Florida External Quality Review Organization

Final

February 2019

2018 Annual

EQRO Technical Report

HealthyKids™

Qsource

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List of Tables

Acknowledgements, Acronyms, and Initialisms[1]

A .....All
AAAHC ... Accreditation Association for Ambulatory Health Care
ACA ..... Annual Compliance Assessment
ADD..... Follow-Up Care for Children Prescribed ADHD Medication
ADHD.....Attention-Deficit/Hyperactivity Disorder
ADV ..... Annual Dental Visit
AMB-ED.....Ambulatory Care: Emergency Department Visits
AMR..... Asthma Medication Ratio
ANA ..... Annual Network Adequacy
AOD..... Alcohol and Other Drug
AON.....Area of Noncompliance
APC ...Use of Multiple Concurrent Antipsychotics in Children and Adolescents
APP.....Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
AWC ... Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
BMI ..... Body Mass Index
BR .....Biased Rate
C ..... Critical
CAP .. Children and Adolescents' Access to Primary Care Practitioners
CDT ..... Code on Dental Procedures and Nomenclature
CFR ..... *Code of Federal Regulations*
CHIP.....Children's Health Insurance Program
CHL .....Chlamydia Screening in Women
CMS..... Centers for Medicare & Medicaid Services
CPT-4 .....Current Procedural Terminology, 4th Edition
CWP .....Appropriate Testing for Children with Pharyngitis
CY .....Calendar Year
DBA.....Doing Business As
DBM ..... Dental Benefit Manager
DSC.....Dental Services Contract
E ..... Expedited
ED..... Emergency Department
EDV.....Encounter Data Validation
ENT .....Otolaryngology (ear, nose, and throat)
EQR/EQRO..... External Quality Review/EQR Organization
FAR ..... Final Audit Report

[1] *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.*

FFS ..... Fee for Service
FHK/FHKC ... Florida Healthy Kids/FHK Corporation
FUA ..... Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence
FUH ..... Follow-Up After Hospitalization for Mental Illness
FUM ..... Follow-Up After Emergency Department Visit for Mental Illness
HEDIS® ..... Healthcare Effectiveness Data and Information Set, a registered trademark of the NCQA
HPV ..... Human Papillomavirus
IDSS ..... Interactive Data Submission System
IET ..... Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment
IHI ..... Institute for Healthcare Improvement
IMA ..... Immunizations for Adolescents
IS ..... Information System(s)
ISCAT ..... Information Systems Capability Assessment Tool
MAT ..... Medication Assisted Treatment
MCO ..... Managed Care Organization
MMA ..... Medication Management for People with Asthma
MR/MRR ..... Medical Record/MR Review
MSC ..... Medical Services Contract
MSR ..... Member Service Representative
N ..... No
NA ..... Not Applicable (ACA)
NA ..... Small Denominator (PMV)
NA ..... Not Assessed (PIP)
NCQA ... National Committee for Quality Assurance
NCQA HEDIS Compliance Audit™ ... a trademark of NCQA
NPI ..... National Provider Identifier
NR ..... Non-Reportable Rate
OB/GYN ..... Obstetrician/Gynecologist
P&P ..... Policy and Procedure
P4Q ..... Pay for Quality
PCP ..... Primary Care Provider/Physician
PDENT ..... Dental Preventive Services
PDSA ..... Plan-Do-Study-Act
PIHP ..... Prepaid Inpatient Health Plan
PIP ..... Performance Improvement Project
PMV ..... Performance Measure Validation
PPC ..... Prenatal and Postpartum Care
Q ..... Quarter
QIPD ... Quality Improvement Program Description
QPIP ..... Quality Performance Incentive Program
Qsource® ..... a registered trademark
R ..... Reportable Rate
Roadmap ..... Record of Administrative Data Management and Processes
S ..... Standard
SAP ..... Subscriber Assistance Program

SAS® ..... a registered trademark of SAS Institute, Inc.[2]
SCA ..... Single Case Agreement
SCP ..... Specialty Care Provider
Td ..... Tetanus and Diphtheria Toxoids Vaccine
Tdap .... Tetanus, Diphtheria Toxoids, and Acellular Pertussis Vaccine
TDENT ..... Dental Treatment Services
TTY/TDD ..... Teletypewriter/ Telecommunications Device for the Deaf
UB-04 ..... Uniform Bill (CMS-1450 form)
URAC® ... United Review Accreditation Commission
URI..... Appropriate Treatment for Children with Upper Respiratory Infection
W34 ... Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
WCC ..... Weight Assessment and Counseling for Nutrition & Physical Activity for Children/Adolescents
Y ..... Yes

Overview

This section provides a brief history of Florida Healthy Kids Corporation (FHKC), its Quality Strategy Plan, the guidelines for this report, and brief descriptions and objectives of the external quality review (EQR) activities conducted in 2018.

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 five to 18 years. The Florida Healthy Kids (FHK) program's inception was the result of an article authored by then-director of the University of Florida's Institute for Child Health Policy, which was published in the March 31, 1988 issue of the *New England Journal of Medicine*.

In 1997, FHK became one of three state programs grandfathered into the original Children's Health

[2] *SAS and all other SAS Institute Inc. product or service names are registered trademarks of SAS Institute Inc. in the United States and other countries.*

Insurance Program (CHIP) legislation created through Title XXI of the *Social Security Act* and reauthorized in 2009. Today, 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 comprise the Florida KidCare program, covering children from birth through age 18. FHK 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. FHK 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.

In 2017, five MCOs and three DBMs operated in Florida. The MCOs included Aetna Better Health of Florida (Aetna), Amerigroup Community Care (Amerigroup), Wellcare doing business as (dba) Staywell Kids (Staywell), Sunshine Health Plan (Sunshine), and UnitedHealthcare Community Plan (UnitedHealthcare). The DBMs were Argus Dental Plan (Argus), DentaQuest, Inc. (DentaQuest), and MCNA Dental Plan (MCNA).

FHKC Quality Strategy Goals

FHKC's goals and vision and mission statements align with the three aims of the National Quality Strategy: better care, healthy people/healthy communities, and affordable care. Its Quality Strategy Plan includes two primary areas of focus, access to quality 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 strong foundation for FHKC and the services it provides the FHK 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 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.

EQR Activity Descriptions and Objectives

EQR requires three mandated activities and can include five optional activities. Each state (in this case, FHKC) may also assign other responsibilities to its designated external quality review organization (EQRO), such as the provision of ongoing technical assistance. This section summarizes the activities that Qsource performed for FHKC in 2018.

EQR Mandatory Activities

As set forth in Title 42 *Code of Federal Regulations* (CFR) Section 438, Part 358 (42 § 438.358), incorporated by 42 CFR § 457.1250, three mandatory EQR activities must be conducted to assess the performance of the Medicaid managed care organizations (MCOs) and dental benefit managers (DMBs):

- Monitoring compliance with regulatory and contractual standards through an Annual Network Adequacy (ANA) Evaluation and Annual Compliance Assessment (ACA)
- Validation of performance measures (PMV)
- Validation of performance improvement projects (PIPs)

Qsource is responsible for the creation and production of this *2018 Annual EQRO Technical Report*, which compiles the results of these EQR activities. Qsource's efforts are a primary means of assessing the quality, timeliness, and accessibility of services provided by FHKC's MCOs and DBMs. Qsource subcontracted with Quest Analytics to assist in the completion of the ANA.

Qsource performed annual EQR activities for 2018 to determine each MCO's and DBM's compliance with federally mandated activities:

- A brief description of the data collection, aggregation, and analyses for each of the EQR compliance activities

- A summary of findings from each review (ANA, ACA, PMV, and PIP validation)
- A summary of strengths and opportunities demonstrated by each MCO and DBM in providing healthcare services to FHK enrollees
- Recommendations for improving the quality of these services

The mandated EQR activity audit and review periods for FHKC MCOs and DBMs are summarized in **Table 1**.

Table 1. 2018 Survey and Review Periods for Mandated EQR Activities

Activity	Audit Period	Period Under Review
ANA	February 2018	January 1–December 31, 2017
ACA	May–June 2018	January 1–December 31, 2017
PMV	June–August 2018	October 1, 2016 – September 30, 2017 (HEDIS)
		January 1–December 31, 2017 (CMS-416)

Table 1. 2018 Survey and Review Periods for Mandated EQR Activities

Activity	Audit Period	Period Under Review
PIP Validation	July–August 2018	January 1–December 31, 2017

The following MCO- and DBM-specific reports were generated for each of the reviews:

- *2018 ANA Reports*
- *2018 ACA Reports*
- *2018 PMV Reports*
- *2018 PIP Validation Reports*

This *2018 Annual EQRO Technical Report* is based on detailed findings that can be examined in the individual reports. Each EQR activity's brief description and objectives are described in the following paragraphs of this section. Trending information for each activity is not included in this year's *Annual EQRO Technical Report* as it is the first year for Qsource to serve as FHKC's EQRO, but it will be included in subsequent reports.

ANA

Per 42 CFR § 438.206, incorporated by 42 § CFR 457.1230, and their respective contracts, FHKC MCOs and DBMs must ensure

- all covered benefits are available and provided to enrollees;
- an adequate number of qualified, skilled providers and healthcare facilities are employed or contracted, as defined by the medical services contract (MSC) or dental services contract (DSC); and
- these providers/facilities have sufficient resources and the ability to guarantee enrollees access to quality medical care for all covered benefits.

ANA reviews are designed to evaluate both the adequacy of each MCO's and DBM's provider network and the completeness of its enrollee and provider communication regarding FHKC-covered services during the review year. The multiple measures used to assess each are listed in the ANA section of this report.

ACA

The ACA is bound by the same mandates as ANA reviews. ACA requirements are further defined by (1) 42 CFR § 434 and 438, incorporated by 42 CFR § 457.1250; (2) each MCO's and DBM's contract with FHKC; and (3) additional quality standards established by FHKC.

Qsource evaluated MCO and DBM compliance using customized CA standard and appeal and grievance file review tools. These tools provide required data and meaningful information that FHKC and the MCOs and DBMs can use to

- compare the quality of service and healthcare that MCOs and DBMs provide to their enrollees;
- identify, implement, and monitor system interventions to improve quality;
- evaluate performance processes; and
- plan/initiate activities to sustain and enhance current performance processes.

Required data were also obtained through the National Committee for Quality Assurance (NCQA), Accreditation Association for Ambulatory Health Care (AAAHC), and United Review Accreditation Commission (URAC®) accreditation standards. In addition to evaluating documentation provided directly by the MCOs and

DBMs, FHKC also allowed certain elements of CA standards to be considered compliant based on MCO or DBM accreditation with an acceptable accrediting body. The multiple measures used to assess each are listed in the ACA section of this report.

PMV

To evaluate performance levels, FHKC selected a process for an objective, comparative review of quality-of-care outcomes and performance measures. Its primary aims were to evaluate the accuracy of MCO- and DBM-reported measures and to determine whether those measures were calculated according to required technical specifications. To satisfy CMS protocol for MCOs and to meet the requirements set forth in 42 CFR § 438.240(b)(2), FHKC identified for validation 21 Healthcare Effectiveness Data and Information Set (HEDIS®) measures, defined by the NCQA and validated through an NCQA HEDIS Compliance Audit. DBMs were evaluated using six CMS-416 dental measures and the HEDIS Annual Dental Visit measure. Comparisons among MCOs and DBMs are available in the PMV section of this report.

PIP Validation

The primary objective of the EQRO's PIP validation is to determine the compliance of each MCO and DBM with the requirements set forth in 42 CFR § 438.240(b)(1). MCOs and DBMs must conduct PIPs that are designed to achieve, through ongoing measurements and interventions, significant and sustained improvement in clinical and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. PIP study topics must reflect FHK enrollment in terms of demographic characteristics and, if applicable, in terms of the prevalence and potential consequences (risks) of disease. Each PIP must be completed in a reasonable timeframe to allow PIP success-related data in the aggregate to produce new information on quality of care every year. In addition to PIP assessment, each MCO and DBM was expected to implement new interventions using the Institute for Healthcare Improvement (IHI) Model for Improvement's Plan-Do-Study-Act (PDSA) model as appropriate for the PIP.

PIPs are further defined in 42 CFR § 438.330(b)(1) to include all of the following:

- Performance measurement using objective quality indicators
- System interventions implementation for quality improvement
- Evaluation of intervention effectiveness
- Planning and initiation of activities to increase or sustain improvement

The 2018 PIP validation process evaluated two PIPs spread across five MCOs and three DBMs. 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 MCO and DBM interventions. The results of the validation process can be found in the PIP section.

EQR Optional Activities

In addition to EQR mandatory activities, 42 CFR § 438.358 outlines five optional activities:

- Validating encounter data (EDV) reported by an MCO/DBM
- Administering or validating consumer or provider surveys of quality of care
- Calculating performance measures in addition to those reported by an MCO/DBM and validated by an EQRO
- Conducting PIPs in addition to those conducted by an MCO/DBM and validated by an EQRO
- Conducting studies on quality that focus on a particular aspect of clinical or non-clinical services at a point in time

Qsource performs one of these optional activities under its current contract with FHKC, EDV, which was conducted quarterly.

CMS protocol for EDV mandates the following five activities:

1. Review of FHKC requirements for collecting and submitting encounter data
2. Review of MCO and DBM capacity for producing encounter data that are accurate and complete
3. Analyses of the accuracy and completeness of MCO- and DBM-submitted encounter data
4. Medical record review (MRR) to confirm EDV findings
5. Submission of EQRO findings

For the baseline validation in quarter 1 (Q1), Qsource focused on preparing data collection guidelines in collaboration with FHKC to fulfill EDV Activity 1 and identifying Missing and Erroneous data to determine invalid rates for encounter files to fulfill EDV Activity 3.

For the second validation in Q2, Qsource refined the Q1 report, evaluating adjudication of claims and encounter data in aggregate and individually for dates of service from January through March 2018 to establish a baseline for the validity and reliability of all service data captured by the MCOs and DBMs. Rather than providing a comparison of Q1 and Q2 data, the Q2 report reanalyzed Q1 encounter and claims data separately for a number of validation measures. The Q3 report analyzed Q2 service data.

In addition to EDV, Qsource also provided FHKC and its MCOs and DBMs with technical assistance—an EQR-related activity also defined by 42 CFR § 438.358. In this capacity, Qsource maintained ongoing, collaborative communication with FHKC and supported the MCOs and DBMs in their EQR activities. Qsource also conducted PIP training for MCO and DBM staff.

Finally, Qsource conducted three health and dental Plan meetings that were attended by FHKC, MCO, and DBM staff. The first meeting was face to face, while the other two were virtual. The three 2018 meetings featured seminars about Qsource as the EQRO for FHKC and CMS EQR requirements; using digital communication effectively to produce better Plan-level results; legal aspects of outreach for enrollees, parents, and/or guardians; PIP and PDSA quality tips; and building a foundation of telehealth quality through research and education. Additional meeting information is presented in Appendix C.

Technical Report Guidelines

To assist both EQROs and state agencies, CMS supplemented the requirements of 42 CFR § 438.364 and provided guidelines for this *2018 Annual EQRO Technical Report*, which—in addition to this Overview—includes the following sections:

- ANA
- ACA
- PMV
- PIP Validation

- EDV
- Conclusions and Recommendations

FHKC Utilization of the EQRO Technical Report

The *Annual EQRO Technical Report* provides FHKC with unbiased data for the MCOs and DBMs. As mandated by 42 CFR § 438.364, these data make it possible to benchmark performance statewide and nationally. The data also depict the healthcare landscape for the state's FHK population, which assists FHKC in its collaborations with other state agencies to address common health issues—particularly those that are prevalent, chronic, and preventable. FHKC can use these data to measure progress toward goals and objectives of its Quality Strategy Plan, identify areas where targeted quality improvement interventions could be beneficial, and determine if new or restated goals are needed.

Annual Network Adequacy (ANA)

Assessment Background

For the ANA reviews, directed by FHKC, Qsource evaluated each MCO and DBM to determine if it had a provider network adequate to ensure the effective and efficient delivery of healthcare to enrollees, pursuant to 42 CFR § 438.68. Prior to 2018, reviews were done for primary care providers, but beginning in 2018, the network validation process expanded to include certain pediatric and adult specialists, dental specialists, and hospitals. The ANA reviews were conducted from May through June of 2018.

Technical Methods of Data Collection

The 2018 ANA evaluation included MCO and DBM provider networks as of February 2018. MCO and DBM relevant policies and procedures (P&Ps) and provider and enrollee communication materials were assessed. The surveyors focused on the following areas:

- Analyses of the distribution and availability of providers to FHK enrollees
- Appointment availability standards documented in P&Ps, member handbooks, and provider manuals or provider agreements

Description of Data Obtained

The data used in the quantitative analyses were derived from provider files supplied by the MCOs and DBMs and enrollment data from the third-party administrator supplied by FHKC. Once extracted from their respective source files, provider and enrollment data were prepared by Quest Analytics using a software application called DataCleaner from GeoAccess, Inc. Provider and enrollee address information was first validated, then cleaned and standardized to United States Postal Service specifications. Next, data were geocoded using these updated, standardized addresses. The files generated from this process were analyzed to assess network adequacy for all MCOs and DBMs. Further details can be found in each MCO's and DBM's *2018 Annual Network Adequacy Report*.

Comparative Findings

All MCOs and DBMs received 90.6% or higher compliance scores for overall Network Adequacy, as shown in **Table 2**, with the MCOs achieving an average of 95.98% compliance and the DBMs averaging a 92.7% compliance score. Since this is the first year for Qsource to serve as the EQRO for the FHK program, comparisons from year to year are not possible; however, they will be included in the *2019 Annual EQRO Technical Report* where possible.

Table 2. 2018 ANA Overall Compliance by MCO and DBM

MCO	Network Adequacy
Aetna	92.6%
Amerigroup	98.9%
Staywell	96.8%
Sunshine	95.0%
UnitedHealthcare	96.6%
DBM	
Argus	92.9%
DentaQuest	90.6%
MCNA	94.6%

MCO Network Adequacy

For the 2018 evaluation, all MCOs were deemed compliant. Four of the five MCOs achieved 95.0% or higher compliance scores, with Amerigroup earning the highest score at 98.9%. Staywell and UnitedHealthcare shared similar scores—96.8% and 96.6%, respectively. Sunshine (95.0%) and Aetna (92.6%) also had overall high scores for this year's evaluation.

DBM Network Adequacy

The DBMs also were all deemed as compliant for Network Adequacy, with MCNA achieving the highest score among the three at 94.6%. Argus (92.9%) and DentaQuest (90.6%) shared similar scores.

Strengths and Recommendations

Strengths

The MCOs demonstrated a shared strength for providing access to over 99.0% of their enrollees to adult and pediatric primary care providers (PCPs), acute care hospitals, laboratories, and pharmacies within the required travel time standard. In addition, 99.0% of enrollees of four of the five MCOs had appropriate access to specialty care providers (SCPs), whether pediatric, adult, or both: Amerigroup (pediatric), Staywell (both),

Sunshine (adult), and UnitedHealthcare (adult). Three MCOs also provided over 99.0% of their enrollees with access to inpatient psychiatric facilities. Finally, Amerigroup and Staywell both demonstrated high overall percentages for access within time standards, with Amerigroup providing access for over 90.0% of enrollees for all of the 10 provider type categories and Staywell providing access for over 99.0% of enrollees for eight of the 10.

The DBMs also demonstrated shared strengths. Both DentaQuest and MCNA provided approximately 98.5% of their enrollees with access to primary care general dentists; Argus did so for approximately 99.5% of its enrollees. In addition, Argus demonstrated access within time travel standards for at least 90.0% of enrollees for five of the six provider type categories.

Recommendations

Qsource recommended taking appropriate action to improve access to certain provider type categories for four of the five MCOs:

- Aetna, certain adult and pediatric SCPs and behavioral health SCPs
- Amerigroup, certain SCPs and substance abuse specialists
- Staywell, substance abuse specialists
- UnitedHealthcare, pediatric gastroenterologists

In addition, Qsource suggested that all MCOs continue to monitor their provider network and implement correct action for identified deficiencies. The recommendation to ensure all relevant MCO materials—P&Ps, member handbook, and provider manual—are up to date and include appropriate appointment access standards also was made. Aetna indicated in its response to the 2018 ANA review that it would address the deficiencies identified for the access to specialists standard by continuing to develop its specialty physician network, and Staywell stated that it has a process by which Single Case Agreements (SCAs) are executed to ensure access to care for enrollees. Those MCOs whose materials were identified as needing updates responded that they already had updated or that they would be updating relevant P&Ps, member handbooks, and provider manuals.

Qsource made a recommendation to all three DBMs to improve access to specialty type providers:

- Argus, prosthodontists
- DentaQuest, periodontists and prosthodontists
- MCNA, prosthodontists

Just as with the MCOs, Qsource also suggested that all three DBMs continue to monitor their provider network and implement corrective action for identified deficiencies. Finally, Qsource recommended that Argus update its member handbook to include appropriate appointment availability standards and that both DentaQuest and MCNA update their member handbook and provider manual.

Annual Compliance Assessment (ACA)

Assessment Background

Qsource conducted the ACA reviews pursuant to the requirements in (1) 42 CFR § 438, Subpart L – Managed Care; (2) CMS's *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs), Final Protocol* (Version 2.0, February 2012); and (3) FHKC MSCs and DSCs. The survey team consisted of clinicians with expertise in quality improvement. FHKC has chosen to review approximately one-third of the compliance standards annually, resulting in all standards being reviewed within the required three-year time period. Standards reviewed for 2018 include Access and Availability of Services, Grievance System, Quality Assessment and Performance Improvement, and Program Integrity.

Technical Methods of Data Collection

For each MCO and DBM, the ACA included a pre-assessment documentation review, an onsite visit, and post-onsite analysis. Qsource developed evidence-based oversight tools in consultation with FHKC and by referencing the MSCs and DSCs and the requirements included in 42 CFR § 438, Subparts E, F, and H, as incorporated by 42 CFR § 457, Subpart L. Qsource

provided the ACA onsite tools to each MCO and DBM prior to pre-assessment, giving the MCOs and DBMs opportunities to ask questions before the onsite visit. Once onsite, the review team interacted with MCO and DBM staff to determine the degree of compliance with regulatory and contractual requirements, to explore any issues not fully addressed in the documentation reviewed, and to increase overall understanding of the MCO's or DBM's performance. The 2018 onsite surveys took place May through June of 2018.

In addition to compliance standards, the ACA includes reviews of a random sample of appeal and grievance cases to evaluate how the MCO or DBM applies the processes and procedures required in 42 CFR § 438, Subpart F, in its operational practice. Qsource asked that MCOs and DBMs provide the universe of 2018 appeal and grievance files, from which Qsource abstracted a random sample and an oversample using SAS software. Files in this selection included 15 appeal and 15 grievance files (10 sample and 5 oversample). When less than 10 applicable files were available, the entire universe of reported cases was reviewed.

Description of Data Obtained

Throughout the documentation review and onsite assessment processes, Qsource reviewers used the survey tools to collect information and document findings regarding the MCO's or DBM's compliance with contractual and regulatory standards through a review of P&Ps, committee minutes, quality studies, reports, medical record/file, and other related MCO and DBM documentation. Qsource analyzed every element in the survey tools using weighted point values to determine the MCO's or DBM's performance on each standard.

Comparative Findings

Overall ACA Compliance

Both the MCOs and the DBMs achieved overall compliance for the ACA. Compliance scores ranged widely for the individual compliance assessment standards for both the MCOs and the DBMs, with a range of 32.1% and 48.2%, respectively. There was less variance in compliance scores for the file reviews. The variance range between the lowest and highest scores for the appeal file review was 2.7% for the MCOs and 15.4% for the DBMs; the grievance file review scores had a variance range of 5.0% for the MCOs and 20.0% for the DBMs.

MCO CA Standard Compliance

For the MCOs, Aetna and Staywell had the highest overall compliance standard scores at 97.5%. Two of the three remaining MCOs achieved compliance of more than 90.0%, with Amerigroup scoring 93.5% and UnitedHealthcare achieving 92.8%. Sunshine's overall compliance score was near 90.0% at 88.8%.

The MCOs achieved the highest scores overall for the Quality Assessment and Performance Improvement standard; Aetna, Amerigroup, Staywell, and UnitedHealthcare all achieved 100% compliance while Sunshine achieved 99.1%. The Access and Availability of Services standard also had mostly high scores among the MCOs—100% for Aetna, Amerigroup, and Staywell. Sunshine and UnitedHealthcare both performed significantly lower for the same standard—75.0% and 67.9%, respectively. The lower scores for these two MCOs were primarily a result of P&Ps, member handbooks, and provider manuals not including the recently updated regulatory language. The MCOs not achieving full compliance indicated in their responses to their individual *2018 ACA Report* that they had already incorporated the required language or announced their intentions to do so.

Scores were mostly above 90.0% for the Grievance System standard: Aetna, 96.4%; Amerigroup, 84.3%; Staywell, 96.4%; Sunshine, 84.3%; and UnitedHealthcare, 98.2%. The Program Integrity standard scores were consistently higher than other standard scores among the MCOs: Amerigroup, 100%; Aetna, Staywell, and Sunshine, 94.4%; and UnitedHealthcare, 88.7%. Similar to the other individual compliance standards, the lower scores for Grievance System and Program Integrity were due to missing language in enrollee and provider materials as well as MCO P&Ps.

DBM CA Standard Compliance

DBM performance was also high overall for all of the CA compliance standards combined. Argus's overall score was the highest among the DBMs at 97.75%, while MCNA's overall score was 95.5% and DentaQuest's was 74.0%. All three DBMs achieved 100% compliance for the Access and Availability of Services standard. Grievance System scores were mostly high as well, with 100% for Argus and 96.4% for MCNA; DentaQuest's score of 51.8% for this standard was lower, primarily because some of the DBM's P&Ps and enrollee materials were missing recently updated regulatory language. Two of the three DBMs

achieved high scores for Quality Assessment and Performance Improvement—Argus, 95.3%, and MCNA, 100%. DentaQuest's score of 85.0% for the same standard was slightly lower. The Program Integrity scores also varied, with 100% for MCNA and 94.4% for Argus, and a slightly lower score of 88.7% for DentaQuest.

MCO File Review Compliance

MCO performance for the file reviews was high. Aetna, Amerigroup, Sunshine, and UnitedHealthcare all achieved 100% compliance for the appeal and grievance file reviews, with Staywell achieving 97.3% for appeals and 95.0% for grievances. Staywell's slightly lower scores were a result of lack of acknowledgment for one appeal file and two grievance files randomly selected for review.

