

January 2026

2025 Annual

# Quality Review Technical Report

**Florida Healthy Kids Children's Health Insurance Program**

Review Period: January 1, 2024 – December 31, 2024

Final



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## Acknowledgements, Acronyms, and Initialisms<sup>1</sup>

AACS.....	Assurances of Adequate Capacity and Services	C&M .....	Continuation and Maintenance
AAAH.....	Accreditation Association for Ambulatory Health Care	CA .....	Compliance Assessment
AAB-CH.....	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	CAHPS® ..	Consumer Assessment of Healthcare Providers & Systems
ACA .....	Annual Compliance Assessment	CAP .....	Corrective Action Plan
ADD.....	Improving Care Coordination to Improve Follow- Children Prescribed ADHD Medication	CCP.....	Community Care Plan
ADD-CH ....	Improving Care Coordination to Improve Follow-Up Care for Children Prescribed ADHD Medication	CCP-CH .....	Contraceptive Care – Postpartum Women Ages 15–20
ADHD .....	Attention Deficit Hyperactivity Disorder	CCW-CH .....	Contraceptive Care – All Women Ages 15–20
ADV .....	Annual Dental Visit	CDF-CH... ..	Screening for Depression and Follow-up Plan: Ages 12-17
Aetna .....	Aetna Better Health of Florida	CDT .....	Current Dental Terminology
AHCA .....	Agency for Healthcare Administration	CFR .....	Code of Federal Regulations
AHRQ.....	Agency for Healthcare Research and Quality	CHIP .....	Children's Health Insurance Program
AMB-CH .....	Ambulatory Care: Emergency Department Visits	CHL-CH.....	Chlamydia Screening in Women
AMR-CH .....	Asthma Medication Ratio	CMS .....	Centers for Medicare & Medicaid Services
ANA .....	Annual Network Adequacy	CPC.....	CAHPS® Health Plan Survey 5.1H, Child Version
AOD.....	Alcohol and Other Drug Abuse/Dependence	CPC-CH .....	Children with Chronic Conditions Supplemental Items
AON.....	Area of Noncompliance	CWP .....	Appropriate Testing for Pharyngitis
AOS.....	Availability of Services	D .....	Day/Dental
APM-CH .....	Metabolic Monitoring for Children and Adolescents on Antipsychotics	DBM .....	Dental Benefit Manager
APP-CH.....	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	DEA .....	Drug Enforcement Administration
BH .....	Behavioral Health	DentalTrac™ .....	a registered trademark of MCNA Systems Corporation
BMI .....	Body Mass Index	DentaQuest .....	DentaQuest of Florida, Inc.
BR .....	Biased Rate	DMH .....	Diagnosed Mental Health Disorders
C.....	Credentialing	DOH .....	Department of Health
		DSC.....	Dental Services Contract
		DSU.....	Diagnosed Substance Use Disorders
		E .....	Expedited

<sup>1</sup> Other company and product names may be trademarks of the respective companies with which they are associated. The mention of such companies and product names is with due recognition and without intent to misappropriate such names or marks.

## Acknowledgments, Acronyms, and Initialisms

ED .....	Emergency Department	MPT .....	Mental Health Utilization
ENT .....	Ear, nose, and throat (Otolaryngology)	MSC .....	Medical Services Contract
EPSDT .....	Early and Periodic Screening, Diagnostic and Treatment	MY .....	Measurement Year
EQR.....	External Quality Review	N .....	No/Number
EQRO.....	External Quality Review Organization	NA .....	Not Applicable
FAR .....	Final Audit Report	NA .....	Small Denominator
FHKC.....	Florida Healthy Kids Corporation	NABD .....	Notice of Adverse Benefit Determination
FUA-CH.....	Follow-up After Emergency Department Visit for Drug Abuse or Dependence	NCQA.....	National Committee for Quality Assurance
FUH .....	Follow-up After Hospitalization for Mental Illness	NCQA HEDIS Compliance Audit™ .....	a trademark of NCQA
FUH-CH.....	Follow-up After Hospitalization for Mental Illness	NPDB .....	National Practitioner Data Bank
FUM-CH .....	Follow-Up After Emergency Department Visit for Mental Illness	NPI .....	National Provider Identifier
GA .....	Grievances and Appeals	NPPES .....	National Plan and Provider Enumeration System
HEDIS®.....	Healthcare Effectiveness Data and Information Set, a registered trademark of the NCQA	NR .....	Not Reported (PMV)
HHS.....	U.S. Department of Health and Human Services	NS .....	New Stratification
HIS .....	Health Information Systems	OB/GYN .....	Obstetrician/gynecologist
HPV .....	Human papillomavirus	OEV-CH .....	Oral Evaluation, Dental Services
HRA.....	Health Risk Assessment	OIG.....	Office of the Inspector General
ID.....	Identification/Identifier	OPA.....	Office of Population Affairs
IDSS.....	Interactive Data Submission System	P&P .....	Policy and Procedure
IET.....	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	PCP .....	Primary Care Provider/Physician
IMA-CH.....	Immunizations for Adolescents	PDP .....	Primary Dental Provider
ISCA.....	Information Systems Capability Assessment	PIDENT .....	Preventive Dental
ISCAT.....	Information Systems Capability Assessment Tool	PG .....	Practice Guidelines
LARC.....	Long-acting reversible method of contraception	PIP.....	Performance Improvement Project
Liberty.....	Liberty Dental Plan of Florida, Inc.	PMV.....	Performance Measure Validation
M .....	Month/Medical	PPC2-CH.....	Prenatal and Postpartum Care
MCNA.....	Managed Care of North America, Inc.	Q.....	Quarter
MCO.....	Managed Care Organization	QAPI.....	Quality Assessment and Performance Improvement
		QI.....	Quality Improvement
		QP .....	Quality Performance
		Qsource® .....	EQRO, a registered trademark

**Acknowledgments, Acronyms, and Initialisms**

Quest Analytics Suite.....	a registered trademark	SSA .....	Social Security Administration
R.....	Recredentialing	SUD .....	Substance Use Disorder
R.....	Reportable Rate	Tdap .....	Tetanus, diphtheria, and pertussis
Roadmap.....	Record of Administrative Data Management and Processes	TDENT .....	Enrolled Children Receiving Dental Treatment Services
S .....	Standard	TFL-CH.....	Topical Fluoride for Children
SAM.....	System for Award Management	TTY/TDY .....	Telecommunication device for the deaf
SEA: With Exclusions....	Enrolled Children Receiving Dental Sealants on Permanent Molars – With Exclusions	UM.....	Utilization management
SFM-CH .....	Sealant Receipt on Permanent First Molars	URAC®.....	Utilization Review Accreditation Commission
SHCN .....	Special Health Care Needs	URI .....	Appropriate Treatment for Upper Respiratory Infection
SHOTS .....	State Health Online Tracking System	WCC.....	Weight Assessment and Counseling for Nutrition and Physical Activity
Simply Healthcare .....	Simply Healthcare Plans, Inc.	WCC-CH .....	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
SOP .....	Standard Operating Procedures	WCV-CH.....	Child and Adolescent Well-Care Visits
SQL .....	Structured Query Language	Y .....	Yes
		YY.....	Year

## Overview

In accordance with Title 42 *Code of Federal Regulations* (CFR) § 438.364, Qsource has produced this *2025 Annual External Quality Review Organization (EQRO) Technical Report* to summarize the quality, timeliness, and accessibility of care furnished to enrollees in the Florida Healthy Kids program by the managed care organizations (MCOs) and dental benefit managers (DBMs) contracted by the Florida Healthy Kids Corporation (FHKC) and to identify areas for improvement and recommend interventions to improve the process and outcomes of care. Title 42 of the CFR governs that states providing Children's Health Insurance Program (CHIP) services through contracts with MCOs/DBMs are required by federal mandate (42 CFR §§ 438.310–438.370, incorporated in § 457.1250) to conduct external quality review activities and ensure that the results of those activities are used to perform an external, independent assessment and produce an annual report. This section provides a brief history of FHKC, the organization's strategy for the Florida Healthy Kids program, external quality review (EQR) activities conducted in 2025, the guidelines for this report, and intended uses for this report.

### Florida Healthy Kids Background

Created in 1990 by the Florida legislature, FHKC aims to improve access to medical and dental health insurance for the state's uninsured children, ages 5 to 18 years. In 1997, Florida Healthy Kids became one of three state programs grandfathered

into the original CHIP legislation created through Title XXI of the *Social Security Act* and reauthorized in 2009. FHKC is one of four Florida KidCare partners: Florida Healthy Kids, Medicaid, MediKids, and Children's Medical Services. Together, these four state healthcare programs for children make up the Florida KidCare program, covering children from birth through age 18. Florida Healthy Kids includes subsidized health and dental insurance for children ages five through 18 years whose families exceed the income eligibility threshold for Medicaid but whose income does not exceed 200% of the federal poverty level. Florida Healthy Kids also includes a full-pay option that is not part of CHIP and is available to Florida children whose family income exceeds 200% of the federal poverty level.

As of June 2025, 461,079 children were enrolled in the Florida Healthy Kids program, according to enrollment data from FHKC's vendor, Maximus. Enrollment numbers for the medical plans were as follows: Aetna totaled 106,771, CCP totaled 18,185, and Simply totaled 106,065. The dental plans total enrollees were as follows: DentaQuest totaled 86,318, Liberty totaled 43,883, and MCNA totaled 99,857. In June 2024, 436,075 children were enrolled in the program. All plans, with the exception of Community Care Plan (CCP), service all 67 counties in Florida. CCP provides services for Florida Healthy Kids enrollees in eight counties (Broward, Indian River, Martin, Miami-Dade, Monroe, Okeechobee, Palm Beach, and St. Lucie).

In 2024, the measurement year (MY) under review, three MCOs and three DBMs operated in Florida:

- ◆ Aetna Better Health of Florida (Aetna), MCO
- ◆ Community Care Plan (CCP), MCO
- ◆ DentaQuest, DBM
- ◆ Liberty Dental Plan of Florida, Inc. (Liberty), DBM
- ◆ Managed Care of North America, Inc., doing business as MCNA Dental Plans (MCNA), DBM
- ◆ Simply Healthcare Plans, Inc. (Simply Healthcare), MCO

These entities are referred to as plans as well as MCOs and DBMs in this report.

## FHKC Quality Strategy Plan

Striving to ensure high-quality, timely, accessible care for the Florida Healthy Kids population, FHKC developed the *Florida Healthy Kids Managed Care Quality Strategy Plan* (Quality Strategy Plan) effective July 1, 2018. The Quality Strategy Plan also fulfills federal expectations for states, as required by Centers for Medicare & Medicaid Services (CMS) under regulations at 42 CFR § 438.340(a), as incorporated by 42 CFR § 457.1240(e). Updates were made to the Quality Strategy Plan in 2021 following FHKC's evaluation of the plan's effectiveness, as mandated at least every three years.

The Quality Strategy Plan is implemented through the ongoing comprehensive quality assessment and performance

improvement programs (QAPIs) that the MCOs and DBMs must have in place. Each plan's QAPI includes performance improvement projects and performance measures as determined by FHKC and evaluated by Qsource to foster alignment among QAPI requirements, the Quality Strategy Plan, and the annual EQR activities.

FHKC's goals, vision, and mission statements align with the three aims of the National Quality Strategy: better care, improved health for people and communities, and affordable healthcare. FHKC's Quality Strategy Plan includes two primary areas of focus: access to quality of care and quality assurance. FHKC's vision and mission statements serve as a guide for ensuring quality remains a top priority. These statements are a solid foundation for FHKC and the services it provides for the Florida Healthy Kids population:

- ◆ Vision Statement: All Florida's children have comprehensive, quality health care services.
- ◆ Mission Statement: Ensure the availability of child-centered health plans that provide comprehensive, quality health care services.

Using their vision and mission statements, FHKC developed six primary goals. These goals helped shape FHKC's approach to improving the quality, timeliness, and accessibility of healthcare for its enrollees:

1. Quality: Ensure child-centered standards of health care excellence in all Florida Healthy Kids health plans.

2. Satisfaction: Fulfill child health care insurance expectations and the needs of families.
3. Growth: Increase enrollment and retention.
4. Effectiveness: Ensure an appropriate structure and the processes to accomplish the mission.
5. Leadership: Provide direction and guidance to efforts that enhance child health care in Florida.

6. Advancement: Maintain necessary resources and authority to achieve the mission.

**Table 1** outlines the current goals from FHKC’s Quality Strategy, how they fit into FHKC’s two areas of focus, their alignment with the National Quality Strategy, and the steps that FHKC and its plans are taking to meet their goals.

**Table 1. Quality Strategy Goals and Alignment**

FHKC Goals	Primary Area of Focus	CMS Quality Strategy Alignment	FHKC Steps
<p><b>Quality:</b> Ensure child-centered standards of health care excellence in all Florida Healthy Kids plans.</p>	<p><b>Quality Assurance</b></p>	<p>Quality of Care</p>	<p>FHKC monitors quality assurance for the Florida Healthy Kids program through continuous quality improvement requirements for the plans as well as annual EQR activities. FHKC’s plans must maintain an ongoing quality improvement plan that meets the following requirements:</p> <ul style="list-style-type: none"> <li>◆ Objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered;</li> <li>◆ Promotes quality of care and quality patient outcomes; and</li> <li>◆ Demonstrates specific interventions to better manage the care of and promote healthier outcomes for enrollees.</li> </ul> <p>These qualities ensure health care excellence from all plans.</p>

**Table 1. Quality Strategy Goals and Alignment**

FHKC Goals	Primary Area of Focus	CMS Quality Strategy Alignment	FHKC Steps
<p><b>Satisfaction:</b> Fulfill child health care insurance expectations and the needs of families.</p>		<p>Quality of Care, Timeliness of Care, and Access to Care</p>	<p>FHKC’s plans are required to maintain quality improvement plans that include written policies and procedures for effective health care management including anticipation, identification, monitoring, measurement, and evaluation of enrollees’ health care needs, as well as effective action to promote quality of care. The plans define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management. It is FHKC’s belief that satisfying the needs of patients and providers can only occur through the constant monitoring and improvement of these aspects.</p>
<p><b>Leadership:</b> Provide direction and guidance to efforts that enhance child health care in Florida.</p>		<p>Quality of Care and Access to Care</p>	<p>Three primary challenges affect the provision of care for Florida Healthy Kids enrollees: the rural nature of the state, physician hesitancy to contract with publicly funded insurance programs or accept patients with publicly funded insurance coverage, and the insufficient number of pediatric subspecialists currently in the workforce.</p> <p>To mitigate these challenges, FHKC requires its plans to meet network adequacy time and distance standards established in the Quality Strategy Plan and supported by the plan contracts. FHKC also requires each plan to demonstrate its capacity to service the expected population of Florida Healthy Kids enrollees and to adhere to time standards for providing</p>

Table 1. Quality Strategy Goals and Alignment

FHKC Goals	Primary Area of Focus	CMS Quality Strategy Alignment	FHKC Steps
			services. Other areas monitored toward achieving access to quality care include provider information accuracy, provider quality, care for children with special healthcare needs, transition of care, benefit decisions, and reducing health disparities.
<b>Growth:</b> Increase enrollment and retention.	Access to Quality Care	Quality of Care, Timeliness of Care, and Access to Care	<p>Access to care is just as critical for enrollee health outcomes as quality of care, both of which are lynchpins in enrollment and retention. Access to care and quality of care may be monitored through the following EQR activities:</p> <ul style="list-style-type: none"> <li>◆ Annual Network Adequacy</li> <li>◆ Annual Compliance Assessment</li> <li>◆ Performance Improvement Projects</li> <li>◆ Performance Measure Validation</li> </ul>
<b>Effectiveness:</b> Ensure an appropriate structure and the processes to accomplish the mission.		Quality of Care and Access to Care	<p>For quality care to be effective, it must be delivered in an appropriate timely manner. Thus, various standards for timely care were monitored through plan compliance with federal and state and contractual regulations; the plans' network adequacy to deliver services timely; and plan timeliness in processing prior authorization requests, claims, grievances, and appeals. These aspects are monitored through the following annual EQR activities:</p> <ul style="list-style-type: none"> <li>◆ Annual Compliance Assessment</li> </ul>

**Table 1. Quality Strategy Goals and Alignment**

FHKC Goals	Primary Area of Focus	CMS Quality Strategy Alignment	FHKC Steps
<p><b>Advancement:</b> Maintain necessary resources and authority to achieve the mission.</p>			<ul style="list-style-type: none"> <li>◆ Annual Network Adequacy</li> </ul>
		Quality of Care	<p>Serving as an EQRO for the CMS EQR Protocol activities, FHKC has partnered with Qsource to provide FHKC and its MCOs and DBMs with technical assistance as defined by 42 CFR § 438.358 and incorporated by 42 CFR § 457.1250. In this capacity, Qsource maintained ongoing, collaborative communication with FHKC and supported the plans in their EQR activities. Qsource also helped FHKC and its plans with advancement of education, conducting three health and dental All-Plan meetings that were attended by FHKC, MCO, and DBM staff.</p>

## Quality Strategy Conclusions

FHKC should continue to work with the plans and focus on standards which consistently show no improvement or minimal improvement to ensure quality, timeliness, and access to care for the enrollees. FHKC should ensure that the plans review their workflows and ensure timely care and reporting of data. FHKC should continue to develop reports that follow HEDIS updates, additions, and new guidelines. Overall, the Quality Strategy was an effective tool for measuring and improving FHKC's managed care services, specifically in improving the quality, timeliness,

and access to care for enrollees. The MCOs, DBMs, and the State are making progress towards the Quality Strategy goals and objectives.

## EQR Activities

As set forth in Title 42 *Code of Federal Regulations*, Section 438, Part 358 (42 § 438.358), incorporated by 42 CFR § 457.1250, there are four mandated and six optional EQR activities. In addition, a state agency can assign other

responsibilities to its designated EQRO. This section summarizes the mandatory activities that Qsource performed for FHKC in 2025, in accordance with the CMS *External Quality Review Protocols* (released in 2023).

### EQR Mandatory Activities

Following the CMS Protocols published in February 2023, Qsource conducted the EQR activities shown in [Table 2](#).

Qsource maintained ongoing, collaborative communication with FHKC and provided technical assistance to the plans in their EQR activities. The technical assistance, an EQR-related activity also defined by 42 CFR § 438.358, consisted of targeted support through phone calls, webinars, written guides, and trainings.

Finally, Qsource provided each plan with an information packet explaining the EQR activities in greater detail and dates for data submission.

Table 2. EQR Activities Conducted in 2025			
Protocol #	Activity Name	Mandatory or Optional	Measurement Period
1	Validation of Performance Improvement Projects	Mandatory	January 1, 2024 – December 31, 2024

Table 2. EQR Activities Conducted in 2025			
Protocol #	Activity Name	Mandatory or Optional	Measurement Period
2	Validation of Performance Measures	Mandatory	January 1, 2024 – December 31, 2024
3	Review of Compliance	Mandatory	January 1, 2024 – December 31, 2024
4	Validation of Network Adequacy	Mandatory	January 1, 2024 – December 31, 2024

## Technical Report Guidelines

Qsource is responsible for the creation and production of this *2025 Annual EQRO Technical Report*, which compiles the results of these EQR activities. To assist both EQROs and state agencies, CMS supplemented the requirements of 42 CFR § 438.364, as incorporated by 42 CFR § 457.1250, and provided guidelines in the 2023 EQR Protocols for producing annual technical reports.

The report includes the following EQR-activity-specific sections:

- ◆ Protocol 1. Validation of Performance Improvement Projects
- ◆ Protocol 2. Validation of Performance Measures

- ◆ Protocol 3. Annual Compliance Assessment
- ◆ Protocol 4. Validation of Network Adequacy

Each activity conducted by Qsource monitored each plan's compliance with federally mandated activities and assessed the quality, timeliness, and accessibility of services provided by the plans. This report includes the following results of these activities:

1. A brief description of the data collection, aggregation, and analyses for each of the EQR compliance activities;
2. A summary of findings from each review;
3. Comparative information and assessments of the degree to which benefit managers have addressed prior year EQRO recommendations for Quality Improvement (QI);
4. Strengths and weaknesses demonstrated by each plan in providing healthcare services to enrollees;
5. Recommendations for improving the quality of these services, including how FHKC can target goals and objectives in achieving the goals of the quality strategy to support improvement better; and
6. Comparative information regarding the plans, consistent with CMS EQR Protocol guidance.

The *2025 Annual EQRO Technical Report* provides FHKC with substantive, unbiased data on the plans as well as recommendations for action toward far-reaching performance improvement. This report is based on detailed findings that can be reviewed in the individual EQR activity reports provided to

FHKC. Recommendations for how to utilize Qsource's findings can be found in the [Conclusions and Recommendations](#) section of this report.

The appendices provide additional EQR activity information:

- ◆ [Appendix A](#) | 2025 PIP Measurement Results
- ◆ [Appendix B](#) | 2025 PMV Audited Measures
- ◆ [Appendix C](#) | 2025 Sample EQR Assessment Tools and Instructions
- ◆ [Appendix D](#) | ACA Quality Performance (QP) Tool with NCQA Crosswalk

### EQRO Team

The review team included the following staff:

- ◆ Rebel McKnight, Qsource, Vice-President of Operations
- ◆ Kristen Gloria, Qsource, EQRO Program Director
- ◆ Hira Siddiqui, Qsource, Florida EQRO Program Manager
- ◆ Jill Edmonson, Qsource, EQRO Program Manager
- ◆ Albert Kennedy, Qsource, Contract Reporting Specialist
- ◆ Fidencio Caballero, Qsource, Healthcare Quality Analyst

# Performance Improvement Project (PIP) Validation

## Objectives

The *Balanced Budget Act of 1997* established certain managed care quality safeguards that were described by Title 42 of the *Code of Federal Regulations*, Section 438.320 (42 CFR § 438.320), which defines “external quality review” as the “analysis and evaluation...of aggregated information on quality, timeliness, and access to health care services.” These reviews, described in 42 CFR § 438.358, include four required external quality review activities, one of which is the validation of quality improvement projects.

As part of its EQR contract with Florida Healthy Kids Corporation (FHKC), Qsource validated the PIPs of FHKC’s managed care organizations (MCOs) and dental benefit managers (DBMs). Qsource’s *PIP Validation Technical Papers* present validation findings by MCO/DBM and PIP topic.

The primary objective of PIP validation is to determine each PIP’s compliance with the requirements set forth in Title 42 of the *Code of Federal Regulations*, Section 438.330(d)(2), as incorporated by 42 CFR § 457.1240(b). Plans must conduct PIPs that are designed to achieve, through ongoing measurements and interventions, significant and sustained improvement in clinical and nonclinical care areas. The improvement is expected to have a favorable effect on health outcomes and enrollee satisfaction. PIP study topics must reflect enrollment in terms of

demographic characteristics and, if applicable, in terms of the prevalence and potential consequences (risks) of disease as well as enrollee needs for specific services. Each PIP must be completed within a timeframe that allows PIP success-related data in the aggregate to produce new information on quality of care every year. PIPs are further defined in 42 CFR § 438.330(d)(2) to include the following:

- ◆ measuring performance with objective quality indicators;
- ◆ implementing interventions for quality improvement;
- ◆ evaluating intervention effectiveness; and
- ◆ planning and initiating activities to increase or sustain improvement.

## Technical Methods of Data Collection and Analysis

Each plan was contractually required to submit PIP studies annually to FHKC as requested. Submitted PIPs should include the necessary documentation for data collection, data analysis plans, and an interpretation of all results. Plans should also address threats to validity of data analysis and include an interpretation of study results.

Each plan submitted either a continuation of their established PIPs, as PIPs are typically conducted over a three-year period,

### Performance Improvement Project Validation

or PIPs that were in their initial baseline measurement period. To validate PIPs, Qsource assembled a validation team of experienced staff specializing in clinical quality improvement and a healthcare data analyst. The validation process included a review of each PIP’s study design and approach, an evaluation of each PIP’s compliance with the analysis plan, and an assessment of the effectiveness of interventions.

Qsource’s scoring methodology determines whether a PIP is valid by rating the MCO/DBM’s percentage of compliance with the Centers for Medicare & Medicaid Services’ (CMS’s) *EQR Protocol 1: Validation of Performance Improvement Projects* (February 2023). Qsource developed a PIP Summary Form (with accompanying PIP Summary Form Completion Instructions) and a PIP Validation Tool to standardize the process by which each plan delivers PIP information to FHKC and how the information is assessed. Using Qsource’s PIP Summary Form, each plan submitted the PIP studies and supplemental information in July 2025. The MY for this validation was January 1, 2024, through December 31, 2024.

Validation of each PIP involves nine required steps for successful completion, and each step consists of one or more elements essential to the successful completion of a PIP. The elements within each step were scored as Met, Not Met, or Not Applicable. Qsource evaluated each MCO or DBM’s performance on each evaluation element and detailed the number of elements met compared to the number of elements assessed for each step.

Qsource provided a validation score and two validation ratings for the PIP. The validation score was calculated by dividing the number of elements met by the number of elements assessed. The first validation rating was determined by the percentage score of elements met. The rating indicated Qsource’s overall confidence (from no confidence to high confidence) that the PIP adhered to acceptable methodology for all phases of design and data collection and included accurate data analysis and interpretation of PIP results.

The second validation rating was based on the assessment of whether the PIP produced significant evidence of improvement. To determine this rating, Qsource reviewed the PIPs results and processes along with their relative strengths and weaknesses and the extent to which they affected confidence in the generalizability and usefulness of the PIP’s findings.

[Table 3](#) presents the validation status criteria for the PIPs.

**Table 3. Validation Status and Confidence Statements**

Validation Status	
Met	Received a rating of high or moderate confidence on PIP validation rating 1.
Not Met	Received a rating of low or no confidence on PIP validation rating 1.
Rating 1 (Confidence Statements)	
High Confidence	90–100% of all assessed elements are Met.

## Performance Improvement Project Validation

**Table 3. Validation Status and Confidence Statements**

Moderate Confidence	80–89.99% of all assessed elements are Met.
Low Confidence	70–79.99% of all assessed elements are Met.
No Confidence	Less than 70% of all assessed elements are Met.

**Rating 2 (Confidence Statements)**

High Confidence	The PIP achieved statistically significant improvement for all performance measures and interventions resulted in demonstrated improvement.
Moderate Confidence	The PIP achieved statistically or non-statistically significant improvement for at least one measure.
Low Confidence	The PIP did not demonstrate statistically or non-statistically significant improvement or none of the interventions resulted in demonstrated improvement.
No Confidence	The PIP did not follow approved methodology or processes through the end date.

**Table 4** lists the nine PIP steps used for assessing the PIP methodology.

**Table 4. PIP Assessment Steps**

Step	PIP Activity
1	State the Selected PIP Topic
2	State the PIP Aim Statement
3	Identify the PIP Population
4	Describe the Sampling Method
5	Describe the Selected PIP Variables and Performance Measures
6	Describe Data Collection Procedures
7	Analyze Data and Interpret PIP Results
8	Describe Improvement Strategies
9	Assess for Significant and Sustained Improvement

## Validation of PIP Topics and Description of Data Obtained

The MCOs were required to produce one clinical PIP topic and one nonclinical PIP topic. The DBMs were required to produce three PIP topics; DentaQuest and Liberty produced two clinical PIP topics and one nonclinical PIP topic, while MCNA produced one clinical PIP topic and two nonclinical PIP topics. Qsource received and assessed PIP Summary forms for the following PIP topics in **Table 5**.

## Performance Improvement Project Validation

Table 5. 2025 PIP Validation Rating and Validation Score

MCO/ DBM	PIP Type	PIP Topic	Quality	Timeliness	Access	Validation Rating 1	Validation Rating 2	Validation Score	Validation Status
Aetna	Clinical	<i>Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH)</i>	✓	✓		High	High	100%	Met
	Non clinical	<i>Timely Follow-up for Patients After They Have Been Hospitalized for Mental Illness – 7-Day (FUH 7-Day)</i>	✓	✓		High	High	100%	Met
CCP	Clinical	<i>Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)</i>	✓	✓		Moderate	High	88.89%	Met
	Non clinical	<i>Follow-up After Hospitalization for Mental Illness – 7 Days</i>	✓	✓		High	Moderate	91.67%	Met
DentaQuest	Clinical	<i>Preventive Dental</i>	✓	✓	✓	High	NA	100%	Met
	Clinical	<i>Improving Preventive Care Dental Visits in Children with Special Healthcare Needs (SHCN)</i>	✓	✓	✓	High	NA	100%	Met
	Non clinical	<i>Implementing Digital Technology to Improve Access to Care</i>	✓	✓	✓	High	NA	100%	Met
Liberty	Clinical	<i>Increasing the Percentage of Enrollees Receiving Preventive Services</i>	✓	✓	✓	High	High	97.62%	Met
	Clinical	<i>Improving Utilization Rate of Special Care Enrollees</i>	✓	✓	✓	High	NA	100%	Met

## Performance Improvement Project Validation

Table 5. 2025 PIP Validation Rating and Validation Score

MCO/ DBM	PIP Type	PIP Topic	Quality	Timeliness	Access	Validation Rating 1	Validation Rating 2	Validation Score	Validation Status
	Non clinical	<i>Access to Care in Rural and Urban Counties</i>		✓	✓	Moderate	High	82.22%	Met
MCNA	Clinical	<i>Improving Sealant Receipt on Permanent First Molars</i>	✓	✓	✓	High	NA	100%	Met
	Non clinical	<i>Increasing the Number of Special Needs Members Receiving an Annual Dental Visit</i>	✓	✓	✓	High	NA	100%	Met
	Non clinical	<i>Increasing the Rate of Providers Reporting Member No-shows</i>	✓	✓		High	NA	100%	Met
Simply Healthcare	Clinical	<i>Screening for Depression and Follow-Up Plan Ages 12 to 17 (CDF-CH)</i>	✓	✓		High	High	100%	Met
	Non clinical	<i>Improving Care Coordination to Improve Follow-up for Children Prescribed ADHD Medication (ADD)</i>	✓	✓		High	Low	100%	Met

## Strengths, Weaknesses and Recommendations

**Table 6** includes strengths and **Table 7** includes weaknesses and recommendations. Strengths for the PIP validation indicate that the plans demonstrated proficiency in a given activity and can be identified regardless of the validation rating. The lack of an identified strength should not be interpreted as a shortcoming on the part of a plan. Weaknesses, or Areas of Noncompliance (AONs), arise from evaluation elements that receive a Not Met

score, indicating that those elements were not in full compliance with CMS Protocols. The recommendations were created by Qsource to address the weaknesses evaluated in the PIPs. Strengths, weaknesses, and recommendations are useful to the plan in determining whether to continue or retire a specific PIP. Any PIP topic not listed had no strengths and/or weaknesses identified.

**Table 6. PIP Strengths**

MCO/DBM	PIP Title	Strengths
Aetna	<i>Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH)</i>	<p><b>Step 6:</b> Review the Data Collection Procedures—The MCO submitted evidence demonstrating the data collection algorithm, which was the HEDIS – FL Data Integration Flow Chart.</p> <p><b>Step 8:</b> Assess the Improvement Strategies—The MCO included a driver diagram with both primary and secondary drivers of its intervention strategy.</p> <p><b>Step 9:</b> Assess the Likelihood that Significant and Sustained Improvement Occurred—The MCO included a graph which demonstrated sustained improvement from baseline was achieved and was maintained through repeated measurements over time.</p>
	<i>Timely Follow-up for Patients After They Have Been Hospitalized for Mental Illness – 7-Day (FUH 7-Day)</i>	<p><b>Step 8:</b> Assess the Improvement Strategies—The MCO included a driver diagram with both primary and secondary drivers of its intervention strategy.</p>
DentaQuest	<i>Preventive Dental</i>	<p><b>Step 6:</b> Review the Data Collection Procedures—The DBM included a graphic that illustrated the collection and flow of data used to calculate the performance measure results.</p>

**Table 6. PIP Strengths**

MCO/DBM	PIP Title	Strengths
	<p data-bbox="390 289 730 431"><i>Improving Preventive Care Dental Visits in Children with Special Healthcare Needs (SHCN)</i></p> <p data-bbox="390 711 693 815"><i>Implementing Digital Technology to Improve Access to Care</i></p>	<p data-bbox="764 298 1885 402"><b>Step 6:</b> Review the Data Collection Procedures—The DBM included a graphic that illustrated the collection and flow of data used to calculate the performance measure results.</p> <p data-bbox="764 444 1894 1062"><b>Step 1:</b> Review the Selected PIP Topic—The DBM provided an extensive analysis for the need of digital outreach for their enrollees to increase access of care by stating, “Preventative care is necessary and an integral part of providing preventative care, as well as informing those in need of urgent dental care, is to educate them on the means to access care. This includes utilizing resources that are readily available to most via things such as email, text messages, find a dentist tools, website sources, member handbook, dental home, benefits etc. By providing the types of resources that most individuals are utilizing at their fingertips and educating the members on the importance of their dental care needs, they are more likely to access care resulting in an established routine moving forward. We have evaluated the current accessibility of our network and outreach and have found that providing the information necessary for members to gain access to care by digital outreach is in the best interest of the members. Our goal is that by offering new routes for outreach, members will more easily be able to access the services they need.” Furthermore, the DBM sought input from dental professionals and provided startling statistics on the effects of the lack of dental care for children and the greater impact it can have on their lives.</p>
MCNA	<p data-bbox="390 1175 735 1279"><i>Improving Sealant Receipt on Permanent First Molars</i></p>	<p data-bbox="764 1091 1843 1227"><b>Step 5:</b> Review the Selected PIP Variables and Performance Measures—The DBM provided extensive clinical research to convey the importance of the selected PIP performance measures and the impact that improvement could have on their enrollees.</p> <p data-bbox="764 1253 1835 1357"><b>Step 6:</b> Review the Data Collection Procedures—The DBM provided additional documentation for the data analysis plan and a flowchart for information system structure to illustrate the process of collecting consistent and accurate data.</p>

**Table 6. PIP Strengths**

MCO/DBM	PIP Title	Strengths
	<i>Increasing the Number of Special Needs Members Receiving an Annual Dental Visit</i>	<b>Step 6:</b> Review the Data Collection Procedures—The DBM provided additional documentation for the data analysis plan and a flowchart of the information system structure to illustrate the process of collecting consistent and accurate data.
	<i>Increasing the Rate of Providers Reporting Member No-shows</i>	<b>Step 6:</b> Review the Data Collection Procedures—The DBM provided additional documentation for the data analysis plan and a flowchart of the information system structure to illustrate the process of collecting consistent and accurate data.
Simply Healthcare	<i>Screening for Depression and Follow-Up Plan Ages 12 to 17 (CDF-CH)</i>	<b>Step 1:</b> Review the Selected PIP Topic—The MCO submitted graphs demonstrating total enrollees, regional gender, age, ethnicity, and language breakdown.
	<i>Improving Care Coordination to Improve Follow-up for Children Prescribed ADHD Medication</i>	<b>Step 1:</b> Review the Selected PIP Topic—The MCO submitted graphs demonstrating total enrollees, regional gender, age, ethnicity, and language breakdown.

**Table 7. PIP Weaknesses (AONs)**

MCO/DBM	PIP Title	AONs and Recommendations
CCP	<i>Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)</i>	<p><b>Step 5:</b> Review the Selected PIP Variables and Performance Measures—The MCO should clearly define the benchmark consistently throughout the steps so correct information is reflected in the applicable section of the summary form.</p> <p><b>Step 7:</b> Review the Data Analysis and Interpretation of PIP Results—The MCO should include a discussion assessing the statistical significance of any differences between baseline and the current remeasurement year (remeasurement 4).</p> <p><b>Step 7:</b> Review the Data Analysis and Interpretation of PIP Results—The MCO should address lessons learned about less-than-optimal performance or include a statement as to lessons learned.</p>

**Table 7. PIP Weaknesses (AONs)**

MCO/DBM	PIP Title	AONs and Recommendations
		<p><b>Step 8:</b> Assess the Improvement Strategies—The MCO should clearly document follow-up activities based on the findings for the current remeasurement year.</p> <p><b>Step 9:</b> Assess the Likelihood that Significant and Sustained Improvement Occurred—The MCO should ensure the correct and current methodology for the current measurement year is presented when noting whether the remeasurement methodology is the same as the baseline methodology.</p>
	<p><i>Follow-up After Hospitalization for Mental Illness – 7 Days</i></p>	<p><b>Step 2:</b> Review the PIP Aim Statement—The MCO should include the PIP time period as the measurement year that is reflected in the PIP.</p> <p><b>Step 5:</b> Review the Selected PIP Variables and Performance Measures—The MCO should include the timeframe under review in the performance measure.</p> <p><b>Step 6:</b> Review the Data Collection Procedures—The MCO should give a written description of the process used to determine the degree of completeness.</p> <p><b>Step 9:</b> Assess the Likelihood that Significant and Sustained Improvement Occurred—The MCO should state how improvement in performance, if any, is likely to be the result of the selected improvement strategy.</p>
Liberty	<p><i>Increasing the Percentage of Enrollees Receiving Preventive Services</i></p>	<p><b>Step 5:</b> Review the Selected PIP Variables and Performance Measures—The DBM should ensure that all information is updated and accurate, particularly for the baseline rate, time period, and benchmark rate.</p>

**Table 7. PIP Weaknesses (AONs)**

MCO/DBM	PIP Title	AONs and Recommendations
	<i>Access to Care in Rural and Urban Counties</i>	<p><b>Step 2:</b> Review the PIP Aim Statement—The DBM should include all required components into one cohesive PIP aim statement to specifically address the population the PIP affects and the time period in which the DBM is measuring the impact of the PIP.</p> <p><b>Step 3:</b> Review the Identified PIP Population—The DBM should clearly define the PIP population in the PIP aim statement. Furthermore, the DBM should include specific information about the population (e.g., age, length of enrollment, diagnoses, procedures, and other characteristics).</p> <p><b>Step 5:</b> Review the Selected PIP Variables and Performance Measures—The DBM should ensure all information is defined and updated, specifically the baseline and benchmark rates.</p>

## Interventions

**Table 8** presents the reported PIP interventions. The table contains direct quotes from the plans. Acronyms appearing in the direct quotes will not be included in Acknowledgments, Acronyms, and Initialisms.

**Table 8. 2025 PIP Interventions**

MCO/DBM	PIP Title	Interventions
Aetna	<i>Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH)</i>	<p>Provider Notification: ABHFL distributed provider bulletins to all FHK providers notifying them of the reimbursement rates for the depression screening codes.</p> <p>The intent of these interventions is to: 1) promote depression screening among this age group; 2) educate practitioners on the depression screening requirements, especially those associated with the CDF-CH measure and 3) inform and educate practitioners about the correct, appropriate coding/billing for effective reimbursement of these services.</p>

Table 8. 2025 PIP Interventions

MCO/DBM	PIP Title	Interventions
		<p>ABHFL aims to improve depression screening as evidenced by an increase in the rate of FHK members ages 12 to 17 who were screened for clinical depression on the date of the encounter or 14 days prior to the date of encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.</p> <p>The provider intervention educated FHK providers about the billing codes and reimbursement rates for depression screening on a regular basis to bring them in compliance with the recommended depression screening. The intervention is expected to contribute to the improvement in rate of depression screenings completed (CDF-CH) over time because it is designed to encourage billing of depression screens by providers. This intervention focuses on providers because they would have the greatest impact on increasing the rate of depression screens completed.</p>
	<p><i>Timely Follow-up for Patients After They Have Been Hospitalized for Mental Illness – 7-Day (FUH 7-Day)</i></p>	<p>BH Liaison Member Outreach:</p> <p>Member Outreach calls placed by ABHFL BH Liaisons to members (or their parents/guardians) during or after the child’s acute BH hospitalization or BH residential treatment to obtain and if need be, verify aftercare appointment information (date/time/provider) OR to coordinate aftercare appointments with a licensed MH professional within 7 days of discharge if appointment has not been made by facility within the specified time frame.</p>
CCP	<p><i>Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)</i></p>	<p>Education of provider offices on coding the depression screening completion on encounter submissions or submitting a separate data file pulled from their EHR.</p> <p>Flat Files from Provider Offices. Utilized Provider Operations and a contract addendum to encourage quarterly submission of EHR data which would include non-payable codes. Larger pediatric offices consistently submitted data for measurement year 2022 and 2023. These data files were sent directly to the CCP contracted HEDIS vendor for ingesting and use in calculating the ongoing monthly rates.</p>

**Table 8. 2025 PIP Interventions**

MCO/DBM	PIP Title	Interventions
	<i>Follow-up After Hospitalization for Mental Illness – 7 Days</i>	<p>Medical Records for members seen from Grant Funded Programs (Not used MY24). CCP collected data from Henderson Behavioral Health and Memorial Behavioral Health and submitted the file to the HEDIS vendor for testing. The file format and data were accepted without error and resulted in a positive uptick in the numerator number. Since the program is grant-funded, CCP received medical records for members seen. This allows CCP to show the follow up service is rendered for that member.</p> <p>Provider Assessment Following BH Admission: CCP partnered with a behavioral health provider to complete a follow up assessment after a member is discharged from the hospital.</p>
DentaQuest	<i>Preventive Dental</i>	<i>DentaQuest did not report any improvement strategies for this baseline PIP.</i>
	<i>Improving Preventive Care Dental Visits in Children with Special Healthcare Needs (SHCN)</i>	<i>DentaQuest did not report any improvement strategies for this baseline PIP.</i>
	<i>Implementing Digital Technology to Improve Access to Care</i>	<i>DentaQuest did not report any improvement strategies for this baseline PIP.</i>
Liberty	<i>Increasing the Percentage of Enrollees Receiving Preventive Services</i>	<p>Increasing preventive services utilization through member outreach and education: This improvement focuses on preventive dental visits that aim to reduce negative long-term health outcomes. Research from the Center of Disease Control and Prevention (CDC) and American Dental Association (ADA) support that patient education and outreach significantly increase utilization of preventive dental services, especially in underserved populations. The studies highlight that knowledge gaps are a common barrier which can be mitigated through targeted education and outreach. This implementation targets known barriers to care: lack of awareness of dental health benefits, low health literacy, other possible barriers to care such as transportation.</p>

Table 8. 2025 PIP Interventions

MCO/DBM	PIP Title	Interventions
	<i>Improving Utilization Rate of Special Care Enrollees</i>	<i>Liberty did not report any improvement strategies for this baseline PIP.</i>
	<i>Access to Care in Rural and Urban Counties</i>	Provider Relations (PR) Recruitment and Network Expansion: Research indicates that robust provider networks are correlated with improved access to care and better outcomes. Studies from the Agency of Healthcare Research and Quality (AHRQ) and Center for Medicare and Medicare Services (CMS) have shown that network adequacy and strong provider engagement are key contributors to reducing disparities in access. Moreover, evidence supports that provider recruitment efforts, when tailored to underserved areas, directly reduce the need for access waivers and improve overall services availability and care. The primary barrier was the overreliance on access waivers due to inadequate network coverage in certain geographic areas. This improvement strategy is designed to target areas with high waivers, strengthen the recruitment and retention of providers, and engage existing and new providers.
MCNA	<i>Improving Sealant Receipt on Permanent First Molars</i>	<p>Utilization of Sealant CARC: The Utilization Management team will implement an informational sealant CARC and attach it to pre-authorizations for eligible members who have not received dental sealants. This will serve as a reminder to providers to review the member's history and apply sealants as needed.</p> <p>Member Outbound Call Campaign: The Care Connections team will conduct monthly outbound calls to all eligible members who have not received at least one dental sealant on a permanent first molar. Members will be provided with education on the importance of dental sealants, coverage benefits, and encouraged to schedule an appointment with their dentist.</p> <p>Sealant Postcards: The Quality Improvement team will send postcards to members unsuccessfully reached by phone, who have not received at least one dental sealant on a permanent first molar. Members will be provided with education on the importance of dental sealants, coverage benefits, and encouraged to schedule an appointment with their dentist.</p>

**Table 8. 2025 PIP Interventions**

MCO/DBM	PIP Title	Interventions
	<i>Increasing the Number of Special Needs Members Receiving an Annual Dental Visit</i>	<p>Outbound Call Campaign to New Members: The Care Connections team will conduct outbound calls to newly enrolled special needs members within 60 days of enrollment and provide education to the member and or parent guardian on the importance of routine dental checkups and assist with locating a provider who can accommodate their needs and scheduling an appointment.</p> <p>Outbound Call Campaign to Existing Members: The Care Connections team will conduct outbound calls to existing special needs members who are overdue for their annual dental checkup. The member and/or parent guardian will receive education on the importance of routine dental checkups and assist with locating a provider who can accommodate their needs and scheduling an appointment.</p> <p>Collaborative Efforts with Special Needs Advocacy Groups: Collaborate with special needs advocacy groups, such as Arc Broward, Parent to Parent of Miami, and others to increase oral health awareness and promote dental visits by conducting monthly oral health presentations to members and or caregivers.</p>
	<i>Increasing the Rate of Providers Reporting Member No-shows</i>	<p>Provider Webinars: MCNA's Provider Relations team will conduct quarterly provider webinars to general and pediatric provider offices to educate providers and administrative staff on how to submit claims using CDT code D9986 for missed appointments. During these webinars, staff will also be informed about what happens after the claim is received, specifically, that MCNA's Member Advocate Outreach Specialists (MAOS) will contact the member to provide education on the importance of keeping dental appointments and receiving routine care. MAOS will also address any social determinants of health that may be preventing the member from attending their appointment and assist with rescheduling. By explaining this follow-up process, providers are reassured that reporting missed appointments leads to meaningful member outreach and support.</p> <p>Provider Outreach Calls: MCNA's Provider Relations team will conduct monthly telephonic outreach to general and pediatric provider offices to educate providers and administrative staff on how to submit claims using CDT code D9986 for missed appointments. During these calls, staff are also informed about what happens after the</p>

**Table 8. 2025 PIP Interventions**

MCO/DBM	PIP Title	Interventions
		claim is received, specifically, that MCNA’s Member Advocate Outreach Specialists (MAOS) will contact the member to provide education on the importance of keeping dental appointments and receiving routine care. MAOS will also address any social determinants of health that may be preventing the member from attending their appointment and assist with rescheduling. By explaining this follow-up process, providers are reassured that reporting missed appointments leads to meaningful member outreach and support.
Simply Healthcare	<i>Screening for Depression and Follow-Up Plan Ages 12 to 17 (CDF-CH)</i>	Identifying whether medical record review and subsequent provider education improve the percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.
	<i>Improving Care Coordination to Improve Follow-up for Children Prescribed ADHD Medication</i>	Care Gaps: Developed a system where gaps in care among members recently prescribed ADHD medications (last 90 days) without follow-up are identified and shared with BH Providers. This was designed to address gaps in communication among PCPs and BH prescribers.

## Comparison of PIP Improvements

[Table 9](#) compares PIP scores from MY 2023 to MY 2024. Improvements from the previous measurement year are indicated in green, and decreases in performance are indicated in red.

## Performance Improvement Project Validation

Table 9. PIP Performance Comparison

MCO/DBM	PIP Name	MY 2023 Validation Rating	MY 2024 Validation Rating	MY 2023 Score	MY 2024 Score
Aetna	<i>Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH)</i>	Rating 1: High Confidence	Rating 1: High Confidence	100%	100%
		Rating 2: High Confidence	Rating 2: High Confidence		
	<i>Timely Follow-up for Patients After They Have Been Hospitalized for Mental Illness – 7-Day (FUH 7-Day)</i>	Rating 1: High Confidence	Rating 1: High Confidence	100%	100%
		Rating 2: High Confidence	Rating 2: High Confidence		
CCP	<i>Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)</i>	Rating 1: High Confidence	Rating 1: Moderate Confidence	93.18%	88.89%
		Rating 2: High Confidence	Rating 2: High Confidence		
	<i>Follow-up After Hospitalization for Mental Illness – 7 Days</i>	Rating 1: Moderate Confidence	Rating 1: High Confidence	85.42%	91.67%
		Rating 2: Moderate Confidence	Rating 2: Moderate Confidence		
DentaQuest	<i>Preventive Dental</i>	NA	Rating 1: High Confidence	100%	100%
		NA	Rating 2: NA		
	<i>Improving Preventive Care Dental Visits in Children with Special Healthcare Needs (SHCN)</i>	NA	Rating 1: High Confidence	NA	100%
		NA	Rating 2: NA		

## Performance Improvement Project Validation

Table 9. PIP Performance Comparison

MCO/DBM	PIP Name	MY 2023 Validation Rating	MY 2024 Validation Rating	MY 2023 Score	MY 2024 Score
	<i>Implementing Digital Technology to Improve Access to Care</i>	NA	Rating 1: High Confidence	NA	100%
		NA	Rating 2: NA		
Liberty	<i>Increasing the Percentage of Enrollees Receiving Preventive Services</i>	Rating 1: High Confidence	Rating 1: High Confidence	96.77%	97.62%
		Rating 2: Moderate Confidence	Rating 2: High Confidence		
	<i>Improving Utilization Rate of Special Care Enrollees</i>	NA	Rating 1: High Confidence	NA	100%
		NA	Rating 2: NA		
	<i>Access to Care in Rural and Urban Counties</i>	Rating 1: Moderate Confidence	Rating 1: Moderate Confidence	81.81%	82.22%
		Rating 2: Moderate Confidence	Rating 2: High Confidence		
MCNA	<i>Improving Sealant Receipt on Permanent First Molars</i>	NA	Rating 1: High Confidence	NA	100%
		NA	Rating 2: NA		
	<i>Increasing the Number of Special Needs Members Receiving an Annual Dental Visit</i>	NA	Rating 1: High Confidence	NA	100%
		NA	Rating 2: NA		

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Table 9. PIP Performance Comparison					
MCO/DBM	PIP Name	MY 2023 Validation Rating	MY 2024 Validation Rating	MY 2023 Score	MY 2024 Score
	<i>Increasing the Rate of Providers Reporting Member No-shows</i>	NA	Rating 1: High Confidence	NA	100%
		NA	Rating 2: NA		
Simply Healthcare	<i>Screening for Depression and Follow-Up Plan Ages 12 to 17 (CDF-CH)</i>	Rating 1: High Confidence	Rating 1: High Confidence	91.49%	100%
		Rating 2: High Confidence	Rating 1: High Confidence		
	<i>Improving Care Coordination to Improve Follow-up for Children Prescribed ADHD Medication</i>	Rating 1: High Confidence	Rating 1: High Confidence	100%	100%
		Rating 2: High Confidence	Rating 1: Low Confidence		

**Table 10** displays the degree to which the plan addressed the previous year’s recommendations, with a score of high (green) when all recommendations were addressed, medium (yellow) when they were partially addressed, low (red) when they were not addressed, and not applicable when there was no comparison available.

