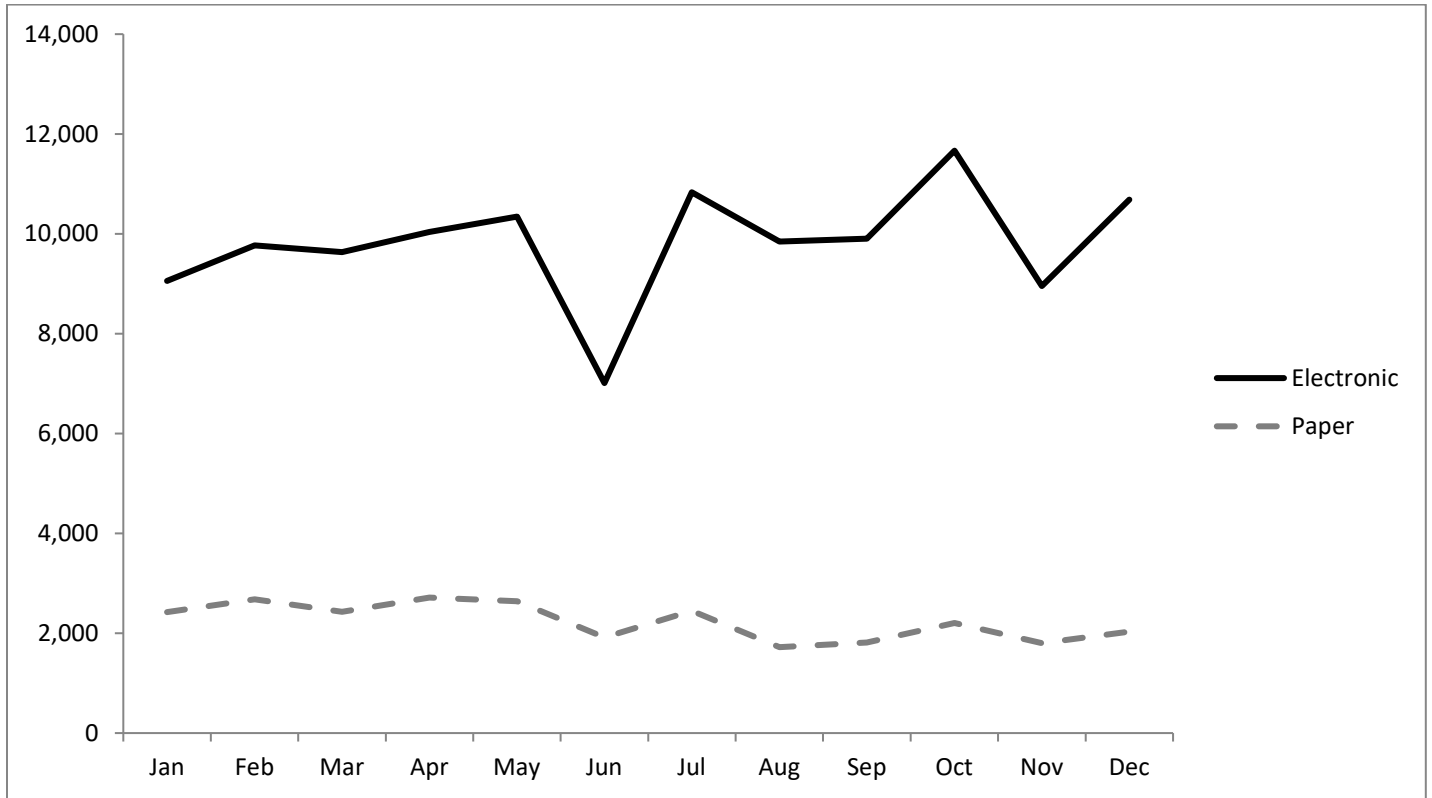
Claims Processing

Claims Volume by Provider Type

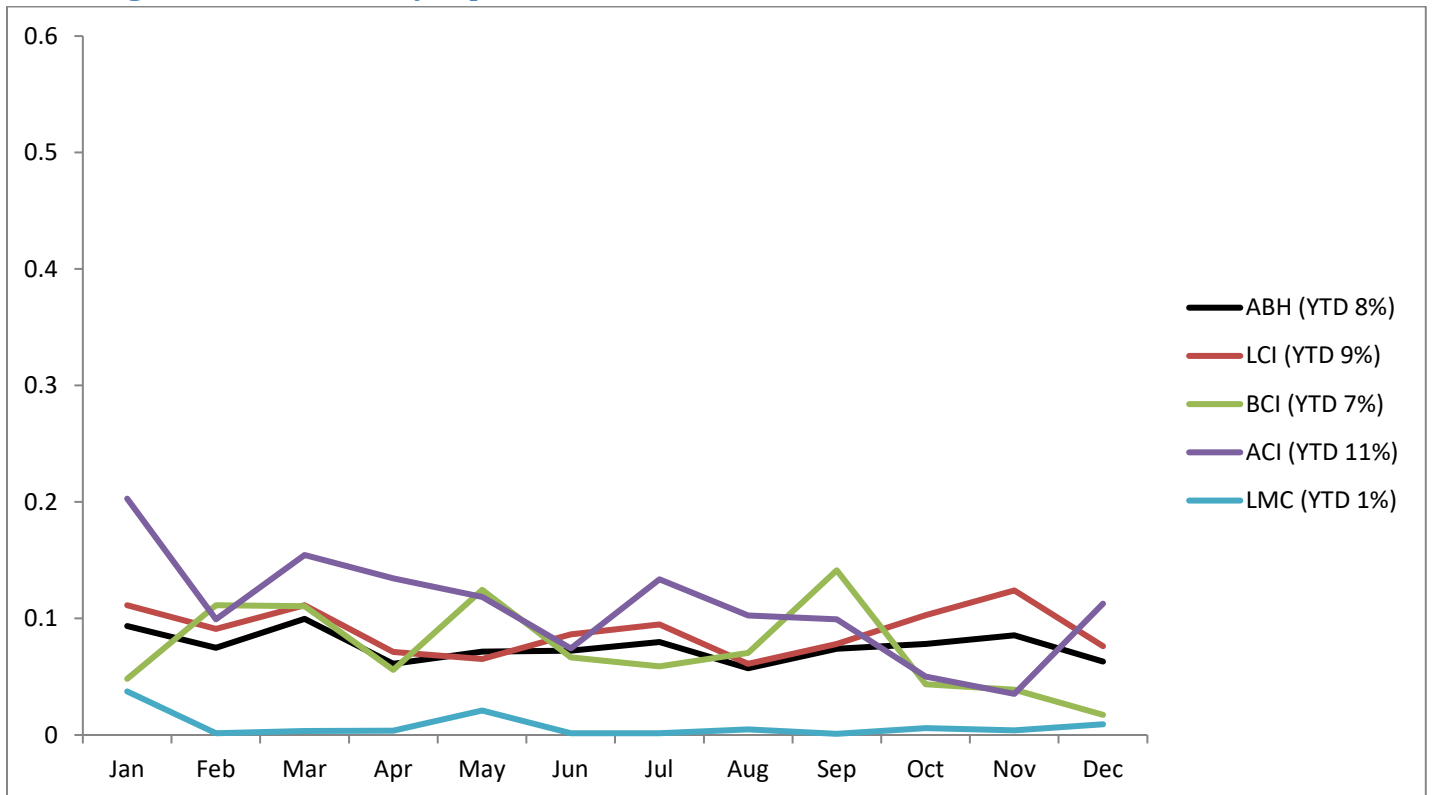


	2023		2024		2025	
	# Claims	YoY %	# Claims	YoY %	#Claims	YoY %
Total	181,361	-7.63%	136,791	-24.58%	143,267	4.73%
Capitated Providers	90,184	-18.32%	74,588	-17.29%	83,447	11.88%
HCA Hospitals	1,960	66.10%	135	-93.11%	75	-44.44%
Non-HCA Hospital	10,582	-25.09%	1,508	-85.75%	1,886	25.07%
Other Providers	78,635	11.32%	60,560	-22.99%	57,859	-4.46%

Claims Volume by Submission Type



Percentage of Claims Denied by Capitated Providers



Claims TAT Measures

ABH measures claims turnaround time (TAT) for both paper and electronic claims to ensure service level agreements related to claims processing are met. TAT is measured from the date the claim is received to the date the claim notice of payment or denial is sent to the provider. Paper claims require processing within 20 calendar days; electronic claims require processing within 15 calendar days.

Claims TAT													
2025	Goal	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
% within 7 days	>85%	82%	86%	84%	85%	88%	87%	90%	91%	89%	92%	88%	82%
% within 10 days	>95%	91%	97%	97%	95%	95%	95%	98%	98%	97%	98%	95%	85%
% within 20 days	>98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TAT Paper	<20 days	9.7	7.7	7.5	8.6	8.2	7.9	7.5	7.8	7.4	7.1	8.6	12.2
TAT Electronic	<15 days	0.9	0.6	1.1	0.9	0.7	0.9	0.7	0.5	1.2	0.8	1.0	1.2

Claims TAT					
	Goal (<2025)	2023	2024	Goal (>2025)	2025
% within 7 days	>50%	75%	80%	>85%	87.4%
% within 10 days	>70%	87%	90%	>95%	95.1%
% within 20 days	>90%	100%	100%	>98%	100%