DBM File Review Compliance

MCNA achieved the highest file review compliance scores, 100% for both appeals and grievances. DentaQuest scored 100% for appeals and 96.4% for grievances. DentaQuest's less than perfect score was due to a failure to notify an enrollee of the grievance resolution in one randomly selected file. Argus achieved the lowest file review compliance scores among the DBMs. The 84.6% score for appeals was attributed to a failure to acknowledge an enrollee appeal for four of the nine files reviewed in addition to not meeting the appeal resolution time standard of 30 days for two of 10 files. The grievance score of 80.0% was due to the DBM not acknowledging grievances for three of the 10 files reviewed and for not providing notification of the resolution for four of the 10 files randomly selected for review.

Strengths and Opportunities for Improvement

Strengths

Qsource identified only one strength for the 2018 ACA among all the MCOs and DBMs. Amerigroup earned a strength for element 10 in Access and Availability of Services, Timely Access—Cultural Considerations for receiving the Multicultural Healthcare Distinction from NCQA.

Suggestions

Across both the MCOs and the DBMs, Qsource identified 46 suggestions, with the MCOs' suggestions constituting 69.6% of the total. Amerigroup and UnitedHealthcare amassed the most suggestions among the MCOs, with 11 and nine, respectively. The remaining MCOs had fewer: Aetna, three; Staywell, five; and Sunshine, four. The DBMs

had 14 suggestions identified, with DentaQuest having eight, Argus having five, and MCNA having only one. The majority of the suggestions for the 2018 ACA were to update existing or create new P&Ps to be effective for the review year, to include all regulatory and contractual requirements. The others were similar, suggesting updates to enrollee and provider materials as well as to some Plans' quality improvement program description (QIPD).

Areas of Noncompliance (AONs)

Where full compliance with regulatory and contractual requirements was not achieved for the CA standards, an area of noncompliance (AON) was noted for the MCO or DBM. Qsource identified 51 AONs during the 2018 ACA, with a nearly equal split between the MCOs (25) and DBMs (26) collectively. MCNA had one AON identified, and both Aetna and Staywell had two. Argus had three AONs identified, Amerigroup had four, UnitedHealthcare had seven, and Sunshine had 10. DentaQuest had the most AONs of the DBMs at 22.

By compliance assessment standard, Grievance System had the most AONs identified across all the MCOs (12) and DBMs (18), for a total of 30. The majority were identified for DentaQuest (17). Access and Availability of Services had the second highest number of AONs at eight, all of which were identified only for two of the MCOs: UnitedHealthcare, five, and Sunshine, three. Program Integrity had seven AONs, with four identified across four MCOs and three identified for two of the three DBMs. As with the suggestions identified for the 2018 ACA, most AONs were the result of missing required language in the MCOs' and DBMs' P&Ps and other materials as well as the member handbooks and provider manuals.

Performance Measure Validation (PMV)

Assessment Background

Qsource's PMV team consisted of members selected for their various skill sets, including statistics, analysis, managed care operations, clinical expertise, performance measure reporting, information system assessments, and computer programming capabilities.

Technical Methods of Data Assessment for MCOs

FHKC identified 21 HEDIS performance measures to be calculated and reported by the contracted MCOs. 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 CMS publication, *Protocol 2: Validation of Performance Measures Reported by the MCO* (Version 2.0; September 2012), outlines activities for validation of performance measures. Per the protocol, completion of the HEDIS Roadmap is an acceptable substitute for the Information Systems Capability Assessment Tool (ISCAT), and all MCOs used NCQA HEDIS-certified software for measure calculation; thus, onsite audits and source code review 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. For the 2018 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), Non-Reportable Rate (NR), Biased Rate (BR), or Small Denominator (NA).

Technical Methods of Data Assessment for DBMs

FHKC identified seven performance measures to be calculated and reported by the contracted DBMs. Five of these were CMS-416 dental service measures, one was a modified CMS-416 dental service measure, and the last was the HEDIS Annual Dental Visit (ADV) measure. Qsource followed CMS's *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 (if any).
- **Performance Measure Reports:** Qsource reviewed calculated rates for the current measurement period to assess rate reasonability.
- **Supportive Documentation:** Qsource reviewed additional information to complete the validation process, including, but not limited to, P&Ps, file layouts, system flow diagrams, system log files, and data collection process descriptions. Issues or areas needing further clarification were flagged for further follow-up.

For the DBMs, validation included the following basic steps:

1. Pre-Review Activities: In addition to scheduling the onsite reviews and developing the agenda, the team prepared a data collection tool based on established validation protocols. Additionally, each DBM was required to complete the ISCAT. Qsource responded directly to ISCAT-related questions from the DBMs during the pre-onsite phase. 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.
2. Onsite reviews lasted one day and included the following:
   - Opening session
   - Evaluation of system compliance, specifically the processing of claim, encounter, enrollment, and provider data where applicable
   - Overview of data integration and control procedures, including discussion and observation of source code logic where applicable
   - Review of how all data sources were combined and the method used to produce the analytical file for performance measures reporting

- Interviews with DBM staff members involved with any aspect of the performance measure reporting
- Closing session summarizing preliminary findings and recommendations

Comparative Findings

2018 Validated Measures

As this is the first year for Qsource to serve as the EQRO for FHKC, trending analysis is not included; however, it will be included in future reports where possible. No issues were identified for any of the MCOs. All of the MCOs' performance measures were determined to conform to the HEDIS Technical Specifications, which means each received a Reportable (R) rate and passed the PMV. Similarly, all three DBMs were determined to be in full compliance; no issues were identified, and they all passed the PMV. **Table 3** provides a description of the audited measures for MCOs, and Table 4 provides a description of the audited measures for DBMs.

Table 3. 2018 PMV MCO HEDIS Performance Measures

Measure Name	Measure Description
Access and Availability of Care	
Children and Adolescents' Access to Primary Care Practitioners (CAP)	CAP assesses general access to care for children and adolescents through the percentage of enrollees 12 months to 6 years of age who had a visit with a primary care provider (PCP; e.g., pediatrician, family physician) during the measurement year, and enrollees 7 to 19 years of age who had a visit with a PCP during the measurement year or the year prior. MCOs report four separate percentages (only three apply to the FHK population): ♦ 25 months – 6 years ♦ 7–11 years ♦ 12–19 years

Table 3. 2018 PMV MCO HEDIS Performance Measures	
Measure Name	**Measure Description**
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	IET assesses the percentage of adolescent and adult enrollees and older who demonstrated a new episode of alcohol or other drug (AOD) abuse or dependence and received the following: ♦ Initiation of AOD Treatment—Initial treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis ♦ Engagement of AOD Treatment—Two or more services with an AOD diagnosis within 34 days of the initiation visit in addition to initiating treatment MCOs report a total rate and two age stratifications for each: ♦ 13–17 years ♦ ≥ 18 years Starting with HEDIS 2018 (measurement year 2017), MCOs report three stratifications (Alcohol, Opioid, and Other Drug) within the total rate and age stratifications, and Initiation and Engagement total rates for all ages and stratifications.

Table 3. 2018 PMV MCO HEDIS Performance Measures	
Measure Name	**Measure Description**
Prenatal and Postpartum Care (PPC)	PPC measures the percentage of live birth deliveries on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the composite assesses the percentage of deliveries where enrollees received the following PPC facets: ♦ Timeliness of Prenatal Care—Received a prenatal care visit as an enrollee of the MCO in the first trimester or within 42 days of MCO enrollment ♦ Postpartum Care—Had a postpartum visit on or between 21 and 56 days after delivery
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	APP measures the percentage of children and adolescents 1 to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment. MCOs report a total rate and three age stratifications: ♦ 1–5 years ♦ 6–11 years ♦ 12–17 years
Utilization	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	W34 reports the percentage of enrollees who were 3 to 6 years of age who had one or more well-child visits with a PCP during the measurement year.

Table 3. 2018 PMV MCO HEDIS Performance Measures	
Measure Name	**Measure Description**
Adolescent Well-Care Visits (AWC)	AWC assesses the percentage of enrollees 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an obstetrician-gynecologist (OB-GYN) practitioner during the measurement year.
Ambulatory Care: Emergency Department Visits (AMB-ED)	AMB-ED summarizes utilization of ambulatory care for enrollees in the category of emergency department (ED) visits.
Identification of Alcohol and Other Drug Services (IAD)	IAD summarizes the number and percentage of enrollees with an AOD claim who received the following chemical dependency services during the measurement year: ♦ Any services (includes all stratifications below) ♦ Inpatient ♦ Telehealth ♦ Outpatient or an ambulatory MAT dispensing event ♦ Intensive outpatient or partial hospitalization ♦ ED
Mental Health Utilization (MPT)	MPT summarizes the number and percentage of enrollees receiving the following mental health services during the measurement year: ♦ Any services (includes all stratifications below) ♦ Inpatient ♦ Telehealth ♦ Outpatient ♦ ED ♦ Intensive outpatient or partial hospitalization

Table 3. 2018 PMV MCO HEDIS Performance Measures	
Measure Name	**Measure Description**
Effectiveness of Care – Prevention and Screening	
Chlamydia Screening in Women (CHL)	CHL assesses the percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. This measure calculates a total rate as well as two age stratifications (only one applies to the FHK population): ♦ Women age 16–20
Immunizations for Adolescents (IMA)*	IMA measures the percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine and one dose of 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: meningococcal and Tdap/Td; and meningococcal, Tdap/Td, and HPV.
Weight Assessment and Counseling for Nutrition & Physical Activity for Children/Adolescents (WCC)**	WCC measures the percentage of enrollees 3 to 17 years of age who had an outpatient visit with a PCP or OB-GYN and who had evidence of three indicators: body mass index (BMI) percentile documentation, and counseling for nutrition and physical activity during the measurement year. For WCC, a total rate and two age stratifications are reported for each indicator: ♦ 3–11 years ♦ 12–17 years

Table 3. 2018 PMV MCO HEDIS Performance Measures	
Measure Name	**Measure Description**
Effectiveness of Care – Respiratory Condition	
Appropriate Testing for Children with Pharyngitis (CWP)	CWP measures the percentage of children 3 to 18 years of age during the intake period who were diagnosed with pharyngitis only, were not prescribed an antibiotic within 30 days of intake nor had an active prescription for one on the episode date, were dispensed an antibiotic prescription on or during the three days after the episode date, and received a group A streptococcus (strep) test for the episode that occurred during the intake period between July 1 of the year prior to the measurement year and June 30 of the measurement year. A higher rate represents better performance (i.e., appropriate testing).
Medication Management for People with Asthma (MMA)	MMA records the percentage of enrollees 5 to 64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported for the percentage of enrollees who remained on an asthma controller medication: ♦ For at least 50% of their treatment period ♦ For at least 75% of their treatment period For MMA, a total rate and four age stratifications are reported (only two apply to the FHK population): ♦ 5–11 years ♦ 12–18 years

Table 3. 2018 PMV MCO HEDIS Performance Measures	
Measure Name	**Measure Description**
Asthma Medication Ratio (AMR)	AMR assesses the percentage of enrollees 5 to 64 years of age 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. This measure calculates a total rate as well as four age stratifications (only two apply to the FHK population): ♦ 5–11 years ♦ 12–18 years
Effectiveness of Care – Behavioral Health	
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	ADD assesses the 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 these visits must have been within 30 days of the earliest ambulatory prescription dispensed for ADHD medication, at which time the enrollee must have been 6 to 12 years of age. Two rates are reported: ♦ Initiation Phase—The percentage who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase ♦ Continuation and Maintenance Phase—The percentage who remained on the medication for at least 210 days and who, in addition to the Initiation Phase follow-up, had at least two follow-up visits with a practitioner and within 270 days (nine months) of the end of the Initiation Phase

Table 3. 2018 PMV MCO HEDIS Performance Measures	
Measure Name	**Measure Description**
Follow-Up After Hospitalization for Mental Illness (FUH)	FUH examines continuity of care for mental illness through the percentage of discharges for enrollees 6 years of age and older who were hospitalized for selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported as the percentage of discharges for which the enrollee received follow-up within the following: ♦ 7 days of discharge ♦ 30 days of discharge
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	FUM is the percentage of ED visits for enrollees 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported as the percentage of ED visits for which the enrollee received follow-up within the following: ♦ 7 days of discharge ♦ 30 days of discharge
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	FUA is the percentage of ED visits for enrollees 13 years of age and older with a principal diagnosis of AOD abuse or dependence, who had a follow-up visit for AOD. Two rates are reported as the percentage of ED visits for which the enrollee received follow-up within the following: ♦ 7 days of discharge ♦ 30 days of discharge For FUA, a total rate and two age stratifications are reported: ♦ 13–17 years ♦ 18 years and older

Table 3. 2018 PMV MCO HEDIS Performance Measures	
Measure Name	**Measure Description**
Overuse/Appropriateness	
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	URI measures the percentage of children 3 months to 18 years of age who were given only a diagnosis of upper respiratory infection (URI), were not dispensed an antibiotic prescription, and did not have other diagnoses on the same date of service. This measure is reported as an inverted rate [1 - (numerator/eligible population)], with a higher rate indicating appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed).
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)†	APC measures the percentage of children and adolescents 1 to 17 years of age who were on two or more concurrent antipsychotic medications. This measure calculates a total rate as well as three age stratifications: ♦ 1–5 years ♦ 6–11 years ♦ 12–17 years

** The HPV measure for female adolescents was retired for HEDIS 2017 and incorporated into IMA. IMA aligns with ACIP guidelines in only including the quadrivalent meningococcal conjugate vaccine (serogroups A, C, W, and Y) and requiring the minimum two-dose HPV interval to be 150 days with a four-day grace period.*

*** Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed not an absolute BMI value. Documentation related to an enrollee's appetite does not count as Nutrition Counseling. Female enrollees diagnosed as pregnant during the MY can be excluded.*

† For this measure, a lower rate indicates better performance (i.e., low rates of concurrent antipsychotics indicate better care).

Table 4. 2018 PMV CMS-416 and HEDIS Measures: DBMs	
Measure Name	**Measure Description**
Annual Dental Visit (HEDIS – ADV)	The percentage of enrollees 2–20 years of age who had at least one dental visit during the measurement year
Any Dental Services	The percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 30 continuous days who received at least one dental service by or under the supervision of a dentist
Dental Diagnostic Services	The percentage of enrollees ages 1 to 20 who received at least one diagnostic dental service by or under the supervision of a dentist
Dental Preventive Services (PDENT)	The percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 30 continuous days, who are eligible for EPSDT services, and who received at least one preventive dental service during the reporting period
Dental Treatment Services (TDENT)	The percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 30 continuous days, who are eligible for EPSDT services, and who received at least one dental treatment service during the reporting period
Dental Sealants on Permanent Molars	The percentage of enrollees ages 6 to 14 who have a dental sealant placed on a permanent molar tooth in the federal fiscal year, regardless of whether a dentist or non-dentist applied it
Dental Sealants on Permanent Molars – With Exclusions	A modified CMS-416 measure, the percentage of enrollees ages 6 to 14 who have a dental sealant placed on a permanent molar tooth in the federal fiscal year, regardless of whether a dentist or non-dentist applied it, excluding enrollees who have had molars previously sealed, restored, or extracted from the denominator

MCO-specific results appear in tables **5**, 6, and 7.

Table 5. 2018 PMV Results: MCOs

Measure	Aetna	Amerigroup	Staywell	Sunshine	United Healthcare
Access and Availability of Care					
Children and Adolescents' Access to Primary Care Practitioners (CAP)					
25 Months – 6 Years	88.21%	90.95%	92.15%	91.44%	90.97%
7–11 Years	92.86%	96.35%	96.25%	96.49%	92.98%
12–19 Years	90.52%	94.35%	94.61%	94.04%	91.06%
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)					
Alcohol abuse or dependence: Initiation of AOD Treatment: 13–17 Years	NA	NA	NA	NA	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: 13–17 Years	NA	NA	NA	NA	NA
Opioid abuse or dependence: Initiation of AOD Treatment: 13–17 Years	NA	NA	NA	NA	NA

Table 5. 2018 PMV Results: MCOs					
Measure	**Aetna**	**Amerigroup**	**Staywell**	**Sunshine**	**United Healthcare**
Opioid abuse or dependence: Engagement of AOD Treatment: 13–17 Years	NA	NA	NA	NA	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13–17 Years	42.50%	NA	39.74%	NA	NA
Other drug abuse or dependence: Engagement of AOD Treatment: 13–17 Years	5.00%	NA	7.69%	NA	NA
Total: Initiation of AOD Treatment: 13–17 Years	41.51%	38.24%	39.08%	NA	NA
Total: Engagement of AOD Treatment: 13–17 Years	5.66%	8.82%	8.05%	NA	NA
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	NA	NA	NA	*	NA

Table 5. 2018 PMV Results: MCOs					
Measure	**Aetna**	**Amerigroup**	**Staywell**	**Sunshine**	**United Healthcare**
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	NA	NA	NA	*	NA
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	NA	NA	NA	*	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	NA	NA	NA	*	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	NA	NA	33.33%	NA	NA
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	NA	NA	4.44%	NA	NA
Total: Initiation of AOD Treatment: 18+ Years	NA	20.00%	29.31%	NA	NA

Table 5. 2018 PMV Results: MCOs					
Measure	**Aetna**	**Amerigroup**	**Staywell**	**Sunshine**	**United Healthcare**
Total: Engagement of AOD Treatment: 18+ Years	NA	0%	3.45%	NA	NA
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	NA	NA	NA	NA	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	NA	NA	NA	NA	NA
Opioid abuse or dependence: Initiation of AOD Treatment: Total	NA	NA	NA	NA	NA
Opioid abuse or dependence: Engagement of AOD Treatment: Total	NA	NA	NA	NA	NA
Other drug abuse or dependence: Initiation of AOD Treatment: Total	37.70%	28.30%	37.40%	NA	NA

Table 5. 2018 PMV Results: MCOs					
Measure	**Aetna**	**Amerigroup**	**Staywell**	**Sunshine**	**United Healthcare**
Other drug abuse or dependence: Engagement of AOD Treatment: Total	6.56%	5.66%	6.50%	NA	NA
Total: Initiation of AOD Treatment: Total	34.57%	29.69%	35.17%	NA	NA
Total: Engagement of AOD Treatment: Total	6.17%	4.69%	6.21%	NA	NA
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care	NA	NA	NA	NA	NA
Postpartum Care	NA	NA	NA	NA	NA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)					
1–5 Years	*	*	*	*	*
6–11 Years	NA	NA	NA	NA	100%
12–17 Years	32.00%	51.22%	48.84%	NA	53.85%
Utilization					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	72.51%	80.29%	81.20%	71.84%	69.35%
Adolescent Well-Care Visits (AWC)	60.10%	73.72%	70.00%	64.13%	56.49%

Table 5. 2018 PMV Results: MCOs					
Measure	**Aetna**	**Amerigroup**	**Staywell**	**Sunshine**	**United Healthcare**
Ambulatory Care: Emergency Department Visits (AMB-ED) – Visits / 1,000 Enrollee Months					
1–9 Years	28.24	30.20	27.78	21.39	32.58
10–19 Years	23.85	26.06	26.21	21.88	28.35
Effectiveness of Care – Prevention and Screening					
Chlamydia Screening in Women (CHL)					
16–20 Years	51.49%	58.06%	52.59%	50.31%	40.09%
Immunizations for Adolescents (IMA)					
Meningococcal	68.61%	80.05%	81.02%	77.35%	70.37%
Tdap/Td	91.97%	93.43%	93.92%	89.24%	91.11%
HPV	25.06%	34.79%	36.01%	24.49%	25.93%
Combination #1 (Meningococcal and Tdap/Td)	67.64%	79.56%	80.29%	75.74%	69.63%
Combination #2 (Meningococcal, Tdap/Td, and HPV)	22.63%	32.60%	34.55%	22.88%	23.46%
Weight Assessment and Counseling for Nutrition & Physical Activity for Children/Adolescents (WCC)					
BMI Percentile 3–11 Years	81.77%	93.10%	68.72%	74.24%	68.47%
Counseling for Nutrition 3–11 Years	77.83%	82.27%	66.15%	67.23%	49.74%

Table 5. 2018 PMV Results: MCOs					
Measure	**Aetna**	**Amerigroup**	**Staywell**	**Sunshine**	**United Healthcare**
Counseling for Physical Activity 3–11 Years	74.88%	76.85%	31.28%	27.41%	25.50%
BMI Percentile 12–17 Years	82.69%	94.71%	71.43%	72.61%	68.44%
Counseling for Nutrition 12–17 Years	76.44%	85.58%	62.56%	67.90%	50.93%
Counseling for Physical Activity 12–17 Years	73.08%	84.62%	27.09%	30.07%	26.32%
BMI Percentile Total	82.24%	93.92%	70.10%	73.46%	68.46%
Counseling for Nutrition Total	77.13%	83.94%	64.32%	67.55%	50.35%
Counseling for Physical Activity Total	73.97%	80.78%	29.15%	28.68%	25.92%
Effectiveness of Care – Respiratory Condition					
Appropriate Testing for Children with Pharyngitis (CWP)	80.56%	81.69%	84.25%	79.89%	56.81%
Medication Management for People with Asthma (MMA)					
Medication Compliance 50% 5–11 Years	48.84%	57.14%	56.33%	51.16%	74.47%

Table 5. 2018 PMV Results: MCOs					
Measure	**Aetna**	**Amerigroup**	**Staywell**	**Sunshine**	**United Healthcare**
Medication Compliance 75% 5–11 Years	22.09%	26.64%	27.33%	30.23%	44.68%
Medication Compliance 50% 12–18 Years	53.42%	52.44%	49.77%	74.29%	57.14%
Medication Compliance 75% 12–18 Years	23.29%	25.61%	23.96%	37.14%	42.86%
Asthma Medication Ratio (AMR)					
5–11 Years	78.26%	88.93%	87.90%	84.78%	72.34%
12–18 Years	67.90%	70.43%	77.22%	91.43%	48.48%
Effectiveness of Care – Behavioral Health					
Follow-Up Care for Children Prescribed ADHD Medication (ADD)					
Initiation Phase	42.60%	48.19%	56.41%	43.22%	36.23%
Continuation and Maintenance Phase	56.36%	66.67%	65.49%	NA	NA
Follow-Up After Hospitalization for Mental Illness (FUH)					
7-day follow-up	40.61%	45.70%	43.05%	43.64%	43.40%
30-day follow-up	63.64%	61.99%	68.45%	65.45%	66.04%

Table 5. 2018 PMV Results: MCOs					
Measure	**Aetna**	**Amerigroup**	**Staywell**	**Sunshine**	**United Healthcare**
Follow-Up After Emergency Department Visit for Mental Illness (FUM)					
7-day follow-up	NA	38.46%	34.43%	NA	16.57%
30-day follow-up	NA	66.67%	55.74%	NA	50.00%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)					
7-day follow-up 13–17 Years	NA	NA	NA	NA	0%
30-day follow-up 13–17 Years	NA	NA	NA	NA	0%
7-day follow-up 18+ Years	NA	NA	NA	NA	0%
30-day follow-up 18+Years	NA	NA	NA	NA	0%
Overuse/Appropriateness					
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	86.92%	90.48%	88.57%	88.24%	27.69%

Table 5. 2018 PMV Results: MCOs					
Measure	**Aetna**	**Amerigroup**	**Staywell**	**Sunshine**	**United Healthcare**
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)					
1–5 Years	*	*	*	*	0%
6–11 Years	NA	NA	NA	NA	0%
12–17 Years	2.04%	0%	1.77%	0%	0%

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.

** Zero Denominator: A rate was not calculated because the denominator had a value of zero. This measure designation is not an NCQA result.*

Table 6 provides the MCOs' PMV results for the IAD measure.