Table 10. MY 2023 Recommendations Addressed in MY 2024			
Plan	Recommendation	Action Taken	Degree to Which Plan Addressed Recommendation(s)
CCP	<b>Step 5:</b> Review the Selected PIP Variables and Performance Measures—The MCO should ensure that it has the correct information reflected in the applicable section of the summary form.	<b>Step 5:</b> CCP had the correct information on its summary form but did not clearly define the benchmark consistently throughout the steps to be reflected in	Medium

Table 10. MY 2023 Recommendations Addressed in MY 2024

Plan	Recommendation	Action Taken	Degree to Which Plan Addressed Recommendation(s)
	<p><b>Step 7:</b> Review the Data Analysis and Interpretation of PIP Results—The MCO should include a discussion assessing the statistical significance of any differences between baseline and the current remeasurement year (Remeasurement 3).</p> <p><b>Step 9:</b> Assess the Likelihood that Significant and Sustained Improvement Occurred—The MCO should ensure the correct and current methodology is presented when noting whether the remeasurement methodology is the same as the baseline methodology.</p>	<p>the applicable section of the summary form.</p> <p><b>Step 7:</b> CCP did not address the inclusion of a discussion assessing the statistical significance of any differences between baseline and the current remeasurement year as they had the same AON for MY 2024.</p> <p><b>Step 9:</b> CCP did not ensure the correct and current methodology for the current measurement year was presented when noting whether the remeasurement methodology is the same as the baseline methodology as they had the same AON for MY 2024.</p>	
	<p><b>Step 2:</b> Review the PIP Aim Statement—The MCO should note the PIP time period as the measurement year that is reflected in the PIP.</p> <p><b>Step 5:</b> Review the Selected PIP Variables and Performance Measures—The MCO should ensure that the correct information is reflected in the applicable section of the summary form.</p> <p><b>Step 6:</b> Review the Data Collection Procedures—The MCO should describe</p>	<p><b>Step 2:</b> CCP did not note the PIP time period as the measurement year that is reflected in the PIP as they had the same AON for MY 2024.</p> <p><b>Step 5:</b> CCP had the correct information on its summary form but did not include the timeframe under review in the performance measure.</p> <p><b>Step 6:</b> CCP addressed all of MY 2023’s AONs for Step 6, but did not give a written description of the process used to determine the degree of completeness.</p>	Medium

Table 10. MY 2023 Recommendations Addressed in MY 2024

Plan	Recommendation	Action Taken	Degree to Which Plan Addressed Recommendation(s)
	<p>the process used to determine the degree of completeness.</p> <p><b>Step 6:</b> Review the Data Collection Procedures—The MCO should clearly specify data sources.</p> <p><b>Step 6:</b> Review the Data Collection Procedures—The MCO should describe qualifications of staff responsible for abstracting data for medical record review.</p> <p><b>Step 6:</b> Review the Data Collection Procedures—The MCO should describe both inter-rater and intra-rater reliability processes in place for medical record review.</p> <p><b>Step 6:</b> Review the Data Collection Procedures—The MCO should include guidelines developed for abstraction staff for medical record review.</p>		
Liberty	<p><b>Step 5:</b> Review the Selected PIP Variables and Performance Measures—The DBM should ensure that all information in each step is updated and define the baseline rate.</p>	<p><b>Step 5:</b> Liberty did not ensure that all information is updated and accurate, particularly for the baseline rate, time period, and benchmark rate, as they had the same AON for MY 2024.</p>	Low
	<p><b>Step 2:</b> Review the PIP Aim Statement—The DBM should include all necessary</p>	<p><b>Step 2:</b> Review the PIP Aim Statement—Liberty included answerable and measurable goals in the PIP aim</p>	Medium

Table 10. MY 2023 Recommendations Addressed in MY 2024

Plan	Recommendation	Action Taken	Degree to Which Plan Addressed Recommendation(s)
	<p>components into one concise PIP aim statement.</p> <p><b>Step 2:</b> Review the PIP Aim Statement—The DBM should include answerable and measurable goals in the PIP aim statement.</p> <p><b>Step 3:</b> Review the Identified PIP Population—The DBM should clearly define the PIP population in the PIP aim statement.</p> <p><b>Step 3:</b> Review the Identified PIP Population—The DBM should also include details (e.g., age, length of enrollment, diagnoses, procedures, and other characteristics) about how they will select eligible enrollees to whom the PIP aim statement applies.</p> <p><b>Step 5:</b> Review the Selected PIP Variables and Performance Measures—The DBM should ensure that all information in each step is updated and define the baseline rate and benchmark.</p>	<p>statement but did not include all required components into one cohesive PIP aim statement to specifically address the population the PIP affects and the time period as they had this same AON for MY 2024.</p> <p><b>Step 3:</b> Review the Identified PIP Population—Liberty did not clearly define the PIP population in the PIP aim statement nor include specific information about the population (e.g., age, length of enrollment, diagnoses, procedures, and other characteristics) as they had the same AON for MY 2024.</p> <p><b>Step 5:</b> Review the Selected PIP Variables and Performance Measures—Liberty did not ensure that all information was defined and updated, specifically the baseline and benchmark rates, as they had the same AON for MY 2024.</p>	

**Table 10. MY 2023 Recommendations Addressed in MY 2024**

Plan	Recommendation	Action Taken	Degree to Which Plan Addressed Recommendation(s)
Simply Healthcare	<p>Step 6: Review the Data Collection Procedures—The MCO should clearly specify data sources.</p> <p>Step 6: Review the Data Collection Procedures—The MCO should describe qualifications of staff responsible for abstracting data for medical record review.</p> <p>Step 6: Review the Data Collection Procedures—The MCO should describe both inter-rater and intra-rater reliability processes in place for medical record review.</p> <p>Step 6: Review the Data Collection Procedures—The MCO should include guidelines developed for abstraction staff for medical record review.</p>	<p>Step 6: Review the Data Collection Procedures—Simply Healthcare did not clearly specify data sources as they had the same AON for MY 2024.</p> <p>Simply Healthcare addressed all other recommendations for MY 2023 in MY 2024.</p>	Medium

## Conclusions and Recommendations

### Aetna

Aetna received a score of 100% (High Confidence) for its clinical PIP *Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH)*. The PIP focused on early identification, and diagnosis of depression through screening for depression at the PCP level, and was in Remeasurement Year 4.

Aetna’s score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with instructions. Aetna’s score of High Confidence for Validation Rating 2 indicated that the PIP achieved statistically significant improvement for all performance measures and interventions resulted in demonstrated improvement. This PIP topic aligned

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with the National Quality Strategy goal and CMS priority of improved health, as early identification, and diagnosis of depression through screening for depression at the PCP level is associated with better health outcomes, the CMS priority of better health by initiating appropriate treatment in coordination with behavioral health care providers and preventing the negative outcomes associated with depression, and the CMS initiative of focusing on child quality improvement. The PIP topic aligned with FHKC's Quality Strategy Goal of Quality: Ensure child-centered standards of health care excellence in all Florida Healthy Kids plans.

Aetna received a score of 100% (High Confidence) for its nonclinical PIP *Timely Follow-up for Patients After They Have Been Hospitalized for Mental Illness – 7-Day (FUH 7-Day)*. The PIP focused on improving follow-up care after hospitalization for mental illness and was in Remeasurement Year 6.

Aetna's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with instructions. Aetna's score of High Confidence for Validation Rating 2 indicated that the PIP achieved statistically significant improvement for all performance measures and interventions resulted in demonstrated improvement. This PIP topic aligned with priority areas identified by the Department of Health and Human Services (HHS) and CMS by addressing improved health outcomes due to timely follow-up care and with the CMS initiative of focusing on child quality improvement. The PIP topic aligned with CMS priority areas of better care for patients

and families, improved health for communities and populations, lower cost through improvement, child and adult quality improvement and prevention, and patient safety. The PIP topic aligned with FHKC's Quality Strategy Goals of Quality: Ensure child-centered standards of health care excellence in all Florida Healthy Kids plans, and Growth: Increase enrollment and retention.

**CCP**

CCP received a score of 88.89% (Moderate Confidence) for its clinical PIP *Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH)*. The PIP focused on engaging adolescents in seeing their pediatricians for well visits, allowing the physician to screen for depression and refer to appropriate behavioral health services for follow-up and was in Remeasurement Year 4.

CCP's score of Moderate Confidence for Validation Rating 1 indicated that the PIP was mostly written in accordance with instructions. CCP's score of High Confidence for Validation Rating 2 indicated that the PIP achieved statistically significant improvement for all performance measures and interventions resulted in demonstrated improvement. This PIP topic aligned with the National Quality Strategy goal and CMS priority of improved health, as early identification, and diagnosis of depression through screening for depression at the PCP level is associated with better health outcomes, the CMS priority of better health by initiating appropriate treatment in coordination with behavioral health care providers and preventing the

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negative outcomes associated with depression, and the CMS initiative of focusing on child quality improvement. The PIP topic aligned with FHKC's Quality Strategy Goal of Quality: Ensure child-centered standards of health care excellence in all Florida Healthy Kids plans.

CCP received a score of 91.67% (High Confidence) for its nonclinical PIP *Follow-up After Hospitalization for Mental Illness – 7 Days*. The PIP focused on increasing access to care and linking enrollees with behavioral, emotional, or developmental issues to providers with the best quality of care and was in Remeasurement Year 2.

CCP's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with instructions. CCP's score of Moderate Confidence for Validation Rating 2 indicated that the PIP achieved statistically or non-statistically significant improvement for at least one measure. This PIP topic aligned with priority areas identified by HHS and CMS by addressing improved health outcomes due to timely follow-up care and with the CMS initiative of focusing on child quality improvement. The PIP topic aligned with CMS priority areas of better care for patients and families, improved health for communities and populations, lower cost through improvement, child and adult quality improvement and prevention, and patient safety. The PIP topic aligned with FHKC's Quality Strategy Goals of Quality: Ensure child-centered standards of health care excellence in all Florida

Healthy Kids plans, and Satisfaction: Fulfill child health care insurance expectations and the needs of families.

**DentaQuest**

DentaQuest received a score of 100% (High Confidence) for its clinical PIP *Preventive Dental*. This PIP focused on preventive care critical to long term oral health for children and was in its initial measurement period.

DentaQuest's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with instructions. DentaQuest's score for Validation Rating 2 was not applicable as the PIP was in its initial measurement period for its baseline year. The PIP focused on the CMS 416 12b measure, PDENT, and was used to assess the effectiveness of the state Early and Periodic Screening, Diagnostic and Treatment (EPSDT) programs. This PIP topic aligned with CMS priorities around child quality improvement and better health. The PIP topic aligned with FHKC's Quality Strategy Goal of Quality: Ensure child-centered standards of health care excellence in all Florida Healthy Kids plans.

DentaQuest received a score of 100% (High Confidence) for its clinical PIP *Improving Preventive Care Dental Visits in Children with Special Healthcare Needs (SHCN)*. This PIP focused on preventive care critical to long term oral health for children and was in its initial measurement period.

DentaQuest's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with

instructions. DentaQuest's score for Validation Rating 2 was not applicable as the PIP was in its initial measurement period for its baseline year. This PIP topic aligned with CMS priorities around child quality improvement and better health. The PIP topic aligned with FHKC's Quality Strategy Goals of Quality: Ensure child-centered standards of health care excellence in all Florida Healthy Kids plans, and Satisfaction: Fulfill child health care insurance expectations and the needs of families.

DentaQuest received a score of 100% (High Confidence) for its nonclinical PIP *Implementing Digital Technology to Improve Access to Care*. The PIP focused on the implementation of digital technology related to its impact on increasing the access and availability of care and improved health outcomes for children with special healthcare needs, and was in its initial measurement period.

DentaQuest's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with instructions. DentaQuest's score for Validation Rating 2 was not applicable as the PIP was in its initial measurement period for its baseline year. This PIP topic aligned with CMS priorities around child quality improvement and better health. The PIP topic aligned with FHKC's Quality Strategy Goals of Satisfaction: Fulfill child health care insurance expectations and the needs of families, and Growth: Increase enrollment and retention.

### **Liberty**

Liberty received a score of 97.62% (High Confidence) for its clinical PIP *Increase the Percentage of Enrollees Receiving Preventive Dental Services*. This PIP focused on preventive dental services for enrollees under 21 years of age who are enrolled in Medicaid or Children's Health Insurance Program (CHIP) Medicaid Expansion programs and are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and was in Remeasurement Year 1.

Liberty's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with instructions. Liberty's score of High Confidence for Validation Rating 2 indicated that the PIP achieved statistically significant improvement for all performance measures and interventions resulted in demonstrated improvement. The PIP focused on the CMS 416 12b measure Preventive Dental Services (PDENT) and was used to assess the effectiveness of the state EPSDT programs. This PIP topic aligned with CMS priorities around child quality improvement and better health. The PIP topic aligned with FHKC's Quality Strategy Goals of Quality: Ensure child-centered standards of health care excellence in all Florida Healthy Kids plans, and Satisfaction: Fulfill child health care insurance expectations and the needs of families.

Liberty received a score of 100% (High Confidence) for its clinical PIP *Improving Utilization Rate of Special Care Enrollees*. This PIP focused on improving the overall utilization

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rate of Sealant CMS-416 of enrollees under 21 years of age who have special needs and was in its initial measurement period.

Liberty's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with instructions. Liberty's score for Validation Rating 2 was not applicable as the PIP was in its initial measurement period for its baseline year. This PIP topic aligned with CMS priorities around child quality improvement and better health. The PIP topic aligned with FHKC's Quality Strategy Goals of Quality: Ensure child-centered standards of health care excellence in all Florida Healthy Kids plans, and Satisfaction: Fulfill child health care insurance expectations and the needs of families.

Liberty received a score of 82.22% (Moderate Confidence) for its nonclinical PIP *Access to Care in Rural and Urban Counties*. The PIP focused on improving enrollee access to necessary dental care: primary dental providers (PDPs), specialists, or orthodontists within adequate distance of their place of residence and was in Remeasurement Year 1.

Liberty's score of Moderate Confidence for Validation Rating 1 indicated that the PIP was mostly written in accordance with instructions. Liberty's score of High Confidence for Validation Rating 2 indicated that the PIP achieved statistically significant improvement for all performance measures and interventions resulted in demonstrated improvement. This PIP topic aligned with the National Quality Strategy to improve health for communities, CMS's priority of better health and CMS's

initiative to improve health oral health. The PIP topic aligned with FHKC's Quality Strategy Goal of Growth: Increase enrollment and retention.

**MCNA**

MCNA received a score of 100% (High Confidence) for its clinical PIP *Improving Sealant Receipt on Permanent First Molars*. This PIP focused on improving sealant receipt on permanent first molars by the enrollee's 10th birthday and was in its initial measurement period.

MCNA's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with instructions. MCNA's score for Validation Rating 2 was not applicable as the PIP was in its initial measurement period for its baseline year. This PIP topic aligned with CMS priorities around child quality improvement and better health. The PIP topic aligned with FHKC's Quality Strategy Goal of Quality: Ensure child-centered standards of health care excellence in all Florida Healthy Kids plans.

MCNA received a score of 100% (High Confidence) for its nonclinical PIP *Increasing the Number of Special Needs Members Receiving an Annual Dental Visit*. The PIP focused on increasing the rate of all special needs enrollees who are receiving an annual dental visit, and was in its initial measurement period.

MCNA's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with

instructions. MCNA's score for Validation Rating 2 was not applicable as the PIP was in its initial measurement period for its baseline year. The PIP topic aligned with the three aims of the National Quality Strategy to improve health and CMS's initiatives of prevention and to improve oral health. The PIP topic aligned with FHKC's Quality Strategy Goals of Quality: Ensure child-centered standards of health care excellence in all Florida Healthy Kids plans, and Satisfaction: Fulfill child health care insurance expectations and the needs of families.

MCNA received a score of 100% (High Confidence) for its nonclinical PIP *Increasing the Rate of Providers Reporting Member No-shows*. The PIP focused on increasing the rate of providers reporting when a enrollee has missed a dental appointment using a Current Dental Terminology (CDT) code, and was in its initial measurement period.

MCNA's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with instructions. MCNA's score for Validation Rating 2 was not applicable as the PIP was in its initial measurement period for its baseline year. The PIP topic aligned with the three aims of the National Quality Strategy to improve health and CMS's initiatives of prevention and to improve oral health. The PIP topic aligned with FHKC's Quality Strategy Goal of Satisfaction: Fulfill child health care insurance expectations and the needs of families.

### **Simply Healthcare**

Simply Healthcare received a score of 100% (High Confidence) for its clinical PIP *Screening for Depression and Follow-Up Plan Ages 12 to 17 (CDF-CH)*. The PIP focused on improving the percentage of beneficiaries ages 12 to 17 screened for depression using an age-appropriate standardized depression screening tool and subsequent follow-up, and was in Remeasurement Year 5.

Simply Healthcare's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with instructions. Simply Healthcare's score of High Confidence for Validation Rating 2 indicated that the PIP achieved statistically significant improvement for all performance measures and interventions resulted in demonstrated improvement. This PIP topic aligned with the National Quality Strategy goal and CMS priority of improved health, as early identification, and diagnosis of depression through screening for depression at the PCP level is associated with better health outcomes, the CMS priority of better health by initiating appropriate treatment in coordination with behavioral health care providers and preventing the negative outcomes associated with depression, and the CMS initiative of focusing on child quality improvement. The PIP topic aligned with FHKC's Quality Strategy Goal of Quality:

Ensure child-centered standards of health care excellence in all Florida Healthy Kids plans.

Simply Healthcare received a score of 100% (High Confidence) for its nonclinical PIP *Improving Care Coordination to Improve Follow-up for Children Prescribed ADHD Medication*. The PIP focused on improving care coordination and improving follow-up for children prescribed medication for attention deficit hyperactivity disorder (ADHD) and was in Remeasurement Year 6.

Simply Healthcare's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with

instructions. Simply Healthcare's score of Low Confidence for Validation Rating 2 indicated that the PIP did not demonstrate statistically or non-statistically significant improvement and/or none of the interventions resulted in demonstrated improvement. This PIP topic aligned with priority areas identified by HHS and CMS by addressing improved health outcomes due to timely follow-up care and with the CMS initiative of focusing on child quality improvement. The PIP topic aligned with high priority areas identified by HHS and CMS by addressing child quality improvement and better care for patients and families. The PIP topic aligned with FHKC's Quality Strategy Goal of Quality: Ensure child-centered standards of health care excellence in all Florida Healthy Kids plans.

## Performance Measure Validation (PMV)

### Objectives

The Balanced Budget Act of 1997 established certain managed care quality safeguards that were further described by Title 42 of the Code of Federal Regulations, Section 438.320 (42 CFR § 438.320), which defines "external quality review" as the "analysis and evaluation ... of aggregated information on quality, timeliness, and access to health care services." To satisfy CMS Protocols for the plans and to meet the requirements set forth in 42 CFR § 438.330(c), FHKC selected a process for an objective, comparative review of performance measures related to quality-of-care outcomes. The primary aim of PMV is to evaluate the accuracy of MCO and DBM-reported

performance measures and to determine whether those measures were calculated according to required technical specifications. To satisfy CMS protocol for MCOs/DBMs and to meet the requirements set forth in 42 CFR § 438.330(c), as incorporated by 42 CFR § 457.1250, FHKC selected a process for an objective, comparative review of quality measures.

The PMV included validation of performance measures for the plans providing care services for enrollees. The measurement year for this validation was January 1, 2024, through December 31, 2024 (MY 2024).

The 2025 PMV, which validates performance measures for MY 2024, was conducted virtually. The validation activities for these measures were conducted as outlined in Centers for Medicare & Medicaid Services' *EQR Protocol 2: Validation of Performance Measures (February 2023)*. Per the protocol, the plans should complete an Information Systems Capabilities Assessment Tool (ISCAT) that the EQRO uses to validate information systems, processes, and data. Protocol guidance indicates that the EQRO may review results from a recent comprehensive, independent assessment of the plan's information systems, such as the HEDIS Compliance Audit, conducted in the previous two years provided that the HEDIS measures were calculated using National Committee for Quality Assurance HEDIS-certified software and all non-HEDIS rates were included under the scope of the HEDIS audit.

## Description of Performance Measures Data Obtained for Validation

FHKC identified for validation 19 HEDIS<sup>®</sup> measures, defined by the National Committee for Quality Assurance (NCQA) and validated through an NCQA HEDIS Compliance Audit<sup>™</sup>; one CMS measure, two U.S. Office of Population Affairs (OPA) measures to be calculated and reported by the contracted MCOs. Of the 22 total measures included in the 2025 PMV, 15 were part of the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set). Audited measures and their technical descriptions for the MCOs are provided in [Appendix B](#).

Each of the MCOs underwent a full NCQA HEDIS Compliance Audit by an NCQA-certified HEDIS auditor, including completion of a HEDIS Record of Administrative Data Management and Processes (Roadmap), validation of performance measure rates, submission of rates to NCQA through the Interactive Data Submission System (IDSS), and the production of a Final Audit Report (FAR). The five non-HEDIS measures required to be reported by FHKC in 2025 were all included under the scope of the formal HEDIS audit. All HEDIS and non-HEDIS measures were validated via inclusion in the scope of the MCOs' HEDIS Audits. CMS's *Protocol 2: Validation of Performance Measures (2023)* outlines activities for validation of performance measures. The HEDIS Compliance Audit information is recorded in each MCO's Information Systems Capability Assessment Tool (ISCAT). Per the protocol, if the MCO recently had a comprehensive, independent assessment of its information systems, the EQRO may review those results. All FHKC's MCOs used NCQA HEDIS-certified software for performance measure calculation. As a result of the MCOs' successful completion of the HEDIS audit process, onsite audits, and source code review (also components of the protocol) by Qsource were not necessary.

Based on all validation activities, results were determined for each performance measure. For the MCOs, NCQA's HEDIS Compliance Audit protocol was followed, and an Information Systems Capabilities Assessment Tool (ISCAT) was completed, for the EQRO to validate MCO information systems, processes,

and data. For the 2025 PMV, this entailed a report of preliminary findings; a review of the final rates; and the production of a final report stating whether the MCO had a Reportable Rate (R), Biased Rate (BR), or Small Denominator (NA).

## Technical Methods of Data Collection and Analysis

### Pre-Review Strategy

Virtual Systems Review is performed for DBMs, as they do not go through a systems audit. Qsource customized the ISCAT for the Florida Healthy Kids program from Appendix V, Attachment A of the CMS EQR protocols published in 2023. Qsource provided the modified version of the ISCAT to the DBMs, along with a timetable for completion and instructions for submission. In addition to the ISCAT, Qsource requested source code for the CMS-416 measures and the HEDIS ADV measure. Any questions from the plan were answered by Qsource during the pre-virtual-review phase.

FHKC identified 10 dental performance measures to be calculated and reported by the contracted DBMs. Six of these were CMS-416 dental service measures, three were CMS Core Set Measures, and the last was a measure that has been retired from HEDIS. Audited measures and their technical descriptions for the DBMs are provided in [Appendix B](#).

Qsource followed EQR Protocol 2, which identifies key data sources that should be reviewed as part of the validation process:

- ◆ **ISCATs:** Completed ISCATs received from the DBMs were reviewed to ensure all sections were complete and all attachments were available. The validation team reviewed all ISCAT documents, noting issues or items needing follow-up.
- ◆ **Source Code (Programming Language) for Performance Measures:** The validation team completed line-by-line code review and observation of program logic flow to ensure compliance with measure technical specifications. Areas of deviation were identified to evaluate the impact of the deviation on the measure and assess the degree of bias.
- ◆ **Performance Measure Reports:** Qsource reviewed calculated rates for the current measurement period.
- ◆ **Supportive Documentation:** Qsource reviewed additional information to complete the validation process, including, but not limited to, policies and procedures (P&Ps), file layouts, system flow diagrams, system log files, and data collection process descriptions. Issues or areas needing clarification were flagged for follow-up and clarification during the virtual review.

For the DBMs, validation included the following basic steps:

- ◆ **Pre-Review Activities:** In addition to scheduling the virtual reviews and developing the agenda, the team prepared a data collection tool based on established validation protocols. The validation team conducted a review of the ISCAT and supportive documentation, including an evaluation of processes used for collecting, storing, validating, and reporting the performance measure data.

### Performance Measure Validation

- ◆ **Reviews:** The virtual review lasted one day and included the following:
  - **Opening Session:** The validation team and key DBM staff involved in performance measure activities introduced themselves and discussed the purpose of the review, required documentation, meeting logistics, and queries to be performed.
  - **Claims and Encounter System Review:** The validation team reviewed information systems and staff resources utilized for the processing of dental claims and encounter data.
  - **Enrollment Systems Review:** The validation team reviewed information systems and staff resources utilized for the processing of enrollment data.
  - **Provider Credentialing/Contracting Data System:** The validation team reviewed credentialing systems and processes and provider data storage systems and processes.
  - **Data Integration and Primary Source Review:** The validation team reviewed the procedures and supporting documentation for integrating all required data sources to produce the analytic file structures required for reporting of selected measures through the DBM or vendor source code. In addition, the

team also performed primary source review to further validate the output files against the data source systems. Finally, the session also addressed reviewed data control and security procedures to ensure data integrity.

- **Closing Session:** The validation team presented the DBM with preliminary findings based on review of the ISCAT and virtual sessions, along with a summary of documentation requirements for post-virtual-review activities.

### Description of Data Obtained

[Table 11](#) lists the audited measures for MCOs, and [Table 12](#) lists the audited measures for DBMs. Age stratifications that do not apply to the Florida Healthy Kids population (ages 5–18 years) have been omitted. In the case that a measure had an overlapping age stratification that does apply to Florida Healthy Kids enrollees, data for that category was reported. However, due to enrollment data aberrations, total rates reported for measures that include overlapping age stratifications may include a minimal number of enrollees outside the Florida Healthy Kids population age range of 5–18 years. Measures are organized by categories of care defined by FHKC and based on the CMS Child Core Set categories. They are labeled according to the aspect of care they assess: quality, timeliness, or access.

Table 11. 2025 PMV: MCO Performance Measures

Quality	Timeliness	Access	Measure
<b>Primary Care Access and Preventive Care</b>			
✓	✓	✓	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)
✓	✓		Chlamydia Screening in Women Ages 16–20 (CHL-CH)
✓	✓	✓	Immunizations for Adolescents (IMA-CH)
✓	✓	✓	Child and Adolescent Well-Care Visits (WCV-CH)
<b>Maternal and Perinatal Health</b>			
✓	✓	✓	Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)
✓	✓	✓	Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)
✓	✓	✓	Prenatal and Postpartum Care: Under Age 21 (PPC2-CH)
<b>Care of Acute and Chronic Conditions</b>			
✓	✓		Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years (AAB-CH)
✓	✓	✓	Asthma Medication Ratio: Ages 5–18 (AMR-CH)
✓	✓		Appropriate Testing for Children with Pharyngitis (CWP)
✓	✓		Appropriate Treatment for Children with Upper Respiratory Infection (URI)
✓	✓		Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)
<b>Behavioral Healthcare</b>			
✓	✓		Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)

**Table 11. 2025 PMV: MCO Performance Measures**

<b>Quality</b>	<b>Timeliness</b>	<b>Access</b>	<b>Measure</b>
✓	✓		Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)
✓	✓	✓	Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)
✓	✓		Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH)
✓	✓	✓	Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17 (FUA-CH)
✓		✓	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
✓	✓		Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)
✓	✓	✓	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
✓	✓		Diagnosed Substance-Related Disorders (DSU)
✓	✓		Diagnosed Mental Health Disorders (DMH)*
<b>Experience of Care</b>			
✓			Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.1H, Child Version (CPC)

\* The former MPT measure was replaced by the DMH measure.

**Table 12. 2025 PMV: DBM Performance Measures**

Quality	Timeliness	Access	Measure
✓	✓	✓	Enrolled Children Receiving Dental Sealants on Permanent Molars – With Exclusions (SEA: With Exclusions)
✓	✓	✓	Enrolled Children Receiving Preventive Dental Services (PDENT)
✓	✓	✓	Enrolled Children Receiving Any Dental Services
✓	✓	✓	Enrolled Children Receiving Dental Treatment Services (TDENT)
✓	✓	✓	Enrolled Children Receiving Diagnostic Dental Services
✓	✓	✓	Enrolled Children Receiving Any Preventive Dental or Oral Health Service
✓	✓	✓	Annual Dental Visit (ADV)
✓	✓	✓	Oral Evaluation, Dental Services (OEV-CH)
✓	✓	✓	Topical Fluoride for Children (TFL-CH)
✓	✓	✓	Sealant Receipt on Permanent First Molars (SFM-CH)

## Comparative Findings

Trending analysis is included where possible from the 2024 PMV to the 2025 PMV. To better identify trends for these rates, the use of green and red is used to indicate this year's result for each measure as compared to results from 2024. [Table 13](#) and [Table 14](#) indicate an increase (green), decrease (red), or no change from the previous year's rate.

Compared to MY 2023, all MCOs and DBMs saw an increase in the total stratifications being reported. For the MCOs, Aetna was noted to have the most improvements with 40 rates trending positively in MY 2024. CCP had 24 rates trend positively in MY 2024, and Simply Healthcare had 35 rates trend positively.

CCP was also noted to have four rates with significant (>10.00%) improvement between MY 2023 to MY 2024, and

## Performance Measure Validation

Simply Healthcare having four rates improve significantly, the most among the MCOs, with Aetna having two rates improve significantly. CCP showed less rates trending down (29) compared to Aetna and Simply Healthcare during the same time; Aetna reported 34 rates trending down while Simply Healthcare reported 39 rates trending down for MY 2024.

For the DBMs, MCNA had the most improvements for MY 2024 with a total of 116 rates improving from MY 2023, while

15 rates declined. DentaQuest improved performance in 60 rates while 60 declined. Liberty improved performance in 34 rates, while declining in nine.

DentaQuest was also noted to have 15 rates with significant (>10.00%) improvement between MY 2023 to MY 2024, the most among the DBMs, with Liberty having five rates improve significantly and MCNA having seven rates improve significantly.

**Table 13. 2024 and 2025 PMV Measure Results: MCOs**

Measure	Aetna		CCP		Simply Healthcare	
	2024	2025	2024	2025	2024	2025
<b>Primary Care Access and Preventive Care</b>						
<b>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)</b>						
Body Mass Index (BMI) Percentile: 3–11 Years	85.86%	81.44%	84.91%	83.04%	86.96%	90.32%
BMI Percentile: 12–17 Years	89.67%	81.28%	84.42%	83.59%	89.87%	93.30%
BMI Percentile: Total	87.83%	81.36%	84.67%	83.29%	88.56%	91.73%
Nutrition Counseling: 3-11 Years	83.84%	73.26%	76.42%	78.03%	84.24%	82.00%
Nutrition Counseling: 12-17 Years	84.04%	74.08%	80.40%	78.62%	85.46%	87.00%
Nutrition Counseling: Total	83.94%	73.69%	78.35%	78.30%	84.91%	84.00%
Physical Activity Counseling: 3-11 Years	82.32%	72.23%	75.94%	75.76%	83.15%	79.26%
Physical Activity Counseling: 12-17 Years	84.04%	73.64%	79.90%	76.96%	84.14%	85.05%
Physical Activity Counseling: Total	83.21%	72.98%	77.86%	76.32%	83.70%	82.00%
<b>Chlamydia Screening in Women (CHL-CH)</b>						
16–20 Years	54.28%	57.44%	55.56%	70.37%	58.33%	57.24%

**Table 13. 2024 and 2025 PMV Measure Results: MCOs**

Measure	Aetna		CCP		Simply Healthcare	
	2024	2025	2024	2025	2024	2025
<b>Immunizations for Adolescents (IMA-CH)</b>						
<b>Meningococcal</b>	77.01%	77.52%	85.40%	83.95%	76.40%	76.89%
<b>Meningococcal (by Race/Ethnicity)</b>						
American Indian or Alaska Native alone or in combination	NS	66.67%	NS	100%	NS	0.00%
Asian alone or in combination	NS	82.80%	NS	66.67%	NS	0.00%
Black or African American or in combination	NS	84.58%	NS	90.79%	NS	77.42%
Hispanic or Latino alone or in combination	NS	85.60%	NS	84.44%	NS	82.61%
Middle Eastern or North African alone or in combination	NS	0.00%	NS	0.00%	NS	0.00%
Native Hawaiian or Other Pacific Islander alone or in combination	NS	0.00%	NS	0.00%	NS	100%
White alone or in combination	NS	69.51%	NS	83.71%	NS	73.63%
Missing or Not Reported	NS	78.35%	NS	2.25%	NS	77.74%
<b>Meningococcal (by Sex)</b>						
Male	NS	77.83%	NS	85.16%	NS	77.60%
Female	NS	77.20%	NS	82.17%	NS	76.26%
Missing or Not Reported	NS	0.00%	NS	0.00%	NS	0.00%
<b>Meningococcal (by Geography)</b>						
Urban	NS	77.85%	NS	83.76%	NS	77.06%
Rural	NS	67.47%	NS	83.33%	NS	70.00%
Missing or Not Reported	NS	0.00%	NS	0.00%	NS	0.00%

**Table 13. 2024 and 2025 PMV Measure Results: MCOs**

Measure	Aetna		CCP		Simply Healthcare	
	2024	2025	2024	2025	2024	2025
<b>Tdap (Tetanus, diphtheria, and pertussis)</b>	92.83%	91.62%	95.13%	94.44%	87.10%	88.08%
Tdap (by Race/Ethnicity)						
American Indian or Alaska Native alone or in combination	NS	66.67%	NS	100%	NS	0.00%
Asian alone or in combination	NS	93.55%	NS	100%	NS	0.00%
Black or African American or in combination	NS	96.67%	NS	97.37%	NS	96.77%
Hispanic or Latino alone or in combination	NS	94.74%	NS	94.55%	NS	91.30%
Middle Eastern or North African alone or in combination	NS	0.00%	NS	0.00%	NS	0.00%
Native Hawaiian or Other Pacific Islander alone or in combination	NS	100%	NS	0.00%	NS	100%
White alone or in combination	NS	88.39%	NS	91.86%	NS	89.01%
Missing or Not Reported	NS	90.72%	NS	95.48%	NS	86.93%
Tdap (by Sex)						
Male	NS	91.13%	NS	94.14%	NS	87.50%
Female	NS	92.14%	NS	94.35%	NS	88.58%
Missing or Not Reported	NS	0.00%	NS	0.00%	NS	0.00%
Tdap (by Geography)						
Urban	NS	91.74%	NS	94.02%	NS	88.28%
Rural	NS	87.95%	NS	100%	NS	80.00%
Missing or Not Reported	NS	0.00%	NS	0.00%	NS	0.00%
<b>HPV</b>	38.80%	38.71%	37.96%	41.15%	38.93%	41.12%

**Table 13. 2024 and 2025 PMV Measure Results: MCOs**

Measure	Aetna		CCP		Simply Healthcare	
	2024	2025	2024	2025	2024	2025
<b>HPV (by Race/Ethnicity)</b>						
American Indian or Alaska Native alone or in combination	NS	33.33%	NR	100%	NR	0.00%
Asian alone or in combination	NS	46.24%	NS	77.78%	NS	0.00%
Black or African American or in combination	NS	45.42%	NS	50.00%	NS	35.48%
Hispanic or Latino alone or in combination	NS	45.03%	NS	40.86%	NS	36.52%
Middle Eastern or North African alone or in combination	NS	0.00%	NS	0.00%	NS	0.00%
Native Hawaiian or Other Pacific Islander alone or in combination	NS	0.00%	NS	0.00%	NS	80.00%
White alone or in combination	NS	30.74%	NS	34.84%	NS	39.56%
Missing or Not Reported	NS	43.99%	NS	42.94%	NS	41.70%
<b>HPV (by Sex)</b>						
Male	NS	38.01%	NS	40.63%	NS	37.50%
Female	NS	39.45%	NS	41.74%	NS	44.29%
Missing or Not Reported	NS	0.00%	NS	0.00%	NS	0.00%
<b>HPV (by Geography)</b>						
Urban	NS	38.67%	NS	41.88%	NS	40.90%
Rural	NS	39.76%	NS	22.22%	NS	50.00%
Missing or Not Reported	NS	0.00%	NS	0.00%	NS	0.00%
<b>Combination #1 (Meningococcal and Tdap)</b>	76.90%	77.15%	85.16%	83.95%	75.67%	76.40%
<b>Combination #1 (Meningococcal and Tdap) (by Race/Ethnicity)</b>						
American Indian or Alaska Native alone or in combination	NS	66.67%	NS	100%	NS	0.00%

**Table 13. 2024 and 2025 PMV Measure Results: MCOs**

Measure	Aetna		CCP		Simply Healthcare	
	2024	2025	2024	2025	2024	2025
Asian alone or in combination	NS	81.72%	NS	66.67%	NS	0.00%
Black or African American or in combination	NS	84.58%	NS	90.79%	NS	77.42%
Hispanic or Latino alone or in combination	NS	85.37%	NS	84.44%	NS	82.61%
Middle Eastern or North African alone or in combination	NS	0.00%	NS	0.00%	NS	0.00%
Native Hawaiian or Other Pacific Islander alone or in combination	NS	0.00%	NS	0.00%	NS	100%
White alone or in combination	NS	69.09%	NS	83.71%	NS	73.63%
Missing or Not Reported	NS	77.66%	NS	81.36%	NS	77.03%
<b>Combination #1 (Meningococcal and Tdap) (by Sex)</b>						
Male	NS	77.40%	NS	85.16%	NS	77.08%
Female	NS	76.89%	NS	82.17%	NS	75.80%
Missing or Not Reported	NS	0.00%	NS	0.00%	NS	0.00%
<b>Combination #1 (Meningococcal and Tdap) by Geography)</b>						
Urban	NS	77.46%	NS	83.76%	NS	76.56%
Rural	NS	67.47%	NS	83.33%	NS	70.00%
Missing or Not Reported	NS	0.00%	NS	0.00%	NS	0.00%
<b>Combination #2 (Meningococcal, Tdap, and HPV)</b>	37.21%	37.36%	37.47%	39.30%	38.20%	40.15%
<b>Combination #2 (Meningococcal, Tdap, and HPV) (by Race/Ethnicity)</b>						
American Indian or Alaska Native alone or in combination	NS	33.33%	NS	100%	NS	0.00%
Asian alone or in combination	NS	45.16%	NS	55.56%	NS	0.00%
Black or African American or in combination	NS	44.17%	NS	47.37%	NS	32.26%

**Table 13. 2024 and 2025 PMV Measure Results: MCOs**

Measure	Aetna		CCP		Simply Healthcare	
	2024	2025	2024	2025	2024	2025
Hispanic or Latino alone or in combination	NS	43.66%	NS	39.30%	NS	35.65%
Middle Eastern or North African alone or in combination	NS	0.00%	NS	0.00%	NS	0.00%
Native Hawaiian or Other Pacific Islander alone or in combination	NS	0.00%	NS	0.00%	NS	80.00%
White alone or in combination	NS	29.46%	NS	34.39%	NS	39.56%
Missing or Not Reported	NS	42.27%	NS	40.68%	NS	40.64%
<b>Combination #2 (Meningococcal, Tdap, and HPV) (by Sex)</b>						
Male	NS	36.85%	NS	39.45%	NS	36.46%
Female	NS	37.90%	NS	39.13%	NS	43.38%
Missing or Not Reported	NS	0.00%	NS	0.00%	NS	0.00%
<b>Combination #2 (Meningococcal, Tdap, and HPV) (by Geography)</b>						
Urban	NS	37.36%	NS	39.96%	NS	39.90%
Rural	NS	37.35%	NS	22.22%	NS	50.00%
Missing or Not Reported	NS	0.00%	NS	0.00%	NS	0.00%
<b>Child and Adolescent Well-Care Visits (WCV-CH)</b>						
<b>Child and Adolescent Well-Care Visits (WCV-CH) (by Age)</b>						
3 to 11 Years	NS	70.47%	NS	74.95%	NS	70.54%
12 to 17 Years	NS	68.97%	NS	71.31%	NS	69.14%
18 to 21 Years	NS	53.15%	NS	60.13%	NS	54.02%
Total (Ages 3-21)	NS	68.36%	NS	72.38%	NS	68.64%
<b>Child and Adolescent Well-Care Visits (WCV-CH) (by Race/Ethnicity, 2024 stratifications)</b>						
White	62.74%	NR	68.12%	NR	66.72%	NR
Black or African American	70.68%	NR	68.30%	NR	69.97%	NR

**Table 13. 2024 and 2025 PMV Measure Results: MCOs**

Measure	Aetna		CCP		Simply Healthcare	
	2024	2025	2024	2025	2024	2025
American Indian or Alaska Native	61.11%	NR	NA	NR	57.14%	NR
Asian	71.84%	NR	75.41%	NR	NA	NR
Native Hawaiian or Other Pacific Islander	NA	NR	NA	NR	69.43%	NR
Some Other Race	82.28%	NR	75.00%	NR	75.64%	NR
Two or More Races	NA	NR	62.86%	NR	NA	NR
Asked But No Answer	NA	NR	69.98%	NR	71.41%	NR
Unknown	69.72%	NR	NA	NR	71.18%	NR
<b>Child and Adolescent Well-Care Visits (WCV-CH) (by Race/Ethnicity, 2025 stratifications)</b>						
American Indian or Alaska Native alone or in combination	NS	50.00%	NS	0.82%	NS	62.88%
Asian alone or in combination	NS	69.76%	NS	81.82%	NS	0.00%
Black or African American or in combination	NS	70.19%	NS	75.70%	NS	70.58%
Hispanic or Latino alone or in combination	NS	72.37%	NS	71.29%	NS	69.34%
Middle Eastern or North African alone or in combination	NS	0.00%	NS	0.00%	NS	0.00%
Native Hawaiian or Other Pacific Islander alone or in combination	NS	100%	NS	0.00%	NS	67.10%
White alone or in combination	NS	65.11%	NS	73.50%	NS	66.11%
Missing or Not Reported	NS	68.44%	NS	69.46%	NS	69.34%
<b>Child and Adolescent Well-Care Visits (WCV-CH) (by Sex)</b>						
Male	NS	68.36%	NS	71.92%	NS	68.46%
Female	NS	68.48%	NS	72.86%	NS	68.82%
Missing or Not Reported	NS	0.00%	NS	0.00%	NS	0.00%
<b>Child and Adolescent Well-Care Visits (WCV-CH) (by Geography)</b>						
Urban	NS	68.60%	NS	73.00%	NS	68.93%
Rural	NS	59.69%	NS	56.00%	NS	55.89%

**Table 13. 2024 and 2025 PMV Measure Results: MCOs**

Measure	Aetna		CCP		Simply Healthcare	
	2024	2025	2024	2025	2024	2025
Missing or Not Reported	NS	0.00%	NS	0.00%	NS	0.00%
<b>Maternal and Perinatal Health</b>						
<b>Contraceptive Care – Postpartum Women Ages 15–20 (CCP-CH)</b>						
Most or moderately effective contraception – 3 days	NA	33.33%	NA	NA	NA	0.00%
Most or moderately effective contraception – 60 days	NA	33.33%	NA	NA	NA	75.00%
Long-acting reversible method of contraception (LARC) – 3 days	NA	33.33%	NA	NA	NA	0.00%
LARC – 60 days	NA	33.33%	NA	NA	NA	25.00%
<b>Contraceptive Care – All Women Ages 15–20 (CCW-CH)</b>						
Most effective or moderately effective method of contraception	15.47%	14.65%	10.01%	8.56%	14.38%	14.24%
LARC	1.15%	0.94%	0.77%	0.20%	1.22%	1.11%
<b>Prenatal and Postpartum Care: Under Age 21 (PPC2-CH)</b>						
<b>Timeliness of Prenatal Care</b>	NA	NA	NA	NA	NA	NA
<b>Timeliness of Prenatal Care (by Race/Ethnicity)</b>						
American Indian or Alaska Native alone or in combination	NS	NA	NS	NA	NS	NA
Asian alone or in combination	NS	NA	NS	NA	NS	NA
Black or African American or in combination	NS	NA	NS	NA	NS	NA
Hispanic or Latino alone or in combination	NS	NA	NS	NA	NS	NA
Middle Eastern or North African alone or in combination	NS	NA	NS	NA	NS	NA
Native Hawaiian or Other Pacific Islander alone or in combination	NS	NA	NS	NA	NS	NA
White alone or in combination	NS	NA	NS	NA	NS	NA
Missing or Not Reported	NS	NA	NS	NA	NS	NA

**Table 13. 2024 and 2025 PMV Measure Results: MCOs**

Measure	Aetna		CCP		Simply Healthcare	
	2024	2025	2024	2025	2024	2025
Timeliness of Prenatal Care (by Sex)						
Male	NS	NA	NS	NA	NS	NA
Female	NS	NA	NS	NA	NS	NA
Missing or Not Reported	NS	NA	NS	NA	NS	NA
Timeliness of Prenatal Care (by Geography)						
Urban	NS	NA	NS	NA	NS	NA
Rural	NS	NA	NS	NA	NS	NA
Missing or Not Reported	NS	NA	NS	NA	NS	NA
Postpartum Care	NA	NA	NA	NA	NA	NA
Postpartum Care (by Race/Ethnicity)						
American Indian or Alaska Native alone or in combination	NS	NA	NS	NA	NS	NA
Asian alone or in combination	NS	NA	NS	NA	NS	NA
Black or African American or in combination	NS	NA	NS	NA	NS	NA
Hispanic or Latino alone or in combination	NS	NA	NS	NA	NS	NA
Middle Eastern or North African alone or in combination	NS	NA	NS	NA	NS	NA
Native Hawaiian or Other Pacific Islander alone or in combination	NS	NA	NS	NA	NS	NA
White alone or in combination	NS	NA	NS	NA	NS	NA
Missing or Not Reported	NS	NA	NS	NA	NS	NA
Postpartum Care (by Sex)						
Male	NS	NA	NS	NA	NS	NA
Female	NS	NA	NS	NA	NS	NA
Missing or Not Reported	NS	NA	NS	NA	NS	NA
Postpartum Care (by Geography)						
Urban	NS	NA	NS	NA	NS	NA
Rural	NS	NA	NS	NA	NS	NA
Missing or Not Reported	NS	NA	NS	NA	NS	NA

**Table 13. 2024 and 2025 PMV Measure Results: MCOs**

Measure	Aetna		CCP		Simply Healthcare	
	2024	2025	2024	2025	2024	2025
<b>Care of Acute and Chronic Conditions</b>						
<b>Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB-CH)</b>						
3 months–17 years	42.36%	39.40%	41.01%	64.55%	37.86%	38.17%
<b>Asthma Medication Ratio: Ages 5-18 (AMR-CH)</b>						
5–11 Years	75.50%	75.34%	90.70%	77.14%	73.80%	68.81%
12–18 Years	67.74%	63.03%	NA	81.82%	65.78%	60.48%
Total (5-18 Years)	NS	68.81%	NS	78.95%	NS	65.04%
<b>Asthma Medication Ratio: Ages 5-18 (AMR-CH) (by Race/Ethnicity)</b>						
American Indian or Alaska Native alone or in combination	NS	100%	NS	0.00%	NS	50.00%
Asian alone or in combination	NS	100%	NS	100%	NS	0.00%
Black or African American or in combination	NS	60.00%	NS	100%	NS	62.07%
Hispanic or Latino alone or in combination	NS	69.09%	NS	80.00%	NS	64.95%
Middle Eastern or North African alone or in combination	NS	0.00%	NS	0.00%	NS	0.00%
Native Hawaiian or Other Pacific Islander alone or in combination	NS	0.00%	NS	0.00%	NS	60.00%
White alone or in combination	NS	70.08%	NS	71.43%	NS	63.01%
Missing or Not Reported	NS	67.65%	NS	85.71%	NS	66.15%
<b>Asthma Medication Ratio: Ages 5-18 (AMR-CH) (by Sex)</b>						
Male	NS	70.63%	NS	72.73%	NS	63.21%
Female	NS	66.89%	NS	87.50%	NS	67.52%
Missing or Not Reported	NS	0.00%	NS	0.00%	NS	0.00%
<b>Asthma Medication Ratio: Ages 5-18 (AMR-CH) (by Geography)</b>						
Urban	NS	68.30%	NS	78.95%	NS	64.54%
Rural	NS	100%	NS	0.00%	NS	87.50%
Missing or Not Reported	NS	0.00%	NS	0.00%	NS	0.00%
<b>Appropriate Testing for Children with Pharyngitis (CWP)</b>						
3–17 Years	85.07%	86.18%	80.13%	86.41%	85.08%	81.73%

**Table 13. 2024 and 2025 PMV Measure Results: MCOs**

Measure	Aetna		CCP		Simply Healthcare	
	2024	2025	2024	2025	2024	2025
18–64 Years	80.65%	83.13%	NA	77.78%	79.05%	78.08%
Total	84.92%	86.10%	80.19%	86.26%	84.94%	81.64%
<b>Appropriate Treatment for Children with Upper Respiratory Infection (URI)</b>						
3 Months – 17 Years	90.91%	90.39%	92.31%	88.87%	91.07%	90.08%
18–64 Years	85.56%	85.44%	83.33%	82.98%	82.09%	85.64%
Total	90.76%	90.25%	92.12%	88.73%	90.88%	89.98%
<b>Ambulatory Care: Emergency Department Visits (AMB-CH) – Visits / 1,000 Enrollee Months</b>						
1–9 Years	384.81	378.55	334.60	25.79	398.78	383.29
10–19 Years	304.41	314.70	230.54	19.11	307.28	317.07
Total	NR	335.17	NR	21.64	NR	338.88
<b>Behavioral Healthcare</b>						
<b>Follow-Up Care for Children Prescribed ADHD Medication (ADD-CH)</b>						
Initiation Phase	48.55%	48.40%	53.06%	50.82%	47.41%	45.62%
Continuation and Maintenance Phase	58.46%	61.24%	72.73%	100%	68.60%	57.63%
<b>Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)</b>						
Screening for Depression and Follow-up on Date of Positive Screen	9.83%	11.90%	13.30%	15.23%	0.75%	10.04%
<b>Follow-Up After Hospitalization for Mental Illness (FUH-CH)</b>						
7-Day Follow-Up: 6–17 Years	45.58%	47.30%	33.33%	39.12%	29.30%	40.43%
<b>7-Day Follow-Up: 6–17 Years (by Race/Ethnicity)</b>						
American Indian or Alaska Native alone or in combination	NS	0.00%	NS	0.00%	NS	0.00%
Asian alone or in combination	NS	45.45%	NS	100%	NS	0.00%
Black or African American or in combination	NS	36.17%	NS	33.33%	NS	10.00%
Hispanic or Latino alone or in combination	NS	57.89%	NS	35.00%	NS	48.05%
Middle Eastern or North African alone or in combination	NS	0.00%	NS	0.00%	NS	0.00%
Native Hawaiian or Other Pacific Islander alone or in combination	NS	0.00%	NS	0.00%	NS	75.00%

**Table 13. 2024 and 2025 PMV Measure Results: MCOs**

Measure	Aetna		CCP		Simply Healthcare	
	2024	2025	2024	2025	2024	2025
White alone or in combination	NS	46.97%	NS	33.33%	NS	37.25%
Missing or Not Reported	NS	41.07%	NS	45.45%	NS	40.67%
<b>7-Day Follow-Up: 6–17 Years (by Sex)</b>						
Male	NS	52.10%	NS	31.25%	NS	38.28%
Female	NS	45.33%	NS	45.16%	NS	39.53%
Missing or Not Reported	NS	0.00%	NS	0.00%	NS	0.00%
<b>7-Day Follow-Up: 6–17 Years (by Geography)</b>						
Urban	NS	48.35%	NS	41.30%	NS	38.58%
Rural	NS	15.38%	NS	0.00%	NS	80.00%
Missing or Not Reported	NS	0.00%	NS	0.00%	NS	0.00%
<b>30-Day Follow-Up: 6–17 Years</b>	65.02%	67.16%	66.67%	59.07%	56.04%	76.60%
<b>30-Day Follow-Up: 6–17 Years (by Race/Ethnicity)</b>						
American Indian or Alaska Native alone or in combination	NS	100%	NS	0.00%	NS	0.00%
Asian alone or in combination	NS	54.55%	NS	100.00%	NS	0.00%
Black or African American or in combination	NS	53.19%	NS	66.67%	NS	20.00%
Hispanic or Latino alone or in combination	NS	77.89%	NS	90.00%	NS	67.53%
Middle Eastern or North African alone or in combination	NS	0.00%	NS	0.00%	NS	0.00%
Native Hawaiian or Other Pacific Islander alone or in combination	NS	0.00%	NS	0.00%	NS	75.00%
White alone or in combination	NS	66.16%	NS	61.11%	NS	48.04%
Missing or Not Reported	NS	66.07%	NS	90.91%	NS	64.93%
<b>30-Day Follow-Up: 6–17 Years (by Sex)</b>						
Male	NS	71.43%	NS	81.25%	NS	55.47%
Female	NS	65.40%	NS	74.19%	NS	60.85%
Missing or Not Reported	NS	0.00%	NS	0.00%	NS	0.00%
<b>30-Day Follow-Up: 6–17 Years (by Geography)</b>						
Urban	NS	67.34%	NS	78.26%	NS	58.79%