TAT Paper	<20 days	7.7	7.1	<20 days	8.3
TAT Electronic	<15 days	3.7	3.8	<15 days	0.9

Enrollment

Current-to-date Members enrolled per month. This includes retroactive enrollment activity.

2025	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
ABH	98602	107326	99783	98063	98213	98160	97147	96652	96068	95638	95648	94801
Adults	35111	39313	35693	34679	34719	34708	34199	34092	33975	33806	33866	33470
Children	63491	68013	64090	63384	63494	63452	62948	62560	62093	61832	61782	61331
ACI	11502	12410	11673	11412	11388	11349	11289	11245	11209	11231	11284	11092
Adults	4170	4820	4284	4170	4159	4163	4178	4169	4150	4162	4213	4127
Children	7332	7590	7389	7242	7229	7186	7111	7076	7059	7069	7071	6965
BCI	17313	17971	17550	17308	17316	17357	17170	16999	16849	16769	16779	16667
Adults	5730	6036	5806	5678	5684	5708	5637	5601	5578	5546	5565	5504
Children	11583	11935	11744	11630	11632	11649	11533	11398	11271	11223	11214	11163
LCI	60619	62409	61289	60360	60513	60479	59745	59476	59067	58714	58662	58248
Adults	21646	22664	21965	21358	21421	21372	20972	20926	20853	20686	20673	20479
Children	38973	39745	39324	39002	39092	39107	38773	38550	38214	38028	37989	37769
LMC	9168	14536	9271	8983	8996	8975	8943	8932	8943	8924	8923	8794
Adults	3565	5793	3638	3473	3455	3465	3412	3396	3394	3412	3415	3360
Children	5603	8743	5633	5510	5541	5510	5531	5536	5549	5512	5508	5434

Average membership by year

	2023		2024		2025	
	Members	YoY %	Members	YoY %	Members	YoY %
Overall	133673	-13.57%	103209	-22.79%	127958	23.98%
Adults	58091	-18.51%	38479	-33.76%	51716	34.40%
Children	75582	-12.56%	64729	-14.36%	76242	17.79%