Table 6. 2018 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure					
Measure	**Aetna No. / %**	**Amerigroup No. / %**	**Staywell No. / %**	**Sunshine No. / %**	**United Healthcare No. / %**
Alcohol					
Any Services: Male					
0–12 Years	3 / 0.03%	1 / 0.01%	0 / 0%	1 / 0.03%	0 / 0%
13–17 Years	7 / 0.09%	6 / 0.07%	14 / 0.12%	3 / 0.14%	0 / 0%
18–24 Years	7 / 0.53%	4 / 0.25%	7 / 0.34%	1 / 0.27%	1 / 0.41%

Table 6. 2018 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure					
Measure	**Aetna No. / %**	**Amerigroup No. / %**	**Staywell No. / %**	**Sunshine No. / %**	**United Healthcare No. / %**
Any Services: Female					
0–12 Years	0 / 0%	1 / 0.01%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	13 / 0.17%	9 / 0.10%	22 / 0.19%	4 / 0.20%	3 / 0.21%
18–24 Years	4 / 0.31%	5 / 0.33%	4 / 0.20%	0 / 0%	0 / 0%
Any Services: Total					
0–12 Years	3 / 0.01%	2 / 0.01%	0 / 0%	1 / 0.01%	0 / 0%
13–17 Years	20 / 0.13%	15 / 0.08%	36 / 0.16%	7 / 0.17%	3 / 0.10%
18–24 Years	11 / 0.42%	9 / 0.29%	11 / 0.27%	1 / 0.14%	1 / 0.21%
Inpatient: Male					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	1 / 0.01%	2 / 0.02%	3 / 0.03%	1 / 0.05%	0 / 0%
18–24 Years	3 / 0.23%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
Inpatient: Female					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	2 / 0.03%	2 / 0.02%	8 / 0.07%	1 / 0.05%	3 / 0.21%
18–24 Years	0 / 0%	1 / 0.07%	0 / 0%	0 / 0%	0 / 0%
Inpatient: Total					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%

Table 6. 2018 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure					
Measure	**Aetna No. / %**	**Amerigroup No. / %**	**Staywell No. / %**	**Sunshine No. / %**	**United Healthcare No. / %**
13–17 Years	3 / 0.02%	4 / 0.02%	11 / 0.05%	2 / 0.05%	3 / 0.10%
18–24 Years	3 / 0.12%	1 / 0.03%	0 / 0%	0 / 0%	0 / 0%
Intensive Outpatient/Partial Hospitalization: Male					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
Intensive Outpatient/Partial Hospitalization: Female					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
Intensive Outpatient/Partial Hospitalization: Total					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
Outpatient/Medication Assisted Treatment: Male					
0–12 Years	2 / 0.02%	1 / 0.01%	0 / 0%	1 / 0.03%	0 / 0%
13–17 Years	1 / 0.01%	1 / 0.01%	4 / 0.03%	2 / 0.09%	0 / 0%
18–24 Years	0 / 0%	1 / 0.06%	1 / 0.05%	0 / 0%	0 / 0%

Table 6. 2018 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure					
Measure	**Aetna No. / %**	**Amerigroup No. / %**	**Staywell No. / %**	**Sunshine No. / %**	**United Healthcare No. / %**
Outpatient/Medication Assisted Treatment: Female					
0–12 Years	0 / 0%	1 / 0.01%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	1 / 0.01%	2 / 0.02%	10 / 0.09%	1 / 0.05%	0 / 0%
18–24 Years	0 / 0%	2 / 0.13%	2 / 0.10%	0 / 0%	0 / 0%
Outpatient/Medication Assisted Treatment: Total					
0–12 Years	2 / 0.01%	2 / 0.01%	0 / 0%	1 / 0.01%	0 / 0%
13–17 Years	2 / 0.01%	3 / 0.02%	14 / 0.06%	3 / 0.07%	0 / 0%
18–24 Years	0 / 0%	3 / 0.10%	3 / 0.07%	0 / 0%	0 / 0%
Emergency Department: Male					
0–12 Years	1 / 0.01%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	6 / 0.08%	3 / 0.03%	8 / 0.07%	1 / 0.05%	0 / 0%
18–24 Years	4 / 0.30%	3 / 0.19%	7 / 0.34%	1 / 0.27%	1 / 0.41%
Emergency Department: Female					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	11 / 0.15%	5 / 0.06%	8 / 0.07%	3 / 0.15%	0 / 0%
18–24 Years	4 / 0.31%	3 / 0.20%	2 / 0.10%	0 / 0%	0 / 0%
Emergency Department: Total					
0–12 Years	1 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%

Table 6. 2018 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure					
Measure	**Aetna No. / %**	**Amerigroup No. / %**	**Staywell No. / %**	**Sunshine No. / %**	**United Healthcare No. / %**
13–17 Years	17 / 11%	8 / 0.05%	16 / 0.07%	4 / 0.10%	0 / 0%
18–24 Years	8 / 0.31%	6 / 0.19%	9 / 0.22%	1 / 0.14%	1 / 0.21%
Telehealth: Male					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
Telehealth: Female					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
Telehealth: Total					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
Opioid					
Any Services: Male					
0–12 Years	2 / 0.02%	1 / 0.01%	0 / 0%	1 / 0.03%	0 / 0%
13–17 Years	1 / 0.01%	1 / 0.01%	1 / 0.01%	0 / 0%	1 / 0.07%

Table 6. 2018 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure					
Measure	**Aetna No. / %**	**Amerigroup No. / %**	**Staywell No. / %**	**Sunshine No. / %**	**United Healthcare No. / %**
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	2 / 0.81%
Any Services: Female					
0–12 Years	0 / 0%	1 / 0.01%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	2 / 0.03%	4 / 0.05%	4 / 0.04%	1 / 0.05%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	1 / 0.05%	0 / 0%	0 / 0%
Any Services: Total					
0–12 Years	2 / 0.01%	2 / 0.01%	0 / 0%	1 / 0.01%	0 / 0%
13–17 Years	3 / 0.02%	5 / 0.03%	5 / 0.02%	1 / 0.02%	1 / 0.03%
18–24 Years	0 / 0%	0 / 0%	1 / 0.02%	0 / 0%	2 / 0.43%
Inpatient: Male					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	1 / 0.01%	0 / 0%	1 / 0.07%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
Inpatient: Female					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	2 / 0.02%	1 / 0.05%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%

Table 6. 2018 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure					
Measure	**Aetna No. / %**	**Amerigroup No. / %**	**Staywell No. / %**	**Sunshine No. / %**	**United Healthcare No. / %**
Inpatient: Total					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	3 / 0.01%	1 / 0.02%	1 / 0.03%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
Intensive Outpatient/Partial Hospitalization: Male					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
Intensive Outpatient/Partial Hospitalization: Female					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
Intensive Outpatient/Partial Hospitalization: Total					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%

Table 6. 2018 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure					
Measure	**Aetna No. / %**	**Amerigroup No. / %**	**Staywell No. / %**	**Sunshine No. / %**	**United Healthcare No. / %**
Outpatient/Medication Assisted Treatment: Male					
0–12 Years	2 / 0.02%	1 / 0.01%	0 / 0%	1 / 0.03%	0 / 0%
13–17 Years	1 / 0.01%	1 / 0.01%	0 / 0%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	1 / 0.41%
Outpatient/Medication Assisted Treatment: Female					
0–12 Years	0 / 0%	1 / 0.01%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	1 / 0.01%	3 / 0.03%	3 / 0.03%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	1 / 0.05%	0 / 0%	0 / 0%
Outpatient/Medication Assisted Treatment: Total					
0–12 Years	2 / 0.01%	2 / 0.01%	0 / 0%	1 / 0.01%	0 / 0%
13–17 Years	2 / 0.01%	4 / 0.02%	3 / 0.01%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	1 / 0.02%	0 / 0%	1 / 0.21%
Emergency Department: Male					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	1 / 0.01%	0 / 0%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	2 / 0.81%

Table 6. 2018 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure					
Measure	**Aetna No. / %**	**Amerigroup No. / %**	**Staywell No. / %**	**Sunshine No. / %**	**United Healthcare No. / %**
Emergency Department: Female					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	1 / 0.01%	1 / 0.01%	0 / 0%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
Emergency Department: Total					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	1 / 0.01%	2 / 0.01%	0 / 0%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	2 / 0.43%
Telehealth: Male					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
Telehealth: Female					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%

Table 6. 2018 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure					
Measure	**Aetna No. / %**	**Amerigroup No. / %**	**Staywell No. / %**	**Sunshine No. / %**	**United Healthcare No. / %**
Telehealth: Total					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
Other					
Any Services: Male					
0–12 Years	0 / 0%	2 / 0.01%	4 / 0.02%	0 / 0%	0 / 0%
13–17 Years	47 / 0.61%	49 / 0.54%	88 / 0.75%	12 / 0.57%	26 / 1.72%
18–24 Years	13 / 0.99%	16 / 1.02%	34 / 1.66%	10 / 2.65%	6 / 2.44%
Any Services: Female					
0–12 Years	1 / 0.01%	2 / 0.02%	4 / 0.02%	2 / 0.06%	0 / 0%
13–17 Years	35 / 0.46%	38 / 0.44%	79 / 0.70%	13 / 0.66%	15 / 1.04%
18–24 Years	6 / 0.46%	11 / 0.72%	20 / 1.00%	1 / 0.30%	3 / 1.34%
Any Services: Total					
0–12 Years	1 / 0%	4 / 0.02%	8 / 0.02%	2 / 0.03%	0 / 0%
13–17 Years	82 / 0.54%	87 / 0.49%	167 / 0.72%	25 / 0.61%	41 / 1.38%
18–24 Years	19 / 0.73%	27 / 0.87%	54 / 1.33%	11 / 1.55%	9 / 1.92%

Table 6. 2018 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure					
Measure	**Aetna No. / %**	**Amerigroup No. / %**	**Staywell No. / %**	**Sunshine No. / %**	**United Healthcare No. / %**
Inpatient: Male					
0–12 Years	0 / 0%	0 / 0%	1 / 0.01%	0 / 0%	0 / 0%
13–17 Years	10 / 0.13%	9 / 0.10%	16 / 0.14%	4 / 0.19%	4 / 0.26%
18–24 Years	4 / 0.30%	2 / 0.13%	9 / 0.44%	2 / 0.53%	2 / 0.81%
Inpatient: Female					
0–12 Years	0 / 0%	1 / 0.01%	1 / 0.01%	0 / 0%	0 / 0%
13–17 Years	11 / 0.15%	9 / 0.10%	34 / 0.30%	5 / 0.25%	4 / 0.28%
18–24 Years	1 / 0.08%	1 / 0.07%	5 / 0.25%	0 / 0%	0 / 0%
Inpatient: Total					
0–12 Years	0 / 0%	1 / 0%	2 / 0.01%	0 / 0%	0 / 0%
13–17 Years	21 / 0.14%	18 / 0.10%	50 / 0.22%	9 / 0.22%	8 / 0.27%
18–24 Years	5 / 0.19%	3 / 0.10%	14 / 0.35%	2 / 0.28%	2 / 0.43%
Intensive Outpatient/Partial Hospitalization: Male					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	1 / 0.07%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%

Table 6. 2018 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure					
Measure	**Aetna No. / %**	**Amerigroup No. / %**	**Staywell No. / %**	**Sunshine No. / %**	**United Healthcare No. / %**
Intensive Outpatient/Partial Hospitalization: Female					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
Intensive Outpatient/Partial Hospitalization: Total					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	1 / 0.03%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
Outpatient/Medication Assisted Treatment: Male					
0–12 Years	0 / 0%	2 / 0.01%	2 / 0.01%	0 / 0%	0 / 0%
13–17 Years	25 / 0.32%	30 / 0.33%	56 / 0.48%	7 / 0.33%	18 / 1.19%
18–24 Years	5 / 0.38%	7 / 0.44%	17 / 0.83%	6 / 1.59%	2 / 0.81%
Outpatient/Medication Assisted Treatment: Female					
0–12 Years	0 / 0%	1 / 0.01%	2 / 0.01%	2 / 0.06%	0 / 0%
13–17 Years	17 / 0.23%	20 / 0.23%	33 / 0.29%	7 / 0.35%	6 / 0.41%
18–24 Years	5 / 0.39%	4 / 0.26%	4 / 0.20%	1 / 0.30%	1 / 0.45%

Table 6. 2018 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure					
Measure	**Aetna No. / %**	**Amerigroup No. / %**	**Staywell No. / %**	**Sunshine No. / %**	**United Healthcare No. / %**
Outpatient/Medication Assisted Treatment: Total					
0–12 Years	0 / 0%	3 / 0.01%	4 / 0.01%	2 / 0.03%	0 / 0%
13–17 Years	42 / 0.28%	50 / 0.28%	89 / 0.39%	14 / 0.34%	24 / 0.81%
18–24 Years	10 / 0.38%	11 / 0.36%	21 / 0.52%	7 / 0.99%	3 / 0.64%
Emergency Department: Male					
0–12 Years	0 / 0%	0 / 0%	1 / 0.01%	0 / 0%	0 / 0%
13–17 Years	13 / 0.17%	12 / 0.13%	18 / 0.15%	2 / 0.09%	4 / 0.26%
18–24 Years	5 / 0.38%	7 / 0.44%	9 / 0.44%	2 / 0.53%	3 / 1.22%
Emergency Department: Female					
0–12 Years	1 / 0.01%	0 / 0%	1 / 0.01%	0 / 0%	0 / 0%
13–17 Years	10 / 0.13%	10 / 0.11%	21 / 0.18%	2 / 0.10%	5 / 0.35%
18–24 Years	1 / 0.08%	6 / 0.40%	11 / 0.55%	1 / 0.30%	2 / 0.89%
Emergency Department: Total					
0–12 Years	1 / 0%	0 / 0%	2 / 0.01%	0 / 0%	0 / 0%
13–17 Years	23 / 0.15%	22 / 0.12%	39 / 0.17%	4 / 0.10%	9 / 0.30%
18–24 Years	6 / 0.23%	13 / 0.42%	20 / 0.49%	3 / 0.42%	5 / 1.06%

Table 6. 2018 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure					
Measure	**Aetna No. / %**	**Amerigroup No. / %**	**Staywell No. / %**	**Sunshine No. / %**	**United Healthcare No. / %**
Telehealth: Male					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
Telehealth: Female					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
Telehealth: Total					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
18–24 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%

Table 7 provides the MCOs' PMV results for the MPT measure.

Table 7. 2018 PMV Results: MCOs – Audited Mental Health Utilization (MPT) Performance Measure					
Measure	**Aetna No. / %**	**Amerigroup No. / %**	**Staywell No. / %**	**Sunshine No. / %**	**United Healthcare No. / %**
Any Services: Male					
0–12 Years	647 / 5.64%	872 / 6.47%	1,419 / 7.94%	284 / 7.61%	149 / 6.52%
13–17 Years	462 / 5.97%	549 / 6.08%	827 / 7.08%	180 / 8.52%	108 / 7.13%
18–64 Years	42 / 3.20%	77 / 4.89%	87 / 4.25%	26 / 6.89%	12 / 4.87%
Any Services: Female					
0–12 Years	415 / 3.61%	619 / 4.71%	899 / 5.18%	147 / 4.39%	94 / 4.29%
13–17 Years	513 / 6.82%	743 / 8.52%	1,308 / 11.51%	219 / 11.05%	136 / 9.39%
18–64 Years	59 / 4.57%	98 / 6.45%	110 / 5.49%	23 / 6.92%	15 / 6.71%
Any Services: Total					
0–12 Years	1,062 / 4.62%	1,491 / 5.60%	2,318 / 6.58%	431 / 6.09%	243 / 5.43%
13–17 Years	975 / 6.39%	1,292 / 7.28%	2,135 / 9.27%	399 / 9.74%	244 / 8.24%
18–64 Years	101 / 3.88%	175 / 5.66%	197 / 4.86%	49 / 6.90%	27 / 5.75%
Inpatient: Male					
0–12 Years	10 / 0.09%	15 / 0.11%	25 / 0.14%	4 / 0.11%	2 / 0.09%
13–17 Years	33 / 0.43%	42 / 0.47%	40 / 0.34%	9 / 0.43%	7 / 0.46%
18–64 Years	3 / 0.23%	2 / 0.13%	5 / 0.24%	4 / 1.06%	2 / 0.81%

Table 7. 2018 PMV Results: MCOs – Audited Mental Health Utilization (MPT) Performance Measure					
Measure	**Aetna No. / %**	**Amerigroup No. / %**	**Staywell No. / %**	**Sunshine No. / %**	**United Healthcare No. / %**
Inpatient: Female					
0–12 Years	12 / 0.10%	18 / 0.14%	23 / 0.13%	3 / 0.09%	6 / 0.27%
13–17 Years	48 / 0.64%	70 / 0.80%	139 / 1.22%	16 / 0.81%	21 / 1.45%
18–64 Years	2 / 0.15%	3 / 0.20%	9 / 0.45%	1 / 0.30%	2 / 0.89%
Inpatient: Total					
0–12 Years	22 / 0.10%	33 / 0.12%	48 / 0.14%	7 / 0.10%	8 / 0.18%
13–17 Years	81 / 0.53%	112 / 0.63%	179 / 0.78%	25 / 0.61%	28 / 0.95%
18–64 Years	5 / 0.19%	5 / 0.16%	14 / 0.35%	5 / 0.70%	4 / 0.85%
Intensive Outpatient/Partial Hospitalization: Male					
0–12 Years	1 / 0.01%	2 / 0.01%	2 / 0.01%	0 / 0%	12 / 0.53%
13–17 Years	1 / 0.01%	3 / 0.03%	2 / 0.02%	0 / 0%	11 / 0.73%
18–64 Years	1 / 0.08%	0 / 0%	1 / 0.05%	0 / 0%	0 / 0%
Intensive Outpatient/Partial Hospitalization: Female					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	7 / 0.32%
13–17 Years	1 / 0.01%	5 / 0.06%	4 / 0.04%	1 / 0.05%	15 / 1.04%
18–64 Years	0 / 0%	1 / 0.07%	0 / 0%	0 / 0%	3 / 1.34%
Intensive Outpatient/Partial Hospitalization: Total					
0–12 Years	1 / 0%	2 / 0.01%	2 / 0.01%	0 / 0%	19 / 0.42%

Table 7. 2018 PMV Results: MCOs – Audited Mental Health Utilization (MPT) Performance Measure					
Measure	**Aetna No. / %**	**Amerigroup No. / %**	**Staywell No. / %**	**Sunshine No. / %**	**United Healthcare No. / %**
13–17 Years	2 / 0.01%	8 / 0.05%	6 / 0.03%	1 / 0.02%	26 / 0.88%
18–64 Years	1 / 0.04%	1 / 0.03%	1 / 0.02%	0 / 0%	3 / 0.64%
Outpatient: Male					
0–12 Years	638 / 5.56%	858 / 6.37%	1,396 / 7.81%	281 / 7.53%	147 / 6.44%
13–17 Years	432 / 5.59%	510 / 5.65%	786 / 6.73%	172 / 8.14%	100 / 6.60%
18–64 Years	38 / 2.89%	75 / 4.76%	82 / 4.00%	22 / 5.83%	9 / 3.65%
Outpatient: Female					
0–12 Years	404 / 3.51%	603 / 4.59%	881 / 5.08%	144 / 4.30%	87 / 3.97%
13–17 Years	473 / 6.28%	680 / 7.79%	1,192 / 10.49%	205 / 10.34%	115 / 7.94%
18–64 Years	54 / 4.18%	94 / 6.19%	101 / 5.04%	23 / 6.92%	13 / 5.82%
Outpatient: Total					
0–12 Years	1,042 / 4.54%	1,461 / 5.49%	2,277 / 6.47%	425 / 6.00%	234 / 5.23%
13–17 Years	905 / 5.93%	1,190 / 6.70%	1,978 / 8.58%	377 / 9.21%	215 / 7.26%
18–64 Years	92 / 3.53%	169 / 5.46%	183 / 4.52%	45 / 6.34%	22 / 4.68%
Emergency Department: Male					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	1 / 0.03%	0 / 0%
13–17 Years	0 / 0%	1 / 0.01%	7 / 0.06%	0 / 0%	1 / 0.07%
18–64 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	1 / 0.41%

Table 7. 2018 PMV Results: MCOs – Audited Mental Health Utilization (MPT) Performance Measure					
Measure	**Aetna No. / %**	**Amerigroup No. / %**	**Staywell No. / %**	**Sunshine No. / %**	**United Healthcare No. / %**
Emergency Department: Female					
0–12 Years	1 / 0.01%	0 / 0%	4 / 0.02%	0 / 0%	2 / 0.09%
13–17 Years	0 / 0%	0 / 0%	3 / 0.03%	0 / 0%	0 / 0%
18–64 Years	3 / 0.23%	0 / 0%	2 / 0.10%	0 / 0%	0 / 0%
Emergency Department: Total					
0–12 Years	1 / 0%	0 / 0%	4 / 0.01%	1 / 0.01%	2 / 0.04%
13–17 Years	0 / 0%	1 / 0.01%	10 / 0.04%	0 / 0%	1 / 0.03%
18–64 Years	3 / 0.12%	0 / 0%	2 / 0.05%	0 / 0%	1 / 0.21%
Telehealth: Male					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
18–64 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
Telehealth: Female					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
18–64 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%

Table 7. 2018 PMV Results: MCOs – Audited Mental Health Utilization (MPT) Performance Measure					
Measure	**Aetna No. / %**	**Amerigroup No. / %**	**Staywell No. / %**	**Sunshine No. / %**	**United Healthcare No. / %**
Telehealth: Total					
0–12 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
13–17 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%
18–64 Years	0 / 0%	0 / 0%	0 / 0%	0 / 0%	0 / 0%

DBM-specific PMV results appear in **Table 8**.

Table 8. 2018 PMV Results: DBMs						
Measure	**Argus**		**DentaQuest**		**MCNA**	
	Rate (%)	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**
Annual Dental Visit						
Enrollees age 4 to 6	55.60%	521/937	62.02%	1,641/ 2,646	59.23%	1,332/ 2,249
Enrollees age 7 to 10	61.40%	4,072/6,632	67.34%	9,258/ 13,748	64.39%	7,930/ 12,316
Enrollees age 11 to 14	59.21%	3,030/5,117	62.45%	9,940/ 15,916	60.33%	9,134/ 15,141

Table 8. 2018 PMV Results: DBMs						
Measure	**Argus**		**DentaQuest**		**MCNA**	
	Rate (%)	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**
Enrollees age 15 to 18	52.01%	2,345/4,526	53.87%	8,469/ 15,722	52.32%	7,816/ 14,939
Any Dental Service (CMS-416)						
Enrolled at Least 1 Month: Age 5*	16.46%	216/1,312	26.99%	764/2,831	26.39%	1,006/ 3,812
Enrolled at Least 1 Month: Age 6–9	40.84%	6,798/ 16,647	49.20%	13,180/ 26,788	46.41%	11,628/ 25,055
Enrolled at Least 1 Month: Age 10–14	41.10%	6,472/ 15,747	48.88%	19,200/ 39,278	45.83%	17,089/ 37,287
Enrolled at Least 1 Month: Age 15–18	36.20%	3,846/ 10,623	41.61%	12,599/ 30,277	39.81%	11,360/ 28,537
Enrolled at Least 3 Months Continuously: Age 5	25.75%	154/598	36.87%	657/1,782	35.39%	923/2,608

Table 8. 2018 PMV Results: DBMs						
Measure	**Argus**		**DentaQuest**		**MCNA**	
	Rate (%)	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**
Enrolled at Least 3 Months Continuously: Age 6–9	48.08%	6,359/ 13,225	55.68%	12,692/ 22,796	52.69%	11,192/ 21,243
Enrolled at Least 3 Months Continuously: Age 10–14	48.28%	6,102/ 12,640	54.41%	18,591/ 34,167	51.29%	16,590/ 32,346
Enrolled at Least 3 Months Continuously: Age 15–18	42.08%	3,674/8,731	46.08%	12,271/ 26,632	44.08%	11,064/ 25,097
Enrolled at Least 6 Months Continuously: Age 5	50.00%	1/2	40.90%	317/775	44.08%	629/1,427
Enrolled at Least 6 Months Continuously: Age 6–9	54.41%	5,359/9,850	59.55%	11,107/ 18,651	58.81%	9,723/ 16,533

Table 8. 2018 PMV Results: DBMs						
Measure	**Argus**		**DentaQuest**		**MCNA**	
	Rate (%)	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**
Enrolled at Least 6 Months Continuously: Age 10–14	54.35%	5,178/9,527	57.07%	16,702/ 29,265	56.43%	14,881/ 26,369
Enrolled at Least 6 Months Continuously: Age 15–18	47.47%	3,146/6,627	48.80%	10,952/ 22,444	48.69%	10,018/ 20,574
Enrolled at Least 11 Months Continuously: Age 5	**	**	**	**	48.61%	122/251
Enrolled at Least 11 Months Continuously: Age 6–9	60.24%	3,379/5,609	66.62%	7,319/ 10,987	64.28%	6,934/ 10,787
Enrolled at Least 11 Months Continuously: Age 10–14	58.74%	3,472/5,911	63.98%	12,355/ 19,310	61.26%	11,207/ 18,295

Table 8. 2018 PMV Results: DBMs						
Measure	**Argus**		**DentaQuest**		**MCNA**	
	Rate (%)	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**
Enrolled at Least 11 Months Continuously: Age 15–18	52.06%	2,136/4,103	54.22%	8,444/ 15,575	53.27%	7,729/ 14,510
Preventive Dental (CMS-416)						
Enrolled at Least 1 Month: Age 5	14.56%	191/1,312	24.34%	689/2,831	24.84%	947/3,812
Enrolled at Least 1 Month: Age 6–9	38.20%	6,359/ 16,647	47.21%	12,646/ 26,788	44.53%	11,156/ 25,055
Enrolled at Least 1 Month: Age 10–14	38.62%	6,082/ 15,747	46.54%	18,280/ 39,278	43.83%	16,342/ 37,287
Enrolled at Least 1 Month: Age 15–18	32.63%	3,466/ 10,623	37.95%	11,491/ 30,277	35.61%	10,162/ 28,537
Enrolled at Least 3 Months Continuously: Age 5	23.08%	138/598	33.89%	604/1,782	33.51%	874/2,608

Table 8. 2018 PMV Results: DBMs						
Measure	**Argus**		**DentaQuest**		**MCNA**	
	Rate (%)	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**
Enrolled at Least 3 Months Continuously: Age 6–9	45.41%	6,006/ 13,255	53.73%	12,248/ 22,796	50.71%	10,722/ 21,243
Enrolled at Least 3 Months Continuously: Age 10–14	45.53%	5,755/ 12,640	52.02%	17,775/ 34,167	49.21%	15,916/ 32,346
Enrolled at Least 3 Months Continuously: Age 15–18	38.20%	3,335/ 8,731	42.23%	11,246/ 26,632	39.63%	9,945/ 25,097
Enrolled at Least 6 Months Continuously: Age 5	50.00%	1/2	38.71%	300/775	42.33%	604/1,427
Enrolled at Least 6 Months Continuously: Age 6–9	51.91%	5,113/9,850	57.54%	10,731/ 18,651	57.01%	9,425/ 16,533

Table 8. 2018 PMV Results: DBMs						
Measure	**Argus**		**DentaQuest**		**MCNA**	
	Rate (%)	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**
Enrolled at Least 6 Months Continuously: Age 10–14	51.66%	4,922/9,527	54.71%	16,011/ 29,265	54.41%	14,348/ 26,369
Enrolled at Least 6 Months Continuously: Age 15–18	43.61%	2,890/6,627	44.83%	10,062/ 22,444	44.17%	9,087/ 20,574
Enrolled at Least 11 Months Continuously: Age 5	**	**	**	**	46.61%	117/251
Enrolled at Least 11 Months Continuously: Age 6–9	57.75%	3,239/5,609	65.16%	7,159/ 10,987	62.60%	6,753/ 10,787
Enrolled at Least 11 Months Continuously: Age 10–14	56.13%	3,318/5,911	61.85%	11,943/ 19,310	59.31%	10,850/ 18,295

Table 8. 2018 PMV Results: DBMs						
Measure	**Argus**		**DentaQuest**		**MCNA**	
	Rate (%)	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**
Enrolled at Least 11 Months Continuously: Age 15–18	47.99%	1,969/4,103	50.56%	7,874/ 15,575	48.79%	7,079/ 14,510
Treatment Dental (CMS-416)						
Enrolled at Least 1 Month: Age 5	4.57%	60/1,312	7.91%	224/2,831	7.35%	280/3,812
Enrolled at Least 1 Month: Age 6–9	16.17%	2,691/ 16,647	18.97%	5,081/ 26,788	17.58%	4,404/ 25,055
Enrolled at Least 1 Month: Age 10–14	15.06%	2,372/ 15,747	17.13%	6,729/ 39,278	15.10%	5,630/ 37,287
Enrolled at Least 1 Month: Age 15–18	15.53%	1,650/ 10,623	16.86%	5,106/ 30,277	15.65%	4,467/ 28,537
Enrolled at Least 3 Months Continuously: Age 5	7.69%	46/598	10.89%	194/1,782	10.16%	265/2,608