**Table 13. 2024 and 2025 PMV Measure Results: MCOs**

Measure	Aetna		CCP		Simply Healthcare	
	2024	2025	2024	2025	2024	2025
Rural	NS	61.54%	NS	0.00%	NS	80.00%
Missing or Not Reported	NS	0.00%	NS	0.00%	NS	0.00%
<b>Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH)</b>						
7-Day Follow-Up: 6–17 Years	38.46%	46.03%	NA	57.14%	20.37%	46.34%
30-Day Follow-Up: 6–17 Years	51.28%	65.08%	NA	57.14%	42.59%	58.54%
<b>Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH)</b>						
7-Day Follow-Up: 13–17 Years	11.76%	NA	NA	NA	NA	NA
7-Day Follow-Up: 13–17 Years (by Race/Ethnicity)						
American Indian or Alaska Native alone or in combination	NS	NA	NS	NA	NS	NA
Asian alone or in combination	NS	NA	NS	NA	NS	NA
Black or African American or in combination	NS	NA	NS	NA	NS	NA
Hispanic or Latino alone or in combination	NS	NA	NS	NA	NS	NA
Middle Eastern or North African alone or in combination	NS	NA	NS	NA	NS	NA
Native Hawaiian or Other Pacific Islander alone or in combination	NS	NA	NS	NA	NS	NA
White alone or in combination	NS	NA	NS	NA	NS	NA
Missing or Not Reported	NS	NA	NS	NA	NS	NA
7-Day Follow-Up: 13–17 Years (by Sex)						
Male	NS	NA	NS	NA	NS	NA
Female	NS	NA	NS	NA	NS	NA
Missing or Not Reported	NS	NA	NS	NA	NS	NA
7-Day Follow-Up: 13–17 Years (by Geography)						
Urban	NS	NA	NS	NA	NS	NA
Rural	NS	NA	NS	NA	NS	NA
Missing or Not Reported	NS	NA	NS	NA	NS	NA

**Table 13. 2024 and 2025 PMV Measure Results: MCOs**

Measure	Aetna		CCP		Simply Healthcare	
	2024	2025	2024	2025	2024	2025
<b>30-Day Follow-Up: 13–17 Years</b>	29.41%	NA	NA	NA	NA	NA
<b>30-Day Follow-Up: 13–17 Years (by Race/Ethnicity)</b>						
American Indian or Alaska Native alone or in combination	NS	NA	NS	NA	NS	NA
Asian alone or in combination	NS	NA	NS	NA	NS	NA
Black or African American or in combination	NS	NA	NS	NA	NS	NA
Hispanic or Latino alone or in combination	NS	NA	NS	NA	NS	NA
Middle Eastern or North African alone or in combination	NS	NA	NS	NA	NS	NA
Native Hawaiian or Other Pacific Islander alone or in combination	NS	NA	NS	NA	NS	NA
White alone or in combination	NS	NA	NS	NA	NS	NA
Missing or Not Reported	NS	NA	NS	NA	NS	NA
<b>30-Day Follow-Up: 13–17 Years (by Sex)</b>						
Male	NS	NA	NS	NA	NS	NA
Female	NS	NA	NS	NA	NS	NA
Missing or Not Reported	NS	NA	NS	NA	NS	NA
<b>30-Day Follow-Up: 13–17 Years (by Geography)</b>						
Urban	NS	NA	NS	NA	NS	NA
Rural	NS	NA	NS	NA	NS	NA
Missing or Not Reported	NS	NA	NS	NA	NS	NA
<b>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)</b>						
1–11 Years	NA	36.84%	NA	66.67%	NA	80.00%
12–17 Years	54.88%	59.17%	NA	50.00%	61.90%	63.38%
Total	52.00%	56.12%	57.14%	55.00%	59.21%	67.03%
<b>Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)</b>						
Blood Glucose Testing: 1–11 Years	56.67%	47.62%	NA	75.00%	40.00%	38.18%
Cholesterol Testing: 1–11 Years	40.00%	34.92%	NA	25.00%	23.33%	23.64%

**Table 13. 2024 and 2025 PMV Measure Results: MCOs**

Measure	Aetna		CCP		Simply Healthcare	
	2024	2025	2024	2025	2024	2025
Blood Glucose and Cholesterol Testing: 1–11 Years	36.67%	33.33%	NA	25.00%	23.33%	20.00%
Blood Glucose Testing: 12–17 Years	59.69%	62.50%	NA	80.00%	68.66%	62.07%
Cholesterol Testing: 12–17 Years	47.12%	48.05%	NA	75.00%	48.51%	47.13%
Blood Glucose and Cholesterol Testing: 12–17 Years	43.46%	46.88%	NA	75.00%	46.27%	45.98%
Blood Glucose Testing Total	59.28%	59.56%	64.71%	78.57%	63.41%	56.33%
Cholesterol Testing Total	46.15%	45.45%	52.94%	60.71%	43.90%	41.48%
Blood Glucose and Cholesterol Testing Total	42.53%	44.20%	52.94%	60.71%	42.07%	39.74%
<b>Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)</b>						
Alcohol Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	NA	NA	NA	NA	NA	NA
Alcohol Abuse or Dependence: Engagement of AOD Treatment: 13–17 Years	NA	NA	NA	NA	NA	NA
Opioid Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	NA	NA	NA	NA	NA	NA
Opioid Abuse or Dependence: Engagement of AOD Treatment: 13–17 Years	NA	NA	NA	NA	NA	NA
Other Drug Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	48.53%	50.67%	NA	NA	45.45%	37.25%
Other Drug Abuse or Dependence: Engagement of AOD Treatment: 13–17 Years	10.29%	12.00%	NA	NA	7.27%	11.76%
Initiation of AOD Treatment: 13–17 Years Total	48.72%	49.41%	NA	NA	43.94%	41.67%
Engagement of AOD Treatment: 13–17 Years Total	10.26%	10.59%	NA	NA	6.06%	10.00%
Alcohol Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	NA	NA	NA	NA	NA	NA

**Table 13. 2024 and 2025 PMV Measure Results: MCOs**

Measure	Aetna		CCP		Simply Healthcare	
	2024	2025	2024	2025	2024	2025
Alcohol Abuse or Dependence: Engagement of AOD Treatment: 18+ Years	NA	NA	NA	NA	NA	NA
Opioid Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	NA	NA	NA	NA	NA	NA
Opioid Abuse or Dependence: Engagement of AOD Treatment: 18+ Years	NA	NA	NA	NA	NA	NA
Other Drug Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	NA	NA	NA	NA	NA	NA
Other Drug Abuse or Dependence: Engagement of AOD Treatment: 18+ Years	NA	NA	NA	NA	NA	NA
Initiation of AOD Treatment: 18+ Years Total	NA	NA	NA	NA	NA	NA
Engagement of AOD Treatment: 18+ Years Total	NA	NA	NA	NA	NA	NA
Alcohol Abuse or Dependence: Initiation of AOD Treatment Total	NA	NA	NA	NA	NA	NA
Alcohol Abuse or Dependence: Engagement of AOD Treatment Total	NA	NA	NA	NA	NA	NA
Opioid Abuse or Dependence: Initiation of AOD Treatment Total	NA	NA	NA	NA	NA	NA
Opioid Abuse or Dependence: Engagement of AOD Treatment Total	NA	NA	NA	NA	NA	NA
Other Drug Abuse or Dependence: Initiation of AOD Treatment Total	48.75%	48.84%	NA	NA	44.26%	38.46%
Other Drug Abuse or Dependence: Engagement of AOD Treatment Total	11.25%	12.79%	NA	NA	6.56%	12.31%
Initiation of AOD Treatment Total	47.87%	44.66%	50.00%	NA	42.47%	41.77%
Engagement of AOD Treatment Total	11.70%	10.68%	12.50%	NA	5.48%	10.13%

**Table 13. 2024 and 2025 PMV Measure Results: MCOs**

Measure	Aetna		CCP		Simply Healthcare	
	2024	2025	2024	2025	2024	2025
<b>Diagnosed Substance-Related Disorders (DSU)</b>						
Diagnosed Substance Use Disorders: Alcohol: 13–17 Years	0.13%	0.14%	0.14%	0.03%	0.07%	0.07%
Diagnosed Substance Use Disorders: Alcohol: 18–64 Years	0.07%	0.22%	0.26%	0.36%	0.23%	0.06%
Diagnosed Substance Use Disorders: Alcohol: Total	0.12%	0.15%	0.16%	0.08%	NA	0.07%
Diagnosed Substance Use Disorders: Opioid: 13–17 Years	0.01%	0.02%	0.00%	0.00%	0.09%	0.02%
Diagnosed Substance Use Disorders: Opioid: 18–64 Years	0.07%	0.00%	0.00%	0.00%	0.01%	0.06%
Diagnosed Substance Use Disorders: Opioid: Total	0.02%	0.02%	0.00%	0.00%	0.00%	0.02%
Diagnosed Substance Use Disorders: Other: 13–17 Years	0.52%	0.60%	0.23%	0.43%	NA	0.47%
Diagnosed Substance Use Disorders: Other: 18–64 Years	0.77%	0.98%	0.26%	0.36%	0.01%	0.76%
Diagnosed Substance Use Disorders: Other: Total	0.56%	0.66%	0.24%	0.42%	0.50%	0.52%
Diagnosed Substance Use Disorders: Any: 13–17 Years	0.55%	0.67%	0.32%	0.43%	1.12%	0.51%
Diagnosed Substance Use Disorders: Any: 18–64 Years	0.84%	1.15%	0.52%	0.54%	NA	0.79%
Diagnosed Substance Use Disorders: Any: Total	0.60%	0.76%	0.35%	0.45%	0.61%	0.56%
<b>Diagnosed Mental Health Disorders (DMH)* (Formerly Mental Health Utilization (MPT))</b>						
Diagnosed Mental Health Disorders: 1-17 Years	NS	21.30%	NS	18.48%	NS	21.15%

**Table 13. 2024 and 2025 PMV Measure Results: MCOs**

Measure	Aetna		CCP		Simply Healthcare	
	2024	2025	2024	2025	2024	2025
Diagnosed Mental Health Disorders: 18-64 Years	NS	20.44%	NS	14.10%	NS	20.78%
Diagnosed Mental Health Disorders: Total	NS	21.23%	NS	18.18%	NS	21.12%
<b>Experience of Care: CAHPS® Health Plan Survey 5.1H, Child Version (General Population)</b>						
Rating of All Healthcare (9+10)	67.37%	68.78%	77.60%	75.20%	68.94%	72.37%
Rating of Personal Doctor (9+10)	76.95%	72.69%	84.10%	80.90%	73.04%	78.74%
Rating of Specialist Seen Most Often (9+10)	79.09%	73.62%	80.00%	81.80%	NA	75.59%
Rating of MCO (9+10)	66.14%	59.28%	65.80%	68.10%	64.52%	68.87%
Getting Needed Care (Always + Usually)	81.31%	83.63%	84.30%	82.80%	85.96%	83.57%
Getting Care Quickly (Always + Usually)	88.37%	88.85%	92.00%	83.00%	89.93%	88.29%
How Well Doctors Communicate (Always + Usually)	97.21%	93.87%	96.50%	94.10%	92.57%	95.54%
Customer Service (Always + Usually)	87.89%	87.22%	85.10%	90.70%	NA	90.77%
Coordination of Care (Always + Usually)	85.78%	75.00%	86.30%	93.20%	NA	82.46%
Rating of Number of Doctors (9+10)	NR	NR	NR	56.90%	NR	NR
<b>Experience of Care: CAHPS® Health Plan Survey 5.1H, Child Version (Children with Chronic Conditions)</b>						
Rating of All Healthcare (9+10)	NR	64.15%	NR	71.40%	70.47%	66.09%
Rating of Personal Doctor (9+10)	NR	73.86%	NR	80.60%	73.53%	72.69%
Rating of Specialist Seen Most Often (9+10)	NR	74.46%	NR	69.40%	NA	76.57%
Rating of MCO (9+10)	NR	50.00%	NR	60.70%	60.73%	58.22%
Getting Needed Care (Always + Usually)	NR	84.16%	NR	78.60%	86.94%	85.18%
Getting Care Quickly (Always + Usually)	NR	88.07%	NR	86.30%	89.04%	89.23%
How Well Doctors Communicate (Always + Usually)	NR	94.69%	NR	95.00%	93.52%	95.03%
Customer Service (Always + Usually)	NR	89.29%	NR	90.40%	NA	88.39%
Coordination of Care (Always + Usually)	NR	76.40%	NR	83.30%	NA	83.58%
Rating of Number of Doctors (9+10)	NR	NR	NR	59.80%	NR	NR

NA = Small Denominator: The MCO followed the specifications, but the denominator was too small (<30) to report a valid rate. For utilization measures that count enrollee months, this

result is reported when the denominator is <360 enrollee months.

NR = Not Reported.

NS = Indicates that the rate stratification was new for 2025; the rate did not have corresponding data for 2024.

\* Based on the updated guidance from NCQA, the Mental Health Utilization (MPT) measure was replaced by the Diagnosed Mental Health Disorders (DMH) measure.

DBM-specific PMV results appear in [Table 14](#). The green and red shading indicates an increase, decrease, or no change from the previous year's rate.

Table 14. 2025 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
<b>Annual Dental Visit (ADV)</b>									
All Enrollees	1,608	1,045	64.99%	15,258	9,682	63.46%	35,287	21,225	60.15%
Enrollees Aged 5 to 6†	9,973	6,935	69.54%	786	522	66.41%	2,194	1,347	61.39%
Enrollees Aged 7 to 10	11,929	7,599	63.70%	5,065	3,554	70.17%	10,467	6,956	66.46%
Enrollees Aged 11 to 14	12,188	6,606	54.20%	5,009	3,160	63.09%	11,047	6,870	62.19%
Enrollees Aged 15 to 18	351	152	43.30%	4,398	2,446	55.62%	11,579	6,052	52.27%
<b>Dental Sealants – With Exclusions*</b>									
Enrolled at Least 1 Month: All Enrollees	56,027	49,465	88.29%	27,257	3,689	13.53%	86,302	8,699	10.08%
Enrolled at Least 1 Month: Enrollees aged 5†	NS	NS	NS	NS	NS	NS	4,679	31	0.66%
Enrolled at Least 1 Month: Enrollees aged 6 to 9	22,320	18,163	81.38%	12,379	1,754	14.17%	27,113	3,677	13.56%

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Enrolled at Least 1 Month: Enrollees aged 10 to 14	33,707	31,302	92.86%	14,878	1,935	13.01%	30,331	3,526	11.63%
Enrolled at Least 1 Month: Enrollees aged 15 to 18	NS	NS	NS	NS	NS	NS	24,179	1,465	6.06%
Enrolled at Least 3 Months Continuously: All Enrollees	47,039	40,724	86.57%	22,288	3,506	15.73%	67,492	8,327	12.34%
Enrolled at Least 3 Months Continuously: Enrollees aged 5†	NS	NS	NS	NS	NS	NS	2,866	29	1.01%
Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	18,477	14,476	78.35%	9,917	1,651	16.65%	21,043	3,511	16.68%
Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	28,562	26,248	91.90%	12,371	1,855	14.99%	24,037	3,382	14.07%
Enrolled at Least 3 Months	NS	NS	NS	NS	NS	NS	19,546	1,405	7.19%

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Continuously: Enrollees aged 15 to 18									
Enrolled at Least 6 Months Continuously: All Enrollees	43,885	37,748	86.02%	16,927	3,002	17.73%	49,154	7,142	14.53%
Enrolled at Least 6 Months Continuously: Enrollees aged 5†	NS	NS	NS	NS	NS	NS	1,450	22	1.52%
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	17,180	13,288	77.35%	7,413	1,407	18.98%	15,294	2,982	19.50%
Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	26,705	24,460	91.59%	9,514	1,595	16.76%	17,721	2,907	16.40%
Enrolled at Least 6 Months Continuously: Enrollees aged 15 to 18	NS	NS	NS	NS	NS	NS	14,689	1,231	8.38%
Enrolled at Least 11	21,800	17,704	81.21%	9,926	1,890	19.04%	24,322	4,118	16.93%

## Performance Measure Validation

Table 14. 2025 PMV Measure Results: DBMs

Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Months Continuously: All Enrollees									
Enrolled at Least 11 Months Continuously: Enrollees aged 5†	NS	NS	NS	NS	NS	NS	164	5	3.05%
Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	8,022	5,478	68.29%	4,142	861	20.79%	7,646	1,750	22.89%
Enrolled at Least 11 Months Continuously: Enrollees aged 10 to 14	13,778	12,226	88.74%	5,784	1,029	17.79%	8,818	1,645	18.66%
Enrolled at Least 11 Months Continuously: Enrollees aged 15 to 18	NS	NS	NS	NS	NS	NS	7,694	718	9.33%

**Dental Sealants**

## Performance Measure Validation

Table 14. 2025 PMV Measure Results: DBMs

Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 1 Month: All Enrollees	NS	NS	NS	NS	NS	NS	99,468	9,819	9.87%
Enrolled at Least 1 Month: Enrollees aged 5†	NS	NS	NS	NS	NS	NS	4,679	31	0.66%
Enrolled at Least 1 Month: Enrollees aged 6 to 9	NS	NS	NS	NS	NS	NS	29,298	3,754	12.81%
Enrolled at Least 1 Month: Enrollees aged 10 to 14	NS	NS	NS	NS	NS	NS	36,470	4,227	11.59%
Enrolled at Least 1 Month: Enrollees aged 15 to 18	NS	NS	NS	NS	NS	NS	29,021	1,807	6.23%
Enrolled at Least 3 Months Continuously: All Enrollees	NS	NS	NS	NS	NS	NS	79,263	9,424	11.89%
Enrolled at Least 3 Months Continuously: Enrollees aged 5†	NS	NS	NS	NS	NS	NS	2,866	29	1.01%
Enrolled at Least 3 Months	NS	NS	NS	NS	NS	NS	22,972	3,587	15.61%

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Continuously: Enrollees aged 6 to 9									
Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	NS	NS	NS	NS	NS	NS	29,525	4,069	13.78%
Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	NS	NS	NS	NS	NS	NS	23,900	1,739	7.28%
Enrolled at Least 6 Months Continuously: All Enrollees	NS	NS	NS	NS	NS	NS	58,917	8,140	13.82%
Enrolled at Least 6 Months Continuously: Enrollees aged 5†	NS	NS	NS	NS	NS	NS	1,450	22	1.52%
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	NS	NS	NS	NS	NS	NS	16,880	3,050	18.07%
Enrolled at Least 6 Months Continuously:	NS	NS	NS	NS	NS	NS	22,232	3,527	15.86%

## Performance Measure Validation

Table 14. 2025 PMV Measure Results: DBMs

Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrollees aged 10 to 14									
Enrolled at Least 6 Months Continuously: Enrollees aged 15 to 18	NS	NS	NS	NS	NS	NS	18,355	1,541	8.40%
Enrolled at Least 11 Months Continuously: All Enrollees	NS	NS	NS	NS	NS	NS	30,997	4,866	15.70%
Enrolled at Least 11 Months Continuously: Enrollees aged 5†	NS	NS	NS	NS	NS	NS	164	5	3.05%
Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	NS	NS	NS	NS	NS	NS	8,730	1,803	20.65%
Enrolled at Least 11 Months Continuously: Enrollees aged 10 to 14	NS	NS	NS	NS	NS	NS	11,853	2,105	17.76%

Table 14. 2025 PMV Measure Results: DBMs

Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 11 Months Continuously: Enrollees aged 15 to 18	NS	NS	NS	NS	NS	NS	10,250	953	9.30%
<b>Preventive Dental (PDENT)</b>									
Enrolled at Least 1 Month: All Enrollees	89,818	36,477	40.61%	39,261	16,935	43.13%	99,468	37,918	38.12%
Enrolled at Least 1 Month: Enrollees aged 5†	2,883	1,700	58.97%	1,778	559	31.44%	4,679	1,224	26.16%
Enrolled at Least 1 Month: Enrollees aged 6 to 9	22,310	11,382	51.02%	12,379	5,918	47.81%	29,298	12,373	42.23%
Enrolled at Least 1 Month: Enrollees aged 10 to 14	33,691	14,516	43.09%	14,878	6,717	45.15%	36,470	14,975	41.06%
Enrolled at Least 1 Month: Enrollees aged 15 to 18	26,915	8,836	32.83%	10,226	3,741	36.58%	29,021	9,346	32.20%
Enrolled at Least 1 Month: Enrollees aged 19 to 20	4,019	43	1.07%	NS	NS	NS	NS	NS	NS

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Enrolled at Least 3 Months Continuously: All Enrollees	74,872	35,170	46.97%	31,918	15,997	50.12%	79,263	36,118	45.57%
Enrolled at Least 3 Months Continuously: Enrollees aged 5†	1,893	1,586	83.78%	1,098	474	43.17%	2,866	1,068	37.26%
Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	18,469	10,944	59.26%	9,917	5,563	56.10%	22,972	11,724	51.04%
Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	28,553	14,046	49.19%	12,371	6,376	51.54%	29,525	14,331	48.54%
Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	23,007	8,567	37.24%	8,532	3,584	42.01%	23,900	8,995	37.64%
Enrolled at Least 3 Months Continuously: Enrollees aged 19 to 20	2,950	27	0.92%	NS	NS	NS	NS	NS	NS

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Enrolled at Least 6 Months Continuously: All Enrollees	69,427	34,119	49.14%	24,011	13,371	55.69%	58,917	30,299	51.43%
Enrolled at Least 6 Months Continuously: Enrollees aged 5†	1,541	1,487	96.50%	506	272	53.75%	1,450	661	45.59%
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	17,174	10,603	61.74%	7,413	4,608	62.16%	16,880	9,702	57.48%
Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	26,698	13,682	51.25%	9,514	5,421	56.98%	22,232	12,110	54.47%
Enrolled at Least 6 Months Continuously: Enrollees aged 15 to 18	21,564	8,324	38.60%	6,578	3,070	46.67%	18,355	7,826	42.64%
Enrolled at Least 6 Months Continuously: Enrollees aged 19 to 20	2,450	23	0.94%	NS	NS	NS	NS	NS	NS

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Enrolled at Least 11 Months Continuously: All Enrollees	33,536	19,854	59.20%	13,980	8,298	59.36%	30,997	17,848	57.58%
Enrolled at Least 11 Months Continuously: Enrollees aged 5†	1,075	547	50.88%	50	27	54.00%	164	97	59.15%
Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	8,022	6,011	74.93%	4,142	2,762	66.68%	8,730	5,602	64.17%
Enrolled at Least 11 Months Continuously: Enrollees aged 10 to 14	13,777	8,377	60.80%	5,784	3,507	60.63%	11,853	7,222	60.93%
Enrolled at Least 11 Months Continuously: Enrollees aged 15 to 18	11,311	4,916	43.46%	4,004	2,002	50.00%	10,250	4,927	48.07%

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Enrolled at Least 11 Months Continuously: Enrollees aged 19 to 20	335	3	0.90%	NS	NS	NS	NS	NS	NS
<b>Any Dental Services</b>									
Enrolled at Least 1 Month: All Enrollees	89,818	38,620	43.00%	39,261	18,236	46.45%	99,468	40,408	40.62%
Enrolled at Least 1 Month: Enrollees aged 5†	2,883	1,814	62.92%	1,778	603	33.91%	4,679	1,307	27.93%
Enrolled at Least 1 Month: Enrollees aged 6 to 9	22,310	11,807	52.92%	12,379	6,255	50.53%	29,298	12,895	44.01%
Enrolled at Least 1 Month: Enrollees aged 10 to 14	33,691	15,296	45.40%	14,878	7,177	48.24%	36,470	15,771	43.24%
Enrolled at Least 1 Month: Enrollees aged 15 to 18	26,915	9,650	35.85%	10,226	4,201	41.08%	29,021	10,435	35.96%
Enrolled at Least 1 Month: Enrollees aged 19 to 20	4,019	53	1.32%	NS	NS	NS	NS	NS	NS

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Enrolled at Least 3 Months Continuously: All Enrollees	74,872	37,087	49.53%	31,918	17,124	53.65%	79,263	38,287	48.30%
Enrolled at Least 3 Months Continuously: Enrollees aged 5†	1,893	1,679	88.70%	1,098	502	45.72%	2,866	1,126	39.29%
Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	18,469	11,324	61.31%	9,917	5,840	58.89%	22,972	12,161	52.94%
Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	28,553	14,746	51.64%	12,371	6,774	54.76%	29,525	15,014	50.85%
Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	23,007	9,307	40.45%	8,532	4,008	46.98%	23,900	9,986	41.78%
Enrolled at Least 3 Months Continuously: Enrollees aged 19 to 20	2,950	31	1.05%	NS	NS	NS	NS	NS	NS

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Enrolled at Least 6 Months Continuously: All Enrollees	69,427	35,865	51.66%	24,011	14,142	58.90%	58,917	31,876	54.10%
Enrolled at Least 6 Months Continuously: Enrollees aged 5†	1,557	1,506	96.72%	506	281	55.53%	1,450	685	47.24%
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	17,174	10,942	63.71%	7,413	4,789	64.60%	16,880	10,009	59.30%
Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	26,698	14,330	53.67%	9,514	5,686	59.76%	22,232	12,600	56.68%
Enrolled at Least 6 Months Continuously: Enrollees aged 15 to 18	21,564	9,006	41.76%	6,578	3,386	51.47%	18,355	8,582	46.76%
Enrolled at Least 6 Months Continuously: Enrollees aged 19 to 20	2,450	27	1.10%	NS	NS	NS	NS	NS	NS

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Enrolled at Least 11 Months Continuously: All Enrollees	33,536	20,640	61.55%	13,980	8,693	62.18%	30,997	18,644	60.15%
Enrolled at Least 11 Months Continuously: Enrollees aged 5†	1,075	578	53.77%	50	27	54.00%	164	99	60.37%
Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	8,022	6,166	76.86%	4,142	2,856	68.95%	8,730	5,742	65.77%
Enrolled at Least 11 Months Continuously: Enrollees aged 10 to 14	13,777	8,670	62.93%	5,784	3,635	62.85%	11,853	7,482	63.12%
Enrolled at Least 11 Months Continuously: Enrollees aged 15 to 18	11,311	5,223	46.18%	4,004	2,175	54.32%	10,250	5,321	51.91%

**Table 14. 2025 PMV Measure Results: DBMs**

Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 11 Months Continuously: Enrollees aged 19 to 20	335	3	0.90%	NS	NS	NS	NS	NS	NS
<b>Dental Treatment Services (TDENT)</b>									
Enrolled at Least 1 Month: All Enrollees	89,818	13,910	15.49%	39,261	7,065	17.99%	99,468	14,956	15.04%
Enrolled at Least 1 Month: Enrollees aged 5†	2,883	523	18.14%	1,778	141	7.93%	4,679	335	7.16%
Enrolled at Least 1 Month: Enrollees aged 6 to 9	22,310	4,439	19.90%	12,379	2,374	19.18%	29,298	4,971	16.97%
Enrolled at Least 1 Month: Enrollees aged 10 to 14	33,691	5,258	15.61%	14,878	2,687	18.06%	36,470	5,443	14.92%
Enrolled at Least 1 Month: Enrollees aged 15 to 18	26,915	3,665	13.62%	10,226	1,863	18.22%	29,021	4,207	14.50%
Enrolled at Least 1 Month: Enrollees aged 19 to 20	4,019	25	0.62%	NS	NS	NS	NS	NS	NS

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Enrolled at Least 3 Months Continuously: All Enrollees	74,872	13,496	18.03%	31,918	6,758	21.17%	79,263	14,373	18.13%
Enrolled at Least 3 Months Continuously: Enrollees aged 5†	1,893	486	25.67%	1,098	114	10.38%	2,866	296	10.33%
Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	18,469	4,305	23.31%	9,917	2,255	22.74%	22,972	4,753	20.69%
Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	28,553	5,114	17.91%	12,371	2,580	20.86%	29,525	5,253	17.79%
Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	23,007	3,570	15.52%	8,532	1,809	21.20%	23,900	4,071	17.03%
Enrolled at Least 3 Months Continuously: Enrollees aged 19 to 20	2,950	21	0.71%	NS	NS	NS	NS	NS	NS

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Enrolled at Least 6 Months Continuously: All Enrollees	69,427	13,119	18.90%	24,011	5,719	23.82%	58,917	12,331	20.93%
Enrolled at Least 6 Months Continuously: Enrollees aged 5†	1,541	455	29.53%	506	69	13.64%	1,450	191	13.17%
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	17,174	4,182	24.35%	7,413	1,906	25.71%	16,880	4,026	23.85%
Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	26,698	4,988	18.68%	9,514	2,206	23.19%	22,232	4,540	20.42%
Enrolled at Least 6 Months Continuously: Enrollees aged 15 to 18	21,564	3,477	16.12%	6,578	1,538	23.38%	18,355	3,574	19.47%
Enrolled at Least 6 Months Continuously: Enrollees aged 19 to 20	2,450	17	0.69%	NS	NS	NS	NS	NS	NS

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Enrolled at Least 11 Months Continuously: All Enrollees	33,536	7,824	23.33%	13,980	3,626	25.94%	30,997	7,387	23.83%
Enrolled at Least 11 Months Continuously: Enrollees aged 5†	1,075	158	14.70%	50	7	14.00%	164	23	14.02%
Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	8,022	2,474	30.84%	4,142	1,187	28.66%	8,730	2,345	26.86%
Enrolled at Least 11 Months Continuously: Enrollees aged 10 to 14	13,777	3,134	22.75%	5,784	1,448	25.03%	11,853	2,759	23.28%
Enrolled at Least 11 Months Continuously: Enrollees aged 15 to 18	11,311	2,054	18.16%	4,004	984	24.58%	10,250	2,260	22.05%

**Table 14. 2025 PMV Measure Results: DBMs**

Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 11 Months Continuously: Enrollees aged 19 to 20	335	4	1.19%	NS	NS	NS	NS	NS	NS
<b>Dental Diagnostic Services</b>									
Enrolled at Least 1 Month: All Enrollees	89,818	37,808	42.09%	39,261	17,432	44.40%	99,468	38,898	39.11%
Enrolled at Least 1 Month: Enrollees aged 5†	2,883	1,769	61.36%	1,778	586	32.96%	4,679	1,271	27.16%
Enrolled at Least 1 Month: Enrollees aged 6 to 9	22,310	11,639	52.17%	12,379	6,039	48.78%	29,298	12,580	42.94%
Enrolled at Least 1 Month: Enrollees aged 10 to 14	33,691	14,938	44.34%	14,878	6,866	46.15%	36,470	15,202	41.68%
Enrolled at Least 1 Month: Enrollees aged 15 to 18	26,915	9,413	34.97%	10,226	3,941	38.54%	29,021	9,845	33.92%
Enrolled at Least 1 Month: Enrollees aged 19 to 20	4,019	49	1.22%	NS	NS	NS	NS	NS	NS

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Enrolled at Least 3 Months Continuously: All Enrollees	74,872	36,379	48.59%	31,918	16,430	51.48%	79,263	36,981	46.66%
Enrolled at Least 3 Months Continuously: Enrollees aged 5†	1,893	1,646	86.95%	1,098	491	44.72%	2,866	1,102	38.45%
Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	18,469	11,171	60.49%	9,917	5,672	57.19%	22,972	11,908	51.84%
Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	28,553	14,431	50.54%	12,371	6,495	52.50%	29,525	14,516	49.17%
Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	23,007	9,102	39.56%	8,532	3,772	44.21%	23,900	9,455	39.56%
Enrolled at Least 3 Months Continuously: Enrollees aged 19 to 20	2,950	29	0.98%	NS	NS	NS	NS	NS	NS

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Enrolled at Least 6 Months Continuously: All Enrollees	69,427	35,238	50.76%	24,011	13,675	56.95%	58,917	30,940	52.51%
Enrolled at Least 6 Months Continuously: Enrollees aged 5†	1,541	1,535	99.61%	506	280	55.34%	1,450	677	46.69%
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	17,174	10,811	62.95%	7,413	4,678	63.11%	16,880	9,843	58.31%
Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	26,698	14,045	52.61%	9,514	5,503	57.84%	22,232	12,254	55.12%
Enrolled at Least 6 Months Continuously: Enrollees aged 15 to 18	21,564	8,822	40.91%	6,578	3,214	48.86%	18,355	8,166	44.49%
Enrolled at Least 6 Months Continuously: Enrollees aged 19 to 20	2,450	25	1.02%	NS	NS	NS	NS	NS	NS

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Enrolled at Least 11 Months Continuously: All Enrollees	33,536	20,373	60.75%	13,980	8,440	60.37%	30,997	18,154	58.57%
Enrolled at Least 11 Months Continuously: Enrollees aged 5†	1,075	566	52.65%	50	27	54.00%	164	99	60.37%
Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	8,022	6,110	76.17%	4,142	2,805	67.72%	8,730	5,667	64.91%
Enrolled at Least 11 Months Continuously: Enrollees aged 10 to 14	13,777	8,546	62.03%	5,784	3,533	61.08%	11,853	7,297	61.56%
Enrolled at Least 11 Months Continuously: Enrollees aged 15 to 18	11,311	5,149	45.52%	4,004	2,075	51.82%	10,250	5,091	49.67%

Table 14. 2025 PMV Measure Results: DBMs

Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 11 Months Continuously: Enrollees aged 19 to 20	335	2	0.60%	NS	NS	NS	NS	NS	NS
<b>Any Preventive Dental or Oral Health Service</b>									
Enrolled at Least 1 Month: All Enrollees	89,818	36,477	40.61%	39,261	16,935	43.13%	99,468	37,918	38.12%
Enrolled at Least 1 Month: Enrollees aged 5†	2,883	1,700	58.97%	1,778	559	31.44%	4,679	1,224	26.16%
Enrolled at Least 1 Month: Enrollees aged 6 to 9	22,310	11,382	51.02%	12,379	5,918	47.81%	29,298	12,373	42.23%
Enrolled at Least 1 Month: Enrollees aged 10 to 14	33,691	14,516	43.09%	14,878	6,717	45.15%	36,470	14,975	41.06%
Enrolled at Least 1 Month: Enrollees aged 15 to 18	26,915	8,836	32.83%	10,226	3,741	36.58%	29,021	9,346	32.20%
Enrolled at Least 1 Month: Enrollees aged 19 to 20	4,019	43	1.07%	NS	NS	NS	NS	NS	NS

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Enrolled at Least 3 Months Continuously: All Enrollees	74,872	35,170	46.97%	31,918	15,997	50.12%	79,263	36,118	45.57%
Enrolled at Least 3 Months Continuously: Enrollees aged 5†	1,893	1,586	83.78%	1,098	474	43.17%	2,866	1,068	37.26%
Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	18,469	10,944	59.26%	9,917	5,563	56.10%	22,972	11,724	51.04%
Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	28,553	14,046	49.19%	12,371	6,376	51.54%	29,525	14,331	48.54%
Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	23,007	8,567	37.24%	8,532	3,584	42.01%	23,900	8,995	37.64%
Enrolled at Least 3 Months Continuously: Enrollees aged 19 to 20	2,950	27	0.92%	NS	NS	NS	NS	NS	NS

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Enrolled at Least 6 Months Continuously: All enrollees	69,427	34,119	49.14%	24,011	13,371	55.69%	58,917	30,299	51.43%
Enrolled at Least 6 Months Continuously: Enrollees aged 5†	1,541	1,487	96.50%	506	272	53.75%	1,450	661	45.59%
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	17,174	10,603	61.74%	7,413	4,608	62.16%	16,880	9,702	57.48%
Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	26,698	13,682	51.25%	9,514	5,421	56.98%	22,232	12,110	54.47%
Enrolled at Least 6 Months Continuously: Enrollees aged 15 to 18	21,564	8,324	38.60%	6,578	3,070	46.67%	18,355	7,826	42.64%
Enrolled at Least 6 Months Continuously: Enrollees aged 19 to 20	2,450	23	0.94%	NS	NS	NS	NS	NS	NS

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Enrolled at Least 11 Months Continuously: All Enrollees	33,536	19,854	59.20%	13,980	8,298	59.36%	30,997	17,848	57.58%
Enrolled at Least 11 Months Continuously: Enrollees aged 5†	1,075	547	50.88%	50	27	54.00%	164	97	59.15%
Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	8,022	6,011	74.93%	4,142	2,762	66.68%	8,730	5,602	64.17%
Enrolled at Least 11 Months Continuously: Enrollees aged 10 to 14	13,777	8,377	60.80%	5,784	3,507	60.63%	11,853	7,222	60.93%
Enrolled at Least 11 Months Continuously: Enrollees aged 15 to 18	11,311	4,916	43.46%	4,004	2,002	50.00%	10,250	4,927	48.07%

**Table 14. 2025 PMV Measure Results: DBMs**

Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 11 Months Continuously: Enrollees aged 19 to 20	335	3	0.90%	NS	NS	NS	NS	NS	NS
<b>Oral Evaluation, Dental Services (OEV-CH)</b>									
Oral Evaluation, Dental Services (OEV-CH), Enrolled at Least 6 Months Continuously									
By Age									
All Enrollees	53,067	28,794	54.26%	27,434	14,964	54.55%	64,856	33,052	50.96%
Enrollees aged 0 to 2	0	0	0.00%	NA	NA	NA	NA	NA	NA
Enrollees aged 5 <sup>†</sup>	800	368	46.00%	571	300	52.54%	1,473	681	46.23%
Enrollees aged 6 to 7	5,523	3,241	58.68%	3,587	2,165	60.36%	8,351	4,590	54.96%
Enrollees aged 8 to 9	7,435	4,649	62.53%	4,666	2,828	60.61%	9,593	5,634	58.73%
Enrollees aged 10 to 11	8,181	4,941	60.40%	4,322	2,556	59.14%	9,561	5,543	57.98%
Enrollees aged 12 to 14	12,664	7,099	56.06%	6,278	3,414	54.38%	14,353	7,557	52.65%
Enrollees aged 15 to 18	16,977	7,992	47.08%	7,352	3,481	47.35%	19,474	8,457	43.43%
Enrollees aged 19 to 20	1,487	504	33.89%	658	220	33.43%	2,051	590	28.77%
By Race/Ethnicity									
American Indian or	42	13	30.95%	18	6	33.33%	63	16	25.40%

## Performance Measure Validation

**Table 14. 2025 PMV Measure Results: DBMs**

Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Alaska Native alone or in combination									
Asian alone or in combination	824	462	56.07%	241	145	60.17%	922	477	51.74%
Black or African American or in combination	2,765	1,499	54.21%	778	433	55.66%	3,430	1,705	49.71%
Hispanic or Latino alone or in combination	11,425	6,219	54.43%	2,772	1,662	59.96%	11,899	6,131	51.53%
Middle Eastern or North African alone or in combination	0	0	0.00%	0	0	0.00%	NA	NA	NA
Native Hawaiian or Other Pacific Islander alone or in combination	0	0	0.00%	0	0	0.00%	195	102	52.31%
White alone or in combination	11,223	5,748	51.22%	6,393	3,633	56.83%	13,135	6,261	47.67%
Missing or Not Reported	26,788	14,853	55.44%	20,004	10,747	53.72%	35,212	18,360	52.14%
Total	NS	NS	NS	30,206	16,626	55.04%	NS	NS	NS

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
<b>By Sex</b>									
Male	26,922	14,393	53.46%	13,930	7,519	53.98%	32,970	16,641	50.47%
Female	26,145	14,405	55.10%	13,504	7,445	55.13%	31,886	16,411	51.47%
Missing or Not Reported	NA	NA	NA	0	0	0.00%	NA	NA	NA
Total	NR	NR	NR	27,434	14,964	54.55%	NR	NR	NR
<b>By Geography</b>									
Urban	42,664	24,189	56.70%	27,361	14,929	54.56%	782	469	59.97%
Rural	10,402	4,605	44.27%	73	35	47.95%	64,074	32,583	50.85%
Missing or Not Reported	NS	NS	NS	0	0	0.00%	NS	NS	NS
Total	NS	NS	NS	27,434	14,964	54.55%	NS	NS	NS
<b>Topical Fluoride for Children</b>									
Enrolled at Least 12 Months Continuously (Numerator 1): All enrollees	65,640	11,277	0.17%	16,081	4,445	27.64%	NA	NA	NA
Enrolled at Least 12 Months Continuously (Numerator 1): Enrollees aged 1 to 2	0	0	0.00%	NA	NA	NA	NA	NA	NA
Enrolled at Least 12 Months	1,687	65	3.85%	51	7	13.73%	NA	NA	NA

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Continuously (Numerator 1): Enrollees aged 5 <sup>†</sup>									
Enrolled at Least 12 Months Continuously (Numerator 1): Enrollees aged 6 to 7	6,679	1,253	18.76%	1,964	658	33.50%	NA	NA	NA
Enrolled at Least 12 Months Continuously (Numerator 1): Enrollees aged 8 to 9	9,168	1,943	21.19%	2,786	917	32.91%	NA	NA	NA
Enrolled at Least 12 Months Continuously (Numerator 1): Enrollees aged 10 to 11	9,995	2,089	20.90%	2,628	825	31.39%	NA	NA	NA
Enrolled at Least 12 Months Continuously (Numerator 1):	15,492	2,865	18.49%	3,899	1,085	27.83%	NA	NA	NA

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Enrollees aged 12 to 14									
Enrolled at Least 12 Months Continuously (Numerator 1): Enrollees aged 15 to 18	20,507	2,960	14.43%	4,620	936	20.26%	NA	NA	NA
Enrolled at Least 12 Months Continuously (Numerator 1): Enrollees aged 19 to 20	2,112	102	4.83%	133	17	12.78%	NA	NA	NA
Enrolled at Least 12 Months Continuously (Numerator 2): All enrollees	65,640	11,270	0.17%	16,081	4,445	27.64%	37,172	9,422	25.35%
Enrolled at Least 12 Months Continuously (Numerator 2): Enrollees aged 1 to 2	0	0	0.00%	NA	NA	NA	NA	NA	NA

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Enrolled at Least 12 Months Continuously (Numerator 2): Enrollees aged 5 <sup>+</sup>	1,687	65	3.85%	51	7	13.73%	170	38	22.35%
Enrolled at Least 12 Months Continuously (Numerator 2): Enrollees aged 6 to 7	6,679	1,251	18.73%	1,964	658	33.50%	4,727	1,358	28.73%
Enrolled at Least 12 Months Continuously (Numerator 2): Enrollees aged 8 to 9	9,168	1,941	21.17%	2,786	917	32.91%	5,642	1,707	30.26%
Enrolled at Least 12 Months Continuously (Numerator 2): Enrollees aged 10 to 11	9,995	2,089	20.90%	2,628	825	31.39%	5,698	1,698	29.80%
Enrolled at Least 12	15,492	2,862	18.47%	3,899	1,085	27.83%	8,738	2,266	25.93%

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Months Continuously (Numerator 2): Enrollees aged 12 to 14									
Enrolled at Least 12 Months Continuously (Numerator 2): Enrollees aged 15 to 18	20,507	2,960	14.43%	4,620	936	20.26%	12,197	2,355	19.31%
Enrolled at Least 12 Months Continuously (Numerator 2): Enrollees aged 19 to 20	2,112	102	4.83%	133	17	12.78%	12,197	2,355	19.31%
Enrolled at Least 12 Months Continuously (Numerator 3): All enrollees	65,640	0	0.00%	16,081	0	0.00%	37,172	9,422	25.35%
Enrolled at Least 12 Months Continuously (Numerator 3):	0	0	0.00%	NA	NA	NA	NA	NA	NA

## Performance Measure Validation

<b>Table 14. 2025 PMV Measure Results: DBMs</b>									
<b>Measure Name</b>	<b>DentaQuest</b>			<b>Liberty</b>			<b>MCNA</b>		
	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>	<b>Denom.</b>	<b>Num.</b>	<b>Rate (%)</b>
Enrollees aged 1 to 2									
Enrolled at Least 12 Months Continuously (Numerator 3): Enrollees aged 5†	1,687	0	0.00%	51	0	0.00%	170	38	22.35%
Enrolled at Least 12 Months Continuously (Numerator 3): Enrollees aged 6 to 7	6,679	0	0.00%	1,964	0	0.00%	4,727	1,358	28.73%
Enrolled at Least 12 Months Continuously (Numerator 3): Enrollees aged 8 to 9	9,168	0	0.00%	2,786	0	0.00%	5,642	1,707	30.26%
Enrolled at Least 12 Months Continuously (Numerator 3): Enrollees aged 10 to 11	9,995	0	0.00%	2,628	0	0.00%	5,698	1,698	29.80%

## Performance Measure Validation

**Table 14. 2025 PMV Measure Results: DBMs**

Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 12 Months Continuously (Numerator 3): Enrollees aged 12 to 14	15,492	0	0.00%	3,899	0	0.00%	8,738	2,266	25.93%
Enrolled at Least 12 Months Continuously (Numerator 3): Enrollees aged 15 to 18	20,507	0	0.00%	4,620	0	0.00%	12,197	2,355	19.31%
Enrolled at Least 12 Months Continuously (Numerator 3): Enrollees aged 19 to 20	2,112	0	0.00%	133	0	0.00%	12,197	2,355	19.31%
<b>Sealant Receipt on Permanent First Molars</b>									
Enrolled at Least 12 Months Continuously (Numerator 1): Enrollees aged 10	1,622	858	52.90%	1,112	377	33.90%	1,781	920	51.66%

**Table 14. 2025 PMV Measure Results: DBMs**

Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 12 Months Continuously (Numerator 2): Enrollees aged 10	1,622	658	40.57%	1,112	253	22.75%	1,781	706	39.64%
<b>Experience of Care: CAHPS® Dental Satisfaction Survey, Child Version</b>									
Rating of All Dental Care	NA	NA	NR	NA	NA	93.00%	NA	NA	NR
Rating of Dental Plan	NA	NA	NR	NA	NA	93.00%	NA	NA	NR
Rating of Finding a Dentist	NA	NA	NR	NA	NA	78.60%	NA	NA	NR
Rating of Regular Dentist	NA	NA	NR	NA	NA	95.20%	NA	NA	NR
Access to Dental Care	NA	NA	NR	NA	NA	45.30%	NA	NA	NR
Care from Dentists and Staff	NA	NA	NR	NA	NA	83.00%	NA	NA	NR
Dental Plan Services	NA	NA	NR	NA	NA	64.80%	NA	NA	NR
Would Recommend Dental Plan (Spanish)	NA	NA	NR	NA	NA	93.40%	NA	NA	NR

**Table 14. 2025 PMV Measure Results: DBMs**

Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Would Recommend Dental Plan (English)	NA	NA	NR	NA	NA	59.90%	NA	NA	NR
Tele-Dentistry Future Use	NA	NA	NR	NA	NA	31.10%	NA	NA	NR

\* The age 5 and age 15–18 stratifications do not apply to this measure.

† The age range for this stratification is 3–5 years; as ages 3 and 4 years do not apply to the Florida Healthy Kids population, the stratification has been renamed Age 5 for this report. NA = Small Denominator: The MCO followed the specifications, but the denominator was too small (<30) to report a valid rate. For utilization measures that count enrollee months, this result is reported when the denominator is <360 enrollee months.

NR = Not Reported.

NS = New Stratification; indicates that there was no data for this rate for the specific DBM, but the rate was reported for 2025 for one of the other DBMs.

## Strengths, Weaknesses, and Improvements

Strengths for the PMV indicate that the MCO or DBM demonstrated proficiency in processes for calculating performance measures identified by FHKC. Areas for improvement, or weaknesses, are noted when the plans should take action to improve measure calculation processes. Improvements are identified when an MCO or DBM demonstrates improved performance measure results.

### Strengths and Weaknesses

All MCOs and DBMs were deemed fully compliant with all NCQA-defined Information System Standards for HEDIS-applied data and processes. No particular strengths were noted for MCOs. For DBMs, DentaQuest was lauded for its staff, who were well prepared for the review, as evidenced by their identifying subject matter experts for each of the various areas

contributing to performance measure data reporting. DentaQuest had a rigorous data validation and monitoring process, managed in Microsoft Structured Query Language (SQL), which ensured the data elements in the warehouse were correctly transferred into their Windward System to further support successful measure production and reporting. Outside of measure production, the system was used across multiple departments to support various activities.

Likewise, Liberty was lauded for its thorough understanding of the PMV requirements by providing clear and informative responses. In addition, Liberty staff members provided supporting documentation and system walkthroughs that demonstrated subject matter expertise in each of the system and programming components of the PMV. Moreover, Liberty

demonstrated expertise in the management of all its systems and procedures, which ensured valid measure rates that enabled reliable year to year trending. Qsource identified that Liberty failed to account for the anchor date required in the CMS Core Set Technical Specifications when calculating the SFM-CH measure. As part of its corrective action plan (CAP), Liberty submitted a corrected numerator/denominator/rate along with source data. Qsource validated that the revised measure was calculated correctly using required specifications. The validated rates are presented in this report. Liberty's CAP was approved and completed prior to reporting.

Lastly, MCNA was praised for being well prepared for the review, as evidenced by the DBM identifying subject matter experts for each of the various areas contributing to performance measure data reporting. MCNA demonstrated strengths with its internally developed system, DentalTrac. The comprehensive system captured all data required for performance measure reporting, including claims, enrollment, and provider data. The unique system supported seamless data integration and inherently maintained the necessary controls to support data completeness and accurately produce the measures under the scope of the validation. Furthermore, MCNA maintains NCQA certification for applicable HEDIS reporting.

Each of the MCOs was also recognized as having undergone an NCQA HEDIS Compliance Audit, as well as an Information Systems Capabilities Assessment Tool (ISCAT) that the EQRO uses to validate MCO information systems, processes, and data,

and the final opinion indicated that all performance measures were prepared in accordance with the appropriate technical specifications—HEDIS or CMS Child Core Set, indicating no areas for improvement related to the DBMs' processes for data collection and performance measure reporting during the 2025 PMV. The plans did not have any AONs or weaknesses to address; therefore, only the PMV rates and year-to-year comparisons are presented in this report.

### Improvements

[Table 15](#) includes the MCOs' and DBMs' improvements, which were greater than 10% when compared to the previous year's PMV.

Among MCOs, Aetna had the most improvements since the 2024 PMV, with 40 measures trending up. Of those measures with a positive trend, a total of two measures improved at a rate of 10% or greater. CCP showed improvement across its aspects of care with 24 measures trending positively, four improving by 10% or greater. Finally, Simply Healthcare had 35 measures with positive trends, four of which with significant (>10%) improvement.

Among DBMs, MCNA had the most improvements since the 2024 PMV, with 116 measures trending up. Of those measures with a positive trend, a total of seven measures improved at a rate of 10% or greater. DentaQuest showed improvement across its aspects of care with 60 measures trending positively, 15 improving by 10% or greater. Finally, Liberty had 34 measures

with positive trends, of which five had significant (>10%) improvement.

**Table 15. Improvements Since 2024 PMV by MCO/DBM**

MCO/DBM	Measure	Quality	Timeliness	Access	2024 Measure Result	2025 Measure Result
Aetna	Ambulatory Care: Emergency Department Visits (AMB-CH) – Visits / 1,000 Enrollee Months	✓	✓		304.41	314.70
	Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH): 30-Day Follow-Up: 6–17 Years		✓	✓	51.28%	65.08%
CCP	Chlamydia Screening in Women (CHL-CH): 16–20 Years	✓	✓		55.56%	70.37%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD-CH): Continuation and Maintenance Phase	✓	✓		72.73%	100%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH): Blood Glucose Testing Total	✓			64.71%	78.57%
	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB-CH): 3 months–17 years	✓	✓		41.01%	64.55%
Simply Healthcare	Follow-Up After Hospitalization for Mental Illness (FUH-CH): 7-Day Follow-Up: 6–17 Years		✓	✓	29.30%	40.43%
	Follow-Up After Hospitalization for Mental Illness (FUH-CH): 30-Day Follow-Up: 6–17 Years		✓	✓	56.04%	76.60%
	Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH): 7-Day Follow-Up: 6–17 Years		✓	✓	20.37%	46.34%
	Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH): 30-Day Follow-Up: 6–17 Years		✓	✓	42.59%	58.54%

**Table 15. Improvements Since 2024 PMV by MCO/DBM**

MCO/DBM	Measure	Quality	Timeliness	Access	2024 Measure Result	2025 Measure Result
DentaQuest	Dental Sealants – With Exclusions: Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	✓	✓	✓	67.34%	77.35%
	Dental Sealants – With Exclusions: Enrolled at Least 11 Months Continuously: All Enrollees	✓	✓	✓	50.90%	81.21%
	Preventive Dental: Enrolled at Least 1 Month: Enrollees aged 5	✓	✓	✓	26.96%	58.97%
	Preventive Dental: Enrolled at Least 3 Months: Enrollees aged 5	✓	✓	✓	39.82%	83.78%
	Preventive Dental: Enrolled at Least 6 Months: Enrollees aged 5	✓	✓	✓	50.00%	96.50%
	Any Dental Services: Enrolled at Least 1 Month: Enrollees aged 5	✓	✓	✓	29.17%	62.92%
	Any Dental Services: Enrolled at Least 3 Months Continuously: Enrollees aged 5	✓	✓	✓	41.96%	88.70%
	Any Dental Services: Enrolled at Least 6 Months Continuously: Enrollees aged 5	✓	✓	✓	52.31%	96.72%
	Dental Treatment Services: Enrolled at Least 6 Months Continuously: Enrollees aged 5	✓	✓	✓	15.85%	29.53%
	Dental Diagnostic Service Enrolled at Least 1 Month: Enrollees aged 5	✓	✓	✓	28.26%	61.36%
	Dental Diagnostic Service Enrolled at Least 3 Months Continuously: Enrollees aged 5	✓	✓	✓	41.38%	86.95%
	Dental Diagnostic Service Enrolled at Least 6 Months Continuously: Enrollees aged 5	✓	✓	✓	51.73%	99.61%

<b>Table 15. Improvements Since 2024 PMV by MCO/DBM</b>						
<b>MCO/DBM</b>	<b>Measure</b>	<b>Quality</b>	<b>Timeliness</b>	<b>Access</b>	<b>2024 Measure Result</b>	<b>2025 Measure Result</b>
	Any Preventive Dental or Oral Health Service: Enrolled at Least 1 Month: Enrollees aged 5	✓	✓	✓	26.96%	58.97%
	Any Preventive Dental or Oral Health Service: Enrolled at Least 3 Months Continuously: Enrollees aged 5	✓	✓	✓	39.82%	83.78%
	Any Preventive Dental or Oral Health Service: Enrolled at Least 6 Months Continuously: Enrollees aged 5	✓	✓	✓	50.00%	96.50%
Liberty	Dental Sealants – With Exclusions: Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	✓	✓	✓	0.00%	16.65%
	Dental Sealants – With Exclusions: Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	✓	✓	✓	0.00%	18.98%
	Any Dental Services: Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	✓	✓	✓	36.94%	46.98%
	Dental Diagnostic Services: Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	✓	✓	✓	33.88%	44.21%
	Sealant Receipt on Permanent First Molars: Enrolled at Least 12 Months Continuously (Numerator 1): Enrollees aged 10	✓	✓	✓	19.50%	33.90%
MCNA	Topical Fluoride for Children: Enrolled at Least 12 Months Continuously (Numerator 3): All enrollees	✓	✓	✓	0.00%	25.35%
	Topical Fluoride for Children: Enrolled at Least 12 Months Continuously (Numerator 3): Enrollees aged 5	✓	✓	✓	0.00%	22.35%
	Topical Fluoride for Children: Enrolled at Least 12 Months Continuously (Numerator 3): Enrollees aged 6 to 7	✓	✓	✓	0.00%	28.73%

**Table 15. Improvements Since 2024 PMV by MCO/DBM**

MCO/DBM	Measure	Quality	Timeliness	Access	2024 Measure Result	2025 Measure Result
	Topical Fluoride for Children: Enrolled at Least 12 Months Continuously (Numerator 3): Enrollees aged 8 to 9	✓	✓	✓	0.00%	30.26%
	Topical Fluoride for Children: Enrolled at Least 12 Months Continuously (Numerator 3): Enrollees aged 10 to 11	✓	✓	✓	0.00%	29.80%
	Topical Fluoride for Children: Enrolled at Least 12 Months Continuously (Numerator 3): Enrollees aged 12 to 14	✓	✓	✓	0.00%	25.93%
	Topical Fluoride for Children: Enrolled at Least 12 Months Continuously (Numerator 3): Enrollees aged 15 to 18	✓	✓	✓	0.00%	19.31%

## Conclusions

### Aetna

Aetna underwent an NCQA HEDIS Compliance Audit by a NCQA-Certified HEDIS Compliance Auditor for their performance measures. Qsource reviewed all related documentation, which included Aetna's completed ISCAT. Sufficient and complete documentation was available to support the performance measure validation activities. It was determined that all performance measures conformed to the appropriate technical specifications, and they received a Reportable designation. Subsequently, Aetna has passed the PMV.

The final opinion indicated that all HEDIS and non-HEDIS performance measures were prepared in accordance with the

appropriate technical specifications (HEDIS or CMS Child Core Set).

These results indicated an overall high confidence in Aetna's ability to provide quality and timely care for its enrollees.

### Community Care Plan

CCP underwent a NCQA HEDIS Compliance Audit by a NCQA-Certified HEDIS Compliance Auditor for their performance measures. Qsource reviewed all related documentation, which included CCP's completed ISCAT. Sufficient and complete documentation was available to support the performance measure validation activities. It was determined

that all performance measures conformed to the appropriate technical specifications, and they received a Reportable designation. Subsequently, CCP has passed the PMV.

The final opinion indicated that all HEDIS and non-HEDIS performance measures were prepared in accordance with the appropriate technical specifications (HEDIS or CMS Child Core Set).

These results indicated an overall high confidence in CCP's ability to provide quality and timely care for its enrollees.

### **Simply Healthcare**

Simply Healthcare underwent an NCQA HEDIS Compliance Audit by an NCQA-Certified HEDIS Compliance Auditor for their performance measures. Qsource reviewed all related documentation, which included Simply Healthcare's completed ISCAT. Sufficient and complete documentation was available to support the performance measure validation activities. It was determined that all performance measures conformed to the appropriate technical specifications, and they received a Reportable designation. Subsequently, Simply Healthcare has passed the PMV.

The final opinion indicated that all HEDIS and non-HEDIS performance measures were prepared in accordance with the appropriate technical specifications (HEDIS or CMS Child Core Set).

These results indicated an overall high confidence in Simply Healthcare's ability to provide quality and timely care for its enrollees.

### **DentaQuest**

DentaQuest was fully compliant with the PMV Claims/Encounters data systems, eligibility data system findings, provider data systems, and data integration.

Qsource performed primary source verification on a random sample of 10 enrollees with an oversample of 5 for each of the selected CMS Core Set measures, specifically, Sealant Receipt on Permanent First Molars (SFM-CH), Oral Evaluation, Dental Services (OEV-CH), and Prevention: Topical Fluoride for Children (TFL-CH). All data attributes required for measure reporting, including enrollee age, date of service, procedure code, taxonomy, continuous enrollment, and tooth number, were verified. The validated processes used to develop these measures were aggregated into all measures. No discrepancies were identified.

DentaQuest utilized internal, proprietary source code written in SQL for measure production. Qsource conducted source code review to verify that the algorithms used to calculate and report the performance measures, including denominator, numerator, and rates, complied with measure specifications.

These results indicated an overall high confidence in DentaQuest's ability to provide quality and timely care for its enrollees.

## Liberty

Liberty was fully compliant with the PMV requirements for Claims/Encounter data systems, enrollment/eligibility data systems, provider credentialing/contracting data systems, and data integration and control.

Qsource performed primary source verification on a random sample of 10 enrollees with an oversample of 5 for each of the selected CMS Core Set measures, specifically, Sealant Receipt on Permanent First Molars (SFM-CH), Oral Evaluation, Dental Services (OEV-CH), and Prevention: Topical Fluoride for Children (TFL-CH). All data attributes required for measure reporting, including enrollee age, date of service, procedure code, taxonomy, continuous enrollment, and tooth number, were verified. The validated processes used to develop these measures were aggregated to all measures. However, Liberty did not factor in the anchor date required in the CMS Core Set Technical Specifications when calculating the SFM-CH measure. Qsource validated that the revised measure was calculated correctly using required specifications. The validated rates are presented in this report. Liberty's CAP was approved and completed prior to reporting.

Liberty utilized internal, proprietary source code written in SQL for measure production. Qsource conducted source code review to verify that the algorithms used to calculate and report the performance measures, including denominator, numerator, and rates, complied with measure specifications. Liberty accurately defined and tabulated continuous enrollments of enrollees

including the number of days not enrolled and the number of breaks in enrollment.

These results indicated an overall high confidence in Liberty's ability to provide quality and timely care for its enrollees.

## MCNA

MCNA was fully compliant with the claims data system findings, eligibility data system findings, provider systems review, and data integration.

Qsource performed primary source verification on a random sample of 10 services with an oversample of 5 for each of the selected CMS-416 measures, specifically Sealant Receipt on Permanent First Molars (SFM-CH), Oral Evaluation, Dental Services (OEV-CH), and Prevention: Topical Fluoride for Children (TFL-CH). All data attributes required for measure reporting, including enrollee age, date of service, procedure code, and tooth number were verified. The validated processes used to develop these measures were aggregated to all measures. No discrepancies were identified.

MCNA utilized internal, proprietary source code written in SQL for measure production. Qsource conducted source code review to verify that the algorithms used to calculate and report the performance measures, including denominator, numerator, and rates complied with measure specifications.

These results indicated an overall high confidence in MCNA's ability to provide quality and timely care for its enrollees.

# Annual Compliance Assessment (ACA)

## Objectives

Qsource conducted the ACA reviews pursuant to the requirements in:

- ◆ 42 CFR § 438, Subparts D and F, as incorporated by 42 CFR § 457 Subpart L;
- ◆ 42 CFR §§ 438.10 and 438.330;
- ◆ CMS’s EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations (2019); and
- ◆ FHKC medical service contracts (MSCs) and dental services contracts (DSCs).

The team consisted of staff with expertise in program evaluation and quality improvement.

FHKC has chosen for the EQR to review one-third of the compliance standards as shown in [Table 16](#). Coordination and Continuity of Care, Coverage and Authorization of Services, and Subcontractual Relationships and Delegation were the standards reviewed and included in this report.

For a crosswalk demonstrating how Qsource’s assessment tools reflect these required standards, see [Appendix D](#).

**Table 16. Compliance Assessment Standards**

Standard	CFR Citations	Quality	Timeliness	Access	Review Year
Availability of Services (AOS)	42 CFR § 438.206		✓	✓	2024
Assurances of Adequate Capacity and Services (AACS)	42 CFR § 438.207	✓	✓	✓	2024
Grievances and Appeals (GA)	42 CFR § 438.228			✓	2024
Practice Guidelines (PG)	42 CFR § 438.236	✓			2024

**Table 16. Compliance Assessment Standards**

<b>Standard</b>	<b>CFR Citations</b>	<b>Quality</b>	<b>Timeliness</b>	<b>Access</b>	<b>Review Year</b>
Health Information Systems (HIS)	42 CFR § 438.242	✓	✓	✓	2024
Quality Assessment and Performance Improvement (QAPI)	42 CFR § 438.330	✓	✓	✓	2024
Coordination and Continuity of Care	42 CFR § 438.208	✓	✓	✓	2025
Coverage and Authorization of Services	42 CFR § 438.210		✓	✓	2025
Subcontractual Relationships and Delegation	42 CFR § 438.230	✓	✓	✓	2025
Enrollee Information*	42 CFR § 438.224	✓		✓	2026
Enrollee Rights and Protections*	42 CFR § 438.100	✓	✓	✓	2026
Provider Selection (Credentialing/ Recredentialing)	42 CFR § 438.214	✓	✓		2026

\*Confidentiality is divided into two sections: Enrollee Information and Enrollee Rights and Protections.

### Technical Methods for Data Collection and Analysis

The ACA was conducted virtually. Protocols for the 2025 ACA review were guided by CMS’s EQR Protocol 3 (February 2023). The ACA was conducted in three phases: pre-virtual review, virtual review, and post-virtual review. Qsource developed evidence-based oversight tools in consultation with FHKC and by referencing the MCO Services Contract, the DBM Services Contract, the MCO and DBM Provider Manuals, and the requirements included in 42 CFR § 438. Qsource provided an ACA Process Overview document, including an agenda for the virtual review, as well as the standard review tools, to explain the process. Throughout the ACA process, Qsource worked closely with FHKC and the plans to ensure a supportive and coordinated process.

The virtual reviews took place from August through September 2025. During the reviews, plan staff answered questions and provided information to help surveyors determine the degree of compliance with federal and agreement/contract requirements, explored any issues not fully addressed in the document review, and increased overall understanding of the operations. Qsource surveyors used the tools, along with personal observations, interviews with plan staff, virtual system demonstrations, and file/document reviews, to facilitate analyses and compilation of findings. Each plan also provided additional documentation as needed for surveyors during the virtual review. The compliance rating was determined by the percentage score of all elements met, as guided by EQR Protocol 3, and was calculated by

dividing the number of elements met by the number of elements assessed. The compliance rating indicates Qsource’s confidence (ranging from No Compliance to High Compliance) that the plans met the elements for the standards reviewed.

To reduce duplication of assessment activities, FHKC allowed certain standard elements to be deemed compliant when a plan was accredited by a nationally recognized accreditation organization such as NCQA, the Accreditation Association for Ambulatory Health Care (AAAHC), or Utilization Review Accreditation Commission (URAC), and had achieved a full score on an element with similar requirements to the regulatory or contractual element.

[Table 17](#) presents the rating criteria used in the Compliance Assessment (CA) validation.

**Table 1718. Compliance Rating Criteria**

Status	Criteria
<b>High Compliance</b>	Of all elements assessed, 90–100% were met.
<b>Moderate Compliance</b>	Of all elements assessed, 80–<90% were met.
<b>Low Compliance</b>	Of all elements assessed, 70–<80% were met.
<b>No Compliance</b>	Less than 70% of the elements were met.

## Annual Compliance Assessment

In addition to compliance standards, the ACA includes reviews of a random sample of Utilization Management (UM) Denial files to evaluate how the MCO applies the processes and procedures required in 42 CFR § 422.204 and 438.214 in its operational practice. Qsource asked each plan to provide the universe of Utilization Management (UM) Denial files, from which Qsource extracted a random sample and an oversample. Files in this selection included 15 files (10 sample and 5 oversample). The file review tool and tool instructions are included in [Appendix C](#).

### Description of Data Obtained

Throughout the documentation review and virtual assessment processes, Qsource reviewers used the survey tools to collect

information and document findings. Each plan's compliance with regulatory and contractual standards were validated through a review of policies and procedures (P&Ps), quality studies, reports, medical records/files, and other related plan documentation. Each standard element had an assigned point value of 1, and Qsource analyzed every element in the survey tools. Qsource determined plans performance scores by adding the total points earned for each standard element on a scale of 0 to 1. Scores for each standard were calculated by dividing the total points earned for all elements in the standard by the total points possible for all elements in the standard.

## MCO and DBM Findings

### Compliance Standards

[Table 18](#) includes overall compliance scores for all standards evaluated in 2025 for the ACA. [Table 19](#) includes the file review scores.

Table 18. 2025 Compliance Scores and Ratings		
Standards	Score	Compliance Rating
<b>Aetna</b>		
Coordination and Continuity of Care	100%	High Compliance
Coverage and Authorization of Services	100%	High Compliance
Subcontractual Relationships and Delegation	100%	High Compliance
<b>Aetna Overall Compliance Standard Score</b>	<b>100%</b>	<b>High Compliance</b>
<b>CCP</b>		
Coordination and Continuity of Care	100%	High Compliance
Coverage and Authorization of Services	100%	High Compliance

**Table 18. 2025 Compliance Scores and Ratings**

<b>Standards</b>	<b>Score</b>	<b>Compliance Rating</b>
Subcontractual Relationships and Delegation	100%	High Compliance
<b>CCP Overall Compliance Standard Score</b>	<b>100%</b>	<b>High Compliance</b>
<b>DentaQuest</b>		
Coordination and Continuity of Care	97.22%	High Compliance
Coverage and Authorization of Services	100%	High Compliance
Subcontractual Relationships and Delegation	100%	High Compliance
<b>DentaQuest Overall Compliance Standard Score</b>	<b>99.07%</b>	<b>High Compliance</b>
<b>Liberty</b>		
Coordination and Continuity of Care	94.44%	High Compliance
Coverage and Authorization of Services	96.46%	High Compliance
Subcontractual Relationships and Delegation	90.63%	High Compliance
<b>Liberty Overall Compliance Standard Score</b>	<b>93.84%</b>	<b>High Compliance</b>
<b>MCNA</b>		
Coordination and Continuity of Care	100%	High Compliance
Coverage and Authorization of Services	97.56%	High Compliance
Subcontractual Relationships and Delegation	NA	NA
<b>MCNA Overall Compliance Standard Score</b>	<b>98.78%</b>	<b>High Compliance</b>
<b>Simply Healthcare</b>		
Coordination and Continuity of Care	100%	High Compliance
Coverage and Authorization of Services	100%	High Compliance
Subcontractual Relationships and Delegation	100%	High Compliance
<b>Simply Healthcare Overall Compliance Standard Score</b>	<b>100%</b>	<b>High Compliance</b>

**Table 19. 2025 File Review Scores**

<b>File Review</b>	<b>Score</b>	<b>Compliance Rating</b>
<b>Aetna</b>		
UM Denials File Review	100%	High Compliance
<b>Aetna Overall Compliance Standard Score</b>	<b>100%</b>	<b>High Compliance</b>
<b>CCP</b>		
UM Denials File Review	100%	High Compliance
<b>CCP Overall Compliance Standard Score</b>	<b>100%</b>	<b>High Compliance</b>
<b>DentaQuest</b>		
UM Denials File Review	100%	High Compliance
<b>DentaQuest Overall Compliance Standard Score</b>	<b>100%</b>	<b>High Compliance</b>
<b>Liberty</b>		
UM Denials File Review	100%	High Compliance
<b>Liberty Overall Compliance Standard Score</b>	<b>100%</b>	<b>High Compliance</b>
<b>MCNA</b>		
UM Denials File Review	100%	High Compliance
<b>MCNA Overall Compliance Standard Score</b>	<b>100%</b>	<b>High Compliance</b>
<b>Simply Healthcare</b>		
UM Denials File Review	100%	High Compliance
<b>Simply Healthcare Overall Compliance Standard Score</b>	<b>100%</b>	<b>High Compliance</b>

**Table 20. 2025 ACA Overall Compliance Scores**

<b>Standard</b>	<b>Plan Overall Compliance 2025</b>
Coordination and Continuity of Care	99.07%
Coverage and Authorization of Services	99.16%
Subcontractual Relationships and Delegation	98.26%

**Table 20. 2025 ACA Overall Compliance Scores**

Standard	Plan Overall Compliance 2025
UM Denials File Review	100%
<b>Total Overall Score</b>	<b>98.97%</b>

## Conclusions

### Strengths and Weaknesses

Scoring for each evaluated Quality Performance (QP) standard and file review reflects each plan's degree of compliance with applicable contractual, state, and federal requirements. In addition, Qsource identifies strengths, suggestions, and AONs (weaknesses) to highlight areas in which a plan excels, areas in which it could improve, and areas in which it must improve to achieve compliance. This information is shown in [Table 21](#). The

lack of an identified strength should not be considered a deficiency. AONs are identified when a plan achieves less than 100% compliance on any given QP standard element or file review, and may be accompanied by recommendations for policy, procedure, or process changes. Because the plans are not held accountable for addressing suggestions, suggestions are not included in this report.

**Table 2122. ACA Strengths and Weaknesses by Standard**

MCO/DBM	Standard Title	Strength/AON
<b>Strengths</b>		
Aetna	Coverage and Authorization of Services	<b>Element 21: Financial Responsibility for Poststabilization Services:</b> The MCO submitted documents that clearly outlined the financial responsibility of Aetna in regard to post stabilization services and addressed each sub element in detail.
	Coverage and Authorization of Services	<b>Element 41: Enrollee Handbook:</b> The MCO supplied various documents to demonstrate the information that is provided to the enrollee at the time of enrollment and the accessibility of the handbook on Aetna's website.

Table 2122. ACA Strengths and Weaknesses by Standard

MCO/DBM	Standard Title	Strength/AON
CCP	Coordination and Community of Care	<b>Element 16: Social Determinants of Health:</b> The MCO submitted various policies to document the mechanisms in which CCP addressed social service needs for their enrollees through available community-based social services resources.
	Coverage and Authorization of Services	<b>Element 31: Electronic Information:</b> The MCO supplied multiple documents to indicate all the required conditions are met for information provided electronically to enrollees including website screenshots and examples of postcard and welcome letter materials.
	Subcontractual Relationships and Delegation	<b>Element 13: Routine and Non-Routine Monitoring:</b> The MCO provided multiple documents to demonstrate the processes in place to monitor and track activities conducted by their subcontractors.
Liberty	Coverage and Authorization of Services	<b>Element 29: Provider Incentive Plans:</b> Qsource was able to access a Value-Base Program on the Liberty website: Brush Program.
<b>AONs</b>		
DentaQuest	Coordination of Care	<b>Element 6: Coordination of Care:</b> The DBM should include the verbiage “notify FHKC of any enrollees the DBM identifies as covered under other health insurance by the 15th of each month in a manner specified by FHKC.”
Liberty	Coordination and Continuity of Care	<b>Element 6: Coordination of Care:</b> The DBM should include in the policy the verbiage concerning the notification to FHKC by the 15th day of each month.
	Coordination and Continuity of Care	<b>Element 6: Coordination of Care:</b> The DBM should include in the policy, “Insurer will provide a copy of Insurer’s transition of care policy to FHKC by the date established in the approved implementation plan and prior to any

**Table 2122. ACA Strengths and Weaknesses by Standard**

MCO/DBM	Standard Title	Strength/AON
		proposed changes. Changes to Insurer’s transition of care policy are subject to FHKC’s approval.”
	Coverage and Authorization of Services	<b>Element 2: DBM Non-Refusal to Cover Benefits or Services:</b> The DBM should include in the policy the guideline for informing FHKC of information received about changes in an enrollee’s circumstances.
	Coverage and Authorization of Services	<b>Element 13: Covered Outpatient Drug Decisions:</b> The DBM should include the authorization decisions for covered outpatient medications in their policy.
	Coverage and Authorization of Services	<b>Element 21: Electronic Information:</b> The DBM should include in the enrollee information requests policies/Handbook, the DBM provides the information “within five business days.”
	Subcontractual Relationships and Delegation	<b>Element 5: Grievance and Appeal Process:</b> The grievance and appeal process should be described in the entrance information for subcontractors.
	Subcontractual Relationships and Delegation	<b>Element 16: Subcontractor Solvency:</b> The notification time frame should be the same in the policy.
MCNA	Coverage and Authorization of Services	<b>Element 13: Covered Outpatient Drug Decisions</b> The DBM should include in the enrollee information that prescription drugs are covered under their medical, not dental coverage.

**Improvements Since the 2022 ACA**

As ACA standards are measured on a review cycle of every three years, the standards for the 2025 ACA (MY 2024) were last reviewed in the 2022 ACA (MY 2021). [Table 22](#) shows the improvements and addressed AONs from the 2022 ACA to the 2025 ACA.

**Table 22. Improvements from 2022 ACA**

2022 AON (MY 2021)	Improvements	Degree to Which Plan Addressed Recommendation(s)
<b>Aetna</b>		
Aetna did not have any AONs for the 2022 ACA.		
<b>CCP</b>		
<p><b>Coverage and Authorization of Services, Element 43: Enrollee Handbook Content 2</b>—Based on the way in which the information is documented in the member and provider handbooks, it is unclear if the member is required to obtain a referral for family planning providers. CCP should update both the member and provider handbooks to clearly indicate that members do not need a referral for family planning services. Members are informed of the limitations on family planning services for out of network providers, but the information pertaining to referrals before choosing a family planning provider is unclear.</p>	<p>The MCO’s Member Handbook was submitted as evidence. The document detailed emergency and after-hours coverage, restrictions on enrollee’s choice of providers, family planning benefits, and cost sharing information. The document was current and met the criteria for the element.</p>	<p>High</p>
<p><b>Coverage and Authorization of Services, Element 48: MCO Secure Website for Enrollees</b>—CCP does not track copayments for the Florida Healthy Kids lines of business. Per MSC 21: “Cost sharing accumulator information i. Insurer shall track the Enrollees’ cost share contributions to assist families in tracking their progress towards the out-of-pocket maximum.” CCP</p>	<p>The MCO’s Member Handbook and the FHK Enrollee Welcome Letter was submitted as evidence. Both documents addressed the information that is contained on the MCO’s website and how it was accessible to enrollees. The documents were current and met the criteria for the element.</p>	<p>High</p>

**Table 22. Improvements from 2022 ACA**

2022 AON (MY 2021)	Improvements	Degree to Which Plan Addressed Recommendation(s)
<p>should update their policy and procedures to include information regarding the cost-sharing accumulator. The references in response to the cost sharing accumulator is not related to the lifetime limit. The out-of-pocket maximum is 5% of an enrollee's family income per FHKC. Per FHKC feedback received in response to the information provided for Element 48 from CCP the plan must track the enrollee's cost share contributions to help the family keep track of where they are in relation to family income.</p>		

**DentaQuest**

DentaQuest did not have any AONs for the 2022 ACA.

**Liberty**

Liberty was not yet contracted with FHKC in 2022; therefore, no comparisons can be made.

**MCNA**

MCNA did not have any AONs for the 2022 ACA.

**Simply**

Simply Healthcare did not have any AONs for the 2022 ACA.

**Improvements Since the 2024 ACA**

Corrective action plans (CAPs) are designed to improve performance and give plans the opportunity to receive help with quality improvement. FHKC may request CAPs at its discretion, but MCOs and DBMs must submit a CAP for any QP standard element or file review scoring less than 100% compliance, regardless of overall performance on the standard or activity. Qsource provided technical assistance to the MCOs and DBMs

completing CAPs, submitted CAP evaluations to FHKC for follow-up, and encouraged MCOs and DBMs to monitor CAP activities throughout 2024 to ensure they fully met stated goals and to close compliance gaps within documented timelines. All CAPs submitted after last year's ACA met objectives, as shown in [Table 23](#).

Table 23. CAPs from 2024 ACA	
2024 AON (MY 2023)	Improvements
<b>CCP</b>	
<p><b>Grievance and Appeal System, Element 1: Grievance and Appeal System</b>—The MCO should ensure that provides its Grievance and Appeal policies and procedures to FHKC by the date established in the approved implementation plan and at least 60 Calendar Days prior to any proposed changes. While the MCO provided evidence that they will update their policy to reflect the submission requirement, the amended policy was not in place for the 2023 review period.</p>	<p>CCP will update the G&amp;A Policy QM21 to include the required language in GA Element #1 &amp; CAP#1. CCP provided a draft updated policy showing the edits to be made. The edits and additions met the intent of the AON. Qsource staff discussed these changes in the ACA and the submitted draft document showing the changes showed progress in meeting the CAP. CCP made modifications to the policy and had it approved on 10/09/2024. CCP did not give the date FHKC reviewed or would review.</p> <p>Qsource is satisfied with the CAP response. CCP made the requested changes to the handbook. CCP provided an approval date of 10/09/2024.</p>
<p><b>Grievance and Appeal System, Element #4: Timing to File Grievance and Appeal</b>—The MCO should revise its policy and procedure to ensure that enrollees may file a grievance with the MCO at any time.</p>	<p>CCP will update the G&amp;A Policy QM21 to include the required language in GA Element #4 &amp; CAP #2. CCP provided a draft updated policy showing the edits to be made. The edits and additions met the intent of the AON. Qsource staff discussed these changes in the ACA and the submitted draft document describing the changes demonstrated progress in meeting the CAP. CCP made the modifications to the policy and had it approved on 10/09/2024.</p>

Table 23. CAPs from 2024 ACA

2024 AON (MY 2023)	Improvements
	Qsource is satisfied with the CAP response. CCP made the requested changes to the handbook. CCP provided an approval date of 10/09/2024.
<b>DentaQuest</b>	
<p><b>Grievance and Appeal System, Element #8: Timing of Notice</b>—The DBM should update its policies and procedures to ensure that, for denial of payment, a Notice of Adverse Benefit Determination (NABD) is mailed at the time of any action affecting the claim.</p>	<p>DentaQuest stated that this policy is included in the “Claim Letter Templates” policy and procedure document. This addressed the AON. DentaQuest provided policy stating, “Notification of the claim denial is completed at the time of the claim adjudication and/or claim payment.” This met the intent of the AON. The policy showed progress in meeting the CAP.</p> <p>DentaQuest provided the policy that shows “Notification of the claim denial is completed at the time of the claim adjudication and/or claim payment. See page 1, A, Denial Notification #2” with an action date of 10/10/2024.</p> <p>Qsource is satisfied with DentaQuest’s response. DentaQuest provided policy and procedures that include the language in the AON.</p>
<p><b>Health Information Systems, Element #4: Electronic Health Records for Providers Throughout the Contract Term</b>—</p> <p>The DBM should have a policy or procedure which reflects the requirement to report to FHKC annually.</p>	<p>DentaQuest updated their policy and procedures to address Electronic Health Records per the FHKC contract. DentaQuest provided an updated policy showing the edits that were made. The edits and additions met the intent of the AON. DentaQuest updated its policies and procedures and added the language that reflected the requirements in the FHKC contract. DentaQuest made the modifications to the policy and provided a completion date of 9/30/2024. DentaQuest did not give the date FHKC reviewed or would review the updated policies.</p> <p>Qsource is satisfied with DentaQuest’s response. DentaQuest updated the policy and procedures that include the language in the AON.</p>

Table 23. CAPs from 2024 ACA

2024 AON (MY 2023)	Improvements
<p><b>Quality Assessment and Performance Improvement (QAPI) Program, Element #2: Fraud, Waste, and Abuse—</b> The DBM should have a method to verify services that were represented to have been delivered by network Providers were received by Enrollees. The DBM should include in its policy or procedure that it would provide its Fraud, Waste, and Abuse policies to FHKC for approval prior to any changes.</p>	<p>DentaQuest updated their draft policy and procedures to include Exhibit P: FL Healthy Kids to the program policy. Additionally, DentaQuest provided standard operation procedures (SOP) for Member Verification of Services document outlining the method through which they verify services that were represented to have been delivered by network Providers were received by Enrollees. DentaQuest provided an updated draft policy showing the edits that were made. The edits and additional documentation provided met the intent of the AON. DentaQuest updated its draft policies and procedures and added the language that reflected the requirements in the FHKC contract. DentaQuest made the modifications to the draft policy and provided a completion date of 10/3/2024. DentaQuest did not give the date FHKC reviewed or would review the updated policies.</p> <p>Qsource is satisfied with DentaQuest’s response. DentaQuest provided an updated draft policy and procedure that includes language in the AON.</p>
<p><b>Quality Assessment and Performance Improvement (QAPI) Program, Element #3: Accreditation—</b>The DBM should ensure that it informs FHKC of any change in accreditation status within thirty (30) Calendar Days of such change.</p>	<p>DentaQuest updated their QAPI program description to include the required language and stated that any changes to the accreditation status will be submitted within thirty days of the change. This addressed the AON. DentaQuest provided an updated draft policy stating, “DentaQuest shall inform FHKC of any accreditations received by a private independent accrediting entity. Any changes to the accreditation status will be submitted within thirty days of the change.” This met the intent of the AON. The policy showed progress in meeting the CAP. DentaQuest provided the updated draft policy that shows that updates were made with an action date of 10/1/2024.</p>

Table 23. CAPs from 2024 ACA

2024 AON (MY 2023)	Improvements
	<p>Qsource is satisfied with DentaQuest’s response. DentaQuest provided an updated draft policy and procedures that included the language in the AON. DentaQuest did not provide an FHKC approval date.</p>
<p><b>CA Standard: File Review: Grievances, File #: 4, 5, 7</b>—The DBM should ensure that the investigation into each grievance is thoroughly documented. During the Grievance file review, it was determined that some files were missing proper documentation and investigation notes.</p>	<p>DentaQuest stated that “the errors were done by one specialist... coaching and refresher training on proper documentation has been provided.” This addressed the AON. This met the intent of the AON. DentaQuest addressed the issue by coaching and training the specialist which showed progress in meeting the CAP. DentaQuest provided coaching and training to the specialist who made errors with an action date of 10/8/2024.</p> <p>Qsource is satisfied with DentaQuest’s response. DentaQuest provided coaching and refresher training on proper documentation to the specialist that made the errors in the files.</p>
<p><b>Liberty</b></p> <p><b>Availability of Services, Element #2: Delivery Network</b>—While the DBM’s policy stated that it would notify FHKC within seven days of an adverse change, the policy should address the requirement that it give advance notice within 60 calendar days of an anticipated termination of any provider with at least 50 enrollees on its patient panel.</p>	<p>Liberty updated their policy specific to giving an advance notice within 60 calendar days of an anticipated termination of any provider with at least 50 enrollees on its patient panel. Liberty provided the updated policies and procedures showing the edits to be made. The edits and additions met the intent of the AON. Liberty submitted documentation where updates were made. This showed progress in meeting the CAP. Liberty provided a completion date of 10/3/2024.</p> <p>Qsource is satisfied with the CAP response. Liberty made the edits to their policies and procedures and added the language requested in the CAP. The updated policies and procedures were approved on 10/3/2024.</p>
<p><b>MCNA</b></p>	

Table 23. CAPs from 2024 ACA

2024 AON (MY 2023)	Improvements
<p><b>File Review: UM Denials File #: 5 and 9—</b> The DBM should ensure timeliness of UM denial decisions and notifications.</p>	<p>MCNA has updated their internal timeframe for standard authorizations to 7 calendar days in preparation for the CMS update effective in 2026. This addressed the AON. MCNA’s decision to update the internal timeframe met the intent of the AON. The update was made to the internal timeframe which showed progress in meeting the CAP. The action was completed on 9/17/2024.</p> <p>Qsource is satisfied with the DBM’s response. MCNA updated their internal timeframe for standard authorizations to seven calendar days.</p>
<b>Simply Healthcare</b>	
<p><b>Grievance and Appeal System, Element #1: Grievance and Appeal System—</b>The MCO should have a policy or procedure which ensures that it provides its Grievance and Appeal P&amp;Ps to FHKC by the date established in the approved implementation plan and at least 60 calendar days prior to any proposed changes.</p>	<p>Simply updated their policies and procedures for “Member Complaints and Grievances.” Simply provided the updated policies and procedures showing the edits to be made. The edits and additions met the intent of the AON. Simply submitted documentation where updates were made. This showed progress in meeting the CAP. Simply provided a completion date of 6/28/2024. Qsource is satisfied with the CAP response. Simply made the edits to their policies and procedures and added the language requested in the CAP. The updated policies and procedures were approved by FHKC on 10/7/2024.</p>

## Annual Network Adequacy (ANA)

### Objectives

Florida Healthy Kids Corporation (FHKC) administers the Florida Healthy Kids program and has contracted with Qsource,

an EQR organization (EQRO), to conduct an annual analysis of its MCOs’ provider network adequacy as mandated by Title 42

of the Code of Federal Regulations, Sections 457.1218 and 438.68 (42 CFR §§ 457.1218 and 438.68). These sections require that FHKC develop and enforce provider network adequacy standards. The contract between FHKC and its MCOs establishes minimum requirements for services to be provided to Florida Healthy Kids enrollees and includes geographical access time and distance standards for urban and rural primary care, specialty care, hospitals, and ancillary providers as well as appointment availability standards to ensure timely enrollee access to services.

This report presents the results of the Annual Network Adequacy (ANA) review. It describes the review methodologies, the findings for each task, and recommendations for improvement.

Qsource evaluated each MCO to determine if it had an adequate provider network to ensure the effective and efficient delivery of healthcare to enrollees, pursuant to 42 CFR § 457.1218 and 438.68. Geographic network adequacy analysis was conducted to assess the network adequacy of each MCO.

## Methodology

The 2025 ANA review covered the period of January 1, 2024, to December 31, 2024. Qsource contracted with Quest Analytics, LLC, to assess geographical access to primary care providers (PCPs), high-volume specialty care providers, behavioral health providers and facilities, hospitals, laboratories, and pharmacies by calculating the travel time and distance between MCO or

DBM enrollees and providers. The geographical access analyses identify the percentage of enrollees who had access to the various provider types within the travel time and distance standards set by the MCO's or DBM's contract with FHKC.

For the 2025 ANA review, Qsource conducted the following:

- ◆ analyses of the geographic distribution of the MCO's providers as of March 2025; and,
- ◆ review of the MCO's appointment availability and accessibility P&Ps, provider manual, and enrollee handbook in place during 2025.

Information and data for the 2025 ANA review were obtained from the MCO's provider file, the enrollment file provided by the enrollment broker, and the MCO's appointment availability P&Ps, provider manual, and enrollee handbook. This report describes the review methodologies, findings, and recommendations regarding network adequacy for Florida Healthy Kids enrollees.

### Technical Methods of Data Collection and Analysis

The 2025 ANA evaluation included MCO and DBM provider networks as of March 2025. MCO and DBM relevant P&Ps and provider and enrollee communication materials were assessed. The reviewers focused on the following areas:

- ◆ analyses of the geographic distribution and availability of providers to Florida Healthy Kids enrollees; and
- ◆ appointment availability and accessibility standards documented in P&Ps, enrollee handbooks, and provider manuals or provider agreements.

The standards used to evaluate the MCOs' and DBMs' provider networks for FHKC enrollees are provided in [Appendix C](#).

Quest Analytics derived the data for quantitative analyses from provider data files as of March 2025, supplied by each MCO or DBM, and enrollment/eligibility files as of March 2025, provided by FHKC. To be included in the analysis, an enrollee had to have the following:

- ◆ active eligibility and enrollment in the MCO/DBM as of March 2025;
- ◆ an address within Florida; and
- ◆ a valid address as defined by the Quest Analytics Suite™ during data standardization.

Provider and enrollee addresses were standardized to the United States Postal Service address format. The addresses were then geocoded, or converted into spatial data, associating the exact geographical coordinates for the address. Each enrollee and provider address were assigned a latitude and longitude coordinate. If an exact latitude and longitude coordinate could not be identified, but a valid ZIP Code was available, Quest Analytics used a proprietary assignment for latitude and longitude coordinates in a ZIP-distributive geocoding process. ZIP-distributive geocoding considers the number of such ZIP-only points within a ZIP Code area and assigns latitude and longitude coordinates based on the population patterns of that ZIP Code.

### Description of Data Obtained

After geocoding, duplicate provider records were eliminated. The provider data used in the analysis reflected the following:

- ◆ a single provider with multiple addresses was counted once for each address;
- ◆ multiple providers at the same address were counted as distinct providers;
- ◆ a single provider with more than one specialty was counted for each specialty; and
- ◆ providers whose National Provider Identifiers (NPIs) had been deactivated were excluded from the analyses.

All analyses were conducted based on a specified point in time, March 2025. Results were based on the supposition that all variables utilized in the analyses were consistent across the entire period being reviewed.

## Results

### Network Adequacy

This travel time and distance analysis evaluates enrollee access to providers based on the travel time and distance standards specified in the FHKC contract for each provider category. The following tables present the percentage of enrollees by geographical location type with access to the various categories of care within applicable time and distance standards for the MCO's or DBM's service area. For provider categories that include more than one specialty, access was calculated as access to any one of the specialties within the category.

**Table 24** contains the information about the standards used to evaluate the MCO's provider network for FHKC enrollees. Geographic access standards used in ANA analyses were

derived from the Medical Services Contract (MSC) between FHKC and MCOs, section 24-4-2, effective January 1, 2020.

**Table 24. MCO Travel Time and Distance Requirements**

Provider Type	Time (in minutes)		Distance (in miles)	
	Urban	Rural	Urban	Rural
Primary Care Provider (PCP) – Family Medicine	20	20	20	20
PCP – Pediatrics	20	30	20	30
Allergy & Immunology	30	60	30	45
Dermatology	30	60	30	45
Obstetrics & Gynecology	30	30	30	30
Optometry	30	60	30	45
Otolaryngology (ENT)	30	60	30	45
Behavioral Health – Pediatric	30	60	30	45
Behavioral Health – Other	30	60	30	45
Specialist – Pediatric	20	40	20	30
Specialist – Other	20	20	20	20
Hospital	30	30	20	30
Pharmacy	15	15	10	10
Urgent Care Center	Report*	Report*	Report*	Report*
Telehealth Services	Report†	Report†	Report†	Report†

\* FHKC opted to apply hospital access standards to urgent care center access.

† There are currently no established time and distance standards set by FHKC for this provider type. A separate report is provided by provider.

**Table 25** contains information about the standards used to evaluate the DBM’s provider network for FHKC enrollees. Geographic access standards used in ANA analyses were derived from the Dental Services Contract (DSC) between FHKC and DBMs, section 24.9.1, amended March 9, 2022.

<b>Table 25. DBM Travel Time and Distance Requirements</b>				
<b>Provider Type</b>	<b>Time (in minutes)</b>		<b>Distance (in miles)</b>	
	<b>Urban</b>	<b>Rural</b>	<b>Urban</b>	<b>Rural</b>
Primary Care Dentists	20	30	20	30
Orthodontists	30	70	20	50
Dental Specialists	20	40	20	30

**Table 26** presents the percentage of enrollees for each MCO that had access to care within the required travel time standards for each required provider type.

<b>Table 26. MCO Time Analysis by Required Provider Type</b>						
<b>Provider Type</b>	<b>% of Enrollees with Access: Aetna</b>		<b>% of Enrollees with Access: CCP</b>		<b>% of Enrollees with Access: Simply Healthcare</b>	
	<b>Urban 2025</b>	<b>Rural 2025</b>	<b>Urban 2025</b>	<b>Rural 2025</b>	<b>Urban 2025</b>	<b>Rural 2025</b>
Acute Care Hospitals	99.47%	88.69%	99.93%	65.10%	99.79%	90.28%
Allergy & Immunology	99.99%	84.60%	100%	94.18%	100%	84.30%
Behavioral Health – Other	100%	100%	100%	100%	100%	100%
Behavioral Health – Pediatric	100%	99.89%	76.70%	6.37%	100%	99.90%
Dermatology	100%	96.18%	100%	100%	100%	92.01%

**Table 26. MCO Time Analysis by Required Provider Type**

Provider Type	% of Enrollees with Access: Aetna		% of Enrollees with Access: CCP		% of Enrollees with Access: Simply Healthcare	
	Urban 2025	Rural 2025	Urban 2025	Rural 2025	Urban 2025	Rural 2025
Obstetrics & Gynecology	99.94%	93.21%	100%	100%	99.98%	89.77%
Optometry	100%	100%	100%	52.08%	100%	97.22%
Otolaryngology (ENT)	100%	96.16%	100%	51.25%	99.66%	88.97%
PCP – Family Medicine	99.90%	95.43%	100%	89.20%	99.95%	96.39%
PCP – Pediatrician	99.97%	98.13%	100%	100%	99.99%	99.14%
Pharmacy	99.86%	92.31%	20.60%	0.00%	99.85%	92.71%
Specialist – Other	99.92%	96.05%	99.93%	82.83%	99.92%	94.31%
Specialist – Pediatric	100%	99.97%	100%	36.84%	99.86%	89.99%

**Table 27** displays the percentage of enrollees in each MCO that had access to care within the required distance standards for each provider type.

**Table 27. MCO Distance Analysis by Required Provider Type**

Provider Type	% of Enrollees with Access: Aetna		% of Enrollees with Access: Community Care Plan		% of Enrollees with Access: Simply Healthcare	
	Urban 2025	Rural 2025	Urban 2025	Rural 2025	Urban 2025	Rural 2025
Primary Care Provider (PCP) – Family Medicine	99.80%	92.93%	100%	65.65%	99.99%	93.73%
PCP – Pediatrics	99.99%	72.04%	99.88%	85.04%	100%	72.47%

**Table 27. MCO Distance Analysis by Required Provider Type**

Provider Type	% of Enrollees with Access: Aetna		% of Enrollees with Access: Community Care Plan		% of Enrollees with Access: Simply Healthcare	
	Urban 2025	Rural 2025	Urban 2025	Rural 2025	Urban 2025	Rural 2025
Allergy & Immunology	100%	100%	100%	100%	100%	100%
Dermatology	100%	98.94%	84.72%	3.05%	100%	99.65%
Obstetrics & Gynecology	100%	93.76%	100%	100%	99.99%	88.81%
Optometry	99.99%	95.68%	100%	100%	100%	91.53%
Otolaryngology (ENT)	100%	99.81%	100%	50.97%	100%	95.14%
Behavioral Health – Pediatric	100%	93.54%	100%	51.25%	99.66%	84.94%
Behavioral Health – Other	99.95%	96.66%	100%	94.46%	99.97%	97.31%
Specialist – Pediatric	100%	98.58%	100%	100%	100%	99.78%
Specialist – Other	99.42%	83.10%	29.86%	0.00%	99.46%	83.82%
Hospital	99.96%	97.47%	99.97%	83.66%	99.98%	96.61%
Pharmacy	99.99%	99.50%	99.90%	34.07%	99.47%	84.11%

## Annual Network Adequacy

**Table 28** presents the percentage of enrollees for each DBM that had access to care within the required travel time standards for each required provider type.

Provider Type	% of Enrollees with Access: DentaQuest		% of Enrollees with Access: Liberty		% of Enrollees with Access: MCNA	
	Urban 2025	Rural 2025	Urban 2025	Rural 2025	Urban 2025	Rural 2025
Primary Care Dentists*	99.99%	97.94%	99.95%	98.96%	99.99%	98.65%
Pediatric Dentists	99.99%	95.97%	99.92%	98.96%	99.99%	96.92%
General Dentists	98.76%	56.55%	95.61%	31.45%	99.06%	61.30%
Orthodontists*	100%	88.11%	100%	88.43%	99.62%	81.86%
Dental Specialists*	96.53%	33.36%	96.66%	46.74%	98.63%	41.53%
Endodontists	93.05%	27.82%	92.21%	21.07%	95.55%	23.01%
Oral Surgeons	96.18%	32.02%	92.85%	28.26%	97.35%	38.83%
Periodontists	85.37%	13.11%	44.12%	15.58%	62.98%	19.71%
Prosthodontists	29.87%	10.59%	23.43%	8.68%	1.33%	12.74%

\*Only primary care dentists, orthodontists, and dental specialists are subject to contracted standards. Other dental specialists were analyzed for informational purposes only.

**Table 29** displays the percentage of enrollees in each DBM that had access to care within the required distance standards for each provider type.

Provider Type	% of Enrollees with Access: DentaQuest		% of Enrollees with Access: Liberty		% of Enrollees with Access: MCNA	
	Urban 2025	Rural 2025	Urban 2025	Rural 2025	Urban 2025	Rural 2025
Primary Care Dentists*	99.99%	98.66%	99.98%	99.48%	100%	99.47%

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Pediatric Dentists	99.99%	97.10%	99.98%	99.48%	99.99%	99.03%
General Dentists	99.24%	60.88%	96.43%	37.54%	99.46%	70.87%
Orthodontists*	99.99%	78.74%	100%	76.56%	99.62%	72.10%
Dental Specialists*	96.28%	23.03%	97.03%	36.72%	98.31%	29.03%
Endodontists	92.43%	19.62%	92.25%	16.99%	95.57%	13.50%
Oral Surgeons	95.62%	19.71%	92.39%	18.92%	96.72%	22.03%
Periodontists	84.45%	4.71%	49.84%	13.13%	67.78%	13.21%
Prosthodontists	35.83%	5.34%	31.68%	5.04%	1.04%	7.50%

\*Only primary care dentists, orthodontists, and dental specialists are subject to contracted standards. Other dental specialists were analyzed for informational purposes only.

### Appointment Availability

Qsource reviewed the MCO's and DBM's appointment availability standards, documenting that the enrollees had access to the following appointment types within the required timeframes:

- ◆ Emergency care shall be provided immediately.
- ◆ Urgently needed care shall be provided within 24 hours.
- ◆ Routine care of enrollees who do not require emergency or urgent care shall be provided within seven (7) calendar days of the enrollee's request for services.

- ◆ Routine dental examinations shall be provided within four (4) weeks of the enrollee's request.
- ◆ Follow-up care shall be provided as medically appropriate.

Qsource reviewed each MCO's and DBM's P&Ps, provider manual, and enrollee handbook to ensure that appointment availability standards were in place during 2025 and consistent with contract standards. All MCOs and DBMs met these standards; the provider manual and enrollee handbook met all criteria to ensure appointment availability standards were active during 2025 and consistent with contract standards.

### Improvements from 2024 ANA

Based upon the recommendations made by Qsource in the 2024 ANA, the MCOs and DBMs worked to improve their time and distance results for the 2025 ANA. These recommendations and improvements are shown in in [Table 30](#). The table contains direct quotes from the plans. Acronyms appearing in the direct quotes will not be included in Acknowledgments, Acronyms, and Initialisms. The degree

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to which the plans improved was considered high (green) when all rates were improved, medium (yellow) when they were partially improved, low (red) when none were improved, and not applicable when there was no comparison available.