Table 8. 2018 PMV Results: DBMs						
Measure	**Argus**		**DentaQuest**		**MCNA**	
	Rate (%)	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**
Enrolled at Least 3 Months Continuously: Age 6–9	19.06%	2,521/ 13,225	21.55%	4,912/ 22,796	20.15%	4,280/ 21,243
Enrolled at Least 3 Months Continuously: Age 10–14	17.90%	2,262/ 12,640	19.12%	6,534/ 34,167	16.98%	5,492/ 32,346
Enrolled at Least 3 Months Continuously: Age 15–18	18.25%	1,593/8,731	18.71%	4,983/ 26,632	17.43%	4,375/ 25,097
Enrolled at Least 6 Months Continuously: Age 5	0%	0/2	10.97%	85/775	13.03%	186/1,427
Enrolled at Least 6 Months Continuously: Age 6–9	21.91%	2,158/9,850	22.70%	4,234/ 18,651	23.00%	3,802/ 16,533

Table 8. 2018 PMV Results: DBMs						
Measure	**Argus**		**DentaQuest**		**MCNA**	
	Rate (%)	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**
Enrolled at Least 6 Months Continuously: Age 10–14	20.70%	1,972/9,527	19.07%	5,581/ 29,265	19.03%	5,018/ 26,369
Enrolled at Least 6 Months Continuously: Age 15–18	20.81%	1,379/6,627	17.69%	3,971/ 22,444	19.47%	4,005/ 20,574
Enrolled at Least 11 Months Continuously: Age 5	**	**	**	**	12.75%	32/251
Enrolled at Least 11 Months Continuously: Age 6–9	25.07%	1,406/5,609	26.21%	2,880/ 10,987	25.26%	2,725/ 10,787
Enrolled at Least 11 Months Continuously: Age 10–14	22.65%	1,339/5,911	22.67%	4,377/ 19,310	20.77%	3,799/ 18,295

Table 8. 2018 PMV Results: DBMs						
Measure	**Argus**		**DentaQuest**		**MCNA**	
	Rate (%)	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**
Enrolled at Least 11 Months Continuously: Age 15–18	22.59%	927/4,103	21.69%	3,378/ 15,575	21.34%	3,096/ 14,510
Diagnostic Dental (CMS-416)						
Enrolled at Least 1 Month: Age 5	15.24%	200/1,312	26.10%	739/2,831	25.63%	977/3,812
Enrolled at Least 1 Month: Age 6–9	39.09%	6,507/ 16,647	48.52%	12,998/ 26,788	44.81%	11,227/ 25,055
Enrolled at Least 1 Month: Age 10–14	39.06%	6,150/ 15,747	48.05%	18,872/ 39,278	43.38%	16,175/ 37,287
Enrolled at Least 1 Month: Age 15–18	33.41%	3,549/ 10,623	40.54%	12,275/ 30,277	36.20%	10,329/ 28,537
Enrolled at Least 3 Months Continuously: Age 5	23.91%	143/598	36.08%	643/1,782	34.55%	901/2,608

Table 8. 2018 PMV Results: DBMs						
Measure	**Argus**		**DentaQuest**		**MCNA**	
	Rate (%)	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**
Enrolled at Least 3 Months Continuously: Age 6–9	46.29%	6,122/ 13,225	55.07%	12,553/ 22,796	51.01%	10,835/ 21,243
Enrolled at Least 3 Months Continuously: Age 10–14	45.98%	5,812/ 12,640	53.62%	18,321/ 34,167	48.67%	15,743/ 32,346
Enrolled at Least 3 Months Continuously: Age 15–18	38.87%	3,394/8,731	45.01%	11,987/ 26,632	40.23%	10,097/ 25,097
Enrolled at Least 6 Months Continuously: Age 5	50.00%	1/2	40.13%	311/775	43.45%	620/1,427
Enrolled at Least 6 Months Continuously: Age 6–9	52.73%	5,194/9,850	59.07%	11,017/ 18,651	57.19%	9,456/ 16,533

Table 8. 2018 PMV Results: DBMs						
Measure	**Argus**		**DentaQuest**		**MCNA**	
	Rate (%)	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**
Enrolled at Least 6 Months Continuously: Age 10–14	51.95%	4,949/9,527	56.29%	16,472/ 29,265	53.82%	14,193/ 26,369
Enrolled at Least 6 Months Continuously: Age 15–18	44.00%	2,916/6,627	47.81%	10,731/ 22,444	44.69%	9,195/ 20,574
Enrolled at Least 11 Months Continuously: Age 5	**	**	**	**	47.81%	120/251
Enrolled at Least 11 Months Continuously: Age 6–9	58.44%	3,278/5,609	66.23%	7,277/ 10,987	62.71%	6,764/ 10,787
Enrolled at Least 11 Months Continuously: Age 10–14	56.15%	3,319/5,911	63.32%	12,228/ 19,310	58.56%	10,713/ 18,295

Table 8. 2018 PMV Results: DBMs						
Measure	**Argus**		**DentaQuest**		**MCNA**	
	Rate (%)	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**
Enrolled at Least 11 Months Continuously: Age 15–18	47.62%	1,954/4,103	53.35%	8,309/ 15,575	48.92%	7,098/ 14,510
Dental Sealants (The age 5 and age 15–18 stratifications do not apply to this measure.)						
Enrolled at Least 1 Month: Age 5						
Enrolled at Least 1 Month: Age 6–9	11.63%	1,936/ 16,647	13.48%	3,610/ 26,788	11.98%	3,001/ 25,055
Enrolled at Least 1 Month: Age 10–14	10.65%	1,677/ 15,747	11.09%	4,357/ 39,278	10.53%	3,925/ 37,287
Enrolled at Least 1 Month: Age 15–18						
Enrolled at Least 3 Months Continuously: Age 5						

Table 8. 2018 PMV Results: DBMs						
Measure	**Argus**		**DentaQuest**		**MCNA**	
	Rate (%)	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**
Enrolled at Least 3 Months Continuously: Age 6–9	13.83%	1,829/ 13,225	15.45%	3,521/ 22,796	13.73%	2,917/ 21,243
Enrolled at Least 3 Months Continuously: Age 10–14	12.62%	1,595/ 12,640	12.46%	4,258/ 34,167	11.87%	3,839/ 32,346
Enrolled at Least 3 Months Continuously: Age 15–18						
Enrolled at Least 6 Months Continuously: Age 5						
Enrolled at Least 6 Months Continuously: Age 6–9	16.02%	1,578/9,850	16.02%	2,988/ 18,651	15.64%	2,585/ 16,533

Table 8. 2018 PMV Results: DBMs						
Measure	**Argus**		**DentaQuest**		**MCNA**	
	Rate (%)	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**
Enrolled at Least 6 Months Continuously: Age 10–14	14.53%	1,384/9,527	12.52%	3,664/ 29,265	13.32%	3,513/ 26,369
Enrolled at Least 6 Months Continuously: Age 15–18						
Enrolled at Least 11 Months Continuously: Age 5						
Enrolled at Least 11 Months Continuously: Age 6–9	18.79%	1,054/5,609	19.79%	2,174/ 10,987	17.21%	1,856/ 10,787
Enrolled at Least 11 Months Continuously: Age 10–14	14.90%	881/5,911	14.85%	2,867/ 19,310	14.60%	2,671/ 18,295

Table 8. 2018 PMV Results: DBMs						
Measure	**Argus**		**DentaQuest**		**MCNA**	
	Rate (%)	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**
Enrolled at Least 11 Months Continuously: Age 15–18						
Dental Sealants – With Exclusions (The age 5 and age 15–18 stratifications do not apply to this measure.)						
Enrolled at Least 1 Month: Age 5						
Enrolled at Least 1 Month: Age 6–9	12.02%	1,896/ 15,769	†	†	12.92%	2,925/ 22,645
Enrolled at Least 1 Month: Age 10–14	10.73%	1,664/ 15,511	†	†	10.83%	3,423/ 31,619
Enrolled at Least 1 Month: Age 15–18						
Enrolled at Least 3 Months Continuously: Age 5						

Table 8. 2018 PMV Results: DBMs						
Measure	**Argus**		**DentaQuest**		**MCNA**	
	Rate (%)	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**
Enrolled at Least 3 Months Continuously: Age 6–9	14.41%	1,790/ 12,421	†	†	14.96%	2,842/ 18,997
Enrolled at Least 3 Months Continuously: Age 10–14	12.73%	1,582/ 12,424	†	†	12.32%	3,339/ 27,099
Enrolled at Least 3 Months Continuously: Age 15–18						
Enrolled at Least 6 Months Continuously: Age 5						
Enrolled at Least 6 Months Continuously: Age 6–9	16.83%	1,544/9,172	†	†	17.18%	2,512/ 14,623

Table 8. 2018 PMV Results: DBMs						
Measure	**Argus**		**DentaQuest**		**MCNA**	
	Rate (%)	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**	**Rate (%)**	**Numerator / Denom.**
Enrolled at Least 6 Months Continuously: Age 10–14	14.68%	1,371/9,342	†	†	13.92%	3,034/ 21,790
Enrolled at Least 6 Months Continuously: Age 15–18						
Enrolled at Least 11 Months Continuously: Age 5						
Enrolled at Least 11 Months Continuously: Age 6–9	20.35%	1,027/5,047	†	†	19.38%	1,793/ 9,253
Enrolled at Least 11 Months Continuously: Age 10–14	15.15%	871/5,750	†	†	15.51%	2,262/ 14,584

Table 8. 2018 PMV Results: DBMs						
Measure	Argus		DentaQuest		MCNA	
	Rate (%)	Numerator / Denom.	Rate (%)	Numerator / Denom.	Rate (%)	Numerator / Denom.
Enrolled at Least 11 Months Continuously: Age 15–18						

** The age range for this stratification is 3–5 years; as ages 3 and 4 years do not apply to the FHK population, the stratification has been renamed Age 5 for this report.*

*** The rate for this measure stratification was not calculated because the denominator had a value of zero.*

† DentaQuest did not calculate this rate.

Strengths and Opportunities for Improvement

Strengths

The MCOs all were noted as fully compliant with all NCQA-defined IS Standards for HEDIS-applied data and processes. Each of the MCOs was also recognized as having undergone an NCQA Compliance Audit™, and the final opinion indicated that all performance measures were prepared in accordance with the HEDIS Technical Specifications.

Qsource noted several strengths for the DBMs. Both Argus and DentaQuest demonstrated being well prepared for the onsite review through ISCA documentation and making subject matter experts available for the review team. In addition, Qsource highlighted DentaQuest's mature, robust system capabilities for data collection and reporting as well as pointed out the DBM's process for measure production as a best practice. Qsource identified Argus's inclusion of key leadership and dedicated

resources during the review as a high level of engagement and commitment to the FHK program. Argus's process for addressing reinstatements was also identified as very efficient for addressing issues between monthly files, another strength. Finally, Qsource identified MCNA's DentaTrac as an excellent internally developed system and noted the DBM's multi-level validation and auditing processes, which enhance data accuracy. The MCNA staff also was noted as knowledgeable in their various areas of expertise as well as the PMV process.

Areas for Improvement

No areas of improvement were noted for the MCOs for the 2018 PMV. Qsource did identify areas for improvement for some of the DBMs, including a recommendation that Argus maintain and document measure specification versions used in the production of performance measure data as either part of its code or as a footnote to the performance measure rate data reporting to ensure that they are readily available for reference if needed. In addition, Qsource noted that MCNA should consider using the retroactive notification date to determine continuous enrollment as this would assist in identifying enrollees not meeting continuous enrollment criteria.

Performance Improvement Project (PIP) Validation

Assessment Background

To evaluate PIPs, Qsource assembled a validation team of experienced clinicians specializing in quality improvement, a healthcare data analyst, and a biostatistician with expertise in statistics and study design. For the 2018 PIP validation cycle, there were two PIP topics, one for MCOs and one for DBMs, both selected by FHKC. As shown in **Table 9**, half the PIPs evaluated in 2018 achieved a Met status while the other half received a Not Met status.

Table 9. 2018 PIP Validation Statuses

MCO/DBM	Met/Not Met
Aetna	Met
Amerigroup	Met
Argus	Not Met
DentaQuest	Met
MCNA	Not Met
Staywell	Not Met
Sunshine	Not Met
UnitedHealthcare	Met

Technical Methods of Data Collection

Each MCO and DBM is contractually required to submit its 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. MCOs and DBMs should also address threats to validity regarding data analysis and include an interpretation of study results.

Qsource developed a PIP Summary Form and a validation tool to standardize the process by which each MCO and DBM provides PIP information to FHKC and how that information is assessed. Using Qsource's PIP Summary Form, each MCO and DBM submitted its PIP studies and supplemental information in July 2018.

Each PIP validation assessed MCO and DBM performance on 10 activities, and each activity consisted of multiple elements essential to the successful completion of a valid PIP. The actual number of activities validated for each PIP varied depending on how far the MCO or DBM had progressed with an individual study or whether the activity was applicable to

the study's methodology. For example, Activity V was not validated when a study did not use sampling, used an administrative-only data collection methodology, or used HEDIS Technical Specifications for sampling.

The elements within each activity were scored as Met, Not Met, or Not Assessed. To ensure a valid and reliable review, 13 elements across eight activities were designated as "critical"— i.e., necessary to be Met, if applicable, in order for the MCO or DBM to produce an accurate and reliable PIP. Given the importance of the critical elements to this scoring methodology, any applicable critical element that received a Not Met status resulted in an overall validation rating of Not Met and required future revisions of the PIP. More specific information on validation methodology is available in the individual *2018 PIP Validation Report* for each MCO and DBM.

Description of Data Obtained

Table 10 summarizes the 10 CMS protocol activity requirements and the 13 critical elements addressed in the PIP Summary Form.

Table 10. CMS PIP Activities and Critical Elements

PIP Activities	Critical Elements
I. Choose the Study Topic(s)	♦ Has the potential to affect enrollee health, functional status, or satisfaction
II. Define the Study Question(s)	♦ States the problem to be studied in simple terms ♦ Is answerable
III. Use a Representative and Generalizable Study Population	♦ Is accurately and completely defined ♦ Captures all enrollees to whom the study question applies
IV. Select the Study Indicators	♦ Are well-defined, objective, and measurable ♦ Allow for the study questions to be answered ♦ Have available data that can be collected on each indicator
V. Use Sound Sampling Methods	♦ Ensure a representative sample of the eligible population

Table 10. CMS PIP Activities and Critical Elements

PIP Activities	Critical Elements
VI. Use Valid and Reliable Data Collection Procedures	♦ A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications
VII. Analyze Data and Interpret Study Results	♦ Are conducted according to the data analysis plan in the study design ♦ Allow for generalization of results to the study population if a sample was selected
VIII. Include Improvement Strategies	♦ Related to causes/barriers identified through data analysis and quality improvement processes
IX. Assess for Real Improvement	♦ No critical elements
X. Assess for Sustained Improvement	♦ No critical elements

Findings

Table 11 presents a summary of each MCO's and DBM's PIP and includes the PIP's title, summary of performance, interventions, validation results, discussion points, study indicators, populations affected, and any decrease or increase in measurement results. This information is useful for determining whether to continue or retire a specific PIP. All FHK MCO and DBM PIPs for 2017 were clinical. Italicized text was taken directly from MCO and DBM materials and has not been edited by Qsource.

The lack of documentation to support compliance with critical elements, which is required to achieve a Met status for the PIP overall, is mostly attributable for the Not Met status for the two MCOs and two DBMs that received the Not Met status. This is most likely due to the changes in documentation, process, and activity requirements for the PIP evaluation for 2018, especially as they relate to critical elements.

Table 11. Performance Summary for 2018 PIPs	
MCOs	
Aetna: Well Child Visits in the 5th and 6th Years of Life (W34)	
Validation Status	Met
Study Population	All continuously enrolled Florida Healthy Kids (FHK) enrollees who are 5 and 6 years of age during the measurement year with no more than one gap of up to 45 days who meet the HEDIS Technical Specifications for the W34 measure
Study Indicator(s)	*The number of continuously enrolled FHK enrollees, 5 to 6 years of age, with no more than one gap of up to 45 days during the continuous enrollment period and; who received one well-child visit with a primary care practitioner (PCP) during the measurement*
Interventions*	♦ *Live Member Outreach: Call 100% of members who have working telephone numbers.* ♦ *Member Contact Information Improvement: Identify and locate correct contact information for 90% of members with inaccurate (or missing) contact info on file.*
Summary of Performance	Aetna achieved overall validation and critical element scores of 84.4% and 100%, respectively.
Measurement Results	Results have fluctuated across the eight years of this PIP. For the 2017 reporting year, the remeasurement result was 72.50%, compared to the baseline goal of 69.70% and result of 65.20%.
EQRO Discussion	Qsource identified one strength, two suggestions, and five AONs for this PIP study. The strength concerns the MCO's detailed data analysis plan. The suggestions are to present data results in tabular and graphical format and include the root-cause analysis for barrier identification. The AONs concern MCO-specific data and analysis for choosing the study topic,

Table 11. Performance Summary for 2018 PIPs	
	written instructions for completion of the MCO's manual data abstraction tool, discussion of the extent of the study's success, statistical evidence of result variations from year to year, and the use of year-to-year statistical tests to assess for sustained improvement.
Amerigroup: Improving Well Child Visits in the 5th and 6th Year	
Validation Status	Met
Study Population	The Plan follows the HEDIS 2018 technical specifications for the W34 measure (for FHK members 5 to 6 years of age only) for all enrollee criteria. Allowable gap: No more than one gap in enrollment of up to 45 days during the continuous enrollment period. Specific exclusion criteria: Members in hospice are excluded from the eligible population.
Study Indicator(s)	*Well-Child Visits in the 5th and 6th Years of Life (W34): HEDIS*
Interventions*	♦ *Distributed Care Gap Reports* ♦ *Clinic Day Programs* ♦ *Live Outbound Calls* ♦ *Member Contact Information Verification: The Plan is piloted an intervention that will potentially impact the ability to communicate with members across all Lines of Business and products, including FHK. The Plan has contracted with a vendor who is able to review and match member contact information using various proprietary means. The Plan has shared the State's contact information for a sample of members with the vendor in order to determine how accurate that data is when compared to the vendor's information. A comparison of the contact information will be done in order to determine the rate of incorrect contact information. Vendor information will be verified with the*

Table 11. Performance Summary for 2018 PIPs	
	members who will also be encouraged to report their correct contact information to the State. The Plan will document the correct contact information in a separate database that will not be overridden by the State. Root cause or barrier addressed: Unable to contact members due to inaccurate or missing contact information.
Summary of Performance	Amerigroup achieved overall validation and critical element scores of 93.47% and 100%, respectively.
Measurement Results	Results have fluctuated across the eight years of this PIP. For the 2017 reporting year, the remeasurement result was 75.90%, compared to the baseline goal of 77.70% and result of 72.80%.
EQRO Discussion	Qsource identified two strengths, one suggestion, and three AONs for this PIP study. The strengths concern the MCO's inclusion of detailed, comprehensive documentation for data collection procedures and improvement strategies. The suggestion is to present data results in graphical or tabular format and to include information about how the study indicator would be calculated and compared in the data analysis plan. The AONs concern including research-based and MCO-specific data and analysis to support the relevance of the study topic, including statistical evidence and interpretation of indicator result variation, and addressing the year-to-year variations in indicator results as well as the statistically significant decline in the last remeasurement year.
Staywell: Improving Rate of Well-Child Care Visits for 5 and 6 Year Olds	
Validation Status	Not Met
Study Population	The eligible study population includes all children who turned 5 or 6 years old in the measurement year and are still enrolled on December 31 of the measure year, with no more than a one-month gap in enrollment of up to

Table 11. Performance Summary for 2018 PIPs	
	45 days during the continuous enrollment period. Members in hospice are excluded from the eligible population.
Study Indicator(s)	1. *HEDIS Well Child Visit measure administrative rate* 2. *HEDIS Well Child Visit measure hybrid rate*
Interventions*	*Partnership for Quality (P4Q) Program: Program which includes a $20 incentive payment for each care gap closed by a primary care provider*
Summary of Performance	Staywell achieved overall validation and critical element scores of 73.91% and 83.33%, respectively.
Measurement Results	Results for both study indicators fluctuated during the three years of reporting (remeasurement years 5, 6, and 7). The MCO opted to report starting at remeasurement 5, an option approved by FHKC. The remeasurement year 7 result for study indicator 1 was 77.57%, compared to the baseline goal of 77.29% and result of 65.73%. The result for the study indicator 2 was 81.20%, compared to the baseline goal of 77.29% and result of 76.15%.
EQRO Discussion	Qsource identified three suggestions and five AONs for this PIP study. The suggestions are to include a rationale for the study indicator calculation methodology, graphical and tabular presentation of data results, and root-cause analysis for barrier identification. The AONs concern data analysis and reporting and including information in the appropriate activity; providing a medical record data collection tool and other data collection procedures and calculations; expanding the data analysis plan; examining the improvement strategies' impact on study indicator results; and addressing random, year-to-year variations in study indicator results. No strengths were identified for this PIP in 2018.

Table 11. Performance Summary for 2018 PIPs	
Sunshine: Improving Rate of Well-Child Care Visits for 5 and 6 Year Olds	
Validation Status	Not Met
Study Population	The eligible population includes all children ages 5 and 6 years enrolled in Sunshine Healthy Kids as of December 31 of the measurement year with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.
Study Indicator(s)	*Children in the eligible population that had at least one (1) well-child visit with a Primary Care Practitioner (PCP) during the measurement year. The PCP does not have to be assigned to the member.*
Interventions*	♦ *Welcome Calls: Welcome calls are placed to new members to complete a health screening, answer questions and provide information on contact numbers, member services, and benefits.* ♦ *Provider Incentive Program: The Pay-for-Performance incentive program gives participating providers a reimbursement based on their attributed population performance.* ♦ *Provider Onsite Visits: The Sunshine Health Provider Performance Management and Clinical Compliance and Outcomes teams schedule routine onsite provider visits to educate PCP practices on accessing online resources, billing, disease management protocols, and best practices as well as review gaps in care and Pay-for-Performance results.* ♦ *Member Outreach: The Sunshine Health Concierge team makes year-round outbound calls to parents or caregivers with children who have a gap in well-child visits. Member advocates will assist with changes in primary care provider, scheduling of appointments and arrangements for transportation as necessary.*

Table 11. Performance Summary for 2018 PIPs	
Summary of Performance	Sunshine achieved overall validation and critical element scores of 82.1% and 90.0%, respectively.
Measurement Results	Due to a significant change in enrollment characteristics in 2016, which invalidated the initial study baseline, the MCO opted to reinitiate the study with a baseline for 2016. The remeasurement year 1 result was 71.84%, compared to the baseline goal of 72.02% and result of 71.45%.
EQRO Discussion	Qsource identified four suggestions and three AONs for this PIP study. The suggestions are to include a specific statement about enrollees with special healthcare needs not being excluded from the study, discuss data elements to be collected, include a specific root-cause analysis for barrier identification, and present data results in tabular or graphical format. The AONs concern the inclusion of a description of data completeness results in addition to algorithms and flow charts for administrative indicators, the MCO's data analysis plan and interpretation of study results, and the impact of improvement strategies on study indicator results. No strengths were identified for this PIP in 2018.
UnitedHealthcare: Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34)	
Validation Status	Met
Study Population	FHK enrollees who were 5-6 years old as of December 31 of the measurement year and who were continuously enrolled with no more than one gap in enrollment of up to 45 days during the continuous enrollment period will be included in the study population.
Study Indicator(s)	*The percentage of UHC FL members 3–6 years of age who received one or more Well-Child Visits with a PCP during the measurement year. Since the FHK program applies to children ages 5 to 18 years, the denominator will be limited to eligible FHK children 5 and 6 years old only.*

Table 11. Performance Summary for 2018 PIPs	
Interventions*	♦ Quality Performance Incentive Program (QPIP): Incentive program that encourages Providers to work on improving W34 HEDIS performance measure and others. ♦ Welcome Calls and Welcome Packets: New members are educated on the importance of well-visits during welcome calls and through materials included in the welcome packet. ♦ CPC Program and Gap Detail Reports: Assist Providers in delivering effective health services through monitoring of quality outcomes and identifying members with performance measure gaps in care. ♦ Telephone Outreach: Automated calls to parents/caregivers of children due for a well-visit to educate them on the importance of well-visits. ♦ Cobrand Program: Cobranded reminder letter initiative (between Provider and Health Plan) that reminds members to visit their PCP for pediatric annual checkups.
Summary of Performance	UnitedHealthcare achieved overall validation and critical element scores of 92.5% and 100%, respectively.
Measurement Results	The MCO opted to initiate baseline measurement in 2015, due to the change in enrollee population size and demographic characteristics. The result for remeasurement year 2 was 69.35%, compared to the baseline goal of 75.60% and result of 68.20%.
EQRO Discussion	Qsource identified five strengths and two AONs for this PIP study. The strengths concern the MCO's detailed analysis of the study topic and target population, its detailed and comprehensive discussion of data collection procedures, its in-depth analysis of the study results, and its comprehensive description of improvement strategies and analysis of results. The AONs concern including further examination of how the improvement strategies' impact on study indicator results can be

Table 11. Performance Summary for 2018 PIPs	
	measured and addressing random, year-to-year variations in the study indicator. No suggestions were identified for this PIP in 2018.
DBMs	
Argus: Children Receiving Preventive Dental Services	
Validation Status	Not Met
Study Population	FHK enrollees ages 6-18 years as of 9/30/17 All enrollees in the population ages 5-21 are included in the outreach and intervention processes, but for the purposes of measurement and a comparable benchmark, the PIP utilizes the age group 6-18 as the measurement outcome because there is a comparable benchmark available with Florida dental plan data for this age group.
Study Indicator(s)	1. *The percent of Florida Healthy Kid members, aged 6-18 years as of September 30th of the measurement year, enrolled for at least one month in the dental plan and who receive dental preventive services (per CMS Form-416 specifications).* 2. *The percent of Florida Healthy Kid members, aged 6-18 years as of September 30th of the measurement year, enrolled continuously for at least three months in the dental plan, who receive dental preventive services (per CMS Form-416 specifications).*
Interventions*	♦ *Welcome to Argus and Healthy Kids: Automated outreach calls/emails (Spanish, English, or Creole) to new enrollees and outreach by Customer Care staff for those new enrollees whose ID cards were returned as undeliverable.* ♦ *Enrollee Outreach Campaign: Automated outreach calls/emails (Spanish, English, or Creole) to those enrollees in need of dental service.*

Table 11. Performance Summary for 2018 PIPs	
Summary of Performance	Argus achieved overall validation and critical element scores of 80.0% and 90.0%, respectively.
Measurement Results	Results have steadily increased across the five years of this PIP for both study indicators. For the 2017 reporting year, the remeasurement result for study indicator 1 was 36.81%, compared to the baseline goal of 52.00% and result of 24.70%. For study indicator 2, the remeasurement result was 43.63%, compared to the baseline goal of 52.00% and result of 24.70%.
EQRO Discussion	Qsource identified one strength, one suggestion, and four AONs for this PIP study. The strength concerns the DBM's comprehensive research and data analysis for the study topic, while the suggestion is to include the DBM's root-cause analysis in its discussion of improvement strategies. The AONs concern missing information across four activities, including algorithms and/or flow charts, statistical methods for study indicator rate comparison, calculation methodologies, and statistical testing result analysis.
DentaQuest: Preventive Dental Services	
Validation Status	Met
Study Population	All FHK enrollees are included in the study populations. The populations for both study indicators are enrollees ages 5-18 meeting the following continuous enrollment periods: at least 1 month continuous enrollment, 3 months continuous enrollment, 6 months continuous enrollment, and 12 months continuous enrollment.
Study Indicator(s)	1. *Preventive Dental Services* 2. *Fluoride Treatment Dental Services*

Table 11. Performance Summary for 2018 PIPs	
Interventions*	♦ *Member Engagement Events: Providing outreach and education on oral health and preventive care to members and the community at large through local events.* ♦ *Robo Call Campaign: Robo calls targeting non-compliant member throughout the state educating on importance of getting in for preventive dental care.* ♦ *Live Call Campaign: Live calls to non-compliant members in a 5 county target area on importance of getting in for preventive dental care. Included assistance with finding a provider if needed.*
Summary of Performance	DentaQuest achieved overall validation and critical element scores of 95.1% and 100%, respectively.
Measurement Results	Results have steadily increased across the five years of this PIP for both study indicators' four stratifications, with only one exception—remeasurement year 2 for the 3 Months Enrollment category for both indicators. The baseline goal for study indicator 1 was 28.00%. The remeasurement year 4 percentage and baseline result percentage, respectively, for study indicator 1 were as follows: 1 Month Enrollment, 43.69%, 41.14%; 3 Months Enrollment, 49.12%, 45.62%; 6 Months Enrollment, 53.89%, 50.27%; and 12 Months Enrollment, 59.67%, 55.88. The same percentages for study indicator 2 were as follows: 1 Month Enrollment, 41.30%, 38.12%; 3 Months Enrollment, 46.49%, 42.32%; 6 Months Enrollment, 51.11%, 46.73%; and 12 Months Enrollment, 56.78%, 52.06%. No baseline goal rate was provided.
EQRO Discussion	Qsource identified five strengths, one suggestion, and two AONs for this PIP study. The strengths concern the DBM's inclusion of comprehensive information about the study topic, data collection procedures, data analysis and study results, improvement strategies, and interpretation of results for both study indicators. The suggestion is to include specific root-

Table 11. Performance Summary for 2018 PIPs	
	cause analysis in the discussion of improvement strategies. The AONs concern missing information, including DBM-specific data and analysis in choosing the study topic and factors affecting indicator rate comparison.
MCNA: Increasing Preventive Dental Services	
Validation Status	Not Met
Study Population	Study Indicator 1: The study population includes enrollees ages 5-18 years who are eligible to receive preventive dental services during the measurement period, meeting the following enrollment criteria: at least 1 month, at least 3 months continuously, at least 6 months continuously, and 11-12 months continuously. Study Indicator 2: The study population includes enrollees ages 6-9 who are eligible to receive a dental sealant during the measurement period, meeting the following criteria: at least 1 month, at least 3 months continuously, at least 6 months continuously, and 11-12 months continuously. Study Indicator 3: The study population includes enrollees ages 10-14 who are eligible to receive a dental sealant during the measurement period, meeting the following criteria: at least 1 month, at least 3 months continuously, at least 6 months continuously, and 11-12 months continuously.
Study Indicator(s)	1. *Preventive Dental Services* 2. *Dental Sealants 6-9 yrs.* 3. *Dental Sealants 10-14 yrs.*
Interventions*	♦ *Preventive Service Reminders: Monthly text messages sent to members with no claims history on file for preventive services.* ♦ *Care Gap Alerts: Alerts triggered in our internal system DentalTrac™, when a member is overdue for a preventive service which prompts*

Table 11. Performance Summary for 2018 PIPs	
	MCNA's Member Service Representatives (MSRs) to offer assistance with scheduling an appointment. ♦ *Community Outreach Events: Participation at community events in geographical areas that have a high population of members for the purposes of providing oral health education and to encourage members to receive routine preventive care.*
Summary of Performance	MCNA achieved overall validation and critical element scores of 85.0% and 90.0%, respectively.
Measurement Results	Results for study indicator 1 steadily increased during the first seven years but decreased for 2017. Results for the remaining two study indicators fluctuated across all eight years of the PIP. For the 2017 reporting year, the remeasurement result for study indicator 1 was 56.50%, compared to the baseline goal of 49.00% and result of 50.60%. For study indicator 2, the remeasurement result was 17.10%, compared to the baseline goal of 17.20% and result of 17.70%. For study indicator 3, the remeasurement result was 14.60%, compared to the baseline goal of 14.80% and result of 13.90%.
EQRO Discussion	Qsource identified three strengths, four suggestions, and five AONs for this PIP study. The strengths concern the DBM's inclusion of comprehensive, detailed information about the study topic, improvement strategies, and assessing for real improvement. The suggestions are to acknowledge that the study topic was selected by FHKC, to report results in tabular or graphical format, to be more specific about the study's success, and to include root-cause analysis for improvement strategies. The AONs concern reporting DBM-specific data and analysis, including more detailed data information and algorithms and/or flow charts for data collection procedures, describing how indicator rates would be calculated and compared in the data analysis plan, explaining if baseline and

Table 11. Performance Summary for 2018 PIPs	
	remeasurement methodologies were the same, and addressing significant changes for one of the study indicators.

** Interventions are provided for the most recent remeasurement year. Further interventions can be found in the individual 2018 PIP Validation Report for each MCO and DBM.*

Strengths and Opportunities for Improvement

Strengths

Strengths for the PIP validation indicate that the MCO or DBM demonstrated particular proficiency on a given activity and can be identified regardless of validation status. The lack of an identified strength should not be interpreted as a shortcoming on the part of an MCO or DBM.

Aetna

- The MCO had a very detailed data analysis plan and demonstrated awareness of factors that could have impacted results.

Amerigroup

- The MCO addressed Activity VI in detail and provided comprehensive supporting documentation.
- The MCO addressed Activity VIII in detail and provided comprehensive supporting documentation.

Staywell

- No strengths were identified.

Sunshine

- No strengths were identified.

UnitedHealthcare

- The MCO provided a detailed analysis of the relevance of the study topic, including a demographic analysis of the target population and how the study can impact provider satisfaction in addition to enrollee health.
- The study population was described in detail and included appropriate HEDIS Technical Specifications for W34.
- The MCO addressed Activity VI in detail and provided comprehensive supporting documentation.
- The MCO did subgroup analysis to better understand the dynamics of the measurement.
- The MCO's description of improvement strategies and analysis of results was extremely well documented and comprehensive.

Argus

- The DBM provided comprehensive, relevant research on the study topic, along with national-, state-, and DBM-level data analysis.

DentaQuest

- The DBM provided comprehensive, relevant research on the study topic.
- The DBM addressed each element requirement in Activity VI in comprehensive detail.
- The DBM presented a comprehensive analysis and interpretation of study results.
- The DBM addressed all improvement strategies, experiences with the interventions, and limitations in detail.
- The DBM provided a comprehensive interpretation of results for each study indicator over each remeasurement period.

MCNA

- The DBM provided comprehensive, relevant research on the study topic.
- The DBM addressed all improvement strategies, results of the interventions, and limitations in detail.
- The DBM identified external factors that could have impacted the study indicator rates. The DBM clearly presented year-to-year statistical results for all three indicators.

Suggestions

Suggestions can be identified when documentation for an evaluation element includes the basic components to meet requirements, but enhanced documentation would demonstrate a stronger understanding of CMS protocols.

Aetna

- The MCO could expand presentation of its data analysis for applicable measurement/ remeasurement periods to include graphs or tables including measurement periods, results, and benchmarks.
- The MCO could include the specific root-cause analysis that led to the identification of barriers.

Amerigroup

- While the MCO included how the study indicator would actually be calculated (i.e., HEDIS-certified software) in Activity VI, it could include that information for this activity as well. The MCO could expand presentation of its data analysis for applicable measurement/remeasurement periods to include graphs or tables including measurement periods, results, and benchmarks.

Staywell

- The MCO could consider selecting either the administrative or the hybrid HEDIS methodology for calculating the study indicators, or include a rationale for why both methodologies were selected.
- The MCO could expand presentation of its data analysis for applicable measurement/ remeasurement periods to include graphs or tables including measurement periods, results, and benchmarks.
- The MCO could include the specific root-cause analysis that led to the identification of barriers. In addition, the MCO could specifically incorporate methods to evaluate the impact of interventions in its intervention planning process.

Sunshine

- The MCO could specifically state in Activity I that enrollees with special healthcare needs were not excluded from the study.
- While the MCO referenced HEDIS W34 Technical Specifications, a general discussion of the data elements to be collected could be included for element 1 in Activity VI.
- The MCO could expand presentation of its data analysis for applicable measurement/remeasurement periods to include graphs or tables including measurement periods, results, and benchmarks.
- The MCO could include the specific root-cause analysis that led to the identification of barriers.

UnitedHealthcare

- No suggestions were identified.

Argus

- While the DBM included the root-cause analysis in Activity VI, it could consider reporting it for Activity VIII as well.

DentaQuest

- The DBM could include the specific root-cause analysis that led to the identification of barriers.

MCNA

- The DBM could explicitly state that the study topic was selected by FHKC.
- While the DBM described data elements collected and sources of data in Activity IV, these topics could be addressed in Activity VI.
- The DBM could report results in tabular or graphical format. In addition, the DBM could specifically indicate the level of success of the study.
- The DBM could include the specific root-cause analysis that led to the identification of barriers.

AONs

AONs arise from evaluation elements that receive a Not Met score, indicating that those elements are not in full compliance with CMS protocols.

Aetna

- The MCO should include research-based and MCO-specific data and analysis that support the relevance of the study topic.
- The MCO should provide written instructions on how to complete the manual data abstraction tool and an overview of the study itself in these instructions. The MCO should also specifically describe how the estimated degree of data completeness was determined.
- The MCO should discuss the extent to which the study was successful.
- While there was statistically significant improvement from the baseline to the remeasurement, the MCO should evaluate statistical significance of improvement from remeasurement to remeasurement.
- The MCO should evaluate sustained improvement between measurement years, as opposed to evaluating between the baseline and remeasurement years.

Amerigroup

- The MCO should include research-based and MCO-specific data and analysis that support the relevance of the study topic.
- While there was statistically significant improvement from the baseline to the remeasurement, the MCO should evaluate statistical significance of improvement from remeasurement to remeasurement.
- The MCO should evaluate sustained improvement between measurement years, as opposed to evaluating between the baseline and remeasurement years, and also the statistically significant decline in the study indicator results.

Staywell

- The MCO should report MCO-specific data and analysis that support the selection of the study topic.
- The MCO should identify data elements to be collected in Activity VI. The MCO also should include the medical record data collection tool. The training materials for hybrid data collection should be included in the submission. Because the MCO selected the W34 administrative rate as a study indicator, data collection algorithms/flow charts should be included. While the MCO provided detailed information on incurred but not reported

(IBNR) calculations, how the 100% completeness score was derived should be described.

- The MCO should include how the study indicators would actually be calculated (i.e., HEDIS-certified software) and how indicators would be compared to the goal or benchmark in the data analysis plan.
- The MCO should further examine how the impact of improvement strategies on study indicator results can be measured. In addition, the MCO should continue efforts to identify revisions to existing interventions and new interventions that would lead to statistically significant improvement.
- The MCO should address the observed random, year-to-year variations in the study indicators.

Sunshine

- The MCO should include algorithms and/or flow charts that describe the production of administrative indicators. Also, the MCO should include a description supporting the data completeness results.
- The MCO should include how the study indicator would be compared to the goal or benchmark in the data analysis plan. The MCO should specifically address any factors that might affect the internal or external validity of the findings. The MCO should also include an interpretation of the study's success to date.
- The MCO should further examine how improvement strategies can impact study indicator results.

UnitedHealthcare

- The MCO should further examine how the impact of improvement strategies on study indicator results can be measured. In addition, the MCO should continue efforts to identify revisions to existing interventions and new interventions that would lead to statistically significant improvement.
- The MCO should address the observed random, year-to-year variations in the study indicator or other factors that may have impacted the study indicator.

Argus

- While the DBM described data elements collected in Activity IV, it also should include that information in Activity VI. The DBM should include algorithms and/or flow charts that describe the production of administrative indicators. Also, the DBM should include a clear explanation of how estimated data completeness was calculated.
- The data analysis plan should include the statistical tests that would be used to compare the study indicator rates. While the DBM included the statistical significance of differences in study indicators over measurement periods in Activity IX, the topic should

also be addressed in Activity VII as part of interpretation of results.

- The DBM should specifically address whether remeasurement and baseline methodologies were the same. Results of statistical tests should be indicated individually for each remeasurement period, in order to determine if true improvement occurred.
- The DBM should include a clear analysis of statistical testing results from remeasurement to remeasurement to assess for real improvement.

DentaQuest

- The DBM should report DBM-specific data and analysis that support the selection of the study topic.
- The DBM should specifically indicate if factors affecting the ability to compare initial and remeasurement rates exist.

MCNA

- The DBM should report DBM-specific data and analysis that support the selection of the study topic.
- The DBM should include algorithms and/or flow charts that describe the production of administrative indicators.
- The DBM should include a general description of how indicator rates would be calculated and compared to the benchmark or goal in the data analysis plan. The DBM should specifically address whether factors affecting the ability to compare initial and remeasurement rates exist.
- The DBM should specifically address whether remeasurement and baseline methodologies were the same.
- The DBM should address statistically significant decreases in study indicators and also the random, year-to-year variation for the third study indicator.

Plan-Do-Study-Act

Assessment Background

In addition to the 10-step PIP evaluation and validation outlined in the CMS EQR Protocol 3, FHKC requested that the MCOs and DBMs implement rapid cycle improvement techniques for the current PIPs in 2018, using the IHI Model for Improvement, PDSA model. The MCOs and DBMs were expected to implement new interventions using the PDSA model as appropriate for the PIP. These efforts focused on developing an appropriate aim; planning for and running small tests of change; identifying and collecting data to measure results; analyzing short-term results compared to set goals; and adopting, modifying, or abandoning interventions to maximize improvement. The PDSA model of successive tests of change leading to sustained improvement over the long term corresponds well with the CMS protocol structure.

Technical Methods of Data Collection

For the PDSA evaluation, the MCOs and DBMs submitted information for Plan-Do in the quarter 1 (Q1) reports and for Study-Act in the Q2 reports. Evaluation included scoring elements for each activity as Met, Opportunity, or Not Assessed (NA).

Description of Data Obtained

Table 12 summarizes the four PDSA activities and elements.

Table 12. PDSA Activities and Elements

PDSA Activities	Elements
I. Plan	♦ Set aim of the project ♦ Define measure ♦ State measure baseline ♦ Develop driver diagram ♦ Select specific change ideas and rationale for selection ♦ Describe planned data collection process ♦ Develop initial sustainability plan
II. Do	♦ Describe the change implemented and the scale of the test ♦ Describe the results of the test
III. Study	♦ Analyze and compare results

Table 12. PDSA Activities and Elements	
PDSA Activities	**Elements**
	♦ Describe what was learned from test of change
IV. Act	♦ Describe action to be taken ♦ Complete sustainability plan ♦ Describe plan for next PDSA cycle

Strengths and Opportunities for Improvement

Strengths

Strengths for the PDSA evaluation indicate that the MCO or DBM demonstrated particular proficiency on a given activity and can be identified regardless of evaluation status. The lack of an identified strength should not be interpreted as a shortcoming on the part of an MCO or DBM.

Aetna

- The initial sustainability plan was comprehensive and addressed multiple factors impacting sustainability.

Amerigroup

- The driver diagram was well thought out and comprehensive, and it included change ideas related to primary and secondary drivers.
- The results of the test were specific to enrollee impact of the intervention, as opposed to dependence on longer term HEDIS results.

Staywell

- The driver diagram was comprehensive and included change ideas related to primary and secondary drivers.

Sunshine

- The driver diagram was comprehensive and included change ideas related to drivers identified. Data collection processes for the two tests of change were well defined and timely.
- The identification of the information issue with the Envolve call script and the revision to improve the effectiveness of the outreach were a good example of change adaptation.
- The MCO provided detailed analysis of lessons learned from the tests of change.
- The sustainability plan was well thought out and relevant to the tests of change.

UnitedHealthcare

- The driver diagram was comprehensive and included change ideas related to primary and secondary drivers. The interventions selected, particularly the test of gap detail report by selected provider, are an excellent example of a small test of change, which could be adopted on a larger scale.
- Tests of change were well defined using PDSA principles.
- The MCO presented detailed graphical displays of both process and outcome measures.
- The sustainability plan described was comprehensive and included the actions necessary to sustain positive change.

Argus

- The description of what was learned from the test of change was comprehensive, relevant, and actionable.
- Actions to be taken were specific and based on what was learned from the test of change.

DentaQuest

- Overall, Activity I was comprehensive and incorporated appropriate aspects of rapid cycle improvement principles.
- The Do activity was well documented and comprehensive and included appropriate aspects of rapid cycle improvement principles.
- Run charts were clear and included appropriate data for analysis.

MCNA

- Overall, Activity I was comprehensive and incorporated appropriate aspects of rapid cycle improvement principles.
- The sustainability plan was thorough and addressed appropriate needs to sustain improvement.

Suggestions

Suggestions can be identified when documentation for an evaluation element includes the basic components to meet requirements, but enhanced documentation would demonstrate a stronger understanding of the PDSA model.

Aetna

- The MCO should include an achievable goal and the timeframe for improvement in the aim statement. The goal should be a short-term goal to address rapid cycle improvement methodology. The measure should provide results timely and in the short term. The MCO also should consider tracking results of interventions that impact progress toward the aim. The baseline measure should reflect the rate

immediately prior to implementation of the intervention(s). The MCO included appropriate interventions; however, the method for identifying and locating correct enrollee contact information should be included. For the data collection process, the MCO should include how it will collect data on the success of the interventions in the shorter term. The second intervention on enrollee contact information should be considered a process measure.

- The MCO should have implemented interventions during this initial study period. While a large-scale implementation was described, a smaller scale test should have been attempted to determine potential success of the intervention. Results were not available as no interventions were implemented. The MCO should consider results related directly to interventions, e.g. how many enrollees who received reminder calls actually attended well-child visits. For the enrollee contact information intervention, process results—or how many attempts to gain accurate information were successful—should be considered.
- The MCO should have implemented a test of change for the PDSA cycle. For the existing interventions that were in place, periodic (e.g., monthly) results should have been measured and presented in a run or control chart to allow for analysis of trends and the impact of the interventions over time. A goal should have been in place for the second intervention. Based on the data collected, the MCO should have considered abandoning the effort as opposed to continuing through year end.
- The MCO should incorporate true rapid cycle improvement principles in the plan for the next PDSA. The MCO should plan for an appropriate test(s) of change for the next PDSA cycle and plan for short-term periodic measurement and analysis of results. The MCO should also plan for taking action based on results and describe how these actions will be implemented and/or sustained.

Amerigroup

- The MCO should include a shorter term achievable goal and timeframe for improvement in the aim statement. The goal should be a shorter term goal to address rapid cycle improvement methodology. The measure should provide results in the short term. The MCO also should consider tracking results of interventions that impact progress toward the aim, e.g. determining how many enrollees for whom well-child visits were scheduled actually attended the visit by following up with providers (as opposed to waiting for claims to be adjudicated). For the data collection process, the MCO should collect data on the success of interventions in the shorter term.
- The MCO should include justification for continuing the Clinic Day Program, given that the intermediate

goal was not achieved. The Provider Gap Report intervention, implemented in September 2018, should be included in the Act phase of the PDSA.

- The MCO should discuss formal adoption of the Clinic Day Program and Live Outbound Calls and implementation of the Provider Gap Report intervention as a new test of change.

Staywell

- The MCO should include an achievable goal and the timeframe for improvement in the aim statement. The goal should be a short-term goal to address rapid cycle improvement methodology. The baseline measure should reflect the rate immediately prior to implementation of the intervention(s).
- The MCO should include new or modified interventions related to the tests of change identified. Results for these tests of change should be collected and reported on a timely and ongoing basis for the 2018 PDSA cycle.
- The MCO should implement a test of change in the current year; measure outcome rates on a frequent, routine basis; and use a run or control chart to display results. The MCO should also indicate lessons learned based on the test of change and the results experienced in the current year.
- The MCO should describe the sustainability plan in terms of supportive management structure, feedback systems, engaged staff, etc. The next PDSA cycle plan should address more specific issues relative to the adaptation of current programs and adoption of the new intervention.

Sunshine

- The MCO should include an achievable goal and the timeframe for improvement in the aim statement. The goal should be a short-term goal to address rapid cycle improvement methodology. The measure should provide results timely and in the short term. In addition, the MCO should consider tracking results of interventions that impact progress toward the aim. The baseline measure should reflect the rate immediately prior to implementation of the intervention(s).
- The MCO should have described the provider outreach intervention and the results of the intervention.

UnitedHealthcare

- The MCO should include an achievable goal and the timeframe for improvement in the aim statement. The goal should be a short-term goal to address rapid cycle improvement methodology. The measure should provide timely results in the short term. In addition, the MCO should consider tracking results of interventions that impact progress toward the aim.

Argus

- The DBM should clearly state an achievable goal for the PDSA cycle and an appropriate timeframe for achievement. The DBM should include the timeframe for the baseline measures. In addition, the driver diagram should be updated to include primary and secondary drivers that impact the achievement of the goal. If possible, the data collection process should be more frequent, e.g. monthly, to improve timely analysis of intervention effectiveness.
- The DBM should describe new/modified tests of change for the 2018 PDSA cycle and include the scales of the tests. Results from 2018 interventions should be reported.
- The DBM should add the benchmark or goal to the run chart to more easily visualize results relative to the goal.
- A general description of planning for the adapted tests of change in a new PDSA cycle should be addressed.

DentaQuest

- The DBM should restate the aim by evaluation quarter to better address shorter term results.
- The DBM should more specifically address the sustainability plan, to include aspects like supportive management structure, a feedback system for identifying issues that may occur, staff engagement, and a culture of improvement.

MCNA

- For the remainder of the PDSA cycle, the DBM should report results at 30, 60, and 90 days on an ongoing basis (e.g., monthly).
- Additional information on what was learned during the text messaging intervention should be included.
- The DBM should include the actual intervention adaptations that will occur going forward.

Validation of Encounter Data (EDV)

Assessment Background

FHKC contracted with Qsource to conduct one optional activity, Validation of Encounter Data. CMS encourages EDV conducted by EQROs to assure validity and reliability of encounter data to ensure performance data for payment reform and transparency of payment and delivery of care. Validation determines the accuracy and completeness of encounter data to inform policy and operational decision-making, assess quality, monitor program integrity, and determine capitation payment rates. CMS protocol for EDV mandates the following five activities:

1. Review of FHKC requirements for collecting and submitting encounter data
2. Review of MCO/DBM capacity for producing encounter data that are accurate and complete
3. Analyses of the accuracy and completeness of MCO/DBM-submitted encounter data
4. Medical record review (MRR) to confirm EDV findings
5. Submission of EQRO findings

Technical Methods of Data Collection

FHKC opted to include analysis of fee-for-service claims data, in addition to encounter data, in the quarterly EDV reports. The first quarter 2018 EDV report submission included claims and encounter data in aggregate without separate analysis. Qsource, in consultation with FHKC, decided to expand the quarter 2 (Q2) report to include separate validation of claims versus encounter data. The Q2 report addressed claims and encounter data with service dates between January 1 and March 31, 2018, for all claims and encounters adjudicated between January 1 and June 30, 2018 (to address claim payment lag). The Q3 report addressed claims and encounter data with service dates between April 1 and June 30, 2018, for all claims and encounters adjudicated between April 1 and September 30, 2018 (to address claim payment lag).

Claims and encounter data were analyzed at the facility and professional levels. Facility data included any records submitted by a healthcare facility via a CMS-1450 form (UB-04 [Uniform Bill]), a standard billing claim form for

facility medical claims. Professional data included any records submitted by a provider via a CMS-1500 form (Health Insurance Claim Form), a standard claim form for non-institutional medical provider claims.

To assess the capacity of the MCOs and DBMs to produce accurate and complete claims and encounter data, each MCO underwent an annual HEDIS Compliance Audit™ during 2018, examining encounter and claims processing for measurement year 2017. This audit assessed the MCOs' information systems and capacity to process claims and encounters accurately. For the DBMs, this activity was based on review of the ISCATs submitted.

Qsource used SAS® to statistically determine frequencies and rates in health services data on specific fields or variables created explicitly for data validation to indicate potential concerns. Analyzing claims and encounter data obtained from MCO- and DBM-submitted data, Qsource conducted basic integrity checks to determine if the data existed, if they met expectations, and if they were of sufficient basic quality to proceed with more complex analyses.

Description of Data Obtained

CMS protocol for EDV defines encounter data as "the electronic records of services provided to MCO enrollees by both institutional and practitioner providers (regardless of how the services were paid), when the services would traditionally be a billable service under fee-for-service (FFS) reimbursement system." Encounter data are typically the detailed service data for providers whose services are covered under a capitation financial arrangement (i.e., per enrollee per month payments) and, therefore, are not billed as individual claims to MCOs.