**Table 30. Improvements Since the 2024 ANA by MCO/DBM**

MCO/DBM	Standard and Element	2024 Recommendations for Improvement	MCO/DBM's Action	2024 Rates for Recommendations	2025 Rates	Quality	Timeliness	Access
Aetna	Network Adequacy: Time and Distance Standards	Qsource recommends that Aetna evaluate its potential and take appropriate actions to improve access for rural enrollees to Acute Care Hospitals, Allergy & Immunology and Obstetrics & Gynecology, and Pharmacy. Aetna should continue to monitor its provider network and implement corrective action for identified deficiencies. Aetna should investigate those provider types for which access has decreased from the previous year and identify any trends that can be remedied and/or opportunities to increase access. Finally, Qsource recommends annual review of Aetna's appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.	<p>Aetna Better Health of Florida (ABH) is committed to ensuring that our Florida Healthy Kids enrollees have access to the best quality of care in a timely manner. Network adequacy is a priority and we continuously evaluate our network composition, network data and our approach to measuring adequacy and availability. As part of our monitoring, ABH has implemented significant projects to improve the data in our systems and directories. Network Management Team continues to address gaps, recruit providers, monitor member feedback and complaints pertaining to access and provider service quality prioritizing rural access.</p> <p>In response to the 2024 Annual Network Adequacy Report, ABH is constantly evaluating and taking appropriate action to improve access for rural enrollees and would like to note the following regarding the overall practitioner network adequacy results:</p> <ul style="list-style-type: none"> <li>◆ Acute Care Hospitals- ABH has completed the negotiations with the following acute care hospitals in Region 3 and are in the onboarding process</li> </ul>	<p><b>Rural, time:</b> Acute Care Hospitals: 88.65%</p> <p>Allergy &amp; Immunology: 86.22%</p> <p>Obstetrics &amp; Gynecology: 88.57%</p> <p>Pharmacy: 92.72%</p> <p><b>Rural, distance:</b> Acute Care Hospitals: 92.43%</p> <p>Allergy &amp; Immunology: 75.26%</p> <p>Obstetrics &amp; Gynecology: 92.66%</p>	<p><b>Rural, time:</b> Acute Care Hospitals: 88.69%</p> <p>Allergy &amp; Immunology: 84.60%</p> <p>Obstetrics &amp; Gynecology: 93.21%</p> <p>Pharmacy: 92.31%</p> <p><b>Rural, distance:</b> Acute Care Hospitals: 92.93%</p> <p>Allergy &amp; Immunology: 72.04%</p> <p>Obstetrics &amp; Gynecology: 95.68%</p>		✓	✓

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		<p>(credentialing and/or loading provider record)</p> <ul style="list-style-type: none"> <li>▪ UF Health Spanish Plaines Hospital</li> <li>▪ UF Health Leesburg Hospital</li> </ul> <p>◆ Allergy and Immunology- FHKC has approved waivers for this specialty for regions 2,6, and 8 through December 31, 2023. In addition, ABHFL has requested again waivers for this specialty as of June 2024. Extensive search of PML, NPI registry, competitor directories and internet searches did not result in any additional providers to recruit to improve access for this specialty (not interested in contracting with a Medicaid plan, unresponsiveness, unavailable licensed providers with this specialty in this area).</p> <p>◆ Behavioral Health Pediatric-- ABH works with our vendor to monitor network geographic access. Network adequacy reports are shared with vendor to ensure all providers have been reported in the master rosters. Vendor reviews and advises if all recruiting efforts have been exhausted and/or if there are no other available providers to contract.</p> <p>◆ Dermatology-ABH works with our vendor to monitor network geographic access. Network</p>	<p>Pharmacy: 84.29%</p>	<p>Pharmacy: 83.10%</p>		
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		<p>adequacy reports are shared with vendor to ensure all providers have been reported in the master rosters. Vendor reviews and advises if all recruiting efforts have been exhausted and/or if there are no other available providers to contract.</p> <ul style="list-style-type: none"> <li>◆ Obstetrics &amp; Gynecology- ABH is monitoring and evaluating our network consistently and executing our contracting efforts for any available providers. Provider records are reviewed to remediate any data discrepancies affecting network adequacy/gaps.</li> <li>◆ Otolaryngology (ENT)- FHKC has approved waivers for this specialty for regions 3 and 8 through December 31, 2023. In addition, ABHFL has requested again waivers for this specialty as of June 2024. Extensive search of PML, NPI registry, competitor directories and internet searches did not result in any additional providers to recruit to improve access for this specialty (not interested in contracting with a Medicaid plan, unresponsiveness, unavailable licensed providers with this specialty in this area).</li> </ul> <p>Although the ABH is not contractually accountable for specific access requirements for Inpatient Psychiatric (Free-Standing Psychiatric Facilities),</p>				
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		<p>Laboratory, or Urgent Care Center provider specialty categories, the Network Management Team monitors and recruits these provider types to enhance the network and maintain accessibility to our Florida Healthy Kids enrollees.</p> <ul style="list-style-type: none"> <li>◆ Psychiatric Hospital (Free-Standing Psychiatric Facilities)- ABH has completed the negotiations with the following psychiatric hospitals and are in the onboarding process (credentialing and/or loading provider record) as a result of in-sourcing behavioral health services.             <ul style="list-style-type: none"> <li>▪ BayCare</li> <li>▪ Jackson Memorial Hospital</li> <li>▪ Baptist- Pensacola</li> <li>▪ Baptist- Jacksonville</li> <li>▪ HCA Healthcare</li> <li>▪ Nemours Children’s Hospital</li> <li>▪ Advent Health</li> <li>▪ Stewart Health</li> </ul> </li> <li>◆ Current Negotiations             <ul style="list-style-type: none"> <li>▪ Memorial Regional</li> <li>▪ Health First</li> <li>▪ Independent Psychiatric Hospital (Free-Standing Psychiatric Facilities)</li> </ul> </li> <li>◆ Laboratory- ABH has a national contract with Quest Diagnostics and LabCorp and independent laboratories. Network is monitoring and evaluating our network consistently and executing our contracting efforts for any available providers.</li> </ul>				
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		<p>Provider records are reviewed to remediate any data discrepancies affecting network adequacy/gaps.</p> <ul style="list-style-type: none"> <li>◆ Urgent Care Center (UCC) - ABH is contracted with multiple UCC throughout the state including minute clinics and providers offering after hour care. Network is monitoring and evaluating our network consistently and executing our contracting efforts for any available providers. Provider records are reviewed to remediate any data discrepancies affecting network adequacy/gaps.</li> </ul> <p>ABH evaluates both urban and rural access for all Florida Health Kids enrollees by monitoring our network consistently and executing our contracting efforts. The Network Management Team reviews and investigates those provider types for which access has decreased and completes an analysis to determine the root cause. Some root causes include provider retired or deceased, failed to comply with recredentialing requests, refused to contract at standard rates, and/or provider not willing to contract with Medicaid or CHIP. Member assist requests are closely watched for any recruiting opportunities and single case agreements/letters of agreements are executed as necessary to ensure</p>				
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			<p>continuity of care. To date, there have been no member assist request for any of the identified provider types in rural areas indicating no provider access was affected.</p> <p>Furthermore, the provider engagement team conducts quarterly audits including secret shopper calls of network data for accuracy and remediation. Provider groups are re-educated on the importance of reporting new providers that join the group practice for network adequacy. Appointment Access Surveys are conducted on a quarterly to ensure providers follow regulatory accessibility requirements. To date, the appointment access and availability compliance performance goal of 90% has been met across all measures.</p> <p>Lastly, ABH is promoting and incorporating Telemedicine to the Network. Telemedicine modality is used as an alternative platform when appropriate and offered through MDLive (telemedicine vendor) or specialty providers that comply with the telemedicine requirements.</p>					
CCP	Network Adequacy: Time and Distance Standards	Qsource recommends that CCP evaluate the potential and take appropriate actions to improve rural access to Acute Care Hospitals, Allergy & Immunology, Otolaryngology (ENT), Specialist-Other, and Specialists – Pediatric. CCP	We appreciate the additional submission CCP was able to provide once we recognized errors in our second submission to Qsource for our Annual Network Adequacy Review. In review of the results, we acknowledge the overall weighted result of 98.29% and the comprehensive access achieved for pediatric PCPs and the challenges	<p><b>Rural, time:</b> Acute Care Hospitals: 22.03%</p> <p>Allergy &amp; Immunology: 26.44%</p>	<p><b>Rural, time:</b> Acute Care Hospitals: 65.10%</p> <p>Allergy &amp; Immunology: 94.18%</p>		✓	✓

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		<p>should continue to monitor its provider network and implement corrective actions for identified deficiencies. CCP should investigate those provider types for which access drastically decreased from the previous year and identify any trends that can be remedied and/or opportunities to increase access. CCP should evaluate and remedy any provider data issues which resulted in multiple re-submissions of data. Finally, Qsource recommends annual review of CCP’s appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.</p>	<p>identified in rural family medicine PCPs and other specialties. We currently have waivers approved for the specialties not meeting the required standards and appreciate your feedback as we continue to evaluate and enhance access, if available, to Acute Care Hospitals, Allergy &amp; Immunology, Otolaryngology, and pediatric specialists. We will also address any provider data issues to ensure accurate submissions in the future. Additionally, we will continue monitoring our provider network and implementing corrective actions to improve access and compliance with standards. We value your recommendations and will review our network adequacy regularly and our appointment availability survey process annually to ensure the best continued future network adequacy.</p>	<p>Otolaryngology (ENT): 45.08% Specialist – Other: 77.63%  Specialists – Pediatric: 20.00%  <b>Rural, distance:</b> Acute Care Hospitals: 32.54%  Allergy &amp; Immunology: 25.42%  Otolaryngology (ENT): 45.08%  Specialist – Other: 78.64%  Specialists – Pediatric: 18.31%</p>	<p>Otolaryngology (ENT): 51.25% Specialist – Other: 82.83%  Specialists – Pediatric: 36.84%  <b>Rural, distance:</b> Acute Care Hospitals: 65.65%  Allergy &amp; Immunology: 85.04%  Otolaryngology (ENT): 51.25%  Specialist – Other: 83.66%  Specialists – Pediatric: 34.07%</p>			
Simply Healthcare	Network Adequacy: Time and Distance Standards	<p>Qsource recommends that Simply Healthcare take appropriate actions to improve access to Acute Care Hospitals, Allergy &amp; Immunology, Dermatology, Obstetrics &amp; Gynecology,</p>	<p>Per our latest adequacy network review our member access for the 7 mentioned specialties are:  With waivers submitted:  <ul style="list-style-type: none"> <li>◆ Rural – Allergy &amp; Immunology – (89% time; 80% distance)</li> </ul> </p>	<p><b>Rural, time:</b> Acute Care Hospitals: 88.93%  Allergy &amp; Immunology: 77.28%</p>	<p><b>Rural, time:</b> Acute Care Hospitals: 90.28%  Allergy &amp; Immunology: 84.30%</p>		✓	✓

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	<p>Otolaryngology (ENT), Pharmacies, and Specialists – Pediatric for rural enrollees. Simply Healthcare should continue to monitor its provider network and implement corrective action for identified deficiencies. Simply Healthcare should investigate those provider types for which access has decreased from the previous year and identify any trends that can be remedied and/or opportunities to increase access. Finally, Qsource recommends annual review of Simply Healthcare’s appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.</p>	<ul style="list-style-type: none"> <li>◆ Rural – Dermatology – (81% time; 74% distance)</li> <li>◆ Rural – Obstetrics &amp; Gynecology – (88% time; 94% distance)</li> <li>◆ Rural – Otolaryngology (ENT) – (85% time; 81% distance)</li> <li>◆ Rural – Specialist - Pediatric – (86% time; 76% distance)</li> <li>◆ Rural – Pharmacy – (96% time; 87% distance)</li> </ul> <p>No waiver submitted as we show as passing internally:</p> <ul style="list-style-type: none"> <li>◆ Rural – Hospital – (90% time; 93% distance)</li> </ul> <p>Simply has performed an analysis and will be taking the below steps to cure the issues identified.</p> <ol style="list-style-type: none"> <li>a. Simply is active Statewide in FL, the new rural counties are: Baker, Bradford, Calhoun, Columbia, Dixie, Franklin, Gadsden, Gilchrist, Glades, Gulf, Hamilton, Hardee, Holmes, Jackson, Jefferson, Lafayette, Levy, Liberty, Madison, Putnam, Suwannee, Taylor, Union, Wakulla, Walton, Washington.</li> <li>b. The report identified disparities in access between urban and rural enrollees—particularly for; Allergy &amp; Immunology, Dermatology, Obstetrics &amp; Gynecology, Otolaryngology (ENT), Pharmacy, Specialists – Pediatric and Hospital.</li> </ol>	<p>Dermatology: 82.15%</p> <p>Obstetrics &amp; Gynecology: 84.96%</p> <p>Otolaryngology (ENT): 89.25%</p> <p>Pharmacy: 92.75%</p> <p>Specialists – Pediatric: 86.91%</p> <p><b>Rural, distance:</b> Acute Care Hospitals: 92.57%</p> <p>Allergy &amp; Immunology: 67.51%</p> <p>Dermatology: 78.00%</p> <p>Obstetrics &amp; Gynecology:</p> <p>Otolaryngology (ENT): 89.29%</p>	<p>Dermatology: 92.01%</p> <p>Obstetrics &amp; Gynecology: 89.77%</p> <p>Otolaryngology (ENT): 88.97%</p> <p>Pharmacy: 92.71%</p> <p>Specialists – Pediatric: 89.99%</p> <p><b>Rural, distance:</b> Acute Care Hospitals: 93.73%</p> <p>Allergy &amp; Immunology: 72.47%</p> <p>Dermatology: 88.81%</p> <p>Obstetrics &amp; Gynecology:</p> <p>Otolaryngology (ENT): 91.53%</p>			
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Annual Network Adequacy

			<p>i. For the Hospital category we are passing internally for both urban (100% Time; 99% Distance) and rural (90% Time; 93% Distance) counties.</p> <p>c. The disparities in access to these provider types are due to lack of the provider types within the rural counties. Simply has secured all available providers in the county willing to contract and documented the instances when unable to.</p> <p>d. Simply has submitted waiver requests to Florida Healthy Kids for all quarters of the years: 2020, 2021, 2022, 2023 as well for Q1 in April 2024, and Q2 in July of 2024 where there are no additional providers to recruit to meet the access requirements.</p> <p><b>Allergy &amp; Immunology</b></p> <ul style="list-style-type: none"> <li>◆ Waiver requests submitted in July Q2 2024 for Region 2 for both time and distance.             <ul style="list-style-type: none"> <li>○ Region 2                 <ul style="list-style-type: none"> <li>▪ The Health Plan is contracted with two allergists in this multi-rural county region. Participating providers in Leon and Bay counties provide access to this specialty as there are limited practitioners in this area that are willing to contract with the plan despite offering enhanced rates. DOH lists four</li> </ul> </li> </ul> </li> </ul>	<p>Pharmacy: 84.06%</p> <p>Specialists – Pediatric: 80.31%</p>	<p>Pharmacy: 83.82%</p> <p>Specialists – Pediatric: 84.11%</p>			
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Annual Network Adequacy

			<p>eligible providers in Leon county. One provider is contracted. One provider does not have a Medicaid ID and is not willing to apply for a Medicaid ID or participate with the plan. Two providers (same group) have refused to contract after multiple attempts to contract.</p> <ul style="list-style-type: none"> <li>▪ There are no providers listed in Calhoun county. Members have access to providers in Bay or Leon counties. There are no providers listed in Franklin county. Members have access to the Leon county or Bay county provider. There are no providers listed in Jackson county. Members have access to providers in Bay or Leon counties. There are no allergy providers listed in Liberty county. Members have access to providers in Bay or Leon counties. There are no providers listed in Madison county. Members have access to the Leon county providers. Taylor county – DOH list one provider who is deceased. There are no other allergists listed in Taylor county. Members have access to a provider in Leon county. Additionally, the member has access to one provider in Columbia county.</li> </ul> <p><b>Dermatology</b></p>					
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Annual Network Adequacy

			<ul style="list-style-type: none"> <li>◆ Waiver requests submitted in July Q2 2024 for Region 3 for both time and distance.             <ul style="list-style-type: none"> <li>▪ Network currently has 2 groups with 3 providers in Region 3 that are in negotiations. Network averages overall of 96.7% with access in miles for the region.</li> <li>▪ Network is requesting a waiver at this time as adequacy is still not met.</li> </ul> </li> </ul> <p><b><u>Obstetrics &amp; Gynecology</u></b></p> <ul style="list-style-type: none"> <li>◆ Waiver requests submitted in July Q2 2024 for Region 2 time only.             <ul style="list-style-type: none"> <li>○ Region 2                 <ul style="list-style-type: none"> <li>▪ The Health Plan is contracted with multiple OB/GYN providers in this multi-rural region. Participating providers in Bay, Jackson, Leon and Taylor counties provide access to this specialty as there are limited practitioners in this area that are available to contract with the plan. DOH only lists eligible providers in Bay, Jackson and Leon counties.</li> <li>▪ There are no providers listed in Calhoun county. Members have access to the Bay, Jackson or Leon county providers. There are no providers listed in Franklin county. Members have access to the Leon county or Bay county providers. There are no providers listed in Gadsden county. Members have access to the Leon county providers. There</li> </ul> </li> </ul> </li> </ul>					
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			<p>are no providers listed in Gulf county. Members have access to providers in Bay or Leon counties. There are no providers listed in Jefferson county. Members have access to the Leon county providers. There are no providers listed in Liberty county. Members have access to providers in Bay or Leon counties.</p> <ul style="list-style-type: none"> <li>▪ DOH lists one provider in Madison County who is deceased. There are no other available providers in this county. Members have access to the Leon county and the two providers that have offices in Taylor county. There were no providers listed in Taylor county. Members have access to the Leon county providers. Two of the Leon county providers have an office in Taylor county. DOH list one provider in Wakulla county who is deceased. There are no other available providers in this county. Members have access to the Leon county providers.</li> </ul> <p><b>Otolaryngology (ENT)</b></p> <ul style="list-style-type: none"> <li>◆ Waiver requests submitted in July Q2 2024 for Region 2 both time and distance and in Region 3 time only.             <ul style="list-style-type: none"> <li>○ Region 2                 <ul style="list-style-type: none"> <li>▪ The Health Plan is contracted with four otolaryngologists in the region. Participating providers in Bay, Jackson,</li> </ul> </li> </ul> </li> </ul>					
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			<p>Holmes and Washington counties provide access to this specialty. Leon county – DOH lists 7 providers with active licenses. We are not contracted with these providers in Leon county after numerous attempts to contract and offer enhanced rates.</p> <ul style="list-style-type: none"> <li>▪ There are no providers listed in Franklin, Gadsden, Jefferson, Liberty, Madison, Taylor and Wakulla to contract. Members are typically referred within the region to Bay, Jackson or Washington counties for services. Members can also be referred to Columbia or Alachua counties outside the region.</li> <li>○ Region 3             <ul style="list-style-type: none"> <li>▪ There are no new providers accepting Medicaid in Citrus, Dixie, Levy, Gilchrist, and Sumter counties.</li> </ul> </li> </ul> <p>Otolaryngology specialists in this region are found in Alachua, Citrus, Hernando, Lake, and Marion Counties, with a deficiency in Hamilton and Putnam County. Dixie, Levy, Gilchrist, Hamilton, Sumter and Putnam County do not have any otolaryngology specialists to contract and therefore the Health Plan respectfully request leniency for this performance measure and a waiver of the financial consequences.</p>					
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			<p><b>Specialist – Pediatric</b></p> <ul style="list-style-type: none"> <li>◆ Waiver requests submitted in July Q2 2023 for Region 2, 3 and 4 for both time and distance.             <ul style="list-style-type: none"> <li>○ Region 2                 <ul style="list-style-type: none"> <li>▪ Participating providers in Bay, Holmes and Leon counties provide access to pediatric cardiology, pediatric endocrinology, pediatric gastroenterology, pediatric hematology/oncology and pediatric pulmonology specialties, as there are limited practitioners in Region 2 that are available to contract with the plan.</li> <li>▪ DOH search results found no records of pediatric specialist provider types for Calhoun, Liberty, Franklin, Gulf, Gadsden, Jefferson, Madison, Taylor and Wakulla. The normal pattern of care is for members to travel outside of the Region 2 to Nemours in Jacksonville and UF Shands in Gainesville for certain pediatric some specialty services.</li> </ul> </li> <li>○ Region 3                 <ul style="list-style-type: none"> <li>▪ Total of 82 Pediatric specialists found in the Region. Pediatric specialists in this region are found in Alachua, Hernando, Lake, and Marion Counties, with deficiencies in Citrus, Dixie, Levy, Putnam and Gilchrist, Hamilton, and Lafayette there are no eligible pediatric specialists are found to</li> </ul> </li> </ul> </li> </ul>					
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Annual Network Adequacy

			<p>contract. No Pediatric Specialists found in Citrus, Dixie, Gilchrist, Levy, Suwannee, and Union Counties.</p> <ul style="list-style-type: none"> <li>○ Region 4             <ul style="list-style-type: none"> <li>▪ Pediatric specialists in this region are found in Clay, Duval, St. Johns and Volusia Counties, with deficiencies in Flagler, Nassau and St. Johns counties where no eligible pediatric specialists are found to contract.</li> </ul> </li> <li>◆ Additional waiver requests for Q2 2024 were submitted for Region 8, 9, and 11 in certain counties for distance only.             <ul style="list-style-type: none"> <li>○ Region 8 – The rural counties of Glades and Hendry continue to not have pediatric specialists causing an average distance of 33.8 miles for members without access in Glades and 27.9 miles for members without access in Hendry. There are no eligible pediatric specialists in those counties to contract. Due to no specialists available in the Glades and Hendry county, we respectfully request leniency for this performance measure and a waiver of the financial consequences.</li> <li>○ Region 9 – Pediatric specialists in this region are found in Palm Beach, with deficiencies in Okeechobee County for distance only. No eligible pediatric specialists are found to contract. Due to no specialists available in the region, we respectfully</li> </ul> </li> </ul>					
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			<p>request leniency for this performance measure and a waiver of the financial consequences.</p> <ul style="list-style-type: none"> <li>○ Region 11 – Pediatric specialists in this region are found in Miami-Dade County, with deficiencies in rural Monroe County where no eligible pediatric specialists are found to contract. Due to no specialists available in the region, we respectfully request leniency for this performance measure and a waiver of the financial consequences.</li> </ul> <p><b><u>Pharmacy</u></b></p> <ul style="list-style-type: none"> <li>◆ Waiver requests submitted in July Q2 2024 for Region 2 for distance only</li> <li>○ Network adequacy requirements are met for all counties in Region 2 except for:             <ul style="list-style-type: none"> <li>▪ Calhoun County: There are 2 pharmacies available in this county according to the NCPDP database, all of which are in the FHK pharmacy network.                 <ul style="list-style-type: none"> <li>● Golden Pharmacy Inc.</li> <li>● Blountstown Drugs</li> </ul> </li> <li>▪ Franklin County: There are 2 pharmacies available in this county according to the NCPDP database, all of which are in the FHK pharmacy network.                 <ul style="list-style-type: none"> <li>● Buy Rite Drugs</li> <li>● CVS Pharmacy</li> </ul> </li> <li>▪ Gulf County: There are 2 pharmacies available in this</li> </ul> </li> </ul>					
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Annual Network Adequacy

			<p>county according to the NCPDP database, all of which are in the FHK pharmacy network.</p> <ul style="list-style-type: none"> <li>• Buy Rite Drugs- Port St Joe</li> <li>• Buy Rite Drugs- Wewahitchka</li> <li>▪ Holmes County: There are 2 pharmacies available in this county according to the NCPDP database, all of which are in the FHK network.</li> <li>• Johnsons Pharmacy</li> <li>• A Plus Pharmacy</li> <li>▪ Jackson County: There are 10 pharmacies available in this county according to the NCPDP database, all of which are in the FHK pharmacy network.</li> <li>• Care Rite Pharmacy</li> <li>• Publix Pharmacy</li> <li>• Pancare Rx Malone</li> <li>• Sneads Pharmacy</li> <li>• Paramores Pharmacy</li> <li>• Walmart Pharmacy</li> <li>• Yates Pharmacy and Gifts</li> <li>• Kelson Discount Drug</li> <li>• CVS Pharmacy</li> <li>• Cook Discount Drugs</li> <li>▪ Jefferson County: There is 1 pharmacy available in this county according to the NCPDP database, and it is in the FHK pharmacy network.</li> <li>• CVS Pharmacy</li> <li>▪ Liberty County: There is 1 pharmacy available in this county according to the NCPDP database, and it is in the FHK pharmacy network.</li> <li>• Buy Rite Drugs</li> </ul>					
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			<ul style="list-style-type: none"> <li>▪ Madison County: There are 3 pharmacies available in this county according to the NCPDP database, all of which are in the FHK pharmacy network.             <ul style="list-style-type: none"> <li>• North Florida Pharmacy</li> <li>• CVS Pharmacy</li> <li>• Jay’s Pharmacy of Madison</li> </ul> </li> <li>▪ Wakulla County: There are 5 pharmacies available in this county according to NCPDP database, 4 of which are in the FHK pharmacy network. The only pharmacy that isn’t in the network is Walgreens #9578 (NCPDP #1017044), as they had previously declined network participation.             <ul style="list-style-type: none"> <li>• Walmart</li> <li>• Crawfordville Pharmacy</li> <li>• CVS Pharmacy</li> <li>• Publix Pharmacy</li> </ul> </li> <li>○ Please note that for region 2, there were 9 counties where we didn’t meet the network adequacy requirements. There are no opportunities to contract with additional pharmacies in any of these counties since the pharmacies that exist in these counties are already in our network or have declined network participation.</li> </ul> <p>Simply will continue to monitor the provider network.</p> <ul style="list-style-type: none"> <li>▪ The Provider Relations team continuously reviews the network and the market to identify new providers and to</li> </ul>					
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			<p>address changes to ensure a compliant network.</p> <ul style="list-style-type: none"> <li>▪ Network adequacy is monitored through a monthly Network Gap workgroup and through reports to the FL Compliance committee.</li> </ul> <p>With regards to Appointment Availability Surveys, the Plan is currently working with its vendor to explore ways to potentially enhance its process in order to better analyze access to care for enrollees. The Plan appreciates the feedback provided and will continue to monitor and evaluate its appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.</p>					
DentaQuest	Network Adequacy: Time and Distance Standards	<p>Qsource recommends that DentaQuest take appropriate actions to improve access to orthodontists and dental specialists for rural enrollees. DentaQuest should continue to monitor its provider network and implement corrective action for identified deficiencies. Finally, Qsource recommends annual review of DentaQuest’s appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.</p>	<p>Advancements in 2024 despite the critical dental shortage in Florida:</p> <ul style="list-style-type: none"> <li>▪ Primary Care Dentists: <ul style="list-style-type: none"> <li>○ 99.99% of urban enrollees had access to Primary Care Dentists for both time and distance standards.</li> <li>○ For rural enrollees, access was 95.87% for time and 96.99% for distance standards.</li> </ul> </li> <li>▪ All provider types: <ul style="list-style-type: none"> <li>○ Over 98% of urban enrollees had access to all provider types for both time and distance standards.</li> <li>○ Rural access to all provider types increased for both time</li> </ul> </li> </ul>	<p><b>Rural, time:</b> Orthodontists: 89.08%</p> <p>Dental specialists: 39.55%</p> <p><b>Rural, distance:</b> Orthodontists: 79.42%</p> <p>Dental specialists: 26.74%</p>	<p><b>Rural, time:</b> Orthodontists: 88.11%</p> <p>Dental specialists: 33.36%</p> <p><b>Rural, distance:</b> Orthodontists: 78.74%</p> <p>Dental specialists: 23.03%</p>		✓	✓

Annual Network Adequacy

			<p>and distance standards in 2024.</p> <ul style="list-style-type: none"> <li>▪ Certified Orthodontists access:             <ul style="list-style-type: none"> <li>○ Access to Certified Orthodontists for urban enrollees was 100%.</li> <li>○ Access for rural enrollees is at 89.08% for time standards and 79.42% for distance standards, however, showing improvement compared to previous year.</li> </ul> </li> <li>▪ Dental Specialist:             <ul style="list-style-type: none"> <li>○ Over 99% of urban enrollees had access to at least one Dental Specialist for time standard and 98.56% for distance, an increase from 98.68% and 97.88% in 2023.</li> <li>○ Rural access was still limited for both time and distance standards for Dental Specialists, at 39.55% and 26.74%, however, our access continues to show improvement compared to previous year. Our access increased over 6% from 2023 to 2024.</li> </ul> </li> <li>▪ Based on aggregated claims frequency by specialty, overall weighted network adequacy was 98.51%, 2024 results continue to indicate an increase in access year after year.</li> </ul> <p><b>Network Adequacy Response:</b>            DentaQuest is committed to ensure all Florida Healthy Kids enrollees in urban and rural areas receive oral care. Our</p>					
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Annual Network Adequacy

			<p>efforts include assisting members to access care when a participating provider is either not available or is unable to provide necessary care.</p> <p>If an enrollee has a need to see a specialist, our Member Placement Representatives have a process to place the enrollee with an appropriate provider. During 2023 and 2024, DentaQuest successfully placed all Florida Healthy Kids members with an in-network provider.</p> <p>DentaQuest has a commitment to constantly monitor network participation and network adequacy. We continually recruit and contract new providers as part of our expansion goals in Florida. Some of the tools we use when recruiting include sources like the Florida Board of Dentistry license verification tool, The American Board of Oral and Maxillofacial Surgery tool, The American Board of Orthodontics locator tool, The American Board of Endodontics site, the Provider Master List from The Agency for Health Care Administration, our competitors directories and leads we receive from participating providers, from our own members and from current clients. Also, as part of our ongoing recruiting process, we work with Dental Schools (University of Florida, Lake Erie College of Osteopathic Medicine &amp; Nova Southeastern University) to help recognize new providers entering the system, identify where they will reside</p>					
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			<p>and collaborate on how we can partner together to expand the network.</p> <p>DentaQuest recognizes the importance of network compliance and meeting access goals for targeted areas. The network development team is doing additional research for each deficient area using available sources to ensure that all providers have been contacted. In the event, a special financial arrangement is needed for compliance, a non-panel arrangement is initiated. DentaQuest will negotiate with the provider or group to achieve the most favorable financial arrangement for the plan. Special Fee arrangements are reviewed and approved by DentaQuest management and Underwriting.</p> <p><b>Rural area access to Orthodontists and Dental Specialists:</b></p> <p>DentaQuest has identified significant barriers while meeting specialist access in rural counties. However, DentaQuest’s utilization patterns demonstrate Florida Healthy Kids enrollees are certainly receiving dental care in rural counties. Our review showed 100% of members needing care in 2023 had access to a dental provider and were able to access care with an in-network provider. While most General Dentists and Pediatric Dentists also provide specialty services, we continue to pay close attention to opportunities to increase access in these areas as it is our policy to ensure an appropriate range of services with properly credentialed and licensed</p>					
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			<p>dentists are available to all enrolled members.</p> <p>Barriers in expanding access in Rural Areas:</p> <p><b>a) Time and Distance Standard:</b> The obligation established under the current contract is limited and restricted for rural areas. Dental industry standards in these counties are usually 3 times more for Dental Specialist, extending access to <u>90</u> miles instead of <u>30</u> miles, and almost double for Orthodontist, extending access to <u>90</u> miles instead of <u>50</u> miles. The inaccessibility to meet the current established benchmark often results in a low percentage rate.</p> <p><b>b) Dentist Shortage:</b> Our biggest barrier while recruiting is the limited pool of oral health care providers residing in rural areas. For example, Baker, Bradford, Calhoun, DeSoto, Dixie, Franklin, Gilchrist, Glades, Gulf, Hamilton, Hardee, Hendry, Holmes, Jackson, Jefferson, Lafayette, Levy, Liberty, Madison, Suwannee, Taylor, Union, Wakulla, and Washington have very limited to zero specialists residing in each county.</p> <p>One in four Florida residents – 6 million Floridians – live in areas lacking a sufficient number of dentists (federally designated Dental Health Professional Shortage Areas). Most dentists in Florida are concentrated in large urban counties, with very few dentists in many rural counties.</p>					
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			<p>Circumstances related to meeting access requirement in rural areas are outside of DentaQuest’s control due to lack of certified dental professionals practicing in most of these counties.</p> <p><a href="#">Map of Health Professional Shortage Areas: Dental Care, by County, July 2024 - Rural Health Information Hub</a></p> <p>Also, the most recent Florida Workforce Survey of Dentist can be found by visiting the <a href="#">Florida Workforce Survey Report of Dentists 2019-2020 (floridahealth.gov)</a> released March 2023. The survey shows available specialists by county to facilitate a better understanding of the dental workforce in Florida. This report identifies the supply of workforce professionals practicing in Florida and examines factors related to dental practice location and career plans.</p> <p>We have also confirmed through our own recruitment plan that access is more limited now, the COVID-19 pandemic had a profound impact on all aspects of the oral health care system limiting the availability of dental practitioners in certain areas.</p> <p>The following tables from the <a href="#">Florida Workforce Survey Report of Dentists 2019-2020 (floridahealth.gov)</a> show the number of dentists working in Florida, by county, who self-identified as having specialty board or specialty certification.</p>					
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Annual Network Adequacy

			Approximately, 3,247 dental specialty board statuses or specialty certifications were reported by dentists practicing in Florida.					
Liberty	Network Adequacy: Time and Distance Standards	Qsource recommends that Liberty take appropriate actions to improve access to orthodontists and dental specialists for rural enrollees. Liberty should continue to monitor its provider network and implement corrective action for identified deficiencies. Liberty should investigate those provider types for which access has decreased from the previous year and identify any trends that can be remedied and/or opportunities to increase access. Finally, Qsource recommends annual review of Liberty’s appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.	<ul style="list-style-type: none"> <li>From the Time Standard analysis, Liberty improved its Urban Orthodontists score from 86.93% in 2024 to 88.43% in 2025, and Urban Dental Specialists from 40.81% to 46.74%.</li> <li>From the Distance Standard analysis, Liberty improved its Rural Orthodontists score from 2024 to 2025. Rural Dental Specialists also improved from 2024 to 2025.</li> </ul>	<b>Rural, time:</b> Orthodontists: 86.93%  Dental specialists: 40.81%  <b>Rural, distance:</b> Orthodontists: 74.47%  Dental specialists: 29.24%	<b>Rural, time:</b> Orthodontists: 88.43%  Dental specialists: 46.74%  <b>Rural, distance:</b> Orthodontists: 76.56%  Dental specialists: 36.72%		✓	✓
MCNA	Network Adequacy: Time and Distance Standards	Qsource recommends that MCNA take appropriate actions to improve access to orthodontists, pediatric dentists, endodontists, oral surgeons, periodontists and prosthodontists and dental specialists for rural enrollees. MCNA should continue to monitor its provider network and implement corrective	<ul style="list-style-type: none"> <li>For the time standard analysis, MCNA improved its Urban and Rural scores for Orthodontists and Dental Specialists in 2025.</li> <li>For distance standards, MCNA improved from 2024 to 2025 in Primary Care Dentists and Orthodontists. MCNA also improved its scores for Rural Dental Specialists in 2025.</li> </ul>	<b>Rural, time:</b> Orthodontists: 80.49% Pediatric dentists: 62.70%  Endodontists: 25.17%  Oral surgeons:	<b>Rural, time:</b> Orthodontists: 81.86% Pediatric dentists: 61.30%  Endodontists: 23.01%  Oral surgeons:		✓	✓

Annual Network Adequacy

		<p>action for identified deficiencies. MCNA should investigate those provider types for which access has decreased from the previous year and identify any trends that can be remedied and/or opportunities to increase access. Finally, Qsource recommends annual review of MCNA’s appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.</p>		<p>36.56%</p> <p>Periodontists: 18.06%</p> <p>Prosthodontists: 19.00%</p> <p>Dental specialists: 39.86%</p> <p><b>Rural, distance:</b> Orthodontists: 73.42%</p> <p>Pediatric dentists: 72.51%</p> <p>Endodontists: 14.45%</p> <p>Oral surgeons: 20.96%</p> <p>Periodontists: 10.51%</p> <p>Prosthodontists: 10.44%</p> <p>Dental specialists: 24.60%</p>	<p>38.83%</p> <p>Periodontists: 19.71%</p> <p>Prosthodontists: 12.74%</p> <p>Dental specialists: 41.53%</p> <p><b>Rural, distance:</b> Orthodontists: 72.10%</p> <p>Pediatric dentists: 70.87%</p> <p>Endodontists: 13.50%</p> <p>Oral surgeons: 22.03%</p> <p>Periodontists: 13.21%</p> <p>Prosthodontists: 7.50%</p> <p>Dental specialists: 29.03%</p>			
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## Strengths and Recommendations

The ANA review assists FHKC, Qsource, and the MCO or DBM in identifying recommendations for improvement in addition to network adequacy scores. These can be found in [Table 31](#).

**Table 31. ANA Strengths and Recommendations**

Aetna	<p><b>Strengths</b></p> <ul style="list-style-type: none"> <li>◆ Aetna demonstrated comprehensive access (at least 95.00%) for PCP time and distance standards, for both urban and rural enrollees.</li> <li>◆ Urban access to all required provider types was at least 99.00% for time and distance standards. Access for time and distance increased or remained the same for urban enrollees.</li> <li>◆ Rural access for time standards was over 92.00% for all required provider types, except for Acute Care Hospitals and Allergy &amp; Immunology. Rural access for time standards increased or remained the same for rural enrollees, except for Allergy &amp; Immunology, Pharmacy, and Specialist – Pediatric. Rural access for distance standards was over 92.00% for all required provider types, except for Allergy &amp; Immunology.</li> </ul>
	<p><b>Recommendations</b></p> <ul style="list-style-type: none"> <li>◆ Qsource recommends that Aetna continue to monitor its provider network and implement corrective action for identified deficiencies. Aetna should investigate those provider types for which access has decreased from the previous year and identify any trends that can be remedied and/or opportunities to increase access. Finally, Qsource recommends annual review of Aetna’s appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.</li> </ul>
CCP	<p><b>Strengths</b></p> <ul style="list-style-type: none"> <li>◆ CCP demonstrated comprehensive urban access for time and distance standards for PCP – Family Medicine and PCP – Pediatrician (100%).</li> <li>◆ Urban access to all required provider types was at least 99.00% except for time and distance standards for Behavioral Health – Pediatric and Pharmacy.</li> </ul>
	<p><b>Recommendations</b></p> <ul style="list-style-type: none"> <li>◆ Qsource recommends that CCP evaluate the potential and take appropriate actions to improve rural access to the following provider types: Behavioral Health – Pediatric, Optometry, Pharmacy, and PCP – Family Medicine.</li> </ul>

**Table 31. ANA Strengths and Recommendations**

	<ul style="list-style-type: none"> <li>◆ CCP should continue to monitor its provider network and implement corrective actions for identified deficiencies.</li> <li>◆ CCP should investigate those provider types for which access drastically decreased from the previous year and identify any trends that can be remedied and/or opportunities to increase access.</li> <li>◆ CCP should evaluate and remedy any provider data issues which resulted in multiple re-submissions of data.</li> <li>◆ Finally, Qsource recommends annual review of CCP’s appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.</li> </ul>
Simply Healthcare	<p><b>Strengths</b></p>
	<ul style="list-style-type: none"> <li>◆ Simply Healthcare provided comprehensive access (at least 96.00%) for time and distance standards to PCPs for both urban and rural enrollees.</li> <li>◆ Over 99.00% of urban enrollees had access to all required specialties/specialty categories for both time and distance standards.</li> <li>◆ Rural access for time standards was above 90.00% for all required specialties/specialty categories except for Allergy &amp; Immunology, Obstetrics &amp; Gynecology, Otolaryngology (ENT), and Specialist – Pediatric.</li> <li>◆ Urban access for distance standards remained the same or increased for all required specialties/specialty categories in 2025, except for Pharmacy and Specialist – Pediatric.</li> <li>◆ Rural access for distance standards was above 91.00% for all categories in 2025, except for Allergy &amp; Immunology, Dermatology, Otolaryngology (ENT), Pharmacy, and Specialist – Pediatric.</li> </ul>
	<p><b>Recommendations</b></p>
	<ul style="list-style-type: none"> <li>◆ Qsource recommends that Simply Healthcare take appropriate actions to improve access for rural enrollees. Simply Healthcare should continue to monitor its provider network and implement corrective action for identified deficiencies. Simply Healthcare should investigate those provider types for which access has decreased from the previous year and identify any trends that can be remedied and/or opportunities to increase access. Finally, Qsource recommends annual review of Simply Healthcare’s appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.</li> </ul>
	<p><b>Strengths</b></p>

**Table 31. ANA Strengths and Recommendations**

DentaQuest	<ul style="list-style-type: none"> <li>◆ DentaQuest provided comprehensive access (at least 97.00%) to Primary Care Dentists for both urban and rural enrollees.</li> <li>◆ Rural access to Primary Care Dentists slightly increased for both time and distance standards.</li> <li>◆ Over 96.00% of urban enrollees had access to all provider types for both time and distance standards.</li> </ul> <p><b>Recommendations</b></p> <ul style="list-style-type: none"> <li>◆ Qsource recommends that DentaQuest take appropriate actions to improve access to Orthodontists and Dental Specialists for rural enrollees. DentaQuest should continue to monitor its provider network and implement corrective action for identified deficiencies. Finally, Qsource recommends annual review of DentaQuest’s appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.</li> </ul>
Liberty	<p><b>Strengths</b></p> <ul style="list-style-type: none"> <li>◆ Liberty provided comprehensive access (at least 98.00%) to Primary Care Dentists for both urban and rural enrollees.</li> <li>◆ Rural access for time standards increased for Primary Care Dentists, Orthodontists, and Dental Specialists.</li> <li>◆ Rural access for distance standards increased for Orthodontists and Dental Specialists.</li> </ul> <p><b>Recommendations</b></p> <ul style="list-style-type: none"> <li>◆ Qsource recommends that Liberty take appropriate actions to improve access to Orthodontists and Dental Specialists for rural enrollees. Liberty should continue to monitor its provider network and implement corrective action for identified deficiencies. Liberty should investigate those provider types for which access has decreased from the previous year and identify any trends that can be remedied and/or opportunities to increase access. Finally, Qsource recommends annual review of Liberty’s appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.</li> </ul>
MCNA	<p><b>Strengths</b></p> <ul style="list-style-type: none"> <li>◆ MCNA provided comprehensive access (at least 98.00%) to Primary Care Dentists for both urban and rural enrollees.</li> </ul>

**Table 31. ANA Strengths and Recommendations**

<ul style="list-style-type: none"> <li>◆ Access for time standards for both urban and rural enrollees improved or remained the same from 2024 to 2025, except for rural Primary Care Dentists.</li> <li>◆ Distance standards for urban enrollees increased across all provider types in 2025 except for Dental Specialists.</li> <li>◆ Rural access for distance standards increased for Dental Specialists in 2025.</li> </ul>
<p><b>Recommendations</b></p> <ul style="list-style-type: none"> <li>◆ Qsource recommends that MCNA take appropriate actions to improve access to Dental Specialists (Endodontists, Oral Surgeons, Periodontists, and Prosthodontists) for rural enrollees, and Prosthodontists for urban enrollees. MCNA should continue to monitor its provider network and implement corrective action for identified deficiencies. MCNA should investigate those provider types for which access has decreased from the previous year and identify any trends that can be remedied and/or opportunities to increase access. Finally, Qsource recommends annual review of MCNA’s appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.</li> </ul>

## 2025 EQR Conclusions and Recommendations

Qsource conducted mandatory EQR activities for FHKC’s plans for MY 2024. The results of 2025 EQR activities demonstrate that FHKC’s managed care plans are well qualified and committed to facilitating timely, accessible, and high-quality healthcare for FHKC enrollees. Achieving high or perfect compliance scores in all assessment activities, implementing innovative and successful programs and initiatives for improvement, and acting quickly to correct any noted deficiencies, the plans exemplify FHKC’s Core Values and

strive continuously to fulfill the goals of its Quality Strategy. Qsource recommends that FHKC continue to use stringent measures from the ANA review, ACA, PMV, and PIP validation as the primary means for assessing the Quality Strategy’s success as applied to the integrated physical and behavioral health services delivered by its plans. The 2025 EQR assessment results, including the identification of plan strengths, recommendations, and CAPs, attest to the positive impact of

**2025 EQR Conclusions and Recommendations**

FHKC’s strategy in monitoring plan compliance, improving quality, and aligning healthcare goals.

Each of CMS’s EQR Protocols is a learning opportunity for the plans and FHKC. Qsource used a collaborative approach to assist the State and plans with developing best practices for future reviews and ensuring enrollee quality of care was paramount. Qsource is available to collaborate with FHKC and directly assist the plans in accomplishing the following recommendations for improvement.

To improve the quality of health for all enrollees, Qsource made the following recommendations.

## PIP

FHKC’s Quality Strategy goals of Quality, Satisfaction, and Growth outline specific steps to monitor quality improvement in order to maintain high standards and improve the health of enrollees. Qsource’s analysis of each PIP revealed that the plans demonstrated an understanding of the improvement process by providing descriptions of the intervention, barriers, and likelihood to create a change, as well as future considerations for the interventions implemented. At the same time, weaknesses were noted in a handful of PIPs regarding clear written aim statements, clearly defining the PIP population and its characteristics, assessing the statistical significance of any differences between baseline and remeasurement, lessons learned about less-than-optimal performance, providing the timeframe under review in the performance measure as well as

updated and accurate information (e.g., baseline rate, time period, and benchmark rate), specifying its data sources, missing or incomplete information, and purposeful improvement strategies that effectively state how performance improvement is related to the improvement strategy, all of which compromised the ability of Qsource to fully evaluate and make conclusions about the results and the validity of those studies. For the 2025 EQR evaluation, Qsource developed a PIP Summary Form (with accompanying PIP Summary Form Completion Instructions) and a PIP Validation Tool to standardize the process by which each MCO and DBM delivers PIP information to FHKC and how the information was assessed. Qsource views the results as a learning opportunity for the Plans and will assist in education of the Plans to achieve better results next measurement year. FHKC should continue to monitor the Plans PIPs as part of its Quality Strategy to ensure quality, timeliness, and access to care for its enrollees.

## PMV

The PMV is designed to assess the accuracy of reported performance measures and determine the extent to which the reported rates follow the measure specifications and reporting requirements. FHKC identified 23 performance measures for MCOs and 10 for DBMs. Qsource defined the scope of the validation to include the FHKC required metrics as part of its validation, which included data source, reporting frequency, and format. In addition to document review, the Qsource audit

**2025 EQR Conclusions and Recommendations**

included system demonstrations, review of data output files, observation of data processing, and review of data reports.

Qsource determined that each of the plans aligned with the goals and objectives of CMS' Quality Strategy related to quality of care and access to care for enrollees. Each MCO and DBM had strategies in place to align with FHKC's goals and objectives relating to access to care for its enrollees and increasing enrollee satisfaction with those services.

In the ISCA, Qsource found that all plans were capable of reporting measures and had the capacity to produce accurate and complete encounter data. When reviewing selected encounter fields, the plans were mostly accurate and complete.

Each plan underwent an NCQA HEDIS Compliance Audit by a NCQA-Certified HEDIS Compliance Auditor for their performance measures. Qsource reviewed all related documentation, which included the plan's completed ISCAT. All plans met all specifications for the designated measures. In addition, the data integration, control, and performance measure documentation reviewed indicated an overall high confidence in each's ability to provide quality and timely care for its enrollees. No weaknesses were noted in any MCO's or DBM's processes for data collection and performance measure reporting, except that Liberty did not factor in the anchor date required in the CMS Core Set Technical Specifications when calculating the SFM-CH measure. Qsource validated that the revised measure was calculated correctly using required specifications. The validated

rates are presented in this report. Liberty's CAP was approved and completed prior to reporting.

## ACA

Coordination and Continuity of Care, Coverage and Authorization of Services, and Subcontractual Relationships and Delegation were the areas evaluated during the 2025 ACA activities. Except for one standard for one DBM, all MCOs and DBMs achieved a high level of compliance at 94.00% or greater in all 2025 ACA standards, and overall compliance scores were all above 98.00%. All three areas evaluated during the 2025 ACA were in alignment with FHKC's Quality Strategy goals of quality of care, timeliness of care, and access to care.

## ANA

The Quality Strategy goals of Leadership, Growth, and Effectiveness demonstrate FHKC's commitment to ensuring enrollees have adequate and timely access to care. The plans are contractually required to maintain an administrative and organizational structure that supports effective and efficient delivery of services to enrollees. Furthermore, FHKC is continually evaluating ways to increase cost-effectiveness. The overarching goal to improve access to care extends throughout the quality improvement efforts of FHKC and is embedded into the expectations of the contracted health plans.

The plans demonstrated a shared strength for providing access to their enrollees to providers within the required travel time standard.

**2025 EQR Conclusions and Recommendations**

Based on the analyses of the MCO and DBM's geographical network adequacy, Qsource concluded that all plans met the geographic requirements for urban accessibility to providers. Qsource recommends that MCOs work to improve rural access to Behavioral Health – Pediatric, Optometry, Pharmacy, and PCP – Family Medicine. Qsource recommends that DBMs work to improve rural access to Orthodontists and Dental Specialists. Plans should investigate those provider types for which access has decreased from the previous year and identify any trends that can be remedied and/or opportunities to increase access, along

with annual review of appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses. Toward achievement of Quality Strategy Plan goals, Qsource recommends that the plans be proactive in monitoring and adding providers to their network to ensure a robust provider network for all their enrollees.

Overall, the results of the 2025 EQR activities demonstrated that the Plans were well-qualified and committed to facilitating timely, accessible, and high-quality healthcare for all enrollees.

## Appendix A | 2025 PIP Measurement Results

The following tables list the aim statements and measures, and summarizes each PIP's reported goals and measurement/remeasurement results.