Encounter data are used "to assess and improve quality, monitor program integrity, and determine capitation payment rates" (EQR Protocol 4). Independent standards are established for encounter data accuracy and completeness, a definition for "encounter" and the types MCOs and DBMs are required to report, and objective standards for comparing collected data.

CMS protocol defines potential areas of concern with encounter data validity and acceptable error rates. Encounter data determined to be Missing involve encounters that occurred but were not represented by an encounter record. Missing encounters were not evaluated

in the quarterly EDV reports specifically, but analysis of data volume was included. Encounters that did occur but have records with incorrect data elements are classified as Erroneous. The Acceptable Error Rate is the maximum percentage of these record types (i.e., Missing, Erroneous) that FHKC will accept.

Qsource identified the number of MCO and DBM records with accurate data out of the number examined with data present (completeness) for fields FHKC agreed upon, as detailed in **Table 13**.

Table 13. Validation Techniques for MCO and DBM Claims and Encounter Data

Field	Data Test for Validity
MCOs	
Recipient ID	Valid length, numbers
Gender	Male (M) or female (F)
Plan ID	Plan's ID
Principal Diagnosis	Valid code

Table 13. Validation Techniques for MCO and DBM Claims and Encounter Data

Field	Data Test for Validity
Billing Provider ID	Valid length, numbers
Billed Units	Numbers
Admission Date (Facility Only)	Valid date
KidCare ID	Valid ID
Billing Provider NPI	Valid length, numbers
DBMs	
Recipient ID	Valid length, numbers
Plan ID	Plan's ID
Billing Provider NPI	Valid length, numbers
Service Date	Valid date
Procedure Code	Valid code
Tooth ID or Area ID	Valid ID
Kidcare ID	Valid ID
Dental Insurance ID	Valid ID

Findings

For EDV Activity 2, review of data production capacity, all MCOs and DBMs received an acceptable rating for the ability to produce accurate and complete claims and encounter data. These ratings were based on an evaluation of:

- claims and encounter data processing systems;
- procedures; and
- claims and encounter collection and transaction systems.

While findings are presented by quarter for completeness and validity, trending should be done with caution. As the Q1 analysis was the first EDV Qsource conducted for FHKC, EDV activities were minimized to focus on validation of submitted data (EDV activities 1 and 3) as a baseline for determining appropriate revisions for future validations. Rather than providing a comparison of Q1 and Q2 data, the Q2 report reanalyzed Q1 encounter and claims data separately for a number of validation measures.

Completeness and Validity

Table 14 includes completeness and validity rates of medical facility claims for all MCOs in aggregate. Scores less than 100% are identified in **green** (for scores 90.0% or above) and **red** (for scores below 90.0%).

Table 14. Completeness and Validity Rates for All MCOs—Medical Facility Claims

	Q1 Dates of Service		Q2 Dates of Service	
Field	**Completeness Rate**	**Validity Rate***	**Completeness Rate**	**Validity Rate***
Recipient ID	**92.09%**	**99.96%**	**86.17%**	**99.95%**
Gender	**100%**	**100%**	**100%**	**100%**
Plan ID	**100%**	**99.99%**	**100%**	**99.99%**
Principal Diagnosis	**100%**	**100%**	**100%**	**100%**
Billing Provider ID	**95.66%**	**100%**	**96.40%**	**100%**
Billed Units	**92.03%**	**99.81%**	**86.14%**	**99.81%**

Table 14. Completeness and Validity Rates for All MCOs—Medical Facility Claims				
	Q1 Dates of Service		Q2 Dates of Service	
Field	**Completeness Rate**	**Validity Rate***	**Completeness Rate**	**Validity Rate***
Admission Date	**90.77%**	**99.97%**	**89.87%**	**99.92%**
KidCare ID	**100%**	**100%**	**100%**	**100%**
Billing Provider NPI	**98.57%**	**100%**	**98.54%**	**100%**

** Valid Rates are those deemed accurate of records determined complete.*

Table 15 includes completeness and validity rates of medical professional claims for all MCOs in aggregate.

Table 15. Completeness and Validity Rates for All MCOs—Medical Professional Claims				
	Q1 Dates of Service		Q2 Dates of Service	
Field	**Completeness Rate**	**Validity Rate***	**Completeness Rate**	**Validity Rate***
Recipient ID	**94.17%**	**99.97%**	**85.21%**	**99.97%**
Gender	**100%**	**99.99%**	**100%**	**99.99%**
Plan ID	**100%**	**99.99%**	**100%**	**99.99%**
Principal Diagnosis	**100%**	**100%**	**100%**	**100%**
Billing Provider ID	**96.83%**	**100%**	**96.53%**	**100%**
Billed Units	**100%**	**100%**	**100%**	**100%**
Admission Date	**94.02%**	**99.99%**	**84.53%**	**99.81%**
KidCare ID	**100%**	**100%**	**99.99%**	**99.99%**
Billing Provider NPI	**97.19%**	**100%**	**96.55%**	**100%**

** Valid Rates are those deemed accurate of records determined complete.*

Table 16 includes completeness and validity rates of medical professional encounters for all MCOs in aggregate.

Table 16. Completeness and Validity Rates for All MCOs—Medical Professional Encounters				
	Q1 Dates of Service		Q2 Dates of Service	
Field	**Completeness Rate**	**Validity Rate***	**Completeness Rate**	**Validity Rate***
Recipient ID	**94.83%**	**100%**	**79.32%**	**100%**
Gender	**100%**	**99.99%**	**100%**	**99.95%**
Plan ID	**100%**	**100%**	**100%**	**100%**
Principal Diagnosis	**100%**	**100%**	**100%**	**100%**
Billing Provider ID	**99.97%**	**100%**	**99.99%**	**100%**
Service Start Date	**100%**	**100%**	**100%**	**100%**
Billed Units	**94.96%**	**100%**	**79.45%**	**99.99%**
KidCare ID	**100%**	**100%**	**100%**	**100%**
Billing Provider NPI	**94.36%**	**100%**	**94.12%**	**100%**

** Valid Rates are those deemed accurate of records determined complete.*

The low aggregated completeness rates for the Q2 dates of service are primarily attributed to one MCO's completeness rates decreasing significantly for several data fields. Validity rates were consistently higher, above 99.0% for all fields for the aggregated MCO data for both quarters.

Volume and Consistency

Per CMS protocol, EDV should include an analysis of the volume and consistency of encounter data. To assess if claims and encounter data volume among the MCOs/DBMs was within expectations, Qsource analyzed frequencies of submitted claims and encounter records (Table 17) and volume of records relative to MCO/DBM enrollment (Table 18), as consistency of data among MCOs/DBMs would be expected given the volume of the enrollee population. Qsource also analyzed medical and dental claim data percentages by service type, average time for claims processing based on service date (Table 19), average lines per claim (Table 20), and average

number of claims/encounter lines per enrollee who received services (Table 21).

Table 17 includes total claims and encounters submitted by all MCOs and DBMs.

Table 17. Total Claims and Encounters Submitted by MCOs and DBMs

Total Records (N=1,308,280)				
Q1 Dates of Service	**Claims** N (% of MCO Total)		**Encounters**	**Total**
	Facility	**Professional**	**Professional**	
Total MCOs	147,687 (16.82%)	730,417 (83.18%)	105,444	983,548
Total DBMs				324,732
Total Records (N=1,191,984)				
Q2 Dates of Service	**Claims** N (% of MCO Total)		**Encounters**	**Total**
	Facility	**Professional**	**Professional**	
Total MCOs	128,672 (16.93%)	631,547 (83.07%)	112,680	872,899
Total DBMs				319,085

The distribution of claims and encounter volume data was relatively consistent with the volume of MCO/DBM enrollment for Q1 and Q2, as would be expected. Similarly, the distribution by service type, identified by the Current Procedural Terminology, 4th Edition (CPT-4) codes on the claims and encounter records for the MCOs and by the Code on Dental Procedures and Nomenclature (CDT) codes present on the claim records for the DBMs, was relatively consistent among both the MCOs and DBMs for Q2 and Q3. For the MCOs, Pathology and Laboratory constituted the largest percentage of claims/encounter lines, while Dental Preventive Services accounted for approximately 43% of service lines for the DBMs for both Q2 and Q3.

Table 18 includes the percentage of enrollment versus claims and encounter data by MCO and DBM for Q1 and Q2 dates of service.

Table 18. Percentage of Enrollment Versus Claims and Encounter Data by MCO/DBM				
	Q1 Dates of Service		Q2 Dates of Service	
MCO	**% Enrollment**	**% Claims & Encounters**	**% Enrollment**	**% Claims & Encounters**
Aetna	21.80%	19.89%	22.11%	21.52%
Amerigroup	27.57%	26.33%	26.83%	27.60%
Staywell	36.38%	41.37%	36.78%	37.63%
Sunshine	10.06%	9.13%	10.24%	9.95%
UnitedHealthcare	4.20%	3.27%	4.04%	3.31%
Total	**100%**	**100%**	**100%**	**100%**
DBM				
Argus	20.25%	19.39%	18.27%	18.48%
DentaQuest	42.16%	42.90%	45.07%	43.56%
MCNA	37.59%	37.73%	36.66%	37.96%
Total	**100%**	**100%**	**100%**	**100%**

Table 19 includes the total average number of days from date of service (professional) or date of discharge (facility) to the date of payment for MCO claims for Q1 and Q2 dates of service. The MCO data files did not include claim receipt date; therefore, average days for claims processing could not be calculated. DBMs do not include facility data; thus, the average number of days from the date of the claim receipt to the date of payment is provided for them. All averages were consistent with expectations.

Table 19. Total Average Number of Days from Date of Service/Date of Discharge to Date of Payment for MCOs and DBMs—Claims		
MCOs	**Professional**	**Facility**
	Avg. Days from Date of Service to Date of Payment	Avg. Days from Date of Discharge to Date of Payment
Q1 Dates of Service	23	27
Q2 Dates of Service	21	31
DBMs	Avg. Days from Date of Claim Receipt to Date of Payment	
Q1 Dates of Service	14	
Q2 Dates of Service	14	

Table 20 includes the total average number of lines per claim and per encounter for the MCOs and the total average number of lines per claim for the DBMs. Consistency was a primary finding among the MCOs and DBMs for average number of lines per claim.

Table 20. Average Number of Lines per Claim—MCOs and DBMs and Average Number of Lines per Encounter—MCOs						
Claims						
MCOs	**Facility**			**Professional**		
	Lines	Claims	Avg. Lines per Claim	Lines	Claims	Avg. Lines per Claim
Q1 Dates of Service	128,169	32,163	3.98	603,127	275,285	2.19
Q2 Dates of Service	109,892	26,295	4.18	570,561	257,761	2.21
DBMs	Lines		Claims		Average Lines per Claim	
Q1 Dates of Service	308,307		64,637		4.77	
Q2 Dates of Service	305,737		65,175		4.71	

Table 20. Average Number of Lines per Claim—MCOs and DBMs and Average Number of Lines per Encounter—MCOs			
Encounters			
MCOs	Lines	Claims	Average Lines per Claim
Q1 Dates of Service	99,999	19,616	5.10
Q2 Dates of Service	107,251	20,172	5.32

Table 21 includes the total average number of claim and encounter lines per enrollee who received services for the MCOs and the total average number of claim lines per enrollee who received services for the DBMs. Consistency also was a primary finding among the MCOs and DBMs for the average number of lines per enrollee who received services.

Table 21. Average Number of Claim Lines per Enrollee Who Received Services—MCOs and DBMs and Average Number of Encounter Lines per Enrollee Who Received Services—MCOs						
Claims						
MCOs	**Facility**			**Professional**		
	Lines	Enrollees	Avg. Lines per Enrollee Who Rec'd. Services	Lines	Enrollees	Avg. Lines per Enrollee Who Rec'd. Services
Q1 Dates of Service	128,169	21,928	5.84	603,127	99,626	6.05
Q2 Dates of Service	109,892	18,056	6.09	570,561	94,467	6.04
DBMs	Claim Lines		Enrollees		Average Lines per Enrollee Who Received Services	
Q1 Dates of Service	308,307		46,562		6.62	
Q2 Dates of Service	305,737		46,131		6.64	

Table 21. Average Number of Claim Lines per Enrollee Who Received Services—MCOs and DBMs and Average Number of Encounter Lines per Enrollee Who Received Services—MCOs

	Encounters		
MCOs	Encounter Lines	Enrollees	Average Lines per Enrollee Who Received Services
Q1 Dates of Service	99,999	13,974	7.16
Q2 Dates of Service	107,251	14,562	7.37

Conclusions and Recommendations

Strengths and Opportunities

Overall, FHKC's MCOs and DBMs demonstrated a continued dedication to providing high-quality services to FHK enrollees.

ANA

For the 2018 ANA, the MCOs demonstrated a shared strength for providing access to enrollees to adult and pediatric PCPs, acute care hospitals, laboratories, and pharmacies within the required travel time standard. In addition, four of the five MCOs provided appropriate access to SCPs, whether pediatric, adult, or both. The DBMs demonstrated a shared strength as well, providing most enrollees with access to primary care general dentists. However, the individual Plans also exhibited areas for improvement.

Aetna

Aetna did not present a P&P including required appointment availability standards, but appointment availability standards were included in a provider newsletter, the provider manual, and the member handbook, confirming that Aetna communicates requirements to network providers and enrollees. In addition, overall access to several pediatric and adult specialties was below standard.

Amerigroup

Amerigroup presented draft P&P: Network Standards; Availability of Providers – FL, which included appropriate appointment availability standards. However, this P&P was not effective until April of 2018. The provider manual included standards, but in one section, they were inconsistent with requirements, with a four-week standard listed for routine care and no standard for physical examination included. The member handbook included standards similar, but not identical, to required standards.

Staywell

Staywell presented a P&P including required appointment availability standards. The provider manual included required standards, demonstrating that Staywell communicates standards to network providers. However, standards were not included in the member handbook.

Sunshine

Sunshine did not present a P&P including required appointment availability standards. However, documentation of appropriate appointment availability standards in both the provider manual and member handbook demonstrated that Sunshine communicates standards to both network providers and enrollees.

UnitedHealthcare

UnitedHealthcare presented a P&P including required appointment availability standards. However, the addition of the FHK standards was not effective until March of 2018. The provider manual included required appointment availability standards; however, the member handbook included standards inconsistent with requirements.

Argus

Argus had appropriate access for prosthodontists for 79.4% of enrollees. The DBM presented a P&P including appointment availability standards, and the provider manual included required standards. However, the member handbook did not include appointment availability standards.

DentaQuest

DentaQuest presented a P&P with appropriate appointment availability standards. While the provider manual included appointment standards, they were inconsistent with requirements. The member handbook

did not include appointment availability standards. Overall, the DentaQuest network complied with access standards for all provider specialties, with the exception of periodontists and prosthodontists.

MCNA

Qsource concluded that MCNA complied with access standards for all provider specialties, with the exception of prosthodontists. MCNA presented a P&P with appropriate appointment availability standards. The provider manual included standards similar, but not identical, to required standards. In addition, the member handbook did not include appointment availability standards.

ACA

For the 2018 ACA, Qsource evaluated four CA standards: Access and Availability of Services, Grievance System, Quality Assessment and Performance Improvement, and Program Integrity. In addition, both appeal and grievance file reviews were conducted. Six of the eight MCOs and DBMs maintained 100% overall compliance for Access and Availability of Services, and four maintained 100% compliance for Quality Assessment and Performance Improvement. Five earned 100% compliance for both file reviews. The MCOs and DBMs also demonstrated the following:

Aetna

Aetna should be commended as a gold standard in providing thorough, well-organized pre-assessment documentation. Onsite, the process was well organized, and it was clear the MCO was well prepared. Aetna achieved an overall compliance score of 97.5%. A compliance rate of 100% was achieved for the Access and Availability of Services and the Quality Assessment and Performance Improvement standards. Aetna achieved 96.4% for the Grievance System standard, and 94.4% compliance was achieved for the Program Integrity standard. For both the grievance and the appeal file reviews, Aetna achieved 100% compliance.

Amerigroup

Amerigroup achieved an overall compliance score of 93.5%. A compliance rate of 100% was achieved for the Access and Availability of Services, Quality Assessment and Performance Improvement, and Program Integrity standards. Amerigroup achieved 84.3% for the Grievance System standard. For both the grievance and the appeal file reviews, Amerigroup achieved 100% compliance. The

MCO also had the only strength identified for the 2018 ACA: it earned the Multicultural Healthcare Distinction from NCQA.

Staywell

Staywell achieved an overall compliance score of 97.5%. A compliance rate of 100% was achieved for the Access and Availability of Services and the Quality Assessment and Performance Improvement standards. Staywell achieved 96.4% compliance for the Grievance System standard and 94.4% for the Program Integrity standard. Finally, Staywell achieved 97.3% compliance for the appeal file review and 95.0% for the grievance file review.

Sunshine

Sunshine achieved an overall compliance score of 88.8%. A compliance rate of 99.1% was achieved for the Quality Assessment and Performance Improvement standard, and 94.4% compliance was achieved for the Program Integrity standard. For both the grievance and the appeal file reviews, Sunshine achieved 100% compliance.

UnitedHealthcare

UnitedHealthcare achieved an overall compliance score of 92.8%. A compliance rate of 100% was achieved for the Quality Assessment and Performance Improvement standard, 98.2% for the Grievance System standard, and 88.7% for the Program Integrity standard. For both the grievance and the appeal file reviews, UnitedHealthcare achieved 100% compliance.

Argus

Argus achieved 97.75% overall compliance for the compliance standards. The DBM achieved 100% compliance for the Access and Availability of Services and Grievance System standards, 95.3% for Quality Assessment and Performance Improvement, and 94.4% for Program Integrity.

DentaQuest

DentaQuest achieved 100% compliance for the Access and Availability of Services standard, 85.0% for Quality Assessment and Performance Improvement, and 88.7% for Program Integrity. Compliance scores for the onsite appeal and grievance file reviews were 100% and 96.4%, respectively.

MCNA

MCNA achieved an overall compliance standard score of 98.5% and 100% compliance for three of the four

standards: Access and Availability of Services, Quality Assessment and Performance Improvement, and Program Integrity. For the remaining compliance standard, Grievance System, MCNA achieved 96.4% compliance. The DBM achieved 100% compliance for both the appeal and the grievance file reviews.

PMV

The MCOs and DBMs demonstrated the following strengths for the 2018 PMV:

Aetna

Aetna underwent an NCQA HEDIS Compliance Audit, and the final opinion indicated that all performance measures were prepared in accordance with the HEDIS Technical Specifications

Amerigroup

Amerigroup underwent an NCQA HEDIS Compliance Audit, and the final opinion indicated that all performance measures were prepared in accordance with the HEDIS Technical Specifications.

Staywell

Staywell underwent an NCQA HEDIS Compliance Audit, and the final opinion indicated that all performance measures were prepared in accordance with the HEDIS Technical Specifications.

Sunshine

Sunshine underwent an NCQA HEDIS Compliance Audit, and the final opinion indicated that all performance measures were prepared in accordance with the HEDIS Technical Specifications.

UnitedHealthcare

UnitedHealthcare underwent an NCQA HEDIS Compliance Audit, and the final opinion indicated that all performance measures were prepared in accordance with the HEDIS Technical Specifications.

Argus

The Argus team was well prepared for the onsite review, which was demonstrated both by ISCA documentation and identifying subject matter experts necessary for each of the various areas contributing to performance measure data reporting. The DBM included key leadership and dedicated resources to the FHKC contract during the onsite review, which Qsource noted as a high level of engagement and commitment to the FHK program. Qsource noted that the Argus team was fully transparent

regarding processes, systems, and challenges with reporting performance measure data, which supported an effective onsite review. In addition, the Argus team was receptive to feedback and recommendations. Qsource noted Argus' process for addressing reinstatements as a strength. This process was very efficient for addressing issues between monthly files.

DentaQuest

The DentaQuest team was well prepared for the onsite review, which was demonstrated by ISCA documentation, prepared onsite presentations, and systems demonstrations, as well as identifying subject matter experts necessary for each of the various areas contributing to performance measure data reporting. Qsource noted that DentaQuest had mature and robust system capabilities for data collection and reporting. Qsource identified DentaQuest's process for measure production as a best practice. The process included steps to finalize code for a given measure specification year and retain the code and specifications for future reference. This process allowed for consistency in reporting for various stakeholders.

MCNA

MCNA had an excellent internally developed system, DentaTrac, which was fully integrated on the enterprise level. The DentaTrac system housed all of the claims, enrollment, and provider data and was ultimately used to produce the performance measures. The DBM has multi-level validation and auditing processes, which enhances data accuracy. The staff was knowledgeable about their various areas of expertise and the PMV processes.

PIPs

Eight PIPs (with two unique topics) were selected for validation for 2018, with four of them achieving a Met validation status and four achieving a Not Met validation status. The Not Met status for the two MCOs and two DBMs not achieving a Met validation status was primarily a result of lack of documentation to support compliance with critical elements, which is required to achieve a Met status for the PIP overall. No strengths were identified for Staywell or Sunshine. The other MCOs and DBMs demonstrated the following:

Aetna

Aetna had a very detailed data analysis plan and demonstrated awareness of factors that could have impacted results.

Amerigroup

Amerigroup addressed activities VI and VIII in detail and provided comprehensive supporting documentation.

UnitedHealthcare

UnitedHealthcare provided a detailed analysis of the relevance of the study topic, including a demographic analysis of the target population and how the study can impact provider satisfaction in addition to enrollee health. In addition, the study population was described in detail and included appropriate HEDIS Technical Specifications for W34. The MCO addressed Activity VI in detail and provided comprehensive supporting documentation and did subgroup analysis to better understand the dynamics of the measurement. The MCO's description of improvement strategies and analysis of results was extremely well documented and comprehensive.

Argus

Argus provided comprehensive, relevant research on the study topic, along with national-, state-, and DBM-level data analysis.

DentaQuest

DentaQuest provided comprehensive, relevant research on the study topic and addressed each element requirement in Activity VI in comprehensive detail. In addition, the DBM presented a comprehensive analysis and interpretation of study results. The DBM also addressed all improvement strategies, experiences with the interventions, and limitations in detail. Finally, the DBM provided a comprehensive interpretation of results for each study indicator over each remeasurement period.

MCNA

MCNA provided comprehensive, relevant research on the study topic; addressed all improvement strategies, results of the interventions, and limitations in detail; and identified external factors that could have impacted the study indicator rates. The DBM clearly presented year-to-year statistical results for all three indicators.

Recommendations

ANA

The following recommendations were made for improvement for the MCOs and DBMs:

Aetna

Aetna should work to improve access to adult and pediatric SCPs and behavioral health SCPs that are significantly below standard and continue to monitor the network and implement corrective action for any identified deficiencies. Also, Aetna should develop a P&P regarding appointment availability standards.

Amerigroup

Amerigroup should take appropriate action to improve access to physical, speech, and occupational therapy, and substance abuse specialists. Also, Amerigroup should continue to monitor its provider network and implement corrective action for identified deficiencies. Amerigroup should ensure that its P&P addressing appointment availability requirements is approved and effective and that appointment availability standards included in the provider manual and member handbook are accurate and consistent.

Staywell

Staywell should take appropriate action to improve access to substance abuse specialists, if possible. Also, Staywell should continue to monitor its provider network and implement corrective action for identified deficiencies. Finally, Staywell should update its member handbook to include appropriate appointment availability standards.

Sunshine

Sunshine should continue to monitor its network and implement corrective action for any identified deficiencies. Also, Sunshine should document appointment availability standards in a P&P, to ensure that Sunshine staff is aware of related contract requirements.

UnitedHealthcare

UnitedHealthcare should continue to monitor its network and implement corrective action for any identified deficiencies. Also, UnitedHealthcare should ensure that its P&P including appointment availability standards is reviewed and approved as appropriate and ensure the member handbook includes required standards.

Argus

Argus should take appropriate action to improve access to prosthodontists. Also, Argus should continue to monitor its provider network and implement corrective action for identified deficiencies. Finally, Argus should ensure that the member handbook includes appropriate appointment availability standards.

DentaQuest

DentaQuest should take appropriate action to improve access to periodontists and prosthodontists. Also, DentaQuest should continue to monitor its provider network and implement corrective action for identified deficiencies. Finally, DentaQuest should update its provider manual and member handbook to include appropriate appointment availability standards.

MCNA

MCNA should take appropriate action to improve access to prosthodontists. Also, MCNA should continue to monitor its provider network and implement corrective action for identified deficiencies. Finally, MCNA should update its provider manual and member handbook to include appointment availability standards consistent with requirements.

ACA

Qsource recommended the following changes for improvement for the MCOs and DBMs:

Aetna

Two AONs and three suggestions were identified for Aetna.

The MCO should update its member handbook to indicate that appeals must be requested within 60 days from the date of the adverse benefit determination notice. Policy #3100.70 should also be updated to include the 60-day time limit to request an appeal. Policy #A-FL 3000.01 and the provider manual should be updated to include a mechanism for providers to report overpayments to the MCO, to return the overpayment within 60 calendar days, and to notify the MCO in writing of the reason for the overpayment.

Aetna could update Policy #6100.06 to reflect it is in fact measuring access relative to FHKC time standards as well as update the member handbook to clarify that authorized representatives other than a provider may file a grievance or appeal on the enrollee's behalf. The MCO could also

develop a P&P regarding appropriate appointment availability standards for the FHK program.

Amerigroup

Qsource identified four AONs and 11 suggestions for Amerigroup. The majority of suggestions and AONs for Amerigroup were the result of lack of appropriate language in P&Ps in the review period (2017). Draft P&Ps for 2018 with the required language were submitted. Although appropriate P&P language was not available in 2017, Amerigroup complied in practice with requirements overall.

The MCO's member handbook should indicate that enrollees may file a grievance at any time and that appeals may be requested within 60 calendar days of the date of the Notice of Action. The MCO should approve and finalize the draft P&P Member Complaints and Grievances—FL and update P&P Member Appeals—FL to include that reasonable assistance in completing forms and taking other procedural steps is available to enrollees during the grievance and appeals process. The member handbook should be updated to include the assistance available to enrollees for filing a grievance or appeal. The MCO should approve and finalize draft P&P Member Complaints and Grievances—FL to include provisions for ensuring all individuals who make decisions on grievances are not involved in any previous level of review and have appropriate clinical expertise for grievances that involve clinical issues. P&P Member Appeals—FL should be updated to include the 14-calendar-day limit, and draft P&P Member Complaints and Grievances—FL should be approved and finalized.