Table A-1. PIP Measurement Results, Aetna (Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH))						
<b>Aim Statement:</b> <i>Will targeted provider interventions increase the rate of FHK members ages 12-17 (on date of encounter) who are screened for depression using a standardized tool and, if positive, a follow-up plan is documented on the date of the positive screen, by 20 percentage points over baseline during the fourth measurement period (MY 2024)?</i>	<b>Goal</b>	<b>Baseline</b>	<b>Remeasurement Year</b>			
			<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>Performance Measure 1:</b> The percentage of FHK members ages 12 to 17 who were screened for clinical depression on the date of the encounter, or 14 days prior to the date of encounter, using an age-appropriate standardized depression screening tool, and, if positive, a follow-up plan documented on the date of the eligible encounter.	23.56%	3.56%	6.52%	7.73%	9.86%	11.90%

**Table A-2. PIP Measurement Results, Aetna (Timely Follow-up for Patients After They Have Been Hospitalized for Mental Illness – 7-Day (FUH 7-Day))**

<b>Aim Statement:</b> <i>Will targeted provider and member interventions increase the rate of follow-up visit with a mental health practitioner within 7 days after a hospital stay for FHK members (6 years of age or older as of the date of discharge) hospitalized with a principal diagnosis of mental illness or intentional self-harm to meet or exceed the 2024 NCQA Quality Compass 50th percentile during the sixth re-measurement period (MY 2024)?</i>	<b>Goal</b>	<b>Baseline</b>	<b>Remeasurement Year</b>					
			<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>
<b>Performance Measure 1:</b> The percentage of FHK members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnosis and who had a follow-up visit with a mental health practitioner within 7 days after discharge.	36.94%	33.77%	35.58%	51.08%	49.82%	39.90%	45.08%	46.71%

**Table A-3. PIP Measurement Results, CCP (Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH))**

<b>Aim Statement:</b> <i>Does reminder outreach to schedule a well visit appointment by texting or telephone and education to providers about screening using a standardized tool and submitting the appropriate codes on the encounter submission result in an improvement in screening for clinical depression and appropriate follow up in 12–17-year-old FHKC enrollees in each measurement year?</i>	<b>Goal</b>	<b>Baseline</b>	<b>Remeasurement Year</b>			
			<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>Performance Measure 1:</b> Percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter using an age-appropriate standardized depression screening tool, and, if positive, a follow-up plan is documented on the date of the positive screen.	2.99%	2.72%	4.63%	7.03%	13.30%	15.23%

**Table A-4. PIP Measurement Results, CCP (Follow-up After Hospitalization for Mental Illness – 7 Days)**

<b>Aim Statement:</b> <i>Do targeted interventions increase the rate of Follow-up After Hospitalization for Mental Illness – 7 days for FHKC enrollees 6 and older who were hospitalized for mental illness or intentional self-harm diagnoses?</i>	<b>Goal</b>	<b>Baseline</b>	<b>Remeasurement Year</b>	
			<b>1</b>	<b>2</b>
<b>Performance Measure 1:</b> Follow-Up After Hospitalization for Mental Illness (FUH) for enrollees ages 6 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 7 days after discharge.	43.48%	43.48%	32.61%	38.78%

**Table A-5. PIP Measurement Results, DentaQuest (Preventive Dental)**

<b>Aim Statement:</b> <i>Will the use of targeted member and provider interventions increase the percentage of CMS 416 eligible FHKC members aged 5-18, with 90 days continuous enrollment, who receive a preventative visit Current Dental Terminology (CDT) codes D1000-D1999) by 2% during the measurement period?</i>	<b>Goal</b>	<b>Baseline</b>	<b>Remeasurement Year</b>
			<b>1</b>
<b>Performance Measure 1:</b> The percentage of children ages 5-18, who have been continuously enrolled for 90 days during the measurement year who received at least one preventive dental service by or under the supervision of a dentist as defined by codes D1000 - D1999.	Two percentage point increase in Preventive Dental (PDENT), which has been internally developed. The PIP team felt that a two percentage point improvement year over year showed steady and reliable growth, and therefore will be used as the goal for future measurement periods.	47.54%	NA

**Table A-6. PIP Measurement Results, DentaQuest (Improving Preventive Care Dental Visits in Children with Special Healthcare Needs (SHCN))**

<b>Aim Statement:</b> <i>Will the use of targeted member and provider interventions increase the number of members with SHCN aged 5-18, with 90 days continuous enrollment, who receive a preventative visit Current Dental Terminology (CDT) codes D1000-D1999) during the measurement period?</i>	<b>Goal</b>	<b>Baseline</b>	<b>Remeasure ment Year</b>
			<b>1</b>
<p><b>Performance Measure 1:</b> The percentage of SHCN children ages 5-18, who have been continuously enrolled for 90 days during the measurement year, who received at least one preventative dental service by or under the supervision of a dentist as defined by codes D1000 - D1999.</p>	<p>Two percentage point increase in Annual Dental Services (ADENT) which has been internally developed. The PIP team felt that a two percentage point improvement year over year showed steady and reliable growth, and therefore will be used as the goal for future measurement periods.</p>	37.26%	NA

**Table A-7. PIP Measurement Results, DentaQuest (Implementing Digital Technology to Improve Access to Care)**

<b>Aim Statement:</b> <i>Will the use of digital technology interventions increase the percentage of CMS 416 eligible FHKC members aged 5-18 receiving dental care during the measurement period?</i>	<b>Goal</b>	<b>Baseline</b>	<b>Remeasure ment Year</b>
			<b>1</b>
<p><b>Performance Measure 1:</b> The percentage of children ages 5-18 who have been continuously enrolled for 90 days during the measurement year who received at least one dental service.</p>	<p>Two percentage point increase in Annual Dental Services (ADENT) which has been internally developed. The PIP team felt that a two percentage point improvement year over year showed steady and reliable growth, and therefore will be used as the goal for future measurement periods.</p>	37.26%	NA

**Table A-8. PIP Measurement Results, Liberty (Increasing the Percentage of Enrollees Receiving Preventive Services)**

<b>Aim Statement:</b> <i>Do the targeted interventions increase utilization of dental benefits, measured by an increase in the percentage of eligible enrollees 0 to 20 years of age that had at least one preventive dental service during the measurement year?</i>	<b>Goal</b>	<b>Baseline</b>	<b>Remeasure ment Year</b>
			<b>1</b>
<b>Performance Measure 1:</b> Enrollees Utilizing Preventive Dental Services (PDENT): This indicator was developed by CMS and is the primary indicator in the dental industry to measure preventive dental utilization, which this PIP has been designed to increase.	2% increase in the PDENT utilization rate (0.66% each measure period) from the baseline rate	43.88%	50.12%

**Table A-9. PIP Measurement Results, Liberty (Improving Utilization Rate of Special Care Enrollees)**

<b>Aim Statement:</b> <i>Do the targeted interventions increase utilization of dental benefits, measured by an increase in the percentage of eligible enrollees 0 to 20 years of age identified as “Special Healthcare Needs” that had at least one Sealant service during the measurement year?</i>	<b>Goal</b>	<b>Baseline</b>	<b>Remeasure ment Year</b>
			<b>1</b>
<b>Performance Measure 1:</b> Percentage of Sealant utilization for “Special Needs” Enrollees: This indicator was modeled after CMS-416 and is the primary indicator in the dental industry to measure Sealant utilization (specifically Sealants on a Permanent Molar Tooth), which this PIP has been designed to increase.	14.29%	12.29%	N/A

**Table A-10. PIP Measurement Results, Liberty (Access to Care in Rural and Urban Counties)**

<b>Aim Statement:</b> <i>Do targeted interventions reduce the number of counties from requiring the Time and/or Distance Network Adequacy Standards waiver and/or any access to care barriers identified?</i>	<b>Goal</b>	<b>Baseline</b>	<b>Remeasurement Year</b>
			<b>1</b>
<b>Performance Measure 1:</b> Percentage of Enrollees with Access in Rural and Urban Counties: The percentage of enrollees with access to care to a primary dental provider, specialist, or orthodontist.	5% increase in the Access to Care rate (1.66% per measurement year) from the baseline rate	96.47%	96.47%
<b>Performance Measure 2:</b> Number of Regions Covered by the Time and/or Distance Network Adequacy Standards Waiver: This is the number of regions covered by the Time and/or Distance Network Adequacy Standards Waiver due to the lack of primary dental providers or specialists in these rural or urban regions.	10% reduction in the Waiver Rate (3.33% per measurement year) from the baseline rate	NA	63.64%

**Table A-11. PIP Measurement Results, MCNA (Improving Sealant Receipt on Permanent First Molars)**

<b>Aim Statement:</b> <i>Will targeted member and provider interventions to members turning 10 years old improve the percentage of members receiving sealants by the 10th birthdate, by two percentage points over baseline (CY 2024) during the measurement year (MY) 2025 (01/01/25 – 12/31/25)?</i>	<b>Goal</b>	<b>Baseline</b>	<b>Remeasurement Year</b>
			<b>1</b>
<b>Performance Measure 1:</b> Sealant Receipt on Permanent First Molars, at least one sealant on permanent first molar: Members who receive a dental sealant as defined by Current Dental Terminology (CDT) code D1351 on their first permanent molars (TID's 3, 14, 19 or 30) by their 10th birthdate.	53.66%	51.66%	N/A
<b>Performance Measure 2:</b> Sealant Receipt on Permanent First Molars, all four sealants on	41.64%	39.64%	N/A

**Table A-11. PIP Measurement Results, MCNA (Improving Sealant Receipt on Permanent First Molars)**

<b>Aim Statement:</b> <i>Will targeted member and provider interventions to members turning 10 years old improve the percentage of members receiving sealants by the 10th birthdate, by two percentage points over baseline (CY 2024) during the measurement year (MY) 2025 (01/01/25 – 12/31/25)?</i>	<b>Goal</b>	<b>Baseline</b>	<b>Remeasure ment Year</b>
permanent first molars: Members who receive a dental sealant as defined by CDT code D1351 on all four permanent first permanent molars (TID's 3, 14, 19 or 30) by their 10th birthdate.			<b>1</b>

**Table A-12. PIP Measurement Results, MCNA (Increasing the Number of Special Needs Members Receiving an Annual Dental Visit)**

<b>Aim Statement:</b> <i>Will targeted member interventions increase the percentage of special needs members ages 5-18 receiving an annual dental visit by 1.5 percentage points over baseline (calendar year [CY] 2024) during measurement year (MY) 2025 (01/01/25 – 12/31/25)?</i>	<b>Goal</b>	<b>Baseline</b>	<b>Remeasurement Year</b>
<b>Performance Measure 1:</b> Percentage of special needs members ages 5-18 receiving an annual dental visit (ADV). ADV assesses special needs members ages 5-18 who had at least one dental visit.	60.49%	58.99%	<b>1</b>  N/A

**Table A-13. PIP Measurement Results, MCNA (Increasing the Rate of Providers Reporting Member No-shows)**

<b>Aim Statement:</b> <i>Will targeted provider interventions increase the percentage of all active general and pediatric providers reporting member no-shows using CDT code, D9986 (missed appointment), by two percentage points over baseline (calendar year [CY] 2024) during the measurement year (MY) 2025 (01/01/25 – 12/31/25)?</i>	<b>Goal</b>	<b>Baseline</b>	<b>Remeasure ment Year</b>
			<b>1</b>
<b>Performance Measure 1:</b> The percentage of providers reporting member no-shows using CDT Code D9986. This indicator was internally developed based on the provider feedback received through MCNA’s Dental Advisory Committee (DAC). As a result, MCNA enhanced its system to allow providers to report when a member has missed a dental appointment, by submission of non-reimbursable CDT procedure code D9986 – missed appointment. This enhancement is meant to reduce administrative burdens as MCNA continues to support providers in the reduction of missed appointments.	6.10%	4.10%	N/A

**Table A-14. PIP Measurement Results, Simply Healthcare (Screening for Depression and Follow-Up Plan Ages 12 to 17 (CDF-CH))**

<b>Aim Statement:</b> <i>Will targeted interventions result in an annual 2% improvement in the percentage of beneficiaries ages 12 to 17 who are screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen through Remeasurement 4 with rate sustained in Remeasurement 5 period?</i>	<b>Goal</b>	<b>Baseline</b>	<b>Remeasurement Year</b>				
			<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Performance Measure 1:</b> Improving the percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.	5.02%	3.02%	3.26%	5.12%	6.29%	8.34%	10.04%

**Table A-15. PIP Measurement Results, Simply Healthcare (Improving Care Coordination to Improve Follow-up for Children Prescribed ADHD Medication)**

<b>Aim Statement:</b> <i>Will interventions targeting care coordination among providers improve Follow-up Care for Children Prescribed ADHD Medication (ADD) rates in both initiation as well as continuation/maintenance phase for all FHK Plan enrollees 6-12 years of age who were dispensed an ADHD medication (during the 12-month Intake Period) to the NCQA Quality Compass® 75th percentile during Remeasurement 6?</i>	<b>Goal</b>	<b>Baseline</b>	<b>Remeasurement Year</b>					
			<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>
<b>Performance Measure 1:</b> ADD Initiation Phase: The percentage of members 6–12 years of age as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.	48.10%	42.28%	45.73%	50.47%	44.28%	48.15%	47.63%	45.62%
<b>Performance Measure 2:</b> ADD Continuation and Maintenance (C&M) Phase: The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	69.40%	58.54%	66.25%	60.24%	68.42%	64.03%	69.42%	57.63%



**Table B-1. 2025 PMV: MCO Performance Measures**

Measure Name	Measure Steward and Definition
Chlamydia Screening in Women Ages 16–20 (CHL-CH)	<p><u>NCQA:</u> Percentage of women ages 16 to 20 who were identified as sexually active and who had at least one test for chlamydia during the measurement year.</p>
Immunizations for Adolescents (IMA-CH)	<p><u>NCQA:</u> Percentage of adolescents aged 13 who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.</p> <p>The measure was stratified by:</p> <p>Race/Ethnicity:</p> <ul style="list-style-type: none"> <li>◆ American Indian or Alaska Native alone or in combination</li> <li>◆ Asian alone or in combination</li> <li>◆ Black or African American or in combination</li> <li>◆ Hispanic or Latino alone or in combination</li> <li>◆ Middle Eastern or North African alone or in combination</li> <li>◆ Native Hawaiian or Other Pacific Islander alone or in combination</li> <li>◆ White alone or in combination</li> <li>◆ Missing or Not Reported</li> </ul> <p>Sex:</p> <ul style="list-style-type: none"> <li>◆ Male</li> <li>◆ Female</li> <li>◆ Missing or Not Reported</li> </ul> <p>Geography:</p>

Table B-1. 2025 PMV: MCO Performance Measures

Measure Name	Measure Steward and Definition
	<ul style="list-style-type: none"> <li>◆ Urban</li> <li>◆ Rural</li> <li>◆ Missing or Not Reported</li> </ul> <p>Combination #1: Meningococcal and Tdap</p> <p>Combination #2: Meningococcal, Tdap, and HPV</p>
Child and Adolescent Well-Care Visits (WCV-CH)	<p><u>NCQA:</u></p> <p>Percentage of children ages 3 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement year.</p> <p>The measure was stratified by:</p> <p>Age:</p> <ul style="list-style-type: none"> <li>◆ 3–11 Years</li> <li>◆ 12–17 Years</li> <li>◆ 18–21 Years</li> <li>◆ Total (Ages 3–21)</li> </ul> <p>Race/Ethnicity:</p> <ul style="list-style-type: none"> <li>◆ American Indian or Alaska Native alone or in combination</li> <li>◆ Asian alone or in combination</li> <li>◆ Black or African American or in combination</li> <li>◆ Hispanic or Latino alone or in combination</li> <li>◆ Middle Eastern or North African alone or in combination</li> <li>◆ Native Hawaiian or Other Pacific Islander alone or in combination</li> <li>◆ White alone or in combination</li> <li>◆ Missing or Not Reported</li> </ul>

Table B-1. 2025 PMV: MCO Performance Measures

Measure Name	Measure Steward and Definition
	Sex: <ul style="list-style-type: none"> <li>◆ Male</li> <li>◆ Female</li> <li>◆ Missing or Not Reported</li> </ul> Geography: <ul style="list-style-type: none"> <li>◆ Urban</li> <li>◆ Rural</li> <li>◆ Missing or Not Reported</li> </ul>
Maternal and Perinatal Health	
Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)	<u>OPA:</u> Among women ages 15 to 20 who had a live birth and were provided postpartum contraceptive care. Four rates are reported as the percentage of female enrollees who had a live birth that were provided contraceptive care: <ul style="list-style-type: none"> <li>◆ Most or moderately effective contraception: 3 days</li> <li>◆ Most or moderately effective contraception: 60 days</li> <li>◆ Long-acting reversible method of contraception (LARC): 3 days</li> <li>◆ LARC: 60 days</li> </ul>
Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)	<u>OPA:</u> Among women ages 15 to 20 at risk of unintended pregnancy who were provided contraceptive care. Two rates are reported: <ul style="list-style-type: none"> <li>◆ Most effective or moderately effective method of contraception</li> <li>◆ LARC</li> </ul>

Table B-1. 2025 PMV: MCO Performance Measures

Measure Name	Measure Steward and Definition
Prenatal and Postpartum Care: Under Age 21 (PPC2-CH)	<p data-bbox="552 305 657 337"><u>NCQA:</u></p> <p data-bbox="552 345 1894 475">Percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these beneficiaries, the measure assesses the following facets of prenatal and postpartum care:</p> <ul data-bbox="615 492 1894 638" style="list-style-type: none"> <li data-bbox="615 492 1894 557">◆ Timeliness of Prenatal Care: Percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment.</li> <li data-bbox="615 573 1894 638">◆ Postpartum Care: Percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.</li> </ul> <p data-bbox="552 654 951 686">The measure was stratified by:</p> <p data-bbox="552 703 636 735">Race:</p> <ul data-bbox="615 743 1497 1092" style="list-style-type: none"> <li data-bbox="615 743 1392 776">◆ American Indian or Alaska Native alone or in combination</li> <li data-bbox="615 792 1035 824">◆ Asian alone or in combination</li> <li data-bbox="615 841 1224 873">◆ Black or African American or in combination</li> <li data-bbox="615 889 1203 922">◆ Hispanic or Latino alone or in combination</li> <li data-bbox="615 938 1371 971">◆ Middle Eastern or North African alone or in combination</li> <li data-bbox="615 987 1497 1019">◆ Native Hawaiian or Other Pacific Islander alone or in combination</li> <li data-bbox="615 1036 1035 1068">◆ White alone or in combination</li> <li data-bbox="615 1084 972 1117">◆ Missing or Not Reported</li> </ul> <p data-bbox="552 1125 615 1157">Sex:</p> <ul data-bbox="615 1166 972 1271" style="list-style-type: none"> <li data-bbox="615 1166 720 1198">◆ Male</li> <li data-bbox="615 1214 741 1247">◆ Female</li> <li data-bbox="615 1263 972 1295">◆ Missing or Not Reported</li> </ul> <p data-bbox="552 1304 699 1336">Geography:</p> <ul data-bbox="615 1344 741 1417" style="list-style-type: none"> <li data-bbox="615 1344 741 1377">◆ Urban</li> <li data-bbox="615 1393 741 1425">◆ Rural</li> </ul>

**Table B-1. 2025 PMV: MCO Performance Measures**

Measure Name	Measure Steward and Definition
	<ul style="list-style-type: none"> <li>◆ Missing or Not Reported</li> </ul>
Care of Acute and Chronic Conditions	
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years (AAB-CH)	<u>NCQA:</u> Percentage of episodes for beneficiaries ages 3 months to 17 years with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.
Asthma Medication Ratio: Ages 5–18 (AMR-CH)	<u>NCQA:</u> The percentage of children and adolescents ages 5 to 18 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. The measure was stratified by: Age: <ul style="list-style-type: none"> <li>◆ 5–11 Years</li> <li>◆ 12–18 Years</li> <li>◆ Total (5–18 Years)</li> </ul> Race: <ul style="list-style-type: none"> <li>◆ American Indian or Alaska Native alone or in combination</li> <li>◆ Asian alone or in combination</li> <li>◆ Black or African American or in combination</li> <li>◆ Hispanic or Latino alone or in combination</li> <li>◆ Middle Eastern or North African alone or in combination</li> <li>◆ Native Hawaiian or Other Pacific Islander alone or in combination</li> </ul>

Table B-1. 2025 PMV: MCO Performance Measures

Measure Name	Measure Steward and Definition
	<ul style="list-style-type: none"> <li>◆ White alone or in combination</li> <li>◆ Missing or Not Reported</li> </ul> <p>Sex:</p> <ul style="list-style-type: none"> <li>◆ Male</li> <li>◆ Female</li> <li>◆ Missing or Not Reported</li> </ul> <p>Geography:</p> <ul style="list-style-type: none"> <li>◆ Urban</li> <li>◆ Rural</li> <li>◆ Missing or Not Reported</li> </ul>
Appropriate Testing for Children with Pharyngitis (CWP)	<p><u>NCQA:</u></p> <p>The percentage of episodes for enrollees 3 years of age and older with a diagnosis of pharyngitis, dispensed an antibiotic and received a group A streptococcus test for the episode. A total rate and three age stratifications are reported for CWP (only two apply to the Florida Healthy Kids population):</p> <ul style="list-style-type: none"> <li>◆ 3–17 years</li> <li>◆ 18–64 years</li> </ul>
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	<p><u>NCQA:</u></p> <p>The percentage of episodes for enrollees 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event. The measure is reported as an inverted rate <math>[1 - (\text{numerator}/\text{eligible population})]</math>. A higher rate indicates appropriate URI treatment (i.e., the proportion of episodes that did not result in an antibiotic dispensing event.) A total rate and three age stratifications are reported for URI (only two apply to the Florida Healthy Kids population):</p> <ul style="list-style-type: none"> <li>◆ 3 months–17 years</li> <li>◆ 18–64 years</li> </ul>

**Table B-1. 2025 PMV: MCO Performance Measures**

Measure Name	Measure Steward and Definition
Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	<p><u>NCQA:</u></p> <p>Rate of emergency department (ED) visits per 1,000 beneficiary months among children up to age 19. A total rate and two age stratifications are reported:</p> <ul style="list-style-type: none"> <li>◆ 1–9 years</li> <li>◆ 10–19 years</li> </ul>
Behavioral Healthcare	
Follow-up Care for Children Prescribed Attention- Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	<p><u>NCQA:</u></p> <p>Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:</p> <ul style="list-style-type: none"> <li>◆ Initiation Phase: Percentage of children ages 6 to 12 with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.</li> <li>◆ Continuation and Maintenance (C&amp;M) Phase: Percentage of children ages 6 to 12 with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.</li> </ul>
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)	<p><u>CMS:</u></p> <p>Percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the qualifying encounter.</p>
Follow-up After Hospitalization for	<p><u>NCQA:</u></p>

**Table B-1. 2025 PMV: MCO Performance Measures**

Measure Name	Measure Steward and Definition
Mental Illness: Ages 6–17 (FUH-CH)	<p>Percentage of discharges for beneficiaries ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported:</p> <ul style="list-style-type: none"> <li>◆ Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge.</li> <li>◆ Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge.</li> </ul> <p>The measure was stratified by:</p> <p>Race:</p> <ul style="list-style-type: none"> <li>◆ American Indian or Alaska Native alone or in combination</li> <li>◆ Asian alone or in combination</li> <li>◆ Black or African American or in combination</li> <li>◆ Hispanic or Latino alone or in combination</li> <li>◆ Middle Eastern or North African alone or in combination</li> <li>◆ Native Hawaiian or Other Pacific Islander alone or in combination</li> <li>◆ White alone or in combination</li> <li>◆ Missing or Not Reported</li> </ul> <p>Sex:</p> <ul style="list-style-type: none"> <li>◆ Male</li> <li>◆ Female</li> <li>◆ Missing or Not Reported</li> </ul> <p>Geography:</p> <ul style="list-style-type: none"> <li>◆ Urban</li> <li>◆ Rural</li> <li>◆ Missing or Not Reported</li> </ul>

**Table B-1. 2025 PMV: MCO Performance Measures**

Measure Name	Measure Steward and Definition
Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH)	<p><u>NCQA:</u></p> <p>Percentage of emergency department (ED) visits for beneficiaries ages 6 to 17 with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported:</p> <ul style="list-style-type: none"> <li>◆ Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days).</li> <li>◆ Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).</li> </ul>
Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17 (FUA-CH)	<p><u>NCQA:</u></p> <p>Percentage of emergency department (ED) visits for beneficiaries ages 13 to 17 years with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:</p> <ul style="list-style-type: none"> <li>◆ Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days).</li> <li>◆ Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).</li> </ul> <p>The measure was stratified by:</p> <p>Race:</p> <ul style="list-style-type: none"> <li>◆ American Indian or Alaska Native alone or in combination</li> <li>◆ Asian alone or in combination</li> <li>◆ Black or African American or in combination</li> <li>◆ Hispanic or Latino alone or in combination</li> <li>◆ Middle Eastern or North African alone or in combination</li> <li>◆ Native Hawaiian or Other Pacific Islander alone or in combination</li> <li>◆ White alone or in combination</li> </ul>

Table B-1. 2025 PMV: MCO Performance Measures

Measure Name	Measure Steward and Definition
	<ul style="list-style-type: none"> <li>◆ Missing or Not Reported</li> </ul> <p>Sex:</p> <ul style="list-style-type: none"> <li>◆ Male</li> <li>◆ Female</li> <li>◆ Missing or Not Reported</li> </ul> <p>Geography:</p> <ul style="list-style-type: none"> <li>◆ Urban</li> <li>◆ Rural</li> <li>◆ Missing or Not Reported</li> </ul>
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	<p><u>NCQA:</u></p> <p>Percentage of children and adolescents ages 1 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.</p> <p>A total rate and two age stratifications are reported:</p> <ul style="list-style-type: none"> <li>◆ 1–11 years</li> <li>◆ 12–17 years</li> </ul>
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	<p><u>NCQA:</u></p> <p>Percentage of children and adolescents ages 1 to 17 who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported:</p> <ul style="list-style-type: none"> <li>◆ Percentage of children and adolescents on antipsychotics who received blood glucose testing.</li> <li>◆ Percentage of children and adolescents on antipsychotics who received cholesterol testing.</li> <li>◆ Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.</li> </ul> <p>A total rate and two age stratifications are reported:</p>

Table B-1. 2025 PMV: MCO Performance Measures

Measure Name	Measure Steward and Definition
	<ul style="list-style-type: none"> <li>◆ 1–11 years</li> <li>◆ 12–17 years</li> </ul>
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	<p><u>NCQA:</u> The percentage of new episodes of substance use disorder (SUD) in adults and adolescents 13 years of age and older who received:</p> <ul style="list-style-type: none"> <li>◆ Initiation of SUD Treatment: New episodes, after which the individual initiated treatment through an inpatient SUD admission, outpatient visit, telehealth or intensive outpatient encounter or partial hospitalization, or received medication within 14 days of diagnosis.</li> <li>◆ Engagement of SUD Treatment: New episodes, after which the individual initiated treatment and had two or more additional SUD services or medications within 34 days of the initiation visit.</li> </ul> <p>For IET, a total rate and two age stratifications are reported for each indicator:</p> <ul style="list-style-type: none"> <li>◆ 13–17 years</li> <li>◆ 18–64 years</li> </ul> <p>For the total rate and each age stratification, a total rate and three diagnosis categories are reported for each indicator:</p> <ul style="list-style-type: none"> <li>◆ Alcohol abuse or dependence</li> <li>◆ Opioid abuse or dependence</li> <li>◆ Other drug abuse or dependence</li> </ul>
Diagnosed Substance-Related Disorders (DSU)	<p><u>NCQA:</u> The percentage of enrollees 13 years of age and older who were diagnosed with a substance use disorder (SUD) during the measurement year. Four rates are reported:</p> <ul style="list-style-type: none"> <li>◆ The percentage of enrollees diagnosed with an alcohol disorder.</li> <li>◆ The percentage of enrollees diagnosed with an opioid disorder.</li> <li>◆ The percentage of enrollees diagnosed with a disorder for other or unspecified drugs.</li> </ul>

**Table B-1. 2025 PMV: MCO Performance Measures**

Measure Name	Measure Steward and Definition
	<ul style="list-style-type: none"> <li>◆ The percentage of enrollees diagnosed with any substance use disorder.</li> </ul> <p>For DSU, a total rate and three age stratifications are reported for each indicator (only two apply to the Florida Healthy Kids population):</p> <ul style="list-style-type: none"> <li>◆ 13–17 years</li> <li>◆ 18–64 years</li> </ul>
Diagnosed Mental Health Disorders (DMH)*	<p><u>NCQA:</u></p> <p>The percentage of enrollees 1 year of age and older who were diagnosed with a mental health disorder during the measurement year. Note: The measure provides information on the diagnosed prevalence of mental health disorders. Neither a higher nor lower rate indicates better performance.</p> <ul style="list-style-type: none"> <li>◆ 1–17 years</li> <li>◆ 18–64 years</li> </ul>
Experience of Care	
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.1H, Child Version (CPC)	<p>For 2025, FHKC required the MCOs to add the supplemental question: "How would you rate the number of doctors you had to choose from?"</p> <p>FHKC required the MCOs to report CAHPS® Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH) results.</p>

\* The former MPT measure was replaced by the DMH measure.

## DBM Performance Measures

Qsource validated six CMS-416 dental service measures, three CMS Core Set Measures, and one measure that has been retired from HEDIS for the 2025 PMV activities for the DBMs. These measures are listed and defined in [Table B-2](#).

**Table B-2. 2025 PMV: DBM Performance Measures**

Measure Name	Measure Steward and Definition
Enrolled Children Receiving Dental Sealants on Permanent Molars – With Exclusions (SEA: With Exclusions)	<u>CMS-416:</u> SEA: With Exclusions measures the percentage of enrollees in age categories 6–9 and 10–14 years who received a sealant on a permanent molar tooth during the federal fiscal year, excluding from the denominator any enrollees who had molars previously sealed, restored, or extracted.
Enrolled Children Receiving Preventive Dental Services (PDENT)	<u>CMS-416:</u> PDENT measures the percentage of enrollees who received at least one preventive dental service during the federal fiscal year.
Enrolled Children Receiving Any Dental Services	<u>CMS-416:</u> Enrolled Children Receiving Any Dental Services measures the percentage of enrollees who received at least one dental service during the federal fiscal year.
Enrolled Children Receiving Dental Treatment Services (TDENT)	<u>CMS-416:</u> TDENT measures the percentage of enrollees who received at least one dental treatment service during the federal fiscal year.
Enrolled Children Receiving Diagnostic Dental Services	<u>CMS-416:</u> Enrolled Children Receiving Diagnostic Dental Services measures the percentage of enrollees who received at least one diagnostic dental service during the federal fiscal year.
Enrolled Children Receiving Any Preventive Dental or Oral Health Service	<u>CMS-416:</u> Enrolled Children Receiving Any Preventive Dental or Oral Health Service measures the percentage of enrollees who received either a preventive dental service by or under the supervision of a dentist or a preventive oral health service by a qualified healthcare practitioner who is neither a dentist nor providing services under the supervision of a dentist during the federal fiscal year.
Annual Dental Visit (ADV)	<u>NCQA:</u>

	<p>Retired by CMS; FHKC will continue to report on this measure for 2025. ADV measures the percentage of enrollees 2–20 years of age who had at least one dental visit during the measurement year. For ADV, a total rate and six age stratifications are reported (only four apply to the Florida Healthy Kids population):</p> <ul style="list-style-type: none"> <li>◆ 4–6 years</li> <li>◆ 7–10 years</li> <li>◆ 11–14 years</li> <li>◆ 15–18 years</li> </ul>
<p>Oral Evaluation, Dental Services (OEV-CH)</p>	<p>Percentage of enrolled children aged 3 to 18 who received a comprehensive or periodic oral evaluation within the measurement year:</p> <ul style="list-style-type: none"> <li>◆ children who are aged 3 to 18 as of December 31 of the measurement year.</li> </ul>
<p>Topical Fluoride for Children (TFL-CH)</p>	<p>Percentage of enrolled children aged 3 through 18 who received at least two topical fluoride applications as:</p> <ul style="list-style-type: none"> <li>◆ dental or oral health services;</li> <li>◆ dental services; and</li> <li>◆ oral health services within the measurement year.</li> </ul>
<p>Sealant Receipt on Permanent First Molars (SFM-CH)</p>	<p>Percentage of enrolled children aged 10 who have ever received sealants on permanent first molar teeth:</p> <ul style="list-style-type: none"> <li>◆ at least one sealant; and</li> <li>◆ all four molars sealed by the 10th birthdate.</li> </ul>

## Appendix C | 2025 Sample EQR Assessment Tools

### ACA MCO Tools

**Table C-1. 2025 ACA: MCO Tool, Coordination and Continuity of Care**

2025 Annual Compliance Assessment: <MCO Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coordination and Continuity of Care</b>					
1. Appropriate Source of Care  42 Code of Federal Regulations (CFR) 438.208(b)(1) Medical Services Contract (MSC) 18-2-3-1	The managed care organization (MCO) must ensure that each enrollee has: a. a choice of primary care providers (PCPs) who meet the credentialing, access, and appointment standards of the MCO's Medical Services Contract (MSC) with the Florida Healthy Kids Corporation (FHKC); b. an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee; and c. information on how to contact their designated person or entity.	<input type="checkbox"/> a. Choice of PCP <input type="checkbox"/> b. Ongoing source of care appropriate to needs and primary coordinator of services <input type="checkbox"/> c. Designated entity contact information <input type="checkbox"/> Not Applicable	0.33 0.33 0.34 0.00	1.00	X.XX
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
2. Assignment of Primary Care Provider (PCP)  MSC 18-2-3-1	The MCO must permit enrollees to select another PCP, if the MCO elects to auto-assign enrollees to PCPs.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	1.00 0.00 0.00	1.00	X.XX
<b>Findings</b> <b>Strength</b> <b>AON</b>					

**Table C-1. 2025 ACA: MCO Tool, Coordination and Continuity of Care**

2025 Annual Compliance Assessment: &lt;MCO Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coordination and Continuity of Care</b>					
<b>Suggestion</b>					
3. PCP Assignment Requirements  MSC 18-2-3-1	The MCO must consider the following when auto-assigning enrollees to PCPs: a. the enrollee's last PCP assignment, if known; b. time and distance from the enrollee's home address; c. sibling assignments; and d. the enrollee's age and any age limitations with the PCP.	<input type="checkbox"/> a. Enrollee's last PCP assignment <input type="checkbox"/> b. Time and distance from enrollee's address <input type="checkbox"/> c. Sibling assignments <input type="checkbox"/> d. Enrollee's age and PCP age limitations, if any <input type="checkbox"/> Not Applicable	<b>0.25</b> <b>0.25</b> <b>0.25</b> <b>0.25</b> <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
4. Service Coordination  42 CFR 438.208(b)(2) (i,ii,iv) MSC 9-4-2 MSC 22-11	The MCO must coordinate services it furnishes to the enrollee: a. between settings of care, including appropriate discharge planning for short- and long-term hospital and institutional stays; b. with the services the enrollee receives from any other healthcare coverage or liable third parties; and c. with the services the enrollee receives from community and social support providers.	<input type="checkbox"/> a. Services between settings of care <input type="checkbox"/> b. Services from any other healthcare coverage or liable third party <input type="checkbox"/> c. Services from community and social support providers <input type="checkbox"/> Not Applicable	<b>0.33</b> <b>0.33</b> <b>0.34</b> <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
5. Transition of Care Policy	The MCO must: a. implement a transition of care policy consistent with	<input type="checkbox"/> a. Transition of care policy consistent with FHKC's policy	<b>0.50</b>	<b>1.00</b>	<b>X.XX</b>

**Table C-1. 2025 ACA: MCO Tool, Coordination and Continuity of Care**

2025 Annual Compliance Assessment: &lt;MCO Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coordination and Continuity of Care</b>					
MSC 22-11	the transition of care policy adopted by FHKC, subject to FHKC approval; and b. include summaries of the transition of care policy in its enrollee handbook and relevant notices.	<input type="checkbox"/> b. Summaries in enrollee handbook and relevant notices <input type="checkbox"/> Not Applicable	<b>0.50</b> <b>0.00</b>		
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
6. Liability for Previously Authorized and Ongoing Services  MSC 22-11	The MCO must be liable for the cost of any previously authorized, ongoing course of treatment provided to an enrollee by any provider, regardless of whether such provider has a contract with the MCO, without any further authorizations, for an additional 60 calendar days after termination or expiration of any prior MCO's contract covering such enrollees.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b> <b>0.00</b> <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
7. Dental Coordination  MSC 22-12 MSC 9-4-2	The MCO must: a. coordinate care with enrollees' Florida Healthy Kids dental insurance carriers to provide comprehensive dental care benefits to enrollees, including the provision of prescription coverage for prescriptions prescribed by the enrollee's dental provider; and	<input type="checkbox"/> a. Care coordination with Florida Healthy Kids dental insurance carriers to provide dental care benefits, including prescriptions <input type="checkbox"/> b. Data-sharing agreements and exchange of data	<b>0.50</b> <b>0.50</b>	<b>1.00</b>	<b>X.XX</b>

**Table C-1. 2025 ACA: MCO Tool, Coordination and Continuity of Care**

2025 Annual Compliance Assessment: &lt;MCO Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coordination and Continuity of Care</b>					
	b. enter into data-sharing agreements and exchange data with FHKC's contracted dental insurance carriers as directed by FHKC, including sharing medical encounters for fluoride varnish services.	<input type="checkbox"/> Not Applicable	<b>0.00</b>		
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
8. Initial Health Risk Assessment (HRA)  42 CFR 438.208(b)(3) MSC 18-2-3-3	The MCO must make a best effort to conduct an initial HRA of each enrollee's needs, within 90 calendar days of the coverage effective date for all new enrollees, including subsequent attempts if the first attempt to contact the enrollee is unsuccessful.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b> <b>0.00</b> <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
9. HRA Incentive Plan  MSC 18-2-3-3	The MCO must: a. conduct an HRA incentive plan, as approved by FHKC, to increase the percentage of new enrollees who complete an HRA within the first 90 days of enrollment; b. include in its HRA incentive plan an annual goal reflecting year-over-year improvement; and c. report on the HRA completion rate quarterly.	<input type="checkbox"/> a. Incentive plan conducted <input type="checkbox"/> b. Annual goal included in plan <input type="checkbox"/> c. Quarterly reporting to FHKC <input type="checkbox"/> Not Applicable	<b>0.33</b> <b>0.33</b> <b>0.34</b>	<b>1.00</b>	<b>X.XX</b>

**Table C-1. 2025 ACA: MCO Tool, Coordination and Continuity of Care**

2025 Annual Compliance Assessment: &lt;MCO Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coordination and Continuity of Care</b>					
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
10. Assessment of Enrollee Needs  42 CFR 438.208(b)(4) MSC 18-2-3-3	The MCO must: a. accept such information as assessed by another MCO in the Florida Healthy Kids program from FHKC; and b. share with FHKC or other MCOs serving the enrollee the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities, upon FHKC's request.	<input type="checkbox"/> a. Accept assessment by another Florida Healthy Kids MCO  <input type="checkbox"/> b. Share assessment results with FHKC or other MCOs, at FHKC's request  <input type="checkbox"/> Not Applicable	<b>0.50</b>  <b>0.50</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
11. Enrollee Health Record  42 CFR 438.208(b)(5)	The MCO must ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b> <b>0.00</b> <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
12. Enrollee Privacy	The MCO must ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.00</b> <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>

**Table C-1. 2025 ACA: MCO Tool, Coordination and Continuity of Care**

2025 Annual Compliance Assessment: &lt;MCO Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coordination and Continuity of Care</b>					
42 CFR 438.208(b)(6)	with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.	<input type="checkbox"/> Not Applicable	<b>0.00</b>		
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
13. Special Healthcare Needs Assessment  42 CFR 438.208(c)(2) MSC 18-2-3-3	The MCO must implement mechanisms to comprehensively assess each Florida Healthy Kids enrollee identified by FHKC as having special healthcare needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
14. Treatment or Service Plan  42 CFR 438.208(c)(3)	The MCO must produce a treatment or service plan meeting the following criteria for enrollees with special healthcare needs that are determined through assessment to need a course of treatment or regular care monitoring: a. approved by the MCO in a timely manner, if this	<input type="checkbox"/> a. Timely MCO approval, if required <input type="checkbox"/> b. In accordance with applicable FHKC standards <input type="checkbox"/> c. Reviewed and revised at least every 12 months	<b>0.33</b>  <b>0.33</b>  <b>0.34</b>	<b>1.00</b>	<b>X.XX</b>

Table C-1. 2025 ACA: MCO Tool, Coordination and Continuity of Care

2025 Annual Compliance Assessment: &lt;MCO Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coordination and Continuity of Care</b>					
(iii)-(v)	approval is required by the MCO; b. in accordance with any applicable FHKC quality assurance and utilization review standards; and c. reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee per 42 CFR 441.301(c)(3).	<input type="checkbox"/> Not Applicable	<b>0.00</b>		
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
15. Enrollee Direct Access to Specialists  42 CFR 438.208(c)(4) MSC 18-2-3-3	The MCO must have mechanisms in place to assess enrollees and provide those determined to have special healthcare needs through an assessment [consistent with paragraph 438.208(c)(2)] with direct access to a specialist (for example, through a standing referral or an approved number of visits) in a manner that is appropriate for the enrollee's condition and identified needs. Direct access may include a standing referral or an approved number of visits.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b> <b>0.00</b> <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
16. Social Determinants of	The MCO must: a. have a mechanism to address social services needs	<input type="checkbox"/> a. Mechanism to address enrollee social service needs	<b>0.50</b>	<b>1.00</b>	<b>X.XX</b>

**Table C-1. 2025 ACA: MCO Tool, Coordination and Continuity of Care**

2025 Annual Compliance Assessment: &lt;MCO Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coordination and Continuity of Care</b>					
Health  MSC 22-9	of enrollees through available community-based social service resources; and  b. not require enrollees to access community-based social service resources instead of covered benefits.	<input type="checkbox"/> b. Enrollees not required to substitute social service resources for covered benefits  <input type="checkbox"/> Not Applicable	<b>0.50</b>  <b>0.00</b>		
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
17. Disease and Case Management Services  MSC 22-10	The MCO must: a. provide disease and case management services; and b. inform FHKC of any addition or removal of such programs 60 calendar days prior to the change.	<input type="checkbox"/> a. Provision of disease and case management services  <input type="checkbox"/> b. Notification to FHKC of addition or removal of programs 60 calendar days prior to change  <input type="checkbox"/> Not Applicable	<b>0.50</b>  <b>0.50</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
18. Disease and Case Management Policies and Procedures  MSC 22-10	The MCO must have policies and procedures in place for identifying and enrolling enrollees likely to benefit from disease and case management services.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b> <b>0.00</b> <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b>					

**Table C-1. 2025 ACA: MCO Tool, Coordination and Continuity of Care**

2025 Annual Compliance Assessment: <MCO Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Coordination and Continuity of Care					
AON					
Suggestion					
Coordination and Continuity of Care			XX.XX%	XX.XX	XX.XX

**Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: &lt;MCO Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
1. Service Protections  42 Code of Federal Regulations (CFR) 438.210(a)(3)(i)-(ii) 42 CFR 440.230(b) Medical Services Contract (MSC) Section 22	The managed care organization (MCO): a. must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished; and b. may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee.	<input type="checkbox"/> a. Sufficient services to achieve purpose <input type="checkbox"/> b. No arbitrary denial or reduction of services <input type="checkbox"/> Not Applicable	0.50  0.50  0.00	1.00	X.XX
<p><b>Findings</b></p> <p><b>Strength</b></p> <p><b>AON</b></p> <p><b>Suggestion</b></p>					
2. Service Limitations  42 CFR 438.210(a)(4)(i)-(ii) 42 CFR 440.230(d) MSC 22	The MCO may place appropriate limits on a service on the basis of criteria applied under the Florida Healthy Kids Corporation (FHKC) plan, such as medical necessity, or for the purpose of utilization control, provided that: a. the services furnished can reasonably achieve their purpose, as required in paragraph 42 CFR 438.210(a)(3)(i); b. the services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services; c. family planning services are provided in a manner	<input type="checkbox"/> a. Services furnished can reasonably achieve their purpose <input type="checkbox"/> b. Services authorized in a manner that reflects the enrollee's ongoing need <input type="checkbox"/> c. Family planning services provided in a manner protecting enrollee choice  d. Referring Enrollees to publicly supported health care resources and requiring the Enrollee to utilize those resources	0.25  0.25  0.25  0.25	1.00	X.XX

**Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: &lt;MCO Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
	that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR 441.20; and  d. the MCO shall not avoid costs for services covered under the Contract, including immunization requirements, by referring Enrollees to publicly supported health care resources and requiring the Enrollee to utilize those resources.	<input type="checkbox"/> Not Applicable	<b>0.00</b>		
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
3. Authorization of Services  42 CFR 438.210(b)(1) MSC 22-6	For the processing of requests for initial and continuing authorizations of services, the MCO and its subcontractors have in place, and follow, written policies and procedures and practice guidelines.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
4. Application of Review Criteria  42 CFR 438.210(b)(2)(i)-(iii) MSC 22-6	The MCO must: a. have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and b. consult with the requesting provider for medical services when appropriate.	<input type="checkbox"/> a. Mechanisms to ensure consistent application of review criteria <input type="checkbox"/> b. Requesting provider consulted, when appropriate <input type="checkbox"/> Not Applicable	<b>0.50</b>  <b>0.50</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>

**Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services**  
 2025 Annual Compliance Assessment: <MCO Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
Findings Strength AON Suggestion					
5. Utilization Management Controls  MSC 22-1	The MCO must establish utilization management controls to: a. ensure enrollees receive appropriate care; and b. allow for consideration of factors specific to individual enrollees such as age and medical history.	<input type="checkbox"/> a. Ensure enrollees receive appropriate care <input type="checkbox"/> b. Allow for consideration of factors specific to individual enrollees <input type="checkbox"/> Not Applicable	0.50  0.50  0.00	1.00	X.XX
Findings Strength AON Suggestion					
6. Appropriate Reviewer Expertise  42 CFR 438.210(b)(3) MSC 22-1	The MCO must ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested: a. be made by individuals who have appropriate clinical expertise in addressing the enrollee's medical or behavioral health needs; b. be conducted in a manner that results in interrater reliability sufficient to indicate the appropriateness and validity of the process; and c. include the training given to the reviewers.	<input type="checkbox"/> a. Decisions made by individuals with appropriate clinical expertise <input type="checkbox"/> b. Conducted in a manner resulting in interrater reliability <input type="checkbox"/> c. Reviewer training included <input type="checkbox"/> Not Applicable	0.33  0.33  0.34  0.00	1.00	X.XX
Findings Strength AON Suggestion					



**Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services**  
 2025 Annual Compliance Assessment: <MCO Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
Authorization Extension  42 CFR 438.210(d)(1)(i)-(ii)  42 CFR 438.404(c)(4)(i)-(ii) MSC 22-6-1	authorization decisions up to 14 additional calendar days, if the enrollee or the provider requests an extension or the MCO justifies to FHKC, upon request, a need for additional information and how the extension is in the enrollee's interest, provided that: a. the MCO gives the enrollee written notice of the reason for the decision to extend the timeframe and informs the enrollee of the right to file a grievance; and b. the MCO carries out the determination as expeditiously as the enrollee's health condition requires, but no later than the date the extension expires.	reason for decision and right to file a grievance  <input type="checkbox"/> b. Determination carried out as expeditiously as the enrollee's health condition requires but no later than the date the extension expires  <input type="checkbox"/> Not Applicable	0.50          0.00		
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
10. Timeframe for Expedited Authorization Decisions  42 CFR 438.210(d)(2)(i) 42 CFR 438.404(c)(6) MSC 22-6-1	For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	1.00 0.00 0.00	1.00	X.XX
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					

Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services

2025 Annual Compliance Assessment: &lt;MCO Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
11. Expedited Authorization Extension  42 CFR 438.210(d)(2)(ii) MSC 22-6-1	The MCO may extend the 72-hour time period by up to 14 calendar days if the enrollee or provider requests an extension, or if the MCO justifies to FHKC, upon request, a need for additional information and how the extension is in the enrollee's interest.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
12. Covered Outpatient Drug Decisions  42 CFR 438.210(d)(3) MSC 22-6-1	The MCO must provide notice of a decision in response to a request for authorization of outpatient drugs by telephone or other telecommunication device within 24 hours of the request, in accordance with Section 1927(d)(5)(A) of the <i>Social Security Act</i> .	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
13. Compensation for Utilization Management Activities  42 CFR 438.210(e) MSC 22-1	The MCO must provide that, consistent with 42 CFR 438.3(i) and 42 CFR 422.208, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>

**Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: <MCO Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
<p><b>Findings</b>  <b>Strength</b>  <b>AON</b>  <b>Suggestion</b></p>					
<p>14. Termination, Suspension, or Reduction of Services</p> <p>42 CFR 438.404(c)(1)                      42 CFR 431.211                      42 CFR 431.213(a)-(h)                      MSC 22-6-1</p>	<p>For termination, suspension, or reduction of previously authorized Medicaid-covered services, the MCO must send a notice at least 10 days before the date of action, except when:</p> <p>a. the MCO has factual information confirming the death of the enrollee;</p> <p>b. the MCO receives a clear written statement signed by an enrollee that the enrollee no longer wishes to receive services or the enrollee gives information that requires termination or reduction of services and indicates that the enrollee understands that this must be the result of supplying that information;</p> <p>c. the enrollee has been admitted to an institution where they are ineligible under the plan for further services;</p> <p>d. the enrollee's whereabouts are unknown and the post office returns MCO mail directed to the enrollee indicating no forwarding address;</p> <p>e. the MCO establishes the fact that the enrollee is enrolled in Florida Healthy Kids in another region or has been accepted for services by another jurisdiction, state, territory, or commonwealth;</p> <p>f. a change in the level of medical care is prescribed by the enrollee's physician;</p> <p>g. the notice involves an adverse determination made with regard to the preadmission screening</p>	<p><input type="checkbox"/> a. Death of enrollee</p> <p><input type="checkbox"/> b. Signed enrollee statement forgoing services</p> <p><input type="checkbox"/> c. Enrollee admission to institution rendering the enrollee ineligible for services</p> <p><input type="checkbox"/> d. Enrollee's whereabouts unknown</p> <p><input type="checkbox"/> e. Enrollee enrolled in another MCO</p> <p><input type="checkbox"/> f. Change in level of care prescribed by enrollee's physician</p> <p><input type="checkbox"/> g. Adverse benefit determination made with regard to preadmission screening</p> <p><input type="checkbox"/> h. Date of action in less than 10 days</p> <p><input type="checkbox"/> i. Probable fraud by enrollee and notice provided at least five calendar days before the date of action</p> <p><input type="checkbox"/> Not Applicable</p>	<p><b>0.11</b></p> <p><b>0.11</b></p> <p><b>0.11</b></p> <p><b>0.11</b></p> <p><b>0.11</b></p> <p><b>0.11</b></p> <p><b>0.11</b></p> <p><b>0.11</b></p> <p><b>0.11</b></p> <p><b>0.12</b></p> <p><b>0.00</b></p>	<p><b>1.00</b></p>	<p><b>X.XX</b></p>

**Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services**  
 2025 Annual Compliance Assessment: <MCO Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
	requirements of Section 1919(e)(7) of the <i>Social Security Act</i> ; h. the date of action will occur in less than 10 days, in accordance with 42 CFR 483.15(b)(4)(ii) and (b)(8), which provides exceptions to the 30 days' notice requirements of 42 CFR 483.15(b)(4)(i); or i. the MCO has facts, verified through secondary sources when possible, indicating that action should be taken because of probable fraud by the enrollee, in which case the notice must be provided at least five calendar days before the date of action.				
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
15. Denial of Payment  42 CFR 438.404(c)(2) MSC 22-6-1	For denial of payment, the MCO must provide the notice of adverse benefit determination at the time of any action affecting the claim.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	1.00 0.00 0.00	1.00	X.XX
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
16. Decisions Exceeding Timeframes	For service authorization decisions not reached within the timeframes specified in 42 CFR 438.210(d), which constitutes a denial and is thus an adverse benefit determination, the MCO must provide the notice on the	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	1.00 0.00 0.00	1.00	X.XX



Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services					
2025 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
42 CFR 438.114(c)(2)					
<p><b>Findings</b></p> <p><b>Strength</b></p> <p><b>AON</b></p> <p><b>Suggestion</b></p>					
19. Emergency Service Limitations  42 CFR 438.114(d)(1)(i)-(ii) MSC Attachment A	<p>In compliance with Florida Statutes Section 641.513 and 42 CFR 438.114, the MCO may not:</p> <p>a. limit what constitutes an emergency medical condition with reference to 42 CFR 438.414(d), on the basis of lists of diagnoses or symptoms;</p> <p>b. use terms such as “life threatening” or “bona fide” to qualify the type of emergency that is covered;</p> <p>c. indicate that emergencies are covered only if care is secured within a certain period of time;</p> <p>d. deny payment based on the enrollee’s failure to provide the MCO advanced notification of seeking treatment;</p> <p>e. refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee’s primary care provider, MCO, or FHKC of the enrollee’s screening and treatment within 10 calendar days of presentation for emergency services or based on the enrollee’s failure to provide the MCO notification within a certain period of time after care is provided;</p> <p>f. hold Enrollees liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Enrollee; or</p>	<p><input type="checkbox"/> a. Does not limit what constitutes an emergency medical condition</p> <p><input type="checkbox"/> b. Does not use qualifying terminology</p> <p><input type="checkbox"/> c. Does not indicate emergency coverage is provided only if care is sought within a specific timeframe</p> <p><input type="checkbox"/> d. Does not deny payment based on enrollee lack of notification</p> <p><input type="checkbox"/> e. Does not refuse to cover emergency services based on lack of provider and/or enrollee notification</p> <p><input type="checkbox"/> f. Does not hold enrollees liable for payment of subsequent screening or treatment</p> <p><input type="checkbox"/> g. Does not require prior authorization for emergency or transportation services</p> <p><input type="checkbox"/> Not Applicable</p>	<p><b>0.142</b></p> <p><b>0.142</b></p> <p><b>0.142</b></p> <p><b>0.142</b></p> <p><b>0.142</b></p> <p><b>0.142</b></p> <p><b>0.143</b></p> <p><b>0.00</b></p>	<p><b>1.00</b></p>	<p><b>X.XX</b></p>

**Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: <MCO Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
	g. require prior authorization for emergency transportation or services.				
<p><b>Findings</b>  <b>Strength</b>  <b>AON</b>  <b>Suggestion</b></p>					
20. MCO Responsibility for Poststabilization Services  42 CFR 438.114(d)(3) MSC Attachment A	The MCO is responsible for any poststabilization services administered to maintain, improve, or resolve the enrollee’s stabilized position, regardless of the facility or provider’s network status when: a. such services were pre-approved by the MCO or the MCO’s representative; b. the treating facility or provider sought approval for such services; and c. the MCO failed to respond within one hour of the request.	<input type="checkbox"/> a. Attending/treating provider responsible for determining enrollee transfer or discharge <input type="checkbox"/> b. MCO responsible for coverage and payment <input type="checkbox"/> c. MCO responsible for payment of poststabilization services <input type="checkbox"/> Not Applicable	<p><b>0.33</b></p> <p><b>0.33</b></p> <p><b>0.34</b></p> <p><b>0.00</b></p>	<b>1.00</b>	<b>X.XX</b>
<p><b>Findings</b>  <b>Strength</b>  <b>AON</b>  <b>Suggestion</b></p>					
21. Financial Responsibility for Poststabilization Services  42 CFR 438.114(d)(3) MSC Attachment A	The MCO must agree that: a. the attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge; b. this determination is binding on the MCO as responsible for coverage and payment; and c. the MCO is responsible for payment of poststabilization services that it has not	<input type="checkbox"/> a. Attending/treating provider responsible for determining enrollee transfer or discharge <input type="checkbox"/> b. MCO responsible for coverage and payment <input type="checkbox"/> c. MCO responsible for payment of poststabilization services <input type="checkbox"/> Not Applicable	<p><b>0.33</b></p> <p><b>0.33</b></p> <p><b>0.34</b></p> <p><b>0.00</b></p>	<b>1.00</b>	<b>X.XX</b>

**Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services**  
 2025 Annual Compliance Assessment: <MCO Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
	preapproved until: <ol style="list-style-type: none"> <li>1. an in-network provider with privileges at the treating facility assumes responsibility for the enrollee's care;</li> <li>2. an in-network provider assumes responsibility for the enrollee's care through transfer; or</li> <li>3. the enrollee is discharged.</li> </ol>				
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
22. Behavioral Health Policies and Procedures  MSC 22-2	The MCO must maintain policies and procedures that support: <ol style="list-style-type: none"> <li>a. early identification of behavioral healthcare needs through the use of valid assessments;</li> <li>b. the use of services that enhance the enrollee's likelihood of positive outcomes, improved ability to function at home, school, and in the community, and to live drug-free;</li> <li>c. enrollees' ability to receive services in the least restrictive and most normal environment that is clinically appropriate;</li> <li>d. the use of care or case management and coordination of services; and</li> <li>e. a smooth transition to adult behavioral healthcare, for older enrollees.</li> </ol>	<input type="checkbox"/> a. Early identification through valid assessments <input type="checkbox"/> b. Services that enhance likelihood of improved outcomes and ability to function and live drug-free <input type="checkbox"/> c. Services in least restrictive, most normal, clinically appropriate environment <input type="checkbox"/> d. Care or case management and coordination <input type="checkbox"/> e. Transition to adult behavioral healthcare <input type="checkbox"/> Not Applicable	<b>0.20</b>          <b>0.20</b>          <b>0.20</b>          <b>0.20</b>          <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>

**Findings**  
**Strength**

**Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: &lt;MCO Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
<b>AON</b>					
<b>Suggestion</b>					
23. Behavioral Health Educational Materials  MSC 22-2	The MCO must make educational materials about recognizing child and adolescent behavioral healthcare needs and how to obtain access to treatment and support services available to enrollees.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
24. Parity in Mental Health and Substance Use Disorder Benefits  MSC 22-3	The MCO shall comply with the requirements of 42 CFR 457.496. The MCO shall conduct parity assessments using the Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Children's Health Insurance Programs published by CMS on January 17, 2017, as amended or replaced, unless such toolkit becomes outdated and not revised or replaced. The MCO shall provide an initial parity assessment during implementation of the Contract by the date established in the approved implementation plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
25. Telehealth  MSC 22-5	The MCO must not apply any policies or procedures to telehealth services that are significantly more restrictive or stringent than those applied to in-person services unless such differences are required to maintain the intent and functionality of a policy or procedure that	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>

Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services					
2025 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
	applies to in-person services. MCO must cover benefits for services provided by telehealth to the extent the same services are provided in-person, when possible and appropriate. The MCO shall cover store-and-forward and remote patient monitoring services telehealth modalities, as appropriate.				
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
26. Social Determinants of Health  MSC 22-9	The MCO must: a. have a mechanism to address social services needs of enrollees through available community-based social service resources; and b. not require enrollees to access community-based social service resources instead of covered benefits.	<input type="checkbox"/> a. Mechanism to address social services needs <input type="checkbox"/> b. Enrollees not required to access services instead of covered benefits <input type="checkbox"/> Not Applicable	<b>0.50</b>  <b>0.50</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
27. Disease and Case Management  MSC 22-10	The MCO must have policies and procedures in place for identifying and enrolling enrollees likely to benefit from disease and case management services.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					

Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services

2025 Annual Compliance Assessment: &lt;MCO Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
28. Information Format  42 CFR 438.10(c)(1) MSC 21-3	The MCO must provide all required information to enrollees and potential enrollees in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees in accordance with 42 CFR 457.1207.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
29. Culturally Competent Communication  MSC 20	The MCO must provide services, including oral and written communication to enrollees, in a culturally competent manner appropriate for the population, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
30. Cultural Competency Plan  MSC 20	The MCO must maintain a comprehensive written cultural competency plan describing how the MCO and its providers, employees, and systems effectively provide services to enrollees of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes, affirms, and respects the worth of the enrollee and protects and preserves the dignity of each.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					



**Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: &lt;MCO Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
33. Enrollee Material Language  42 CFR 438.10(d)(2) MSC 21-2 MSC 21-3	The MCO must: a. make oral interpretation available in all languages and written translation available in each prevalent non-English language; b. make all written materials available in English, Spanish, and all other prevalent non-English languages (any language in the MCO's service area spoken by 5% or more of the Florida Healthy Kids population); c. ensure that written materials that are critical to obtaining services for potential enrollees include taglines in the prevalent non-English languages in the state, explaining the availability of written translations or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and the toll-free telephone number of the entity providing choice counseling services as required by 42 CFR 438.71(a); and d. ensure that taglines for written materials critical to obtaining services are printed in a conspicuously visible font size (no smaller than 18 point).	<input type="checkbox"/> a. Oral interpretation and written translation available <input type="checkbox"/> b. Written materials available in English, Spanish, and all other prevalent non-English languages <input type="checkbox"/> c. Taglines included, in prevalent non-English languages, and with information to request aids and services <input type="checkbox"/> d. Conspicuously visible tagline font size <input type="checkbox"/> Not Applicable	0.25  0.25  0.25  0.25  0.00	1.00	X.XX
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
34. Written Material Requirements	For written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and	<input type="checkbox"/> a. Available in the prevalent non-English languages <input type="checkbox"/> b. Available in alternative formats	0.142  0.142	1.00	X.XX

**Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: <MCO Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
42 CFR 438.10(d)(3) MSC 21-2  MSC 21-3	denial and termination notices, the MCO must: a. make them available in the prevalent non-English languages in its particular service area; b. make them available in alternative formats upon request of the potential enrollee or enrollee at no cost; c. include taglines in the prevalent non-English languages in the state and in a conspicuously visible font size (no smaller than 12 point) explaining the availability of written translation or oral interpretation in the prevalent non-English languages in the service areas, as well as in large print, to understand the information provided; d. include information on how to request auxiliary aids and services; e. include the toll-free and telecommunications device for the deaf (TTY/TDY) telephone number of the MCO's enrollee/customer service unit; f. make auxiliary aids and services available upon request of the potential enrollee or enrollee at no cost; and g. include a notice of nondiscrimination.	upon request  <input type="checkbox"/> c. Taglines in the prevalent non-English languages and visible font size  <input type="checkbox"/> d. Information about auxiliary aids and services  <input type="checkbox"/> e. Toll-free and TTY/TDY telephone number included  <input type="checkbox"/> f. Auxiliary aids and services available upon request  <input type="checkbox"/> g. Nondiscrimination notice  <input type="checkbox"/> Not Applicable	<b>0.142</b>  <b>0.142</b>  <b>0.142</b>  <b>0.142</b>  <b>0.143</b>  <b>0.00</b>		
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
35. Notification of Materials to Enrollee	The MCO must notify its enrollees: a. that oral interpretation is available for any language and written translation is available in prevalent	<input type="checkbox"/> a. Translation availability <input type="checkbox"/> b. Auxiliary aid and service availability	<b>0.33</b>  <b>0.33</b>	<b>1.00</b>	<b>X.XX</b>

Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services					
2025 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
42 CFR 438.10(d)(5)(i)-(iii) MSC 21-3	languages; b. that auxiliary aids and services are available upon request and at no cost for enrollees; and c. how to access these services.	<input type="checkbox"/> c. How to access services <input type="checkbox"/> Not Applicable	<b>0.34</b> <b>0.00</b>		
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
36. Written Material Format  42 CFR 438.10(d)(6)(i)-(iii) MSC 21-3	The MCO must provide all written materials for potential enrollees and enrollees consistent with the following: a. use easily understood language and format; b. use a font size no smaller than 12 point; and c. be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency. d. Written materials must include a notice of nondiscrimination and taglines explaining the availability of written or oral translation in the prevalent non-English languages in the Service Area, as required by Section 1557 of the Affordable Care Act, as well as in large print, which means printed in a font size no smaller than 18-point. The MCO shall use the top fifteen (15) prevalent non-English languages determined by HHS unless otherwise approved by FHKC to use another source believes is more accurate.	<input type="checkbox"/> a. Easily understood language and format <input type="checkbox"/> b. Font size no smaller than 12 point <input type="checkbox"/> c. Available in alternative formats <input type="checkbox"/> d. Written materials include a notice of nondiscrimination and taglines explaining the availability of written or oral translation in the prevalent non-English languages in the Service Area <input type="checkbox"/> Not Applicable	<b>0.25</b> <b>0.25</b> <b>0.25</b> <b>0.25</b> <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					

**Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: &lt;MCO Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
<p style="text-align: center;"><b>Strength</b> <b>AON</b> <b>Suggestion</b></p>					
37. Enrollee Material Best Practices  MSC 21-3	The MCO must agree to follow best practices related to accessibility of materials insofar as such best practices are reasonable and practicable.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<p style="text-align: center;"><b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b></p>					
38. Provider Termination Notice  42 CFR 438.10(f)(1) MSC 21-3-1-F	The MCO must notify each enrollee who received their primary care from, or was seen on a regular basis by, a terminating provider within the past six months, at least 60 calendar days before the effective date of termination. When such notice is not possible, the MCO must make a good faith effort to provide written notice to enrollees who received primary or regular care from a terminating network provider by the later of thirty (30) calendar days prior to the effective date of the termination or 15 calendar days after receipt or issuance of the provider termination notice.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<p style="text-align: center;"><b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b></p>					
39. Provider Incentive Plans  42 CFR	The MCO must: a. comply with 42 CFR 457.1201(h) incorporating through 42 CFR 438.3(i) references to 42 CFR 422.208 and 42 CFR 422.210, and any other	<input type="checkbox"/> a. Compliance with CFR and other applicable laws and regulations <input type="checkbox"/> b. No payments as inducement to reduce or limit enrollee services	<b>0.33</b>    <b>0.33</b>	<b>1.00</b>	<b>X.XX</b>



**Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: &lt;MCO Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
41. Enrollee Handbook  42 CFR 438.10(g)(1) MSC 21-3-1-B	The MCO must provide each enrollee with an enrollee handbook based on the model enrollee handbook provided by FHKC that:  a. is provided within a reasonable time after receiving notice of the enrollee's enrollment; and  b. is provided in electronic format on its publicly available website with access to Florida Healthy Kids information.	<input type="checkbox"/> a. Each enrollee provided an enrollee handbook within a reasonable time  <input type="checkbox"/> b. Enrollee handbook available on MCO's publicly available website  <input type="checkbox"/> Not Applicable	<b>0.50</b>  <b>0.50</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
42. Enrollee Handbook Content – 1  42 CFR 438.10(g)(2)(i)-(iv) MSC 21-3-1-B	The MCO's enrollee handbook must include, at a minimum:  a. benefits provided by the MCO;  b. how and where to access any benefits provided by FHKC, including any cost sharing, and how transportation is provided;  c. the amount, duration, scope, and limitations of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled; and  d. procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.	<input type="checkbox"/> a. Benefits provided by the MCO <input type="checkbox"/> b. How and where to access benefits and transportation <input type="checkbox"/> c. Amount, duration, scope, and limitations of available benefits <input type="checkbox"/> d. Procedures for obtaining benefits <input type="checkbox"/> Not Applicable	<b>0.25</b>  <b>0.25</b>  <b>0.25</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>

**Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: <MCO Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
<p><b>Findings</b>  <b>Strength</b>  <b>AON</b>  <b>Suggestion</b></p>					
43. Enrollee Handbook Content – 2  42 CFR 438.10(g)(2)(v)-(viii) MSC 21-3-1-B	<p>The MCO’s enrollee handbook must include, at a minimum:</p> <p>a. the extent to which, and how, after-hours and emergency services, including poststabilization services, are provided, including:</p> <ol style="list-style-type: none"> <li>1. what constitutes an emergency medical condition and emergency services;</li> <li>2. the fact that prior authorization is not required for emergency services; and</li> <li>3. the fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care;</li> </ol> <p>b. any restrictions on the enrollee’s freedom of choice among network providers;</p> <p>c. the extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers. This includes an explanation that the MCO cannot require an enrollee to obtain a referral before choosing a family planning provider; and</p> <p>d. cost sharing, if any, is imposed under the FHKC plan.</p>	<p><input type="checkbox"/> a. Extent to which, and how, after-hours and emergency coverage are provided</p> <p><input type="checkbox"/> b. Restrictions on enrollee’s choice among network providers</p> <p><input type="checkbox"/> c. Extent to which, and how, enrollees may obtain benefits, including explanation about not needing referral for family planning provider</p> <p><input type="checkbox"/> d. Cost sharing, if applicable</p> <p><input type="checkbox"/> Not Applicable</p>	<p><b>0.25</b></p> <p><b>0.25</b></p> <p><b>0.25</b></p> <p><b>0.25</b></p> <p><b>0.00</b></p>	<b>1.00</b>	<b>X.XX</b>

**Findings**  
**Strength**  
**AON**

**Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: <MCO Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
<b>Suggestion</b>					
44. Enrollee Handbook Content – 3  42 CFR 438.10(g)(2)(ix)-(xi) MSC 21-3-1-B	The MCO’s enrollee handbook must include, at a minimum: a. enrollee rights and responsibilities, including the elements specified in 42 CFR 438.100; b. the process of selecting and changing the enrollee’s primary care provider; and c. grievance, appeal, and independent external review procedures and timeframes, consistent with subpart F of this part, in an FHKC-developed or -approved description. Such information must include: 1. the right to file grievances and appeals; 2. the requirements and timeframes for filing a grievance or appeal; 3. the availability of assistance in the filing process; and 4. the right to request an independent external review after the MCO has made a determination on an enrollee’s appeal that is adverse to the enrollee.	<input type="checkbox"/> a. Enrollee rights and responsibilities <input type="checkbox"/> b. Process of selecting and changing enrollee’s primary care provider <input type="checkbox"/> c. FHKC-developed or -approved grievance, appeal, and external review procedures and timeframes <input type="checkbox"/> Not Applicable	<b>0.33</b> <b>0.33</b> <b>0.34</b> <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
45. Enrollee Handbook Content – 4  42 CFR	The MCO’s enrollee handbook must include, at a minimum: a. how to access auxiliary aids and services, including additional information in alternative formats or	<input type="checkbox"/> a. How to access auxiliary aids and services <input type="checkbox"/> b. Toll-free numbers <input type="checkbox"/> c. How to report suspected fraud or	<b>0.25</b> <b>0.25</b> <b>0.25</b>	<b>1.00</b>	<b>X.XX</b>

Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services					
2025 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
438.10(g)(2)(xiii)-(xvi) MSC 21-3-1-B	languages; b. the toll-free telephone number for enrollee services, medical management, and any other unit providing services directly to enrollees; c. information on how to report suspected fraud or abuse; and d. any other content required by FHKC.	abuse <input type="checkbox"/> d. Other FHKC-required content <input type="checkbox"/> Not Applicable	0.25 0.00		
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
46. Information Delivery Methods  42 CFR 438.10(g)(3)(i)-(iv)	The information required to be provided to the enrollee in an enrollee handbook will be considered to be provided if the MCO: a. mails a printed copy of the information to the enrollee's mailing address; b. provides the information by email after obtaining the enrollee's agreement to receive the information by email; c. posts the information on its website and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or d. provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	1.00 0.00 0.00	1.00	X.XX

**Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: <MCO Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
<p><b>Findings</b>  <b>Strength</b>  <b>AON</b>  <b>Suggestion</b></p>					
47. MCO Publicly Available Website  MSC 21	The MCO must provide a publicly available website with access to Florida Healthy Kids information that includes: a. a link to FHKC’s Florida Healthy Kids website; and b. any other information that may be needed by enrollees or potential enrollees.	<input type="checkbox"/> a. Link to Florida Healthy Kids website <input type="checkbox"/> b. Any other necessary information <input type="checkbox"/> Not Applicable	<p><b>0.50</b></p> <p><b>0.50</b></p> <p><b>0.00</b></p>	<b>1.00</b>	<b>X.XX</b>
<p><b>Findings</b>  <b>Strength</b>  <b>AON</b>  <b>Suggestion</b></p>					
48. MCO Secure Website for Enrollees  MSC 21	The MCO must provide a website with secure access for enrollees that includes: a. the ability for enrollees to print a temporary ID card; b. the ability for enrollees to request a new ID card; c. enrollee educational materials (unless the MCO chooses to make such materials available on the publicly available website); and d. cost-sharing accumulator information (MCO must track enrollees’ cost-share contributions to assist families in tracking their progress towards the out-of-pocket maximum).	<input type="checkbox"/> a. Ability to print temporary ID card <input type="checkbox"/> b. Ability to request new ID card <input type="checkbox"/> c. Enrollee education materials <input type="checkbox"/> d. Cost-sharing accumulator information <input type="checkbox"/> Not Applicable	<p><b>0.25</b></p> <p><b>0.25</b></p> <p><b>0.25</b></p> <p><b>0.25</b></p> <p><b>0.00</b></p>	<b>1.00</b>	<b>X.XX</b>
<p><b>Findings</b>  <b>Strength</b>  <b>AON</b>  <b>Suggestion</b></p>					

**Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: &lt;MCO Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
49. Notice of Changes  42 CFR 438.10(g)(4) MSC 21-3-1-E	The MCO must give each enrollee notice of any change that FHKC defines as significant in the information in the enrollee handbook, at least 30 calendar days before the intended effective date of the change.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
50. Pharmacy Information  42 CFR 438.10(i)(1)-(2) MSC 21-3-1-D	The MCO must make available in electronic or print format the following information: a. which medications are covered (both generic and name brand); and b. what tier each medication is on.	<input type="checkbox"/> a. Covered medications <input type="checkbox"/> b. Medication tier <input type="checkbox"/> Not Applicable	<b>0.50</b>  <b>0.50</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
51. Pharmacy Drug Lists  42 CFR 438.10(i)(1)-(2) MSC 21-3-1-D	As specified by the Secretary of Health and Human Services, the MCO must make its drug lists available on its website in a machine-readable file and format.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b>					

**Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: &lt;MCO Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
<b>Suggestion</b>					
52. Pharmacy Drug List Change Notification to Enrollees  MSC 21-3-1-D	The MCO must notify enrollees who have filled a prescription in the last 12 months for a medication that is being removed from the pharmacy drug list or for which additional utilization management requirements will apply 60 calendar days prior to the effective date of change, but not before receiving FHKC approval.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
53. Certificates of Creditable Coverage  MSC 21-3-1-H	The MCO is responsible for issuing certificates of creditable coverage to enrollees upon the enrollee's request.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
54. Enrollee Right to Information  42 CFR 438.100(b)(2)(i),(ii i)-(v) MSC 19	An enrollee has the right to: a. receive information in accordance with 42 CFR 438.10; b. be treated with respect and with due consideration for his or her dignity and privacy; c. receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand;	<input type="checkbox"/> a. Information in accordance with 42 CFR 438.10 <input type="checkbox"/> b. Treated with respect <input type="checkbox"/> c. Information on available treatment options and alternatives in manner appropriate to enrollee's condition and ability to understand <input type="checkbox"/> d. Participation in healthcare-related	<b>0.166</b>  <b>0.166</b>  <b>0.166</b>  <b>0.166</b>	<b>1.00</b>	<b>X.XX</b>

**Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: &lt;MCO Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
	d. participate in decisions regarding their healthcare, including the right to refuse treatment; e. be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion; and f. request and receive a copy of their medical records and request that such medical records be amended or corrected.	<input type="checkbox"/> decisions, including refusal of treatment <input type="checkbox"/> e. Free from any form of restraint or seclusion <input type="checkbox"/> f. Copy of medical records, and amending or correcting them <input type="checkbox"/> Not Applicable	 <b>0.166</b>  <b>0.167</b>  <b>0.00</b>		
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
55. MCO Cost Responsibility  MSC 22	The MCO must not avoid costs for services covered under the MCO's MSC, including immunization requirements, by referring enrollees to publicly supported healthcare resources and requiring the enrollee to utilize those resources.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b> <b>0.00</b> <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
56. Utilization Management Controls  MSC 22-1	The MCO must establish utilization management controls to ensure enrollees receive appropriate care and that allow for consideration of factors specific to individual enrollees such as age and medical history.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b> <b>0.00</b> <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b>					

Table C-2. 2025 ACA: MCO Tool, Coverage and Authorization of Services					
2025 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
AON					
Suggestion					
<b>Coverage and Authorization of Services</b>			XX.XX%	XX.XX	XX.XX

Table C-3. 2025 ACA: MCO Tool, Subcontractual Relationships and Delegation					
2025 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Subcontractual Relationships and Delegation</b>					
1. Contract Compliance	The managed care organization (MCO) must maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its Medical Services Contract (MSC) with Florida Healthy Kids Corporation (FHKC), notwithstanding any relationship(s) the MCO may have with any subcontractor.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	1.00 0.00 0.00	1.00	X.XX
42 Code of Federal Regulations (CFR) 438.230(b)(1) Medical Services Contract (MSC) Section 5					
<b>Findings</b>					
<b>Strength</b>					
AON					
Suggestion					
2. New or Amended	The MCO must submit any proposed new or amended subcontracts to FHKC for review at least 90 calendar	<input type="checkbox"/> Yes <input type="checkbox"/> No	1.00 0.00	1.00	X.XX

**Table C-3. 2025 ACA: MCO Tool, Subcontractual Relationships and Delegation**

2025 Annual Compliance Assessment: &lt;MCO Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Subcontractual Relationships and Delegation</b>					
Subcontracts  MSC 5	days before the proposed effective date of the delegation or amendment, unless FHKC, at its sole discretion, waives the submission timeframe upon MCO request and evidence of good cause.	<input type="checkbox"/> Not Applicable	<b>0.00</b>		
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
3. Subcontract Availability  MSC 5-1	The MCO must provide any executed subcontracts to FHKC within seven business days after request of such documents.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b> <b>0.00</b> <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
4. Subcontractor Disclosures  42 CFR 438.608(c)(1)-(3) MSC 5	The MCO must ensure that: a. its subcontractors provide written disclosures of any prohibited affiliation under 42 <i>Code of Federal Regulations</i> (CFR) 438.610; b. its subcontractors provide written disclosures of information on ownership and control required under 42 CFR 455.104; and c. it reports to FHKC within 60 calendar days when the MCO has identified capitation payments or other payments in excess of amounts specified in the contract.	<input type="checkbox"/> a. Written disclosures of prohibited affiliation <input type="checkbox"/> b. Written disclosures of information on ownership and control <input type="checkbox"/> c. Reporting of excessive payments to FHKC within 60 calendar days <input type="checkbox"/> Not Applicable	<b>0.33</b> <b>0.33</b> <b>0.34</b> <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					

**Table C-3. 2025 ACA: MCO Tool, Subcontractual Relationships and Delegation**  
 2025 Annual Compliance Assessment: <MCO Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Subcontractual Relationships and Delegation</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
5. Delegation of Activities  42 CFR 438.230(c)(1)(i)-(iii) MSC 5-1	If any of the MCO's activities or obligations under its MSC are delegated to a subcontractor: a. the delegated activities or obligations, including related reporting responsibilities, are specified in the subcontract or written agreement; b. the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's contract obligations; c. the subcontract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where FHKC or the MCO determines that the subcontractor has not performed satisfactorily; and d. the subcontractor agrees to maintain complete and accurate records.	<input type="checkbox"/> a. Delegated activities specified in contract <input type="checkbox"/> b. Subcontractor agreement to compliance with MCO's MSC <input type="checkbox"/> c. Provision for revocation of delegation of activities <input type="checkbox"/> d. Subcontractor agreement to record maintenance <input type="checkbox"/> Not Applicable	<b>0.25</b>          <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
6. Regulatory Compliance  42 CFR 438.230(c)(2) MSC 5-1	The subcontractor must agree to comply with all applicable Children's Health Insurance Plan laws and regulations, including applicable subregulatory guidance and contract provisions.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>          <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					

**Table C-3. 2025 ACA: MCO Tool, Subcontractual Relationships and Delegation**

2025 Annual Compliance Assessment: &lt;MCO Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Subcontractual Relationships and Delegation</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
7. Grievance and Appeal Process  42 CFR 438.414 MSC 5	The MCO must provide the following information about its grievance and appeal process to applicable subcontractors upon entrance into the subcontract, in accordance with 42 CFR 457.1260, which incorporates 42 CFR 438.414: a. the right to file grievances and appeals; b. the requirements and timeframes for filing a grievance or appeal; c. the availability of assistance in the filing process; and d. the right to request an independent review after the MCO has made an adverse appeal determination.	<input type="checkbox"/> a. Right to file grievances and appeals <input type="checkbox"/> b. Requirements and timeframes for filing <input type="checkbox"/> c. Assistance in the filing process <input type="checkbox"/> d. Right to request an independent review <input type="checkbox"/> Not Applicable	<b>0.25</b>          <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
8. Delegated Coverage of Services and Claims Payment  MSC 5-1	If the subcontractor delegation involves coverage of services and claims payment, the subcontract must require the subcontractor to implement and maintain arrangements or procedures designed to detect and prevent fraud, waste, and abuse.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>          <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					



**Table C-3. 2025 ACA: MCO Tool, Subcontractual Relationships and Delegation**

2025 Annual Compliance Assessment: <MCO Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Subcontractual Relationships and Delegation</b>					
Behavioral Health Services  MSC 5-1	a. an analysis of the subcontractor’s compliance with 42 CFR 457.496; and b. a plan to assure continued compliance with parity of nonquantitative treatment limitations should the subcontractor or MCO make any changes to utilization management controls or other aspects impacting nonquantitative treatment limitations. c. MCO must conduct routine monitoring of all Subcontractors. MCO must also conduct risk assessments of all Subcontractors and their delegated activities related to this Contract. The outcome of the risk assessment shall directly inform MCO’s Subcontractor monitoring plan. MCO must conduct non-routine monitoring, as needed. MCO must provide a Subcontractor monitoring schedule for all Subcontractors by the date established in the approved implementation plan and then annually by December 1st.	<input type="checkbox"/> c. Subcontractor monitoring <input type="checkbox"/> Not Applicable	<b>0.34</b>		
<p><b>Findings</b></p> <p><b>Strength</b></p> <p><b>AON</b></p> <p><b>Suggestion</b></p>					
11. Risk Assessments  MSC 5-2	The MCO must: a. conduct risk assessments of all subcontractors and their delegated activities related to the MCO’s MSC; b. use the outcome of the risk assessment to directly inform its subcontractor monitoring plan; and c. conduct routine monitoring of all Subcontractors. The MCO shall also conduct risk assessments of all	<input type="checkbox"/> a. Risk assessments conducted <input type="checkbox"/> b. Outcome used in monitoring plan <input type="checkbox"/> c. Conduct routine monitoring of all subcontractors <input type="checkbox"/> Not Applicable	<b>0.33</b> <b>0.33</b> <b>0.34</b> <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>

**Table C-3. 2025 ACA: MCO Tool, Subcontractual Relationships and Delegation**

2025 Annual Compliance Assessment: <MCO Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Subcontractual Relationships and Delegation</b>					
	Subcontractors and their delegated activities related to this Contract. The outcome of the risk assessment shall directly inform the MCO's Subcontractor monitoring plan. The MCO shall conduct non-routine monitoring, as needed. The MCO shall provide a Subcontractor monitoring schedule for all Subcontractors by the date established in the approved implementation plan and then annually by December 1st.				
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
12. Quarterly Monitoring Summary  MSC 5-2	The MCO must provide FHKC with a quarterly summary of subcontractor monitoring, including any findings and corrective action taken during the quarter.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
13. Routine and Non-Routine Monitoring  MSC 5-2	The MCO must conduct: a. routine monitoring of all subcontractors; and b. non-routine monitoring, as needed.	<input type="checkbox"/> a. Routine monitoring <input type="checkbox"/> b. Non-routine monitoring <input type="checkbox"/> Not Applicable	<b>0.50</b>  <b>0.50</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					

**Table C-3. 2025 ACA: MCO Tool, Subcontractual Relationships and Delegation**

2025 Annual Compliance Assessment: <MCO Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Subcontractual Relationships and Delegation</b>					
<p style="text-align: center;"><b>Strength</b> <b>AON</b> <b>Suggestion</b></p>					
14. Contingency Plan  MSC 5-2	The MCO must have a contingency plan for each subcontractor to safeguard performance of the delegated obligations should the subcontractor cease to perform or adequately perform its obligations under the subcontract.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<p><b>1.00</b></p> <p><b>0.00</b></p> <p><b>0.00</b></p>	<b>1.00</b>	<b>X.XX</b>
<p style="text-align: center;"><b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b></p>					
15. Subcontractor Audit  42 CFR 438.230(c)(3)(i)-(iv)	The subcontractor must agree that: a. FHKC, the Centers for Medicare & Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCO's MSC; b. the subcontractor will make available, for purposes of an audit, evaluation, or inspection under 42 CFR 438.230(c)(3)(i), its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its FHKC enrollees; c. the right to audit under 42 CFR 438.230(c)(3)(i) will	<input type="checkbox"/> a. FHKC, CMS, HHS Inspector General, Comptroller General, and designee right to audit <input type="checkbox"/> b. Availability of subcontractor premises and facilities <input type="checkbox"/> c. Right to audit for 10 years <input type="checkbox"/> d. Right to inspect, evaluate, and audit any time there is reasonable possibility of fraud or similar risk <input type="checkbox"/> Not Applicable	<p><b>0.25</b></p> <p><b>0.25</b></p> <p><b>0.25</b></p> <p><b>0.25</b></p> <p><b>0.00</b></p>	<b>1.00</b>	<b>X.XX</b>

**Table C-3. 2025 ACA: MCO Tool, Subcontractual Relationships and Delegation**  
 2025 Annual Compliance Assessment: <MCO Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Subcontractual Relationships and Delegation</b>					
	exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later; and  d. if FHKC, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, FHKC, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.				
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
16. Correction of Subcontractor Noncompliance  MSC 5-2	If FHKC determines a subcontractor is not in compliance with the requirements of the MCO's MSC, the MCO must promptly correct the subcontractor's noncompliance.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
17. Notification of Subcontractor Termination  MSC 5-2	The MCO must inform FHKC of any subcontractor termination, in whole or in part, within the following timeframes: a. for subcontractors delegated management of a covered benefit: 90 calendar days prior to termination; b. for subcontractors terminated for cause: one business day of the earlier of the date the MCO notifies the	<input type="checkbox"/> a. 90 calendar days for covered benefit subcontractor <input type="checkbox"/> b. One business day for subcontractor terminated for cause <input type="checkbox"/> c. 30 calendar days for all other subcontractors	<b>0.33</b>  <b>0.33</b>  <b>0.34</b>	<b>1.00</b>	<b>X.XX</b>

Table C-3. 2025 ACA: MCO Tool, Subcontractual Relationships and Delegation					
2025 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Subcontractual Relationships and Delegation</b>					
	subcontractor of intention to terminate or the date of termination; and c. for all others: 30 calendar days prior to termination.	<input type="checkbox"/> Not Applicable	<b>0.00</b>		
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
18. Subcontractor Solvency  MSC 5-3	If the MCO learns that a subcontractor has become insolvent or is at unacceptable risk for insolvency it must: a. promptly cease delegation of any obligations directly or indirectly related to the MCO's MSC to the subcontractor; and b. notify FHKC within one business day of the insolvency or the filing of a petition for bankruptcy by or against a principal subcontractor.	<input type="checkbox"/> a. Promptly cease delegation of any obligations <input type="checkbox"/> b. Notify FHKC within one business day <input type="checkbox"/> Not Applicable	<b>0.50</b>  <b>0.50</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
<b>Subcontractual Relationships and Delegation</b>			<b>XX.XX%</b>	<b>XX.XX</b>	<b>XX.XX</b>

## ACA DBM Tools

Table C-4. 2025 ACA: DBM Tool, Coordination and Continuity of Care

2025 Annual Compliance Assessment: &lt;DBM Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coordination and Continuity of Care</b>					
1. Appropriate Source of Care  42 Code of Federal Regulations (CFR) 438.208(b)(1) DSC Section 18.8.1	The dental benefit manager (DBM) must ensure that each enrollee has: a. a choice of primary care dental providers who meets the credentialing, access, and appointment standards of the DBM's DSC with the Florida Healthy Kids Corporation (FHKC); b. an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee; and c. information on how to contact their designated person or entity.	<input type="checkbox"/> a. Choice of primary dental care provider <input type="checkbox"/> b. Ongoing source of care <input type="checkbox"/> c. Designated entity contact information <input type="checkbox"/> Not Applicable	<b>0.33</b>  <b>0.33</b>  <b>0.34</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
2. Assignment of Primary Dental Provider (PDP)  DSC 18.8.1	The DBM must permit enrollees to select another primary dental provider (PDP) within the DBM's network, if the DBM elects to auto-assign enrollees to a PDP.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
3. PDP	The DBM must consider the following if auto-assigning	<input type="checkbox"/> a. Enrollee's last PDP assignment	<b>0.25</b>	<b>1.00</b>	<b>X.XX</b>

**Table C-4. 2025 ACA: DBM Tool, Coordination and Continuity of Care**  
 2025 Annual Compliance Assessment: <DBM Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coordination and Continuity of Care</b>					
Assignment Requirements  DSC 18.8.1	enrollees to PDPs: a. the enrollee’s last PDP assignment, if known; b. time and distance from the enrollee’s home address; c. sibling assignments; and d. the enrollee’s age and any limitations within the PDP.	<input type="checkbox"/> b. Time and distance from enrollee address <input type="checkbox"/> c. Sibling assignments <input type="checkbox"/> d. Enrollee’s age <input type="checkbox"/> Not Applicable	<b>0.25</b>   <b>0.25</b>  <b>0.25</b>  <b>0.00</b>		
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
4. Enrollee Health Record  42 CFR 438.208(b)(5) DSC 24.4	The DBM must ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
5. Enrollee Privacy  42 CFR 438.208(b)(6)	The DBM must ensure that in the process of coordinating care, each enrollee’s privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					



**Table C-4. 2025 ACA: DBM Tool, Coordination and Continuity of Care**

2025 Annual Compliance Assessment: &lt;DBM Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coordination and Continuity of Care</b>					
<b>AON</b>					
<b>Suggestion</b>					
7. Transition of Care Policy  DSC Section 22.9	The DBM must: a. implement a transition of care policy consistent with the transition of care policy adopted by FHKC, subject to FHKC approval; and b. include summaries of the transition of care policy in the enrollee handbook and relevant notices.	<input type="checkbox"/> a. Transition of care policy consistent with FHKC's policy <input type="checkbox"/> b. Policy summaries in enrollee handbook and relevant notices <input type="checkbox"/> Not Applicable	<b>0.50</b>          <b>0.50</b>          <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
8. Requests for Eligibility Review  DSC Section 18.2	If the DBM has reasonable cause to believe that an enrollee is not eligible for the Florida Healthy Kids program, (e.g., DBM believes an enrollee should be placed in a different state or federal program for which eligibility would render that enrollee ineligible for the Program), the DBM must: a. provide a written eligibility review request to FHKC; b. provide the reason for the eligibility review request, including how the relevant considerations were discovered; and c. confirm no other considerations influenced the DBM's decision to request the review, including an adverse change in the enrollee's health status, utilization of services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the enrollee's special needs.	<input type="checkbox"/> a. Written request from DBM to FHKC <input type="checkbox"/> b. Reason for eligibility review request <input type="checkbox"/> c. Confirmation that no other considerations about the enrollee influenced the DBM's decision <input type="checkbox"/> Not Applicable	<b>0.33</b>          <b>0.33</b>          <b>0.34</b>          <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					

**Table C-4. 2025 ACA: DBM Tool, Coordination and Continuity of Care**

2025 Annual Compliance Assessment: <DBM Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coordination and Continuity of Care</b>					
Strength					
AON					
Suggestion					
9. Disenrollment  DSC Section 18.9	An Enrollee's coverage shall terminate on the last day of the Coverage Month in which the Enrollee: a. ceases to be eligible to participate; b. establishes residence outside of the Service Area; or c. is determined to have engaged in Fraud. Insurer may not request disenrollment of an Enrollee for any reason. Termination of coverage and the effective date of such termination shall be determined solely by FHKC.	<input type="checkbox"/> a. Enrollee's last day of eligibility to participate  <input type="checkbox"/> b. Enrollee established residence outside of Service Area  <input type="checkbox"/> c. Enrollee determined to have engaged in Fraud	<b>0.33</b>  <b>0.33</b>  <b>0.34</b>	<b>1.00</b>	<b>X.XX</b>
Findings					
Strength					
AON					
Suggestion					
<b>Coordination and Continuity of Care</b>			<b>XX.XX%</b>	<b>XX.XX</b>	<b>XX.XX</b>

**Table C-5. 2025 ACA: DBM Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: <DBM Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
1. Service Protections	The dental benefit manager (DBM):	<input type="checkbox"/> a. Sufficient services to achieve purpose	<b>0.50</b>	<b>1.00</b>	<b>X.XX</b>







**Table C-5. 2025 ACA: DBM Tool, Coverage and Authorization of Services**  
 2025 Annual Compliance Assessment: <DBM Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
	c. include the training given to the reviewers.				
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
7. Notice of Adverse Benefit Determination  42 CFR 438.210(c) 42 CFR 438.404(a) 42 CFR 457.1260 DSC Section 22.4.1	The DBM must notify the requesting provider and give the enrollee written notice of any decision by the DBM to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The enrollee's notice must meet the requirements of 42 CFR 438.404. The enrollee's notice must meet the requirements of 42 CFR 457.1260 and to the extent it incorporates 42 CFR part 438.404 subpart F.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
8. Termination, Suspension, or Reduction of Services  42 CFR 438.404(c)(1) 42 CFR 431.211	For termination, suspension, or reduction of previously authorized covered services, the DBM must send a notice at least 10 days before the date of action, except when: a. the DBM has factual information confirming the death of the enrollee;	<input type="checkbox"/> a. Death of enrollee <input type="checkbox"/> b. Signed enrollee statement forgoing services <input type="checkbox"/> c. Enrollee admission to institution rendering the enrollee ineligible for services <input type="checkbox"/> d. Enrollee's whereabouts unknown	<b>0.11</b>  <b>0.11</b>  <b>0.11</b>  <b>0.11</b>	<b>1.00</b>	<b>X.XX</b>

**Table C-5. 2025 ACA: DBM Tool, Coverage and Authorization of Services**  
**2025 Annual Compliance Assessment: <DBM Name>**

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
42 CFR 431.213(a)-(h) DSC Section 22.4.1	b. the DBM receives a clear written statement signed by an enrollee that the enrollee no longer wishes to receive services or the enrollee gives information that requires termination or reduction of services and indicates that the enrollee understands that this must be the result of supplying that information; c. the enrollee has been admitted to an institution where they are ineligible under the plan for further services; d. the enrollee's whereabouts are unknown and the post office returns DBM mail directed to the enrollee indicating no forwarding address; e. the DBM establishes the fact that the enrollee is enrolled in Florida Healthy Kids in another region or has been accepted for services by another jurisdiction, state, territory, or commonwealth; f. a change in the level of medical care is prescribed by the enrollee's physician; g. the notice involves an adverse determination made with regard to the preadmission screening requirements of Section 1919(e)(7) of the Social Security Act; h. the date of action will occur in less than 10 days, in accordance with 42 CFR 483.15(b)(4)(ii) and (b)(8), which provides exceptions to the 30 days' notice requirements of 42 CFR 483.15(b)(4)(i); or	<input type="checkbox"/> e. Enrollee enrolled in another DBM <input type="checkbox"/> f. Change in level of care prescribed by enrollee's physician <input type="checkbox"/> g. Adverse benefit determination made with regard to preadmission screening <input type="checkbox"/> h. Date of action in less than 10 days <input type="checkbox"/> i. Probable fraud by enrollee and notice provided at least five calendar days before the date of action <input type="checkbox"/> Not Applicable	0.11  0.11  0.11  0.11  0.12  0.00		

**Table C-5. 2025 ACA: DBM Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: <DBM Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
	i. the DBM has facts, verified through secondary sources when possible, indicating that action should be taken because of probable fraud by the enrollee, in which case the notice must be provided at least five calendar days before the date of action.				
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
9. Timeframe for Standard Authorization Decisions  42 CFR 438.210(d)(1) 42 CFR 438.404(c)(3) DSC Section 22.4.1	For standard authorization decisions that deny or limit services, the DBM must provide notice as expeditiously as the enrollee's condition requires not to exceed 14 calendar days following receipt of the request for service and:  a. For rating periods that start before January 1, 2026, within FHKC established time frames that may not exceed 14 calendar days after receiving the request for service.  b. For rating periods that start on or after January 1, 2026, within FHKC established time frames that may not exceed 7 calendar days after receiving the request for service.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>   <b>0.00</b>   <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b>					

**Table C-5. 2025 ACA: DBM Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: &lt;DBM Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
<b>Suggestion</b>					
10. Standard Authorization Extension  42 CFR 438.210(d)(1)(i)-(ii) 42 CFR 438.404(c)(4)(i)-(ii) DSC Section 22.4.1	The DBM may extend the timeframe for standard authorization decisions up to 14 additional calendar days, if the enrollee or the provider requests an extension or the DBM justifies to FHKC, upon request, a need for additional information and how the extension is in the enrollee's interest, provided that: a. the DBM gives the enrollee written notice of the reason for the decision to extend the timeframe and informs the enrollee of the right to file a grievance; and b. the DBM carries out the determination as expeditiously as the enrollee's health condition requires, but no later than the date the extension expires.	<input type="checkbox"/> a. Written notice to enrollee of reason for decision and right to file a grievance  <input type="checkbox"/> b. Determination carried out as expeditiously as the enrollee's health condition requires but no later than the date the extension expires  <input type="checkbox"/> Not Applicable	<b>0.50</b>  <b>0.50</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
11. Timeframe for Expedited Authorization Decisions  42 CFR 438.210(d)(2)(i) 42 CFR 438.404(c)(6) DSC Section 22.4.1	For cases in which a provider indicates, or the DBM determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the DBM must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b> <b>0.00</b> <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					

Table C-5. 2025 ACA: DBM Tool, Coverage and Authorization of Services

2025 Annual Compliance Assessment: &lt;DBM Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
<p style="text-align: center;"><b>Strength</b> <b>AON</b> <b>Suggestion</b></p>					
12. Expedited Authorization Extension  42 CFR 438.210(d)(2)(ii) DSC Section 22.4.1	The DBM may extend the 72-hour time period by up to 14 calendar days if the enrollee or provider requests an extension, or if the DBM justifies to FHKC, upon request, a need for additional information and how the extension is in the enrollee's interest.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<p style="text-align: center;"><b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b></p>					
13. Covered Outpatient Drug Decisions  42 CFR 438.210(d)(3)	For all covered outpatient drug authorization decisions, the DBM must provide notice of a decision in response to a request for authorization of outpatient drugs by telephone or other telecommunication device within 24 hours of the request, in accordance with Section 1927(d)(5)(A) of the <i>Social Security Act</i> .	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<p style="text-align: center;"><b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b></p>					
14. Compensation for Utilization		<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>



**Table C-5. 2025 ACA: DBM Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: &lt;DBM Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
<b>Suggestion</b>					
16. Subsequent Screening and Treatment  42 CFR 438.114(d)(2)	The DBM may not hold an enrollee who has an emergency dental condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>   <b>0.00</b>   <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
17. Financial Responsibility for Post stabilization Care Services  42 CFR 438.114(d)(3) (e) DSC Section 1.6 Section 21.3.1	<p>The DBM must ensure that poststabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c).</p> <p>The DBM must agree that:</p> <p>a. the attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge;</p> <p>b. this determination is binding on the DBM as responsible for coverage and payment; and</p> <p>c. the DBM is responsible for payment of poststabilization services that it has not preapproved until:</p> <p>1. an in-network provider with privileges at the treating facility assumes responsibility for the enrollee's care; or</p>	<input type="checkbox"/> a. Attending/treating provider responsible for determining enrollee transfer or discharge <input type="checkbox"/> b. DBM responsible for coverage and payment <input type="checkbox"/> c. DBM responsible for payment of poststabilization services <input type="checkbox"/> Not Applicable	<b>0.33</b>   <b>0.33</b>   <b>0.34</b>   <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>

Table C-5. 2025 ACA: DBM Tool, Coverage and Authorization of Services

2025 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
	2. an in-network provider assumes responsibility for the enrollee's care through transfer; or the enrollee is discharged.				
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
18. Information Format  42 CFR 438.10(c)(1)	The DBM must provide all required information to enrollees and potential enrollees in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
19. Culturally Competent Communication  DSC Section 20	The DBM must provide services, including oral and written communication to enrollees, in a culturally competent manner appropriate for the population.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
20. Cultural Competency		<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>

**Table C-5. 2025 ACA: DBM Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: <DBM Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
Plan  DSC Section 20	The DBM must maintain a comprehensive written cultural competency plan describing how the DBM and its providers, employees, and systems effectively provide services to enrollees of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes, affirms, and respects the worth of the enrollee and protects and preserves the dignity of each. DBM must submit their initial cultural competency plan for approval by FHKC by the date established in the approved implementation plan and annually thereafter by July 1st.	<input type="checkbox"/> Not Applicable	<b>0.00</b>		
<p><b>Findings</b></p> <p><b>Strength</b></p> <p><b>AON</b></p> <p><b>Suggestion</b></p>					
21. Electronic Information  42 CFR 438.10(c)(6) DSC Section 21.3	The DBM must ensure all of the following conditions are met for information provided electronically to enrollees: a. the format is readily accessible; b. the information is placed in a location on the DBM's website that is prominent and readily accessible; c. the information is provided in an electronic form that can be electronically retained and printed; d. the information is consistent with content and language requirements for enrollee information; and e. the DBM informs the enrollee that the information is available in paper form without charge upon request and provides it upon request within five business days.	<input type="checkbox"/> a. Accessible format <input type="checkbox"/> b. Prominently placed and readily accessible on DBM website <input type="checkbox"/> c. Can be electronically retained and printed <input type="checkbox"/> d. Meets content and language requirements <input type="checkbox"/> e. Enrollee informed that information is available in paper form without charge upon request, to be received within five business days <input type="checkbox"/> Not Applicable	<b>0.20</b> <b>0.20</b> <b>0.20</b> <b>0.20</b> <b>0.20</b> <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>

**Findings**  
**Strength**  
**AON**

**Table C-5. 2025 ACA: DBM Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: &lt;DBM Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
<b>Suggestion</b>					
22. Enrollee Assistance  42 CFR 438.10(c)(7) DSC 22	The DBM must have in place mechanisms to help enrollees and potential enrollees understand the requirements and benefits of the plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
23. Written Material Language Requirements  42 CFR 438.10(d)(2)-(3) DSC 21.2, 21.3, 21.3.1.B.j	<p>For written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, the DBM must:</p> <p>a. make oral interpretation available in all languages and written translation available in the prevalent non-English languages in its particular service area;</p> <p>b. make them available in alternative formats upon request of the potential enrollee or enrollee at no cost;</p> <p>c. include taglines in the prevalent non-English languages in the state and in a conspicuously visible font size (no smaller than 18 point) explaining the availability of written translation or oral interpretation to understand the information provided;</p> <p>d. include information on how to request auxiliary aids and services;</p>	<input type="checkbox"/> a. Oral interpretation available in all languages and written translation available in the prevalent non-English languages in service area <input type="checkbox"/> b. Available in alternative formats upon request at no cost <input type="checkbox"/> c. Taglines in the prevalent non-English languages and conspicuously visible font size <input type="checkbox"/> d. Information about auxiliary aids and services <input type="checkbox"/> e. Toll-free and TTY/TDY telephone number included for customer service <input type="checkbox"/> f. Toll-free telephone number of the entity providing choice counseling services	<b>0.142</b>  <b>0.142</b>  <b>0.142</b>  <b>0.142</b>  <b>0.142</b>	<b>1.00</b>	<b>X.XX</b>