The MCO also could approve and finalize draft P&P Network Standards; Availability of Providers—FL with reference to FHK network geographical access standards, second opinions, out-of-network services and provider payments, FHK appointment availability standards, and timely access requirements. The MCO could ensure that the provider manual, participating provider agreement, and member handbook include consistent and accurate appointment availability standards. To clarify specific requirements for FHK, the MCO could update P&P Member Appeals—FL to include the Subscriber Assistance Program (SAP) in the State Fair Hearing (External Review) section. The MCO could expand evaluation of case management to include specific quality and appropriateness measures for enrollees in the

program. The MCO could finalize and approve draft P&P Network Changes—FL with reference to notification to FHKC of termination of provider contracts. Finally, the MCO could finalize and approve draft P&P Provider Adverse Actions—FL referencing individuals excluded from federal healthcare programs.

Staywell

Two AONs and five suggestions were identified for Staywell.

P&P #C7-AP-012-PR-001 should be updated to indicate that appeals may be requested within 60 days of an adverse benefit determination. The member handbook should be updated to indicate that a grievance may be filed at any time and an appeal may be filed within 60 days of an adverse benefit determination. The MCO should update the provider manual to indicate that overpayments must be returned within 60 days.

The MCO could update the member handbook to include appointment availability standards and ensure that standards in the provider manual are consistent with FHKC requirements; the MCO could also update P&P #C7-AP-012-PR-001 to indicate that this provision applies to the FHK population. In addition, the MCO could update P&P #C7-AP-012-PR-001 and other applicable policy provisions to include the enrollee's right to request a SAP review. The MCO could also update P&P #C7QI-026 to clarify that all clinical practice guidelines, not just revised guidelines, are disseminated to providers. Finally, the MCO could update the QIPD to include specific references to the measurement and submission of mandated performance measures to FHKC.

Sunshine

Qsource identified 10 AONs and four suggestions for Sunshine.

P&P #FLI.CONT.10 should be updated to include FHKC geographical access standards. The member handbook also should be updated to describe the circumstances under which out-of-network services are covered and to reflect that a grievance may be filed at any time and an appeal may be filed up to 60 days after adverse benefit determination notice. The MCO should include the requirement that all providers have hours of operation similar to commercial or Medicaid fee-for-service enrollees in the provider manual or provider agreement. In addition, P&P #FL.QI.11.01 should be updated to reflect

that a grievance may be filed at any time and an appeal may be filed up to 60 days after adverse benefit determination notice to address deemed exhaustion of appeals; to include that a grievance must be resolved as expeditiously as the enrollee's health requires; to include the requirements following an appeal timeline extension that was not requested by the enrollee; and to explain that services will be authorized or provided no later than 72 hours from the date the MCO receives notice reversing the determination. P&P #FL.QI.08 should state the coverage of services is consistent with practice guidelines, and P&P #FLI.COMP.16 should include a specific mechanism described for providers to report an overpayment to the MCO, return overpayments within 60 calendar days, and notify the MCO in writing of the reason for the overpayment.

Suggestions include reviewing and updating P&P: Timeliness of UM Decisions and Notifications as well as P&P #FL.QI.24 annually as needed; developing a P&P regarding appropriate appointment availability standards and ensuring the provider manual includes standards identical to the contractual requirements; and updating the QIPD to include the reporting of FHKC-required measures.

UnitedHealthcare

UnitedHealthcare had seven AONs and nine suggestions.

P&P #NM-01 should be effective for the review period, and P&P #NM-6 should include Geoaccess reports for SCPs providing services in the network. P&P #MMA LTC NM 11 should be effective for the review period. The policy also should be updated to remove inaccurate information about the enrollee's responsibility for up to 40% of costs of medical services provided out of network and to explain that the services are to be provided at no cost to the enrollee. The member handbook should also be updated to include this information about out-of-network service availability. P&P #MMA LTC NM 11, as well as P&P #NM MMA LTC 23, also should be effective for the review period. In addition, the practitioner agreement or the provider manual should be updated to include hours of operation requirements specifically for FHK enrollees, the member handbook should be updated to indicate that enrollees may file a grievance at any time, and the MCO should ensure P&P #HP (SIU) 004 is effective for the review period.

Suggestions include creating a new policy or updating appropriate existing policies to include geographic access standards for FHK; ensuring that P&P #NM-6 is effective for the review period; and updating the member handbook to indicate that there is no cost to the enrollee for a second opinion and that out-of-network second opinions will be covered if services are not available in-network. The member handbook also could be updated to include FHKC-required standards. The MCO could ensure that P&P #MMA LTC NM 08 is effective for the review period and it includes access standards identical to FHKC requirements. In addition, the MCO could update P&P #MMA LTC NM 08 to more thoroughly address ensuring provider compliance and corrective action in the case of deficiencies and update P&P #POL2015-02 to address the enrollee's right to request a review through the SAP. The MCO could add a reference to SAP review to applicable policy provisions and update the QIPD and/or appropriate policies to include the process for reporting FHKC-required performance measures. Finally, the MCO could update the Optum 2017 Whole Person Care Management Program Evaluation to report specific results for the FHK program separately.

Argus

Argus had three AONs and five suggestions.

The DBM should update P&P #UM_62 to include the provision for dissemination of guidelines to enrollees and potential enrollees on request and to ensure guidelines are consistent with enrollee education, coverage of services, and other areas to which guidelines apply. The DBM should update the managed care provider agreement to include the requirement that providers provide written notification of the reason for overpayments to the DBM.

The DBM could update the member handbook to include information on availability of second opinions, on out-of-network provider coverage, and appointment availability standards. The provider manual could be updated to include standards for routine care and routine examinations consistent with standards. The DBM also could capture enrollee race data from the eligibility file to allow for analysis of culturally appropriate provider network and healthcare disparity analysis. Finally, the DBM could add the process of random claim verification calls to enrollees to its compliance program.

DentaQuest

Qsource identified 22 AONs and eight suggestions for DentaQuest.

The DBM should update P&P #200.016 to reflect that a grievance may be filed at any time and an appeal may be filed up to 60 days after adverse benefit determination notice and to indicate that if the DBM fails to adhere to notice and timing requirements for the appeal, the enrollee is deemed to have exhausted the DBM's appeal process and may initiate State review.

The member handbook should be updated to include the following information:

- An expedited appeal does not need to be filed in writing.
- All grievances and appeals, whether filed orally or in writing, will be acknowledged.
- The date of the oral appeal will be treated as the appeal initiation date to establish the earliest possible filing date and oral appeals will be confirmed in writing.
- The information will be provided to the enrollee or their representative free of charge, and notice will be provided to the enrollee or their representative as expeditiously as the enrollee's health requires.
- The process to resolve appeals and provide notice to the affected parties as expeditiously as the enrollee's health condition requires, but not to exceed 30 calendar days after receipt of a standard appeal, and not to exceed 72 hours after receipt of an expedited appeal
- The timeframe extension for appeals and the standard grievance timeframe
- The DBM must provide oral notice of the reason for the delay to the enrollee by close of business on the day of the determination, provide written notice of the reason for the delay to the enrollee within two calendar days, and resolve the appeal as expeditiously as the enrollee's health requires and no later than the date the extension expires.
- For expedited appeals, the DBM makes reasonable efforts to provide oral notice to both the enrollee and the provider.
- Punitive action will not be taken against a provider who requests an expedited appeal resolution or supports an enrollee's appeal.
- If an expedited appeal is denied, the appeal will be resolved within 30 days.

- In the event of a reversal of the decision to deny, limit, or delay services that were not furnished during the appeal process, the services must be authorized or provided as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the decision to overturn the appeal.
- In the event of a reversal of the decision to deny authorization of services, the enrollee who received the disputed services while the appeal was pending should have the services paid by the DBM.
- A grievance may be filed at any time, and an appeal may be filed up to 60 days after adverse benefit determination notice.
- An enrollee's representative may initiate a State review on the enrollee's behalf.
- An expedited appeal does not need to be filed in writing.

In addition, the enrollee letter for an expedited appeal should indicate the limited timeframe available for the enrollee to provide additional information. The DBM also should update P&P #200.018 to indicate that punitive action will not be taken against a provider who requests an expedited appeal resolution or supports an enrollee's appeal. The DBM should adopt appropriate practice guidelines for dental services and conditions and, once adopted, disseminate them to all affected providers and enrollees and potential enrollees upon request. Once guidelines are adopted, decisions for utilization management, enrollee education, coverage of services, and other areas to which guidelines apply should be consistent with the guidelines. The DBM should implement a formal process to regularly verify if services billed have been received by enrollees and update the provider services agreement to include the requirements to refund the overpayment within 60 days and to notify the DBM of the reason for the overpayment.

Actions the DBM could take include updating the member handbook to include information on second opinions and coverage for services from out-of-network providers; updating P&P #900.017 and the member handbook to ensure FHKC-required standards are included; and updating P&P #200.016 to indicate that a grievance or appeal may be filed orally or in writing and to clarify the reference to expedited grievances and expedited appeals. The DBM also could update P&P #200.017 to indicate that a grievance or appeal may be filed orally or in writing; develop a P&P to specifically address the required criteria as they apply specifically to PIPs; and update the Quality

Improvement Program Description (QIPD) to include the reporting of required performance measures to FHKC.

MCNA

Qsource identified one AON and one suggestion for MCNA.

The DBM should update P&P #13.105, P&P #13.200, and the member handbook to reflect that a grievance may be filed at any time and an appeal may be filed up to 60 days after adverse benefit determination notice.

The DBM could update the provider manual and member handbook to include appointment availability standards identical to required standards.

PMV

Qsource did not identify any areas for improvement for Aetna, Amerigroup, DentaQuest, Staywell, Sunshine, or UnitedHealthcare. The following recommendations were made for improvement for two of the DBMs:

Argus

Qsource recommends that Argus maintain and document the measure specification versions used in the production of performance measure data as either part of its code or as a footnote to the performance measure rate data reporting to ensure that they are readily available for reference if needed.

MCNA

For MCNA, consideration should be extended for the use of the retro-active notification date to determine continuous enrollment. This would assist in identifying enrollees not meeting continuous enrollment criteria.

PIPs

Qsource identified the following areas of improvement for the MCOs and DBMs:

Aetna

Qsource identified five AONs and two suggestions for Aetna.

The MCO should include research-based and MCO-specific data and analysis that support the relevance of the study topic. The MCO should provide written instructions on how to complete the manual data abstraction tool and an overview of the study itself in these instructions. The MCO should also specifically describe how the estimated degree of data completeness was determined and discuss the extent to which the study was successful. While there

was statistically significant improvement from the baseline to the remeasurement, the MCO should evaluate statistical significance of improvement from remeasurement to remeasurement and evaluate sustained improvement between measurement years, as opposed to evaluating between the baseline and remeasurement years.

The MCO could expand presentation of its data analysis for applicable measurement/remeasurement periods to include graphs or tables including measurement periods, results, and benchmarks. Finally, the MCO could include the specific root-cause analysis that led to the identification of barriers.

Amerigroup

Amerigroup had three AONs and one suggestion.

The MCO should include research-based and MCO-specific data and analysis that support the relevance of the study topic and evaluate sustained improvement between measurement years, as opposed to evaluating between the baseline and remeasurement years, and also the statistically significant decline in the study indicator results.

While the MCO included how the study indicator would actually be calculated (i.e., HEDIS-certified software) in Activity VI, it could include that information for this activity as well. In addition, the MCO could expand presentation of its data analysis for applicable measurement/remeasurement periods to include graphs or tables including measurement periods, results, and benchmarks.

Staywell

Qsource identified five AONs and three suggestions for Staywell.

The MCO should report MCO-specific data and analysis that support the selection of the study topic and identify data elements to be collected in Activity VI. The MCO also should include the medical record data collection tool. The training materials for hybrid data collection should be included in the submission as well. Because the MCO selected the W34 administrative rate as a study indicator, data collection algorithms/flow charts should be included. While the MCO provided detailed information on incurred but not reported (IBNR) calculations, how the 100% completeness score was derived should be described. The MCO also should include how the study

indicators would actually be calculated (i.e., HEDIS-certified software) and how indicators would be compared to the goal or benchmark in the data analysis plan. The MCO should further examine how the impact of improvement strategies on study indicator results can be measured. In addition, the MCO should continue efforts to identify revisions to existing interventions and new interventions that would lead to statistically significant improvement. Finally, the MCO should address the observed random, year-to-year variations in the study indicators.

The MCO could consider selecting either the administrative or the hybrid HEDIS methodology for calculating the study indicators, or include a rationale for why both methodologies were selected. The MCO could expand presentation of its data analysis for applicable measurement/ remeasurement periods to include graphs or tables including measurement periods, results, and benchmarks. The MCO could include the specific root-cause analysis that led to the identification of barriers. In addition, the MCO could specifically incorporate methods to evaluate the impact of interventions in its intervention planning process.

Sunshine

Sunshine had three AONs and four suggestions. The MCO should include algorithms and/or flow charts that describe the production of administrative indicators. Also, the MCO should include a description supporting the data completeness results. In addition, the MCO should include how the study indicator would be compared to the goal or benchmark in the data analysis plan. The MCO should specifically address any factors that might affect the internal or external validity of the findings. The MCO also should include an interpretation of the study's success to date and further examine how improvement strategies can impact study indicator results.

The MCO could specifically state in Activity I that enrollees with special healthcare needs were not excluded from the study. In addition, while the MCO referenced HEDIS W34 Technical Specifications, a general discussion of the data elements to be collected could be included for element 1 in Activity VI. The MCO could expand presentation of its data analysis for applicable measurement/remeasurement periods to include graphs or tables including measurement periods, results, and

benchmarks. The MCO also could include the specific root-cause analysis that led to the identification of barriers.

UnitedHealthcare

Qsource identified two AONs for UnitedHealthcare.

The MCO should further examine how the impact of improvement strategies on study indicator results can be measured. In addition, the MCO should continue efforts to identify revisions to existing interventions and new interventions that would lead to statistically significant improvement. The MCO also should address the observed random, year-to-year variations in the study indicator or other factors that may have impacted the study indicator.

Argus

Qsource identified four AONs and one suggestion for Argus.

While the DBM described data elements collected in Activity IV, it also should include that information in Activity VI. The DBM should include algorithms and/or flow charts that describe the production of administrative indicators. Also, the DBM should include a clear explanation of how estimated data completeness was calculated. In addition, the data analysis plan should include the statistical tests that would be used to compare the study indicator rates. While the DBM included the statistical significance of differences in study indicators over measurement periods in Activity IX, the topic should also be addressed in Activity VII as part of interpretation of results. The DBM should specifically address whether remeasurement and baseline methodologies were the same. Results of statistical tests should be indicated individually for each remeasurement period, in order to determine if true improvement occurred. The DBM also should include a clear analysis of statistical testing results from remeasurement to remeasurement to assess for real improvement.

While the DBM included the root-cause analysis in Activity VI, it could consider reporting it for Activity VIII as well.

DentaQuest

DentaQuest had two AONs and one suggestion. The DBM should report DBM-specific data and analysis that support the selection of the study topic and specifically indicate if factors affecting the ability to compare initial and remeasurement rates exist.

The DBM could include the specific root-cause analysis that led to the identification of barriers.

MCNA

MCNA had five AONs and four suggestions.

The DBM should report DBM-specific data and analysis that support the selection of the study topic and include algorithms and/or flow charts that describe the production of administrative indicators. The DBM should include a general description of how indicator rates would be calculated and compared to the benchmark or goal in the data analysis plan. The DBM should specifically address whether factors affecting the ability to compare initial and remeasurement rates exist and whether remeasurement and baseline methodologies were the same. The DBM also should address statistically significant decreases in study indicators and the random, year-to-year variation for the third study indicator.

The DBM could explicitly state that the study topic was selected by FHKC. While the DBM described data elements collected and sources of data in Activity IV, these topics could be addressed in Activity VI. The DBM could report results in tabular or graphical format. In addition, the DBM could specifically indicate the level of success of the study and include the specific root-cause analysis that led to the identification of barriers.

APPENDIX A | MCO and DBM Findings

In accordance with CMS guidelines for EQRO technical reporting, this appendix presents MCO- and DBM-specific results for the 2018 ANA, ACA, and PIP Validation activities. The MCO- and DBM-specific results for the 2018 PMV can be found in the PMV section.

ANA

The following evaluation activities were performed for all MCOs and DBMs:

- Provider Ratio Analysis
- Time Analysis
- Appointment Availability

The network adequacy information in **tables A-1** and A-2 for all MCOs and DBMs was obtained from analyses performed on provider and enrollee data.

Table A-1. 2018 ANA Network Adequacy Results: MCOs

Measure	Travel Time Standard (max)	Aetna	Amerigroup	Staywell	Sunshine	United Healthcare
Access by Provider Category Results						
Pediatric Primary Care Providers (PCPs)	Within 20 minutes	99.7%	100%	99.8%	99.8%	99.9%
Adult PCPs	Within 20 minutes	99.5%	99.1%	99.5%	99.7%	99.9%
Pediatric SCPs	Within 60 minutes	85.1%	99.3%	99.7%	97.3%	94.2%
Adult SCPs	Within 60 minutes	95.0%	96.2%	99.6%	99.2%	100%
Behavioral Health Providers	Within 60 minutes	67.3%	92.4%	83.7%	94.2%	100%
Acute Care Hospitals	Within 60 minutes	100%	100%	100%	100%	100%
Freestanding Pediatric Hospitals	Within 60 minutes	64.4%	96.4%	58.3%	63.8%	55.9%
Freestanding Psychiatric Facilities	Within 60 minutes	85.3%	99.9%	100%	83.6%	100%

Table A-1. 2018 ANA Network Adequacy Results: MCOs						
Measure	**Travel Time Standard (max)**	**Aetna**	**Amerigroup**	**Staywell**	**Sunshine**	**United Healthcare**
Laboratories	Within 60 minutes	99.7%	99.2%	99.8%	99.3%	100%
Pharmacies	Within 60 minutes	100%	100%	100%	100%	100%
Access to Specialists Results						
Allergy and Immunology	Within 60 minutes	91.5%	99.2%	99.3%	99.3%	100%
Cardiology	Within 60 minutes	99.9%	99.9%	100%	100%	100%
Chiropractor	Within 60 minutes	99.2%	99.9%	99.9%	99.7%	100%
Dermatology	Within 60 minutes	94.1%	99.2%	99.9%	99.8%	100%
Endocrinology	Within 60 minutes	99.0%	99.7%	98.8%	95.8%	100%
ENT/Otolaryngology	Within 60 minutes	97.5%	99.9%	99.9%	99.3%	100%
Gastroenterology	Within 60 minutes	99.8%	99.9%	99.5%	98.6%	100%
General Surgery	Within 60 minutes	99.8%	99.9%	100%	100%	100%
Infectious Disease	Within 60 minutes	95.7%	99.7%	96.7%	98.8%	100%
Nephrology	Within 60 minutes	91.9%	99.7%	97.9%	99.4%	100%
Neurology	Within 60 minutes	99.8%	99.9%	99.4%	99.3%	100%
OB/GYN	Within 60 minutes	100%	100%	100%	100%	100%
Occupational Therapy	Within 60 minutes	46.5%	36.4%	99.0%	99.3%	100%
Oncology	Within 60 minutes	97.4%	99.9%	99.5%	99.2%	100%
Ophthalmology	Within 60 minutes	100%	98.7%	99.4%	99.5%	100%
Optometry	Within 60 minutes	46.5%	93.3%	100%	100%	100%

Table A-1. 2018 ANA Network Adequacy Results: MCOs						
Measure	**Travel Time Standard (max)**	**Aetna**	**Amerigroup**	**Staywell**	**Sunshine**	**United Healthcare**
Orthopedic Surgery	Within 60 minutes	99.9%	100%	100%	100%	100%
Pediatric Cardiology	Within 60 minutes	99.4%	99.9%	100%	98.8%	100%
Pediatric Endocrinology	Within 60 minutes	91.5%	99.2%	98.8%	96.7%	100%
Pediatric Gastroenterology	Within 60 minutes	96.7%	99.1%	99.5%	97.8%	59.7%
Pediatric Oncology	Within 60 minutes	91.1%	98.9%	99.7%	97.0%	100%
Pediatric Orthopedic Surgery	Within 60 minutes	26.5%	98.9%	100%	95.7%	100%
Pediatric Psychiatry	Within 60 minutes	75.1%	100%	100%	99.4%	100%
Pediatric Pulmonology	Within 60 minutes	93.5%	99.2%	99.4%	99.0%	100%
Pediatric Surgery	Within 60 minutes	97.3%	99.9%	100%	95.8%	99.7%
Physical Therapy	Within 60 minutes	98.7%	76.2%	99.7%	99.7%	100%
Podiatry	Within 60 minutes	98.9%	99.9%	98.6%	99.1%	100%
Psychiatry	Within 60 minutes	92.7%	100%	100%	100%	100%
Psychology	Within 60 minutes	83.2%	99.9%	98.7%	99.4%	100%
Pulmonology	Within 60 minutes	97.8%	99.9%	99.4%	98.8%	100%
Social Work	Within 60 minutes	45.6%	100%	100%	100%	100%
Speech Therapy	Within 60 minutes	83.5%	95.5%	99.4%	97.8%	100%

Table A-1. 2018 ANA Network Adequacy Results: MCOs						
Measure	**Travel Time Standard (max)**	**Aetna**	**Amerigroup**	**Staywell**	**Sunshine**	**United Healthcare**
Substance Abuse Specialist	Within 60 minutes	40.1%	61.9%	20.0%	72.4%	100%
Urology	Within 60 minutes	98.3%	99.9%	97.5%	98.4%	100%
Overall Network Adequacy Results		**92.6%**	**98.9%**	**96.8%**	**95.0%**	**96.6%**

Table A-2. 2018 ANA Network Adequacy Results: DBMs				
Measure	**Standard (max)**	**Argus**	**DentaQuest**	**MCNA**
Pediatric Dentists	Within 20 minutes	92.8%	90.0%	92.6%
General Dentists	Within 20 minutes	99.5%	98.5%	98.5%
Endodontists	Within 60 minutes	95.4%	98.0%	98.8%
Orthodontists	Within 60 minutes	96.8%	99.0%	99.2%
Periodontists	Within 60 minutes	93.4%	87.8%	96.0%
Prosthodontists	Within 60 minutes	79.4%	70.4%	82.3%
Overall Network Adequacy Results		**92.9%**	**90.6%**	**94.6%**

ACA

CA Standards

Table A-3 displays each MCO's and DBM's compliance with federal statutes, its relative contract, and additional compliance standards established by FHKC. Individual results are presented for each CA standard.

Table A-3. 2018 ACA CA Standard Results: MCOs and DBMs								
Standard	**Aetna**	**Ameri-group**	**Argus**	**Denta Quest**	**MCNA**	**Staywell**	**Sunshine**	**United Health-care**
Access and Availability of Services	100%	100%	100%	100%	100%	100%	75.0%	67.9%
Grievance System	96.4%	84.3%	100%	51.8%	96.4%	96.4%	84.3%	98.2%
Quality Assessment and Performance Improvement	100%	100%	95.3%	85.0%	100%	100%	99.1%	100%
Program Integrity	94.4%	100%	94.4%	88.7%	100%	94.4%	94.4%	88.7%

Appeal and Grievance File Reviews

The results in **Table A-4** present each MCO's and DBM's compliance with each file review.

Table A-4. 2018 ACA File Review Results: MCOs and DBMs								
File Review	**Aetna**	**Ameri-group**	**Argus**	**Denta Quest**	**MCNA**	**Staywell**	**Sunshine**	**United Healthcare**
Appeal	100%	100%	84.6%	100%	100%	97.3%	100%	100%
Grievance	100%	100%	80.0%	96.4%	100%	95.0%	100%	100%

PIP Validation

FHKC required that all PIPs submitted by MCOs and DBMs be validated for CY2018. Individual elements were assessed as Met, Not Met, or Not Assessed (NA). Elements were designated NA if related data had not been collected for the PIP study at the time of the review. A Met validation status indicates confidence/high confidence that the PIP was valid, while a Not Met status indicates that PIP results were not credible.

For each applicable activity, tables **A-5** and A-6 summarize overall PIP validation scores, including the total number of evaluation elements assessed and Met, the number of critical elements assessed and Met, the percentage of elements that were Met, as well as the overall validation status. The actual number of activities validated for each MCO and DBM depended on various factors, including the progress of the PIP study and sampling methods.