**Table C-5. 2025 ACA: DBM Tool, Coverage and Authorization of Services**  
 2025 Annual Compliance Assessment: <DBM Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
	e. include the toll-free and telecommunication device for the deaf (TTY/TDY) telephone number of the DBM's enrollee/customer service unit; f. include the toll-free telephone number of the entity providing choice counseling services as required by 42 CFR 438.71(a); and g. make auxiliary aids and services available upon request of the potential enrollee or enrollee at no cost.	<input type="checkbox"/> g. Auxiliary aids and services available upon request at no cost <input type="checkbox"/> Not Applicable	0.143  0.00		
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
24. Notification to Enrollee of Alternate Formats Available  42 CFR 438.10(d)(5)(i)-(iii) DSC 21.3	The DBM must notify its enrollees that information is available in alternative formats: a. at no cost upon request; b. including auxiliary aids and services, oral interpretation in any language, and written interpretation in the language(s) prevalent in the service area; and c. how to access those formats.	<input type="checkbox"/> a. At no cost upon request <input type="checkbox"/> b. Availability of auxiliary aids and services, including oral and written interpretation <input type="checkbox"/> c. How to access formats <input type="checkbox"/> Not Applicable	0.33  0.33  0.34  0.000	1.00	X.XX
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
25. Written Material Content	The DBM must provide all written materials for potential enrollees and enrollees consistent with the following:	<input type="checkbox"/> a. Easily understood language and format	0.33	1.00	X.XX

**Table C-5. 2025 ACA: DBM Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: &lt;DBM Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
Requirements  42 CFR 438.10(d)(6)(i)-(iii) DSC 21.3	a. use easily understood language and format; b. use a font size no smaller than 12 point; and c. be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency.	<input type="checkbox"/> b. Font size no smaller than 12 point <input type="checkbox"/> c. Available in alternative formats that take enrollee special needs into consideration  <input type="checkbox"/> Not Applicable	<b>0.33</b> <b>0.34</b> <b>0.00</b>		
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
26. Enrollee Material Best Practices  DSC 21.3	The DBM must follow best practices related to accessibility of materials, including readability and access by those with physical disabilities, insofar as such best practices are reasonable and practicable.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b> <b>0.00</b> <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
27. Minimum Requirements for Enrollee Notification	At a minimum, the DBM must ensure that all enrollees are made aware of: a. the rights and responsibilities of both the enrollee and the DBM; b. the role of the primary care dentist;	<input type="checkbox"/> a. Rights and responsibilities of both enrollee and DBM <input type="checkbox"/> b. Role of primary care dentist <input type="checkbox"/> c. What to do in an emergency or urgent medical situation	<b>0.11</b> <b>0.11</b> <b>0.11</b>	<b>1.00</b>	<b>X.XX</b>





**Table C-5. 2025 ACA: DBM Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: &lt;DBM Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
	c. a provider directory; and d. the procedures for changing providers.	<input type="checkbox"/> Not Applicable	<b>0.00</b>		
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
31. Enrollee Handbook  42 CFR 438.10(g)(1) DSC 18.8.2, 21.3.1.B	The DBM must provide each enrollee with a model enrollee handbook provided by FHKC that: a. is provided within five business days of receipt of an enrollment file; b. complies with any federal or state requirements; c. uses FHKC-developed definitions for managed care terminology; and d. serves a similar function as the summary of benefits and coverage described in 45 CFR 147.200(a).	<input type="checkbox"/> a. Within five business days <input type="checkbox"/> b. Complies with any federal or state requirements <input type="checkbox"/> c. Uses FHKC-developed managed care terminology definitions <input type="checkbox"/> d. Serves a similar function as the summary of benefits and coverage described in 45 CFR 147.200(a) <input type="checkbox"/> Not Applicable	<b>0.25</b> <b>0.25</b> <b>0.25</b> <b>0.25</b> <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
32. Enrollee Handbook Content – 1  42 CFR 438.10(g)(2)(i)-(iv)	The DBM's enrollee handbook must include, at a minimum: a. benefits provided by the DBM; b. how and where to access any benefits provided by FHKC, including any cost sharing, and how transportation is provided;	<input type="checkbox"/> a. Benefits provided by the DBM <input type="checkbox"/> b. How and where to access benefits and transportation <input type="checkbox"/> c. Amount, duration, and scope of available benefits <input type="checkbox"/> d. Procedures for obtaining benefits	<b>0.25</b> <b>0.25</b> <b>0.25</b> <b>0.25</b>	<b>1.00</b>	<b>X.XX</b>

**Table C-5. 2025 ACA: DBM Tool, Coverage and Authorization of Services**  
**2025 Annual Compliance Assessment: <DBM Name>**

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
DSC 21.3.1.B	c. the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled; and  d. procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.	<input type="checkbox"/> Not Applicable	<b>0.00</b>		
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
33. Enrollee Handbook Content – 2  42 CFR 438.10(g)(2)(v)-(viii) DSC 21.3.1.B	The DBM's enrollee handbook must include, at a minimum: a. the extent to which, and how, after-hours and emergency coverage are provided, including: 1. what constitutes an emergency medical condition and emergency services; 2. the fact that prior authorization is not required for emergency services; and 3. the fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care. b. any restrictions on the enrollee's freedom of choice among network providers;	<input type="checkbox"/> a. Extent to which, and how, after-hours and emergency coverage are provided  <input type="checkbox"/> b. Restrictions on enrollee's choice among network providers  <input type="checkbox"/> c. Extent to which, and how, enrollees may obtain benefits, including explanation about not needing a referral before choosing a family planning provider  <input type="checkbox"/> d. Cost sharing, if applicable  <input type="checkbox"/> Not Applicable	<b>0.25</b>   <b>0.25</b>  <b>0.25</b>  <b>0.25</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>



**Table C-5. 2025 ACA: DBM Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: &lt;DBM Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
	4. the right to request an independent external review after the DBM has made a determination on an enrollee's appeal that is adverse to the enrollee.				
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
35. Enrollee Handbook Content – 4  42 CFR 438.10(g)(2) (xiii)-(xvi) DSC 21.3.1.B	The DBM's enrollee handbook must include, at a minimum: a. how to access auxiliary aids and services, including additional information in alternative formats or languages; b. the toll-free telephone number for enrollee services, medical management, and any other unit providing services directly to enrollees; c. information on how to report suspected fraud or abuse; and d. any other content required by FHKC.	<input type="checkbox"/> a. How to access auxiliary aids and services <input type="checkbox"/> b. Toll-free telephone numbers <input type="checkbox"/> c. How to report suspected fraud or abuse <input type="checkbox"/> d. Other FHKC-required content, if any <input type="checkbox"/> Not Applicable	<b>0.25</b>          <b>0.25</b>          <b>0.25</b>          <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
36. Information Delivery Methods	The information required to be provided to the enrollee in an enrollee handbook will be considered to be provided if the DBM: a. mails a printed copy of the information to the enrollee's mailing address;	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>          <b>0.00</b>          <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>

**Table C-5. 2025 ACA: DBM Tool, Coverage and Authorization of Services**

2025 Annual Compliance Assessment: <DBM Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
42 CFR 438.10(g)(3)(i)-(iv)	b. provides the information by email after obtaining the enrollee's agreement to receive the information by email;  c. posts the information on its website and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or  d. provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.				
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
37. Notice of Changes  42 CFR 438.10(g)(4) DSC 21.3.1.D	Using the model enrollee notice provided by FHKC, the DBM must give each enrollee notice of any change that FHKC defines as significant in the information in the enrollee handbook, at least 30 days before the intended effective date of the change.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
38. Certificates of		<input type="checkbox"/> Yes	<b>1.00</b>	<b>1.00</b>	<b>X.XX</b>

**Table C-5. 2025 ACA: DBM Tool, Coverage and Authorization of Services**  
 2025 Annual Compliance Assessment: <DBM Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
Creditable Coverage  DSC 21.3.1.F	The DBM is responsible for issuing certificates of creditable coverage to enrollees, upon request or upon the enrollee's coverage termination.	<input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>0.00</b>  <b>0.00</b>		
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
39. Enrollee Right to Information  42 CFR 438.100(b)(2)(i), (iii)- (v) DSC 19	An enrollee has the right to: a. receive information in accordance with 42 CFR 438.100; b. be treated with respect and with due consideration for his or her dignity and privacy; c. receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand; d. participate in decisions regarding their healthcare, including the right to refuse treatment; and e. be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.	<input type="checkbox"/> a. Information in accordance with 42 CFR 438.100 <input type="checkbox"/> b. Treated with respect <input type="checkbox"/> c. Information on available treatment options and alternatives in a manner appropriate to enrollee's condition and ability to understand <input type="checkbox"/> d. Participation in healthcare-related decisions, including refusal of treatment <input type="checkbox"/> e. Free from any form of restraint or seclusion <input type="checkbox"/> Not Applicable	<b>0.20</b>  <b>0.20</b> <b>0.20</b>  <b>0.20</b>  <b>0.20</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
40. Staff Education		<input type="checkbox"/> Yes	<b>1.00</b>	<b>1.00</b>	<b>X.XX</b>

Table C-5. 2025 ACA: DBM Tool, Coverage and Authorization of Services					
2025 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Coverage and Authorization of Services</b>					
and Training  DSC 12, 19	The DBM must provide education and training to its staff, as appropriate and applicable to the staff members' duties, including but not limited to, enrollee rights.	<input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>0.00</b>  <b>0.00</b>		
Findings Strength AON Suggestion					
41. Compliance with Federal and State Laws  42 CFR 438.100(d) DSC 35	The DBM must comply with any other applicable federal and state laws, including Title VI of the <i>Civil Rights Act of 1964</i> as implemented by regulations at 45 CFR part 80; the <i>Age Discrimination Act of 1975</i> as implemented by regulations at 45 CFR part 91; the <i>Rehabilitation Act of 1973</i> ; Title IX of the <i>Education Amendments of 1972</i> (regarding education programs and activities); titles II and III of the <i>Americans with Disabilities Act</i> ; section 1557 of the <i>Patient Protection and Affordable Care Act</i> ; Section 654 of the <i>Omnibus Budget Reconciliation Act of 1981</i> ; Title XXI of the federal <i>Social Security Act</i> ; and all applicable state and federal laws and regulations governing FHKC.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
Findings Strength AON Suggestion					
<b>Coverage and Authorization of Services</b>			<b>XX.XX%</b>	<b>40.00</b>	<b>XX.XX</b>

**Table C-6. 2025 ACA: DBM Tool, Subcontractual Relationships and Delegation**

2025 Annual Compliance Assessment: &lt;DBM Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Subcontractual Relationships and Delegation</b>					
1. Contract Compliance  42 Code of Federal Regulations (CFR) 438.230(b)(1) DSC 4	The dental benefit manager (DBM) must maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its DSC with Florida Healthy Kids Corporation (FHKC), notwithstanding any relationship(s) the DBM may have with any subcontractor.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>   <b>0.00</b>   <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
2. New or Amended Subcontracts  DSC 4	The DBM must submit any proposed new or amended subcontracts to FHKC for review at least 90 calendar days before the proposed effective date of the delegation or amendment, unless FHKC, at its sole discretion, waives the submission timeframe upon DBM request and evidence of good cause.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>   <b>0.00</b>   <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
3. Delegation of Activities  42 CFR 438.230(c)(1)(i)-	If any of the DBM's activities or obligations under its DSC with FHKC are delegated to a subcontractor: a. the delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement;	<input type="checkbox"/> a. Delegated activities specified in contract or written agreement  <input type="checkbox"/> b. Subcontractor agreement to perform delegated activities	<b>0.25</b>      <b>0.25</b>	<b>1.00</b>	<b>X.XX</b>

**Table C-6. 2025 ACA: DBM Tool, Subcontractual Relationships and Delegation**  
 2025 Annual Compliance Assessment: <DBM Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Subcontractual Relationships and Delegation</b>					
(iii) DSC 4.1	b. the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the DBM's DSC obligations; c. the contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where FHKC or the DBM determines that the subcontractor has not performed satisfactorily; d. the subcontractor agrees to maintain complete and accurate records.	<input type="checkbox"/> c. Provision for revocation of delegation of activities in contract or written agreement <input type="checkbox"/> d. Subcontractor agreement to record maintenance <input type="checkbox"/> Not Applicable	0.25   0.25  0.00		
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
4. Regulatory Compliance  42 CFR 438.230(c)(2) DSC 4.1	The subcontractor must agree to comply with all applicable Children's Health Insurance Plan laws and regulations, including applicable subregulatory guidance and contract provisions.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	1.00 0.00 0.00	1.00	X.XX
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
5. Grievance and Appeal Process	The DBM must provide the following information about its grievance and appeal process to applicable subcontractors upon entrance into the subcontract, in accordance with 42 CFR 457.1260, which	<input type="checkbox"/> a. Right to file grievances and appeals <input type="checkbox"/> b. Requirements and timeframes	0.25  0.25	1.00	X.XX

Table C-6. 2025 ACA: DBM Tool, Subcontractual Relationships and Delegation					
2025 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Subcontractual Relationships and Delegation</b>					
42 CFR 438.414 DSC Section 4	incorporates 42 CFR 438.414: a. the right to file grievances and appeals; b. the requirements and timeframes for filing a grievance or appeal; c. the availability of assistance in the filing process; and d. the right to request an independent review after the DBM has made an adverse appeal determination.	for filing <input type="checkbox"/> c. Assistance in the filing process <input type="checkbox"/> d. Right to request an independent review <input type="checkbox"/> Not Applicable	<b>0.25</b> <b>0.25</b> <b>0.00</b>		
<p><b>Findings</b></p> <p><b>Strength</b></p> <p><b>AON</b></p> <p><b>Suggestion</b></p>					
6. Risk Assessments  DSC Section 4.2	The DBM must: a. conduct risk assessments of all subcontractors and their delegated activities related to the DBM's DSC; b. use the outcome of the risk assessment to directly inform its subcontractor monitoring plan; and c. conduct routine monitoring of all Subcontractors. Insurer shall also conduct risk assessments of all Subcontractors and their delegated activities related to this Contract. The outcome of the risk assessment shall directly inform Insurer's Subcontractor monitoring plan. Insurer shall conduct non-routine monitoring, as needed. Insurer shall provide a Subcontractor monitoring schedule for all Subcontractors by the date established in the approved implementation plan and then annually by December 1st.	<input type="checkbox"/> a. Risk assessments conducted <input type="checkbox"/> b. Outcome used in monitoring plan <input type="checkbox"/> c. Conduct routine monitoring of all subcontractors <input type="checkbox"/> Not Applicable	<b>0.33</b> <b>0.33</b> <b>0.34</b> <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>

**Table C-6. 2025 ACA: DBM Tool, Subcontractual Relationships and Delegation**

2025 Annual Compliance Assessment: &lt;DBM Name&gt;

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Subcontractual Relationships and Delegation</b>					
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
7. Quarterly Monitoring Summary  DSC 4.2	The DBM must provide FHKC with a quarterly summary of subcontractor monitoring, including any findings and corrective action taken during the quarter.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>   <b>0.00</b>   <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
8. Routine and Non-Routine Monitoring  DSC 4.2	The DBM must conduct: a. routine monitoring of all subcontractors; and b. non-routine monitoring, as needed.	<input type="checkbox"/> a. Routine monitoring <input type="checkbox"/> b. Non-routine monitoring <input type="checkbox"/> Not Applicable	<b>0.50</b>   <b>0.50</b>   <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
9. Contingency Plan  DSC 4.2	The DBM must have a contingency plan for each subcontractor to safeguard performance of the delegated obligations should the subcontractor cease to perform or adequately perform its obligations under the subcontract.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>   <b>0.00</b>   <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					

**Table C-6. 2025 ACA: DBM Tool, Subcontractual Relationships and Delegation**  
 2025 Annual Compliance Assessment: <DBM Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Subcontractual Relationships and Delegation</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
10. Delegated Coverage of Services and Claims Payment  DSC 4.1	If the subcontractor delegation involves coverage of services and claims payment, the subcontract must require the subcontractor to implement and maintain arrangements or procedures designed to detect and prevent fraud, waste, and abuse.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
11. Subcontractor Audit  42 CFR 438.230(c)(3)(i)-(iv)	The subcontractor must agree that: a. FHKC, the Centers for Medicare & Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the DBM's DSC; b. the subcontractor will make available, for purposes of an audit, evaluation, or inspection under 42 CFR 438.230(c)(3)(i), its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Florida	<input type="checkbox"/> a. Subcontractor agreement to FHKC's and/or other specified entities' right to audit <input type="checkbox"/> b. Subcontractor audit availability <input type="checkbox"/> c. Subcontractor agreement to 10-year post-contract right to audit <input type="checkbox"/> d. Subcontractor agreement to FHKC's and/or other specified entities' right to audit at any time there is a possibility of fraud or similar risk <input type="checkbox"/> Not Applicable	<b>0.25</b>  <b>0.25</b>  <b>0.25</b>  <b>0.25</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>



**Table C-6. 2025 ACA: DBM Tool, Subcontractual Relationships and Delegation**  
 2025 Annual Compliance Assessment: <DBM Name>

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
<b>Subcontractual Relationships and Delegation</b>					
	termination.				
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
13. Subcontractor Agreement Availability  DSC 4.1	The DBM must make any agreement it has with a subcontractor or affiliate available to FHKC within seven business days of FHKC's request.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					
<b>Suggestion</b>					
14. Subcontractor Disclosures  42 CFR 438.608(c)(1)-(3) DSC 4	The DBM must ensure that: a. its subcontractors provide written disclosures of any prohibited affiliation under 42 <i>Code of Federal Regulations</i> (CFR) 438.610; b. its subcontractors provide written disclosures of information on ownership and control required under 42 CFR 455.104; and c. it reports to FHKC within 60 calendar days when the DBM has identified capitation payments or other payments in excess of amounts specified in the contract.	<input type="checkbox"/> a. Written disclosures of prohibited affiliation <input type="checkbox"/> b. Written disclosures of information on ownership and control <input type="checkbox"/> c. Reporting of excessive payments to FHKC within 60 calendar days <input type="checkbox"/> Not Applicable	<b>0.33</b>  <b>0.33</b>  <b>0.34</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b>					
<b>Strength</b>					
<b>AON</b>					

<b>Table C-6. 2025 ACA: DBM Tool, Subcontractual Relationships and Delegation</b>					
<b>2025 Annual Compliance Assessment: &lt;DBM Name&gt;</b>					
<b>Evaluation Elements</b>	<b>Criteria</b>	<b>Criteria Met</b>	<b>Criteria Value</b>	<b>Element</b>	
				<b>Value</b>	<b>Score</b>
<b>Subcontractual Relationships and Delegation</b>					
<b>Suggestion</b>					
15. Correction of Subcontractor Noncompliance  DSC 4	If FHKC determines a subcontractor is not in compliance with the requirements of the DBM's DSC, the DBM must promptly correct the subcontractor's noncompliance.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	<b>1.00</b>  <b>0.00</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
16. Subcontractor Solvency  DSC 4.3	If the DBM learns that a subcontractor has become insolvent or is at unacceptable risk for insolvency it must: a. promptly cease delegation of any obligations directly or indirectly related to the DBM's DSC to the subcontractor; and b. notify FHKC within one business day of the insolvency or the filing of a petition for bankruptcy by or against a principal subcontractor.	<input type="checkbox"/> a. Promptly cease delegation of any obligations <input type="checkbox"/> b. Notify FHKC within one business day <input type="checkbox"/> Not Applicable	<b>0.50</b>  <b>0.50</b>  <b>0.00</b>	<b>1.00</b>	<b>X.XX</b>
<b>Findings</b> <b>Strength</b> <b>AON</b> <b>Suggestion</b>					
<b>Subcontractual Relationships and Delegation</b>			<b>XX.XX%</b>	<b>XX.XX</b>	<b>XX.XX</b>

## ACA MCO and DBM File Review Tools

These guidelines were used to conduct file reviews for the 2025 ACA.

### UM Denials

#### Tool Components

Record the name of the MCO/DBM and the date of the review in the spaces provided. Review the MCO/DBM’s policy and procedure regarding UM denials and note the maximum hours/days allowable for a decision to be made and for the enrollee and provider to be notified of the decision to deny/reduce the requested service. Then compare the MCO/DBM’s standards to the CFR timeframes listed below. The time standard used for review is the shorter of the MCO/DBM or CFR timeframe.

CFR Timeframes:

- ◆ Expedited authorization decisions must be made and notice provided as expeditiously as the enrollee’s health condition requires and no later than 72 hours after receipt of the request for service. The MCO/DBM may extend the 72 hour time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO/DBM justifies (to FHKC upon request) a need for additional information and how the extension is in the enrollee’s interest.
- ◆ Standard authorization decisions must be made and notice provided as expeditiously as the enrollee’s condition requires, not to exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days if the enrollee or provider requests the extension or the MCO/DBM justifies (to FHKC upon request) a need for additional information and how the extension is in the enrollee’s interest.

Review the sampled UM denial files for enrollees ages 20 years and younger, completing columns 2–12 on the *UM Denials File Review Tool*. If a file is not applicable (i.e., anything other than a denial), it may be necessary to review additional records from the oversample to reach a denominator of 10 UM denials. Mark each box with an “X” for columns for either a yes (“Y”) or no (“N”) answer.

**Column 1 – File #:** This column is prepopulated (1–10) to identify total number of files required to be reviewed.

**Column 2 – Case ID:** Record the case identification number assigned to the file.

**Column 3 – Date Request Received:** Enter the month, day, and year (M/D/YY) on which the request for the service or procedure was received by the MCO/DBM.

**Column 4 – Appropriate Review Criteria Used?:** Mark under “Y” for the file in each row if review criteria were used appropriately to make the decision to deny or reduce the amount, duration, or scope of the requested service; otherwise, mark the “N” column. If the MCO/DBM did not receive the required medical/dental records with the request and did not follow up with the provider’s office to request such records, mark the “N” column for the file.

**Column 5 – Requesting Provider Consulted:** Mark the “Y” column for that record if the requesting provider was consulted prior to making the denial decision. Mark the “N” column for that record if she or he was not consulted, but there is evidence she or he should have been; otherwise, mark the “NA” column for that record.

**Column 6 – Final Denial Decision by Qualified Professional:** A licensed physician or Doctor of Dental Surgery must make all final denial and reduction of service decisions regarding inpatient hospital services. All other decisions to deny or reduce a service should “be made by a health care professional who has appropriate clinical expertise in treating the enrollee’s condition or disease.” Mark the “Y” column for that record if an appropriate professional made the decision; otherwise, mark the “N” column for that record.

**Column 7 – Decision Based on Medical Necessity of Enrollee’s Condition:** MCO/DBMs may not deny or reduce the amount, duration, or scope of a requested service solely because of the type of illness, diagnosis, or condition of the enrollee. The enrollee’s individual medical needs must be considered. Mark the “Y” column for that record if the decision was based on the enrollee’s individual needs; otherwise, mark the “N” column for that record. If the MCO/DBM did not receive the required medical/dental records necessary to make a determination based on the enrollee’s individual needs and did not follow up with the provider’s office to request such records, mark the “N” column for that record.

**Column 8 – E/S:** Indicate the type of file under review by recording an “E” (expedited) or an “S” (standard).

**Column 9 – Date Notified:** Enter the month, day, and year (M/D/YY) on which the MCO/DBM notified the enrollee and provider of the decision to deny.

**Column 10 – Number of Days for Notification:** The number of days will auto-populate based on the dates entered in column 3 and column 9.

**Column 11 – Notification Time Standard:** Enter the number of days the MCO/DBM used as its time standard to notify enrollees and providers about a denial/reduction in service decision.

**Column 12 – Notification Time Standard Met:** If column 10 is  $\leq$  column 11, mark the “Y” column for that record; otherwise, mark the “N” column for that record.

### Scoring Directions

**Compliant Answers:** Auto-calculates in columns 4-7 and 12 based on compliant answers (i.e., number of Xs designating “Y” for a given column).

**Applicable Answers:** Auto-calculates in columns 4-7 and 12 based on applicable answers (i.e., number of Xs in “Y” and “N” columns).

**Total Compliant:** Auto-calculates sum of the Compliant Answers.

**Total Applicable:** Auto-calculates sum of the Applicable Answers.

**Percent Compliant:** Auto-calculates a percentage by dividing Total Compliant over Total Applicable.

# ACA MCO and DBM File Review Instructions

## Utilization Management Denials File Review Tool Instructions

Authority: 42 Code of Federal Regulations (CFR) § 438.206, 214, FHKC Uniform Utilization Management Denials File Review Policy, Medical Services Contract/Dental Services Contract.

### Tool Components

Record the name of the MCO/DBM and the date of the review in the spaces provided. Review the sample of utilization management denials files, completing the appropriate rows in the Utilization Management Denials File Review Tool. Mark each compliant item with a “1” as noted below. If a file is not appropriate for review (e.g., the file is out of the review period), it may be necessary to review additional records from the oversample to reach a denominator of 10 files.

### Tool Items for Scoring

Applicable items noted in column 4–7, 12: Y=yes, N=no, NA=not applicable.

Table C-7. Utilization Management Denials File Review Tool Instructions for MCOs and DBMs																	
UM Denials File Review Tool																	
MCO:											mm/dd/2025						
1	2	3	4		5			6		7		8	9	10	11	12	
File #	Case ID*	Date Request Received	Appropriate Review Criteria Used		Requesting Provider Consulted			Final Denial Decision by Qualified Professional		Decision NOT Arbitrary = Yes		S/E**	Date Notified	# of Days for Notification	Notification Time Standard	Notification Time Standard Met	
			Y	N	Y	N	NA	Y	N	Y	N					Y	N
1																	
2														0			
3														0			
4														0			
5														0			
6														0			

Table C-7. Utilization Management Denials File Review Tool Instructions for MCOs and DBMs																
7														0		
8														0		
9														0		
10														0		
<b>Compliant Answers</b>		<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>											<b>0</b>
<b>Applicable Answers</b>		<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>											<b>0</b>
														<b>Total Compliant</b>	<b>0</b>	
														<b>Total Applicable</b>	<b>0</b>	
														<b>Percent Compliant</b>	<b>%</b>	

\*Case IDs have been used to protect member information.

\*\*Standard or Expedited

### Scoring

- ◆ **Raw Score** – Auto-calculates:
  - Y = Number of “Y” responses;
  - N = Number of “N” responses; and
  - N/A = Number of “N/A” responses.
  
- ◆ **Compliance Score** – Auto-calculates compliance percentage (Y/(Y+N)).

## ANA Review Tools

**Table C-8** displays the tools for review of the MCOs' and DBMs' appointment availability P&Ps, provider manual, and enrollee handbook as evidence of implementation of required standards.

**Table C-8. 2025 Appointment Availability Review Tool**

Standard	Evident in MCO P&Ps	Comments
Emergency care shall be provided immediately.	<Yes/No>	
Urgently needed care shall be provided within 24 hours.	<Yes/No>	
Routine care shall be provided within seven calendar days of the enrollee's request for services.	<Yes/No>	
Well-child visits, as recommended by the American Academy of Pediatrics, shall be provided within four weeks of the enrollee's request.	<Yes/No>	
Follow-up care shall be provided as medically appropriate.	<Yes/No>	

## Appendix D | ACA QP Tool with NCQA Crosswalk

Qsource's EQR assessment tools review compliance with the 12 standards of 42 CFR 438, Subparts D and E. [Tables D-1](#) through [Table D-6](#) provides a crosswalk between the 3 standards and the tools used to conduct the MY 2024 ACA.

**Table D-1. QP Standard: Coordination and Continuity of Care, MCOs**

Element #	ACA Tool Element Name	42 CFR Reference(s)	2021 NCQA Equivalency Element(s)	2022 NCQA Equivalency Element(s)	Qsource Notes
1	Appropriate Source of Care	42 Code of Federal Regulations (CFR) 438.208(b)(1) Medical Services Contract (MSC) 18-2-3-1	Not Deemable	Not Deemable	
2	Assignment of Primary Care Provider (PCP)	MSC 18-2-3-1	Not Deemable	Not Deemable	
3	PCP Assignment Requirements	MSC 18-2-3-1	Not Deemable	Not Deemable	
4	Service Coordination	42 CFR 438.208(b)(2)(i,ii,iv) MSC 9-4-2 MSC 22-11	Not Deemable	Not Deemable	
5	Transition of Care Policy	MSC 22-11	Not Deemable	Not Deemable	
6	Liability for Previously Authorized and Ongoing Services	MSC 22-11	Not Deemable	Not Deemable	
7	Dental Coordination	MSC 22-12 MSC 9-4-2	Not Deemable	Not Deemable	
8	Initial Health Risk Assessment (HRA)	42 CFR 438.208(b)(3) MSC 18-2-3-3	Not Deemable	Not Deemable	
9	HRA Incentive Plan	MSC 18-2-3-3	Not Deemable	Not Deemable	

## Appendix D | ACA QP Tool with NCQA Crosswalk

10	Assessment of Enrollee Needs	42 CFR 438.208(b)(4) MSC 18-2-3-3	Not Deemable	Not Deemable	
11	Enrollee Health Record	42 CFR 438.208(b)(5)	Not Deemable	Not Deemable	
12	Enrollee Privacy	42 CFR 438.208(b)(6)	Not Deemable	Not Deemable	
13	Special Healthcare Needs Assessment	42 CFR 438.208(c)(2) MSC 18-2-3-3	Not Deemable	Not Deemable	
14	Treatment or Service Plan	42 CFR 438.208(c)(3)(iii)-(v)	Not Deemable	Not Deemable	
15	Enrollee Direct Access to Specialists	42 CFR 438.208(c)(4) MSC 18-2-3-3	Not Deemable	Not Deemable	
16	Social Determinants of Health	MSC 22-9	Not Deemable	Not Deemable	
17	Disease and Case Management Services	MSC 22-10	Not Deemable	Not Deemable	
18	Disease and Case Management Policies and Procedures	MSC 22-10	Not Deemable	Not Deemable	

Table D-2. QP Standard: Coverage and Authorization of Services, MCOs

Element #	ACA Tool Element Name	42 CFR Reference(s)	2021 NCQA Equivalency Element(s)	2022 NCQA Equivalency Element (s)	Qsource Notes
1	Service Protections	42 Code of Federal Regulations (CFR) 438.210(a)(3)(i)-(ii) 42 CFR 440.230(b) Medical Services Contract (MSC) Section 22	Not Deemable	Not Deemable	

## Appendix D | ACA QP Tool with NCQA Crosswalk

2	Service Limitations	42 CFR 438.210(a)(4)(i)-(ii) 42 CFR 440.230(d) MSC 22	Not Deemable	Not Deemable	
3	Authorization of Services	42 CFR 438.210(b)(1) MSC 22-6	Not Deemable	Not Deemable	
4	Application of Review Criteria	42 CFR 438.210(b)(2)(i)-(iii) MSC 22-6	Deemable UM2C UM7	Deemable UM2C UM7	
5	Utilization Management Controls	MSC 22-1	Not Deemable	Not Deemable	
6	Appropriate Reviewer Expertise	42 CFR 438.210(b)(3) MSC 22-1	Not Deemable	Not Deemable	
7	Notice of Adverse Benefit Determination	42 CFR 438.210(c) 42 CFR 438.404(a) 42 CFR 457.1260 MSC 22-6-1	Not Deemable	Not Deemable	
8	Timeframe for Standard Authorization Decisions	42 CFR 438.210(d)(1) 42 CFR 438.404(c)(3) MSC 22-6-1	Not Deemable	Not Deemable	
9	Standard Authorization Extension	42 CFR 438.210(d)(1)(i)-(ii) 42 CFR 438.404(c)(4)(i)-(ii) MSC 22-6-1	Not Deemable	Not Deemable	
10	Timeframe for Expedited Authorization Decisions	42 CFR 438.210(d)(2)(i) 42 CFR 438.404(c)(6) MSC 22-6-1	Not Deemable	Deemable UM 5A UM 5B UM 5C	

## Appendix D | ACA QP Tool with NCQA Crosswalk

11	Expedited Authorization Extension	42 CFR 438.210(d)(2)(ii) MSC 22-6-1	Not Deemable	Not Deemable	
12	Covered Outpatient Drug Decisions	42 CFR 438.210(d)(3) MSC 22-6-1	UM5A	Deemable UM5A	
13	Compensation for Utilization Management Activities	42 CFR 438.210(e) MSC 22-1	Not Deemable	Not Deemable	
14	Termination, Suspension, or Reduction of Services	42 CFR 438.404(c)(1) 42 CFR 431.211 42 CFR 431.213(a)-(h) MSC 22-6-1	Not Deemable	Not Deemable	
15	Denial of Payment	42 CFR 438.404(c)(2) MSC 22-6-1	Not Deemable	Not Deemable	
16	Decisions Exceeding Timeframes	42 CFR 404(c)(5) MSC 22-6-1	Deemable UM 5A UM 5B	Deemable UM5A UM 5B	
17	Emergency Services	42 CFR 438.114(c)(1)(i)-(ii) MSC Attachment A	Not Deemable	Not Deemable	
18	Emergency Services External to Case Management	42 CFR 438.114(c)(2)	Not Deemable	Not Deemable	
19	Emergency Service Limitations	42 CFR 438.114(d)(1)(i)-(ii) MSC Attachment A	Not Deemable	Not Deemable	
20	MCO Responsibility for Poststabilization Services	42 CFR 438.114(d)(3) MSC Attachment A	Not Deemable	Not Deemable	

## Appendix D | ACA QP Tool with NCQA Crosswalk

21	Financial Responsibility for Poststabilization Services	42 CFR 438.114(d)(3) MSC Attachment A	Not Deemable	Not Deemable	
22	Behavioral Health Policies and Procedures	MSC 22-2	Not Deemable	Not Deemable	
23	Behavioral Health Educational Materials	MSC 22-2	Not Deemable	Not Deemable	
24	Parity in Mental Health and Substance Use Disorder Benefits	MSC 22-3	Not Deemable	Not Deemable	
25	Telehealth	MSC 22-5	Not Deemable	Not Deemable	
26	Social Determinants of Health	MSC 22-9	Not Deemable	Not Deemable	
27	Disease and Case Management	MSC 22-10	Not Deemable	Not Deemable	
28	Information Format	42 CFR 438.10(c)(1) MSC 21-3	Not Deemable	Not Deemable	
29	Culturally Competent Communication	MSC 20	Not Deemable	Not Deemable	
30	Cultural Competency Plan	MSC 20	Not Deemable	Not Deemable	
31	Electronic Information	42 CFR 438.10(c)(6) MSC 21	Not Deemable	Not Deemable	
32	Enrollee Assistance	42 CFR 438.10(c)(7) MSC 22	Not Deemable	Not Deemable	
33	Enrollee Material Language	42 CFR 438.10(d)(2) MSC 21-2 MSC 21-3	Not Deemable	Not Deemable	

## Appendix D | ACA QP Tool with NCQA Crosswalk

34	Written Material Requirements	42 CFR 438.10(d)(3) MSC 21-2 MSC 21-3	Not Deemable	Not Deemable	
35	Notification of Materials to Enrollee	42 CFR 438.10(d)(5)(i)-(iii) MSC 21-3	Not Deemable	Not Deemable	
36	Written Material Format	42 CFR 438.10(d)(6)(i)-(iii) MSC 21-3	Not Deemable	Not Deemable	
37	Enrollee Material Best Practices	MSC 21-3	Not Deemable	Not Deemable	
38	Provider Termination Notice	42 CFR 438.10(f)(1) MSC 21-3-1-F	Not Deemable	Not Deemable	
39	Provider Incentive Plans	42 CFR 438.10(f)(3) MSC 24-5	Not Deemable	Not Deemable	
40	Enrollee Identification Card	MSC 21-3-1-A	Not Deemable	Not Deemable	
41	Enrollee Handbook	42 CFR 438.10(g)(1) MSC 21-3-1-B	Not Deemable	Not Deemable	
42	Enrollee Handbook Content – 1	42 CFR 438.10(g)(2)(i)-(iv) MSC 21-3-1-B	Not Deemable	Not Deemable	
43	Enrollee Handbook Content – 2	42 CFR 438.10(g)(2)(v)-(viii) MSC 21-3-1-B	Not Deemable	Not Deemable	
44	Enrollee Handbook Content – 3	42 CFR 438.10(g)(2)(ix)-(xi) MSC 21-3-1-B	Not Deemable	Not Deemable	
45	Enrollee Handbook Content – 4	42 CFR 438.10(g)(2)(xiii)-(xvi) MSC 21-3-1-B	Not Deemable	Not Deemable	
46	Information Delivery Methods	42 CFR 438.10(g)(3)(i)-(iv)	Not Deemable	Not Deemable	

## Appendix D | ACA QP Tool with NCQA Crosswalk

47	MCO Publicly Available Website	MSC 21	Deemable ME2A	Deemable ME2A	
48	MCO Secure Website for Enrollees	MSC 21	Not Deemable	Not Deemable	
49	Notice of Changes	42 CFR 438.10(g)(4) MSC 21-3-1-E	Not Deemable	Not Deemable	
50	Pharmacy Information	42 CFR 438.10(i)(1)-(2) MSC 21-3-1-D	Not Deemable	Not Deemable	
51	Pharmacy Drug Lists	42 CFR 438.10(i)(1)-(2) MSC 21-3-1-D	Not Deemable	Not Deemable	
52	Pharmacy Drug List Change Notification to Enrollees	MSC 21-3-1-D	Not Deemable	Not Deemable	
53	Certificates of Creditable Coverage	MSC 21-3-1-H	Not Deemable	Not Deemable	
54	Enrollee Right to Information	42 CFR 438.100(b)(2)(i),(iii)-(v) MSC 19	Not Deemable	Not Deemable	
55	MCO Cost Responsibility	MSC 22	Not Deemable	Not Deemable	
56	Utilization Management Controls	MSC 22-1	Not Deemable	Not Deemable	

**Table D-3. QP Standard: Subcontractual Relationships and Delegation, MCOs**

<b>Element #</b>	<b>ACA Tool Element Name</b>	<b>42 CFR Reference(s)</b>	<b>2021 NCQA Equivalency Element(s)</b>	<b>2022 NCQA Equivalency Element(s)</b>	<b>Qsource Notes</b>
1	Contract Compliance	42 Code of Federal Regulations (CFR) 438.230(b)(1) Medical Services Contract (MSC) Section 5	Deemable CR 8 ME 8 UM 13 QI	Deemable CR 8 ME 8 UM 13 QI	
2	New or Amended Subcontracts	MSC 5	Not Deemable	Not Deemable	
3	Subcontract Availability	MSC 5-1	Not Deemable	Not Deemable	
4	Subcontractor Disclosures	42 CFR 438.608(c)(1)-(3) MSC 5	Not Deemable	Not Deemable	
5	Delegation of Activities	42 CFR 438.230(c)(1)(i)-(iii) MSC 5-1	Not Deemable	Not Deemable	
6	Regulatory Compliance	42 CFR 438.230(c)(2) MSC 5-1	Not Deemable	Not Deemable	
7	Grievance and Appeal Process	42 CFR 438.414 MSC 5	Not Deemable	Not Deemable	
8	Delegated Coverage of Services and Claims Payment	MSC 5-1	Not Deemable	Not Deemable	
9	Delegated Management of Covered Services	MSC 5-1	Not Deemable	Not Deemable	
10	Delegated Management of Covered Behavioral Health Services	MSC 5-1	Not Deemable	Not Deemable	

**Table D-3. QP Standard: Subcontractual Relationships and Delegation, MCOs**

Element #	ACA Tool Element Name	42 CFR Reference(s)	2021 NCQA Equivalency Element(s)	2022 NCQA Equivalency Element(s)	Qsource Notes
11	Risk Assessments	MSC 5-2	Not Deemable	Not Deemable	
12	Quarterly Monitoring Summary	MSC 5-2	Not Deemable	Not Deemable	
13	Routine and Non-Routine Monitoring	MSC 5-2	Not Deemable	Not Deemable	
14	Contingency Plan	MSC 5-2	Not Deemable	Not Deemable	
15	Subcontractor Audit	42 CFR 438.230(c)(3)(i)-(iv)	Not Deemable	Not Deemable	
16	Correction of Subcontractor Noncompliance	MSC 5-2	Not Deemable	Not Deemable	
17	Notification of Subcontractor Termination	MSC 5-2	Not Deemable	Not Deemable	
18	Subcontractor Solvency	MSC 5-3	Not Deemable	Not Deemable	

**Table D-4. QP Standard: Coordination and Continuity of Care, DBMs**

Element #	ACA Tool Element Name	42 CFR Reference(s)	2021 NCQA Equivalency Element(s)	2022 NCQA Equivalency Element(s)	Qsource Notes
1	Appropriate Source of Care	42 Code of Federal Regulations (CFR) 438.208(b)(1) DSC Section 18.8.1	Not Deemable	Not Deemable	
2	Assignment of Primary Dental Provider (PDP)	DSC 18.8.1	Not Deemable	Not Deemable	

**Table D-4. QP Standard: Coordination and Continuity of Care, DBMs**

Element #	ACA Tool Element Name	42 CFR Reference(s)	2021 NCQA Equivalency Element(s)	2022 NCQA Equivalency Element(s)	Qsource Notes
3	PDP Assignment Requirements	DSC 18.8.1	Not Deemable	Not Deemable	
4	Enrollee Health Record	42 CFR 438.208(b)(5) DSC 24.4	Not Deemable	Not Deemable	
5	Enrollee Privacy	42 CFR 438.208(b)(6)	Not Deemable	Not Deemable	
6	Coordination of Care	DSC Section 9.4.2 DSC Section 22.9, 22.10	Not Deemable	Not Deemable	
7	Transition of Care Policy	DSC Section 22.9	Not Deemable	Not Deemable	
8	Requests for Eligibility Review	DSC Section 18.2	Not Deemable	Not Deemable	
9	Disenrollment	DSC Section 18.9	Not Deemable	Not Deemable	

**Table D-5. QP Standard: Coverage and Authorization of Services, DBMs**

Element #	ACA Tool Element Name	42 CFR Reference(s)	2021 NCQA Equivalency Element(s)	2022 NCQA Equivalency Element(s)	Qsource Notes
1	Service Protections	42 Code of Federal Regulations (CFR) 438.210(a)(3) (i)-(ii) 42 CFR 440.230(b) DSC Section 19	Not Deemable	Not Deemable	
2	DBM Non-Refusal to Cover Benefits or Services	DSC Section 18.1	Not Deemable	Not Deemable	

<b>Table D-5. QP Standard: Coverage and Authorization of Services, DBMs</b>					
<b>Element #</b>	<b>ACA Tool Element Name</b>	<b>42 CFR Reference(s)</b>	<b>2021 NCQA Equivalency Element(s)</b>	<b>2022 NCQA Equivalency Element(s)</b>	<b>Qsource Notes</b>
3	Service Limitations	42 CFR 438.210(a)(4)(i)-(ii) 42 CFR 440.230(d)	Not Deemable	Not Deemable	
4	Authorization of Services	42 CFR 438.210(b)(1) DSC Section 22.4	Not Deemable	Not Deemable	
5	Application of Review Criteria	42 CFR 438.210(b)(2)(i)-(ii) DSC Section 22.4	Deemable UM2C UM7	Deemable UM2C UM7	
6	Appropriate Reviewer Expertise	42 CFR 438.210(b)(3) DSC Sections 22.1 and 22.4	Not Deemable	Not Deemable	
7	Notice of Adverse Benefit Determination	42 CFR 438.210(c) 42 CFR 438.404(a) 42 CFR 457.1260 DSC Section 22.4.1	Not Deemable	Not Deemable	
8	Termination, Suspension, or Reduction of Services	42 CFR 438.404(c)(1) 42 CFR 431.211 42 CFR 431.213(a)-(h) DSC Section 22.4.1	Not Deemable	Not Deemable	
9	Timeframe for Standard Authorization Decisions	42 CFR 438.210(d)(1) 42 CFR 438.404(c)(3) DSC Section 22.4.1	Not Deemable	Not Deemable	
10	Standard Authorization Extension	42 CFR 438.210(d)(1)(i)-(ii) 42 CFR 438.404(c)(4)(i)-(ii) DSC Section 22.4.1	Not Deemable	Not Deemable	

<b>Table D-5. QP Standard: Coverage and Authorization of Services, DBMs</b>					
<b>Element #</b>	<b>ACA Tool Element Name</b>	<b>42 CFR Reference(s)</b>	<b>2021 NCQA Equivalency Element(s)</b>	<b>2022 NCQA Equivalency Element(s)</b>	<b>Qsource Notes</b>
11	Timeframe for Expedited Authorization Decisions	42 CFR 438.210(d)(2)(i) 42 CFR 438.404(c)(6) DSC Section 22.4.1	Not Deemable	Deemable UM 5A UM 5B UM 5C	
12	Expedited Authorization Extension	42 CFR 438.210(d)(2)(ii) DSC Section 22.4.1	Not Deemable	UM5A	
13	Covered Outpatient Drug Decisions	42 CFR 438.210(d)(3)	Not Deemable	UM5A	
14	Compensation for Utilization Management Activities	42 CFR 438.210(e) DSC Section 22.1	Not Deemable	Not Deemable	
15	Emergency Services	42 CFR 438.114(c)(1)(i)-(ii) DSC Section 24.3	Not Deemable	Not Deemable	
16	Subsequent Screening and Treatment	42 CFR 438.114(d)(2)	Not Deemable	Not Deemable	
17	Financial Responsibility for Poststabilization Care Services	42 CFR 438.114(d)(3)(e) DSC Section 1.6, Section 21.3.1	Not Deemable	Not Deemable	
18	Information Format	42 CFR 438.10(c)(1)	Not Deemable	Not Deemable	
19	Culturally Competent Communication	DSC Section 20	Not Deemable	Not Deemable	

**Table D-5. QP Standard: Coverage and Authorization of Services, DBMs**

<b>Element #</b>	<b>ACA Tool Element Name</b>	<b>42 CFR Reference(s)</b>	<b>2021 NCQA Equivalency Element(s)</b>	<b>2022 NCQA Equivalency Element(s)</b>	<b>Qsource Notes</b>
20	Cultural Competency Plan	DSC Section 20	Not Deemable	Not Deemable	
21	Electronic Information	42 CFR 438.10(c)(6) DSC Section 21.3	Not Deemable	Not Deemable	
22	Enrollee Assistance	42 CFR 438.10(c)(7) DSC 22	Not Deemable	Not Deemable	
23	Written Material Language Requirements	42 CFR 438.10(d)(2)-(3) DSC 21.2, 21.3, 21.3.1.B.j	Not Deemable	Not Deemable	
24	Notification to Enrollee of Alternate Formats Available	42 CFR 438.10(d)(5)(i)-(iii) DSC 21.3	Not Deemable	Not Deemable	
25	Written Material Content Requirements	42 CFR 438.10(d)(6)(i)-(iii) DSC 21.3	Not Deemable	Not Deemable	
26	Enrollee Material Best Practices	DSC 21.3	Not Deemable	Not Deemable	
27	Minimum Requirements for Enrollee Notification	DSC 21, 21.3.1.B	Not Deemable	Not Deemable	
28	Provider Termination Notice	42 CFR 438.10(f)(1) DSC 21.3.1.E	Not Deemable	Not Deemable	
29	Provider Incentive Plans	42 CFR 438.10(f)(3) DSC 24.10	Not Deemable	Not Deemable	

**Table D-5. QP Standard: Coverage and Authorization of Services, DBMs**

<b>Element #</b>	<b>ACA Tool Element Name</b>	<b>42 CFR Reference(s)</b>	<b>2021 NCQA Equivalency Element(s)</b>	<b>2022 NCQA Equivalency Element(s)</b>	<b>Qsource Notes</b>
30	Enrollment with a Primary Dental Care Provider	DSC 18.8.1, 18.8.2, 21.3.1.B.f	Not Deemable	Not Deemable	
31	Enrollee Handbook	42 CFR 438.10(g)(1) DSC 18.8.2, 21.3.1.B	Not Deemable	Not Deemable	
32	Enrollee Handbook Content – 1	42 CFR 438.10(g)(2)(i)-(iv) DSC 21.3.1.B	Not Deemable	Not Deemable	
33	Enrollee Handbook Content – 2	42 CFR 438.10(g)(2)(v)-(viii) DSC 21.3.1.B	Not Deemable	Not Deemable	
34	Enrollee Handbook Content – 3	42 CFR 438.10(g)(2)(ix)-(xii) DSC 21.3.1.B	Not Deemable	Not Deemable	
35	Enrollee Handbook Content – 4	42 CFR 438.10(g)(2)(xiii)-(xvi) DSC 21.3.1.B	Not Deemable	Not Deemable	
36	Information Delivery Methods	42 CFR 438.10(g)(3)(i)-(iv)	Not Deemable	Not Deemable	
37	Notice of Changes	42 CFR 438.10(g)(4) DSC 21.3.1.D	Not Deemable	Not Deemable	
38	Certificates of Creditable Coverage	DSC 21.3.1.F	Not Deemable	Not Deemable	
39	Enrollee Right to Information	42 CFR 438.100(b)(2)(i),(iii)- (v) DSC 19	Not Deemable	Not Deemable	
40	Staff Education and Training	DSC 12, 19	Not Deemable	Not Deemable	

**Table D-5. QP Standard: Coverage and Authorization of Services, DBMs**

<b>Element #</b>	<b>ACA Tool Element Name</b>	<b>42 CFR Reference(s)</b>	<b>2021 NCQA Equivalency Element(s)</b>	<b>2022 NCQA Equivalency Element(s)</b>	<b>Qsource Notes</b>
41	Compliance with Federal and State Laws	42 CFR 438.100(d) DSC 35			

**Table D-6. QP Standard: Subcontractual Relationships and Delegation, DBMs**

<b>Element #</b>	<b>ACA Tool Element Name</b>	<b>42 CFR Reference(s)</b>	<b>2021 NCQA Equivalency Element(s)</b>	<b>2022 NCQA Equivalency Element(s)</b>	<b>Qsource Notes</b>
1	Contract Compliance	42 Code of Federal Regulations (CFR) 438.230(b)(1) DSC 4	Deemable CR8A, CR8B, CR8C, CR8D UM13A, UM13 B, UM13C, UM13D	Deemable CR8A, CR8B CR8C, CR8D UM13A, UM1 3B, UM13C, UM13D	
2	New or Amended Subcontracts	DSC 4	Not Deemable	Not Deemable	
3	Delegation of Activities	42 CFR 438.230(c)(1)(i)-(iii) DSC 4.1	Not Deemable	Not Deemable	
4	Regulatory Compliance	42 CFR 438.230(c)(2) DSC 4.1	Not Deemable	Not Deemable	
5	Grievance and Appeal Process	42 CFR 438.414 DSC Section 4	Not Deemable	Not Deemable	
6	Risk Assessments	DSC Section 4.2	Not Deemable	Not Deemable	

<b>Table D-6. QP Standard: Subcontractual Relationships and Delegation, DBMs</b>					
<b>Element #</b>	<b>ACA Tool Element Name</b>	<b>42 CFR Reference(s)</b>	<b>2021 NCQA Equivalency Element(s)</b>	<b>2022 NCQA Equivalency Element(s)</b>	<b>Qsource Notes</b>
7	Quarterly Monitoring Summary	DSC 4.2	Not Deemable	Not Deemable	
8	Routine and Non-Routine Monitoring	DSC 4.2	Not Deemable	Not Deemable	
9	Contingency Plan	DSC 4.2	Not Deemable	Not Deemable	
10	Delegated Coverage of Services and Claims Payment	DSC 4.1	Not Deemable	Not Deemable	
11	Subcontractor Audit	42 CFR 438.230(c)(3)(i)-(iv)	Not Deemable	Not Deemable	
12	Notification of Agreement Termination	DSC 4.2	Not Deemable	Not Deemable	
13	Subcontractor Agreement Availability	DSC 4.1	Not Deemable	Not Deemable	
14	Subcontractor Disclosures	42 CFR 438.608(c)(1)-(3) DSC 4	Not Deemable	Not Deemable	
15	Correction of Subcontractor Noncompliance	DSC 4	Not Deemable	Not Deemable	
16	Subcontractor Solvency	DSC 4.3	Not Deemable	Not Deemable	