Table A-5. 2018 PIP Validation Scores by Review Activity: MCOs

Review Activities	All (A) and Critical (C) Elements Met/Assessed									
	Aetna		Amerigroup		Staywell		Sunshine		United Healthcare	
	A	C	A	C	A	C	A	C	A	C
I. Choose the Study Topic(s)	5/6	1/1	5/6	1/1	5/6	1/1	6/6	1/1	6/6	1/1
II. Define the Study Question(s)	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
III. Use a Representative and Generalizable Study Population	3/3	2/2	3/3	2/2	3/3	2/2	3/3	2/2	3/3	2/2
IV. Select the Study Indicator(s)	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3	6/6	3/3

Table A-5. 2018 PIP Validation Scores by Review Activity: MCOs

Review Activities		All (A) and Critical (C) Elements Met/Assessed									
		Aetna		Amerigroup		Staywell		Sunshine		United Healthcare	
		A	C	A	C	A	C	A	C	A	C
V. Use Sound Sampling Methods		0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
VI. Use Valid and Reliable Data Collection Procedures		7/10	1/1	11/11	1/1	4/11	0/1	4/6	0/0	6/6	0/0
VII. Analyze and Interpret Study Results		8/9	2/2	9/9	2/2	8/9	1/2	5/8	0/1	8/8	1/1
VIII. Include Improvement Strategies		4/4	1/1	4/4	1/1	4/4	1/1	4/4	1/1	4/4	1/1
IX. Assess for Real Improvement		3/4	0/0	3/4	0/0	2/4	0/0	2/4	0/0	2/4	0/0
X. Assess for Sustained Improvement		0/1	0/0	0/1	0/0	0/1	0/0	0/0	0/0	0/1	0/0
Overall Score		**38/45**	**12/12**	**43/46**	**12/12**	**34/46**	**10/12**	**32/39**	**9/10**	**37/40**	**10/10**
Percentage of Elements Met	**Total**	**84.40%**		**93.47%**		**73.91%**		**82.10%**		**92.50%**	
	Critical	**100%**		**100%**		**83.33%**		**90.00%**		**100%**	
Validation Status		**Met**		**Met**		**Not Met**		**Not Met**		**Met**	

Table A-6. 2018 PIP Validation Scores by Review Activity: DBMs						
Review Activities	**All (A) and Critical (C) Elements Met/Assessed**					
	Argus		**DentaQuest**		**MCNA**	
	A	**C**	**A**	**C**	**A**	**C**
I. Choose the Study Topic(s)	6/6	1/1	5/6	1/1	5/6	1/1
II. Define the Study Question(s)	2/2	2/2	2/2	2/2	2/2	2/2
III. Use a Representative and Generalizable Study Population	3/3	2/2	3/3	2/2	3/3	2/2
IV. Select the Study Indicator(s)	6/6	3/3	7/7	3/3	6/6	3/3
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0
VI. Use Valid and Reliable Data Collection Procedures	3/6	0/0	6/6	0/0	5/6	0/0
VII. Analyze and Interpret Study Results	6/8	0/1	7/8	1/1	6/8	0/1
VIII. Include Improvement Strategies	4/4	1/1	4/4	1/1	4/4	1/1
IX. Assess for Real Improvement	2/4	0/0	4/4	0/0	3/4	0/0

Table A-6. 2018 PIP Validation Scores by Review Activity: DBMs							
Review Activities		**All (A) and Critical (C) Elements Met/Assessed**					
		Argus		**DentaQuest**		**MCNA**	
		A	**C**	**A**	**C**	**A**	**C**
X. Assess for Sustained Improvement		0/1	0/0	1/1	0/0	0/1	0/0
Overall Score		**32/40**	**9/10**	**39/41**	**10/10**	**34/40**	**9/10**
Percentage of Elements Met	**Total**	**80.00%**		**95.12%**		**85.00%**	
	Critical	**90.00%**		**100%**		**90.00%**	
Validation Status		**Not Met**		**Met**		**Not Met**	

APPENDIX B | 2018 Sample Assessment Tools

The assessment tools presented in this appendix represent a comprehensive sample of the tools used to evaluate performance for the following EQR activities:

- ANA
- ACA
- PIP Validation

The complete, individual MCO and DBM tools used for these listed reviews are contained within the individual MCO and DBM reports previously submitted to FHKC. Qsource's subcontractor, Quest Analytics, helped to conduct certain EQR activities.

ANA

The ANA tool templates for appointment availability were used to assess appointment availability for FHKC's MCOs and DBMs as part of the 2018 ANA.

2018 Appointment Availability Standards Review Tool		
Standard	**Evident in MCO P&Ps**	**Comments**
Emergency care shall be provided immediately.	<Yes or No>	
Urgently needed care shall be provided within 24 hours.	<Yes or No>	
Routine care of enrollees who do not require emergency or urgent care shall be provided within seven calendar days of the enrollee's request for services.	<Yes or No>	
Routine physical examinations shall be provided within four weeks of the enrollee's request.	<Yes or No>	

2018 Appointment Availability Standards Provider and Member Communication Review Tool		
Standard	**Evident in Provider Manual**	**Evident in Member Handbook**
Emergency care shall be provided immediately.	<Yes or No>	<Yes or No>
Urgently needed care shall be provided within 24 hours.	<Yes or No>	<Yes or No>
Routine care of enrollees who do not require emergency or urgent care shall be provided	<Yes or No>	<Yes or No>

2018 Appointment Availability Standards Provider and Member Communication Review Tool		
Standard	**Evident in Provider Manual**	**Evident in Member Handbook**
within seven calendar days of the enrollee's request for services.		
Routine physical examinations shall be provided within four weeks of the enrollee's request.	<Yes or No>	<Yes or No>

ACA

The following assessment tools were used for the ACA evaluation:

- 2018 ACA CA Standards Survey Tools (MCO and DBM)
- Appeal and Grievance File Review Tools

MCO CA Standards Tool

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Access and Availability of Services					
1. Delivery Network 42 CFR 438.206(b)(1), 42 CFR 438.206(c)(3)	The MCO must maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Geographic Access MSC 3-2-3	The MCO must provide geographical access as follows: - Board-certified family practice physicians, pediatric physicians, primary care providers, or Advanced Registered Nurse Practitioners (ARNPs) experienced in child healthcare within approximately 20 minutes driving time from residence to provider - Specialty medical services, ancillary services, and hospital services available within 60 minutes of driving time from residence to provider	☐ Primary care within 20 minutes of driving time ☐ Specialty care within 60 minutes of driving time	**1.000** **1.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Direct Access to Women's Health Specialist 42 CFR 438.206(b)(2)	The MCO must provide female enrollees with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive healthcare services, in addition to the enrollee's designated source of primary care.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Access and Availability of Services					
Findings **Strength** **AON** **Suggestion**					
4. Second Opinion 42 CFR 438.206(b)(3)	The MCO must provide for a second opinion from a qualified healthcare professional within the network or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
5. Out-of-Network Services 42 CFR 438.206(b)(4)	If the network is unable to provide necessary and covered services, the MCO must adequately and timely cover these services for the enrollee outside of the network.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
6. Out-of-Network Providers MSC 3-31-1	The MCO must provide enrollees with timely approval or denial of authorization for out-of-network services through the assignment of a prior authorization number or similar process approved by Florida Healthy Kids Corporation (FHKC). If the MCO has granted prior authorization for covered and out-of-network services, or in the case of emergency services, the MCO is responsible for the payment of claims incurred as a result of those services.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Access and Availability of Services					
Strength **AON** **Suggestion**					
7. Out-of-Network Provider Payment 42 CFR 438.206(b)(5)	The MCO must require all out-of-network providers to coordinate with the MCO for payment and ensure the cost to the enrollee is no greater than it would be if the services were furnished within network.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
8. Timely Access—Appointment Standards 42 CFR 438.206(c), MSC 3-2-4	The MCO must meet and require its providers to meet the following FHKC standards for timely access to care and services: a. Emergency care must be provided immediately b. Urgently needed care must be provided within 24 hours c. Routine care must be provided within seven calendar days of enrollee's request for services d. Routine physical examinations must be provided within four weeks of the enrollee's request e. Follow-up care must be provided as medically appropriate	☐ a. Emergency care provided immediately ☐ b. Urgently needed care provided within 24 hours ☐ c. Routine care provided within seven calendar days ☐ d. Routine physical examinations provided within four weeks ☐ e. Follow-up care provided as medically appropriate	**0.500** **0.500** **0.500** **0.500** **0.500**	**2.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Access and Availability of Services					
9. Timely Access—Other Requirements 42 CFR 438.206(c)(1)	The MCO must meet the following requirements: a. Ensure that network providers offer hours of operation that are no less than hours of operation offered to commercial enrollees or comparable Medicaid fee-for-service, if the provider serves only Medicaid enrollees b. Make services included in the contract available 24 hours a day, seven days a week, when medically necessary c. Establish mechanisms to ensure compliance by providers d. Monitor providers regularly to determine compliance e. Take corrective action if there is a failure to comply	☐ a. Hours of operation similar to commercial or Medicaid fee-for-service ☐ b. Services available 24 hours a day, seven days a week ☐ c. Mechanisms to ensure compliance in place ☐ d. Providers monitored for compliance regularly ☐ e. Corrective action taken if failure to comply	**0.500** **0.500** **0.500** **0.500** **0.500**	**2.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
10. Timely Access—Cultural Considerations 42 CFR 438.206(c), MSC 3-19-2A	The MCO must have a comprehensive written Cultural Competency Plan describing how the MCO will ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
Access and Availability of Services Score			**0.0%**	**14.000**	**0.000**

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
1. Grievance and Appeal System 42 CFR 438.402(a)	The MCO must have a system in place for enrollees that includes - a grievance process; and - an appeals process.	☐ Grievance process ☐ Appeals process	**1.000** **1.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Level of Appeals 42 CFR 438.402(b)	The MCO must have only one level of appeal for enrollees.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Authority and Timing to File—Enrollee 42 CFR 438.402(c)(2)	An enrollee may - file a grievance at any time; and - request an appeal up to 60 days from the date on the adverse benefit determination notice.	☐ File a grievance ☐ Request an appeal	**0.750** **0.750**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
4. Authority to File—Authorized Representative 42 CFR 438.402(c)(1)(i)	With written consent of the enrollee, a provider or authorized representative may request an appeal or file a grievance, or request a State review, on behalf of an enrollee.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
5. Deemed Exhaustion of Appeals Process 42 CFR 438.402(c)(1)(i)(A), 42 CFR 438.408(c)(3)	If the MCO fails to adhere to the notice and timing requirements for an appeal, the enrollee is deemed to have exhausted the MCO's appeal process and may initiate State review.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
6. Procedures to File Grievance and Appeal 42 CFR 438.402(c)(3)	The enrollee may - file a grievance either orally or in writing with the MCO; and - request an appeal either orally or in writing.	☐ File a grievance either orally or in writing ☐ Request an appeal either orally or in writing	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
7. Procedures—Oral Appeal 42 CFR 438.402(c)(3)	Unless the enrollee requests an expedited appeal, an oral appeal must be followed by a written, signed appeal.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
8. Assistance with Grievances and Appeals 42 CFR 438.406(a)	The MCO must give enrollees reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
9. Acknowledgement of Grievances and Appeals 42 CFR 438.406(b)(1)	The MCO must acknowledge receipt of each - grievance; and - appeal.	☐ Acknowledge receipt of grievances ☐ Acknowledge receipt of appeals	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
10. Individuals Who Make Grievance and Appeal Decisions 42 CFR 438.406(b)(2)(i-iii)	The MCO must ensure that individuals who make decisions on grievances and appeals a. were not involved in any previous level of review or decision-making nor a subordinate of any such individual; b. have the appropriate clinical expertise in treating the enrollee's condition or disease for an appeal of a denial based on lack of medical necessity, a grievance regarding denial of an expedited resolution of an appeal, or a grievance or appeal that involves clinical issues; and c. take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.	☐ a. Were not involved in previous level of review or decision-making nor a subordinate of any such individual ☐ b. Have the appropriate clinical expertise in treating the enrollee's condition or disease ☐ c. Take into account all information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination	**1.000** **1.000** **1.000**	**3.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
11. Oral Appeals 42 CFR 438.406(b)(3)	The MCO must provide that oral inquiries seeking to appeal an adverse benefit determination are - treated as appeals to establish the earliest possible filing date for the appeal; and - confirmed in writing, unless the enrollee or provider requests expedited resolution.	☐ Treated as appeals to establish earliest filing date ☐ Confirmed in writing, unless enrollee or provider requests expedited resolution	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
12. Opportunity to Present Evidence and Allegations of Fact or Law in Appeals 42 CFR 438.406(b)(4)	The process for appeals must - provide the enrollee a reasonable opportunity to present evidence and testimony and make legal and factual arguments; and - inform the enrollee of the limited timeframe available to do so in the case of expedited resolution.	☐ Provide enrollee a reasonable opportunity to present evidence and allegations of fact or law in person and in writing ☐ Inform the enrollee of limited timeframe to do so with expedited resolution	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
13. Opportunity to Examine Enrollee's Case File in Appeals 42 CFR 438.406(b)(5)	The process for appeals must provide the enrollee and their representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO in connection with the appeal of the adverse benefit determination free of charge and sufficiently in advance of the resolution timeframe for appeals.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
14. Parties to the Appeal 42 CFR 438.406(b)(6)	As parties to the appeal, the appeal process must include - the enrollee and their representative; or - the legal representative of a deceased enrollee's estate.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON**					

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
Suggestion					
15. Resolution of Grievance 42 CFR 438.408(a-b)	The MCO must dispose of each grievance and provide notice - as expeditiously as the enrollee's health condition requires; and - not to exceed 90 calendar days from the day the MCO receives the grievance.	☐ As expeditiously as the enrollee's health condition requires ☐ Not to exceed 90 calendar days from the day the MCO receives the grievance	**1.000** **1.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
16. Resolution of Appeal 42 CFR 438.408(b)(2-3)	The MCO must resolve each appeal and provide notice to affected parties a. as expeditiously as the enrollee's health condition requires; b. no longer than 30 calendar days from the day the MCO receives the appeal for standard appeals; and c. no longer than 72 hours after the MCO receives the appeal for expedited appeals.	☐ a. As expeditiously as the enrollee's health condition requires ☐ b. For standard resolution, no longer than 30 calendar days from the day the MCO receives the appeal ☐ c. For expedited resolution, no longer than 72 hours after the MCO receives the appeal	**1.000** **1.000** **1.000**	**3.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
17. Extension of Timeframes 42 CFR 438.408(c)(1)	The MCO may extend the timeframe to resolve grievances and appeals by up to 14 calendar days if - the enrollee requests the extension; or - the MCO shows to the satisfaction of FHKC (upon its request) that there is a need for additional information and how the delay is in the enrollee's interest.	☐ Enrollee requests the extension ☐ MCO shows need for additional information and delay is in enrollee's interest	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
18. Requirements Following Extension 42 CFR 438.408(c)(2)	If the MCO extends the timeframe for appeal not at the request of the enrollee, the MCO must a. make reasonable efforts to give the enrollee prompt oral notice of the delay; b. within two calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if they disagree; and c. resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.	☐ a. Make reasonable efforts to give prompt oral notice ☐ b. Give written notice within two calendar days and inform the enrollee of the right to file a grievance ☐ c. Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires	**0.500** **0.500** **0.500**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
19. Format of Appeal Notice 42 CFR 438.408(d)(2)(i)	For all appeals, the MCO must provide written notice of resolution.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
20. Format of Appeal Notice—Expedited Appeals 42 CFR 438.408(d)(2)(ii)	For notice of an expedited resolution, the MCO must make reasonable efforts to provide oral notice.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
21. Content of Appeal Notice 42 CFR 438.408(e)(1)	The written notice of appeal resolution must include the - the results of the resolution process; and - the date the appeal was completed.	☐ Results of the resolution process ☐ Date the resolution was completed	**1.000** **1.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
22. Content of Appeal Notice—Adverse Decision 42 CF 438.408(e)(2)	For appeals not wholly resolved in favor of the enrollee, the written notice of appeal resolution must include the right to request a State review and how to do so.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
23. Requirements for State Review 42 CFR 438.408(f)(1)	An enrollee may request a State review only after receiving notice that the MCO is upholding the adverse benefit determination.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
24. Expedited Resolution of Appeals 42 CFR 438.410(a)	The MCO must establish and maintain an expedited review process for appeals when the MCO determines (from an enrollee's request) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
25. Punitive Action for Expedited Appeal 42 CFR 438.410(b)	The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
26. Denial of Request for Expedited Resolution 42 CFR 438.410(c)	If the MCO denies a request for expedited resolution of an appeal, it must - transfer the appeal to the timeframe for standard resolution in accordance with §438.408(b)(2); and - follow the requirements in §438.408(c)(2).	☐ Transfer the appeal to the timeframe for standard resolution ☐ Follow the requirements in §438.408(c)(2)	**1.000** **1.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
27. Information about Grievance System to Providers 42 CFR 438.414	The MCO must provide the information specified at §438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
28. Recordkeeping Requirements MSC 3-14, 42 CFR 438.416(b)	The MCO must maintain records of grievances and appeals that contain the following information: a. A general description of the reason for the appeal or grievance b. The date received c. The date of each review or, if applicable, review meeting d. Resolution at each level of the appeal or grievance, if applicable e. Date of resolution at each level f. Name of the covered person for whom the appeal or grievance was filed	☐ a. General description of reason for the grievance or appeal ☐ b. Date received ☐ c. Date of each review or review meeting ☐ d. Resolution of each level ☐ e. Date of resolution at each level ☐ f. Name of covered person	**0.500** **0.500** **0.500** **0.500** **0.500** **0.500**	**3.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
29. Services Not Furnished While Appeal is Pending 42 CFR 438.424(a)	If the MCO or State review office reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.	☐ Yes ☐ No	**1.500** **0.000**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
30. Services Furnished While Appeal is Pending 42 CFR 438.424(b)	If the MCO or the State review office reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, the MCO must pay for those services in accordance with State policy and regulations.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
Grievance System Score			**0.0%**	**41.500**	**0.000**

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement					
1. Adoption of Practice Guidelines 42 CFR 438.236(b)	The MCO must adopt practice guidelines that a. are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field; b. consider the needs of the MCO's enrollees; c. are adopted in consultation with contracting healthcare professionals; and d. are reviewed and updated periodically as appropriate.	☐ a. Based on valid and reliable clinical evidence or consensus of healthcare professionals ☐ b. Consider the needs of MCO enrollees ☐ c. Adopted in consultation with contracting healthcare professionals ☐ d. Reviewed and updated periodically as appropriate	**0.500** **0.500** **0.500** **0.500**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Dissemination of Guidelines 42 CFR 438.236(c)	The MCO must disseminate the practice guidelines to - all affected providers; and - enrollees and potential enrollees upon request.	☐ All affected providers ☐ Enrollees and potential enrollees upon request	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Application of Guidelines 42 CFR 438.236(d)	The following must be consistent with the guidelines: a. Decisions for utilization management b. Enrollee education c. Coverage of services d. Other areas to which guidelines apply	☐ a.Decisions for utilization management ☐ b. Enrollee education ☐ c. Coverage of services ☐ d. Other areas to which guidelines apply	**0.250** **0.250** **0.250** **0.250**	**1.000**	**0.000**
Findings **Strength**					

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement					
AON					
Suggestion					
4. Quality Improvement Plans—General 42 CFR 438.330(a), MSC 3-24-1	The MCO must have an ongoing Quality Improvement Plan (QIP) that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes in service performance for its enrollees.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
5. Quality Improvement Plans—Policies and Procedures MSC 3-24-1(B)	QIPs must include written policies and procedures that address components of effective healthcare management including, but not limited to, anticipation, identification, monitoring, measurement, evaluation of enrollees' healthcare needs, and effective action to promote quality of care.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
6. Quality Improvement Plans—Process Improvement MSC 3-24-1(C)	QIPs must define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management to achieve the highest level of success possible.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement					
AON Suggestion					
7. Quality Improvement Plans—Care Management MSC 3-24-1(D)	Each QIP must include specific interventions for care management to improve care and promote healthier enrollee outcomes.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
8. Quality Improvement Plan Committee MSC 3-24-2	The MCO must have a QIP Committee with the Medical Director serving as either the Chairman or Co-Chairman.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
9. Quality Improvement Plan Committee—Membership MSC 3-24-2	The QIP Committee must include the following members: a. Quality Director b. Grievance Coordinator c. Utilization Review Manager d. Credentialing Manager e. Risk Manager/Infection Control Professional (if applicable) f. Advocate representation (if applicable)	☐ a. Quality Director ☐ b. Grievance Coordinator ☐ c. Utilization Review Manager ☐ d. Credentialing Manager ☐ e. Risk Manager/Infection Control Professional (if applicable)	**0.250** **0.250** **0.250** **0.250** **0.250**	**1.750**	**0.000**

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement					
	g. Provider representation, either through providers serving on the Committee or through a provider liaison position such as a representative from the network management department	☐ f. Advocate representation (if applicable) ☐ g. Provider representation	**0.250** **0.250**		
Findings **Strength** **AON** **Suggestion**					
10. Quality Improvement Plan Committee—Meeting Frequency MSC 3-24-2	The Committee must meet at least quarterly.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
11. Performance Improvement Projects 42 CFR 438.330(d)(1)	The MCO must conduct performance improvement projects that focus on both clinical and non-clinical areas.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement					
12. Performance Improvement Projects—Requirements 42 CFR 438.330(d)(2)	Each performance improvement project must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and must include the following elements: a. Measurement of performance using objective quality measures b. Implementation of interventions to achieve improvement in access to and quality of care c. Evaluation of effectiveness of interventions based on the performance measures described in paragraph (d)(2)(i) of this section d. Planning and initiation of activities for increasing or sustaining improvement	☐ a. Performance measurement using objective quality indicators ☐ b. Implementation of interventions to achieve improvement in access to and quality of care ☐ c. Evaluation of intervention effectiveness ☐ d. Planning and initiation of activities for increasing or sustaining improvement	**0.500** **0.500** **0.500** **0.500**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
13. Performance Improvement Projects—Reporting 42 CFR 438.330(d)(3)	The MCO must report the status and results of each project conducted as requested, but not less than once per year.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
14. Performance Measurement	The MCO must annually measure and report on its performance using standard measures required by FHKC.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement					
42 CFR 438.330(c)(2)(i)					
Findings **Strength** **AON** **Suggestion**					
15. Utilization of Services 42 CFR 438.330(b)(3)	The MCO must have mechanisms in effect to detect both under- and over-utilization of services.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
16. Enrollees with Special Healthcare Needs 42 CFR 438.330(b)(4)	The MCO must have mechanisms in effect to assess the quality and appropriateness of care furnished to enrollees with special healthcare needs.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
17. Health Information Systems—General 42 CFR 438.242(a)	The MCO must maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this subpart.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement					
Findings **Strength** **AON** **Suggestion**					
18. Health Information Systems—Required Information 42 CFR 438.242(a)	The health information system must provide information on areas including but not limited to a. utilization; b. grievances and appeals; and c. disenrollments for other than loss of Medicaid eligibility.	☐ a. Utilization ☐ b. Grievances and appeals ☐ c. Disenrollments	**0.500** **0.500** **0.500**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					
19. Health Information Systems—Basic Elements 42 CFR 438.242(b)(1)	The MCO must collect data on - enrollee and provider characteristics as specified by FHKC; and - services furnished to enrollees through an encounter system.	☐ Enrollee and provider characteristics ☐ Services furnished to enrollees	**1.000** **1.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
20. Health Information Systems—	The MCO must ensure that data received from providers are accurate and complete by	☐ a. Verifying data accuracy and completeness ☐ b. Screening data for completeness, logic, and consistency	**0.500** **0.500**	**1.500**	**0.000**

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement					
Data Received from Providers 42 CFR 438.242(b)(2)	a. verifying the accuracy and timeliness of reported data, including data from network providers the MCO is compensating on the basis of capitation payments; b. screening the data for completeness, logic, and consistency; and c. collecting service information in standardized formats to the extent feasible and appropriate.	☐ c. Collecting information in standardized formats	**0.500**		
Findings					
Strength					
AON					
Suggestion					
Quality Assessment and Performance Improvement Score			**0.0%**	**26.750**	**0.000**

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
1. Program Integrity General Requirements 42 CFR 438.608(a)	The MCO must implement and maintain arrangements or procedures that are designed to guard against fraud and abuse.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Compliance Program 42 CFR 438.608(a)(1)	The program integrity arrangements or procedures must include a compliance program that includes, at a minimum: a. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards; b. The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices and who reports directly to the Chief Executive Officer and the board of directors; c. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program; d. A system for training and education for the compliance officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the contract; e. Effective lines of communication between the compliance officer and the organization's employees; f. Enforcement of standards through well-publicized disciplinary guidelines; and g. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring	☐ a. Written policies, procedures, and standards ☐ b. Designation of compliance officer ☐ c. Establishment of Regulatory Compliance Committee ☐ d. System for training and education ☐ e. Effective lines of communication ☐ f. Enforcement of standards through disciplinary guidelines ☐ g. Provision for routine internal monitoring and auditing	**0.500** **0.500** **0.500** **0.500** **0.500** **0.500** **0.500**	**3.500**	**0.000**

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
	and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, and correction of such problems promptly and thoroughly to reduce the potential for recurrence.				
Findings **Strength** **AON** **Suggestion**					
3. Fraud Prevention MSC 3-13-2	At a minimum, the MCO fraud and abuse program must include the following: a. A compliance officer with sufficient experience in healthcare and has the responsibility and authority for carrying out the provisions of the MCO's fraud and abuse policies and procedures b. Adequate staffing and resources to investigate unusual incidents and develop corrective action plans to assist the MCO with preventing and detecting potential fraud and abuse activities c. Internal controls and policies and procedures that are designed to prevent, detect, and report known or suspected fraud and abuse activities d. Provisions for the investigation and follow-up of any notifications to FHKC of, including but not limited to, any fraud by subcontractors, applicants, or enrollees e. Cooperation in any investigation by FHKC, state, or federal entities or any subsequent legal action that may result from such an investigation f. Non-retaliation policies against any individual that reports violations of the MCO's fraud and abuse policies and procedures or suspected fraud and abuse g. Distribution of written fraud and abuse policies to the MCO's employees in accordance with Section 6032 of the	☐ a. Compliance officer with sufficient experience in healthcare ☐ b. Adequate staffing and resources to investigate unusual incidents and develop corrective action plans ☐ c. Internal controls and policies and procedures to prevent, detect, and report fraud and abuse activities ☐ d. Provisions for investigation and follow-up of any notifications to FHKC ☐ e. Cooperation in any investigation ☐ f. Non-retaliation policies against any individual that reports violations ☐ g. Distribute written policies to employees	**0.500** **0.500** **0.500** **0.500** **0.500** **0.500** **0.500**	**3.500**	**0.000**

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
	federal Deficit Reduction Act of 2005, including the rights of employees to be protected as whistleblowers				
Findings					
Strength					
AON					
Suggestion					
4. Changes in Network Provider Circumstances 42 CFR 438.608(a)(4)	The MCO must have a provision for notification to FHKC when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
5. Services Delivered to Enrollees 42 CFR 438.608(a)(5)	The MCO must have a provision for a method to verify, by sampling or other methods, whether services that have been represented have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
6. Suspension of Payments to Network Providers 42 CFR 438.608(a)(8)	The MCO must have a provision for suspension of payments to a network provider for which FHKC determines there is a credible allegation of fraud.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
7. Overpayments —Providers 42 CFR 438.608(d)(2)	The MCO must require and have a mechanism for a network provider to report to the MCO when it has received an overpayment, to return the overpayment to the MCO within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO in writing of the reason for the overpayment.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
8. Prohibited Affiliations 42 CFR 438.610(a), MSC 3-23-1	The MCO may not knowingly have a relationship with the following: - An individual who is debarred, suspended, or otherwise excluded from participating under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 - An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above	☐ Individual who is debarred, suspended, or otherwise excluded from participating under the Federal Acquisition Regulation ☐ Individual who is an affiliate of person described above	**1.000** **1.000**	**2.000**	**0.000**

2018 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
Findings					
Strength					
AON					
Suggestion					
9. Prohibited Affiliations—Federal Healthcare Programs 42 CFR 438.610(b)	The MCO may not have a relationship with an individual or entity that is excluded from participation in any federal healthcare program.	☐ Yes ☐ No	**1.750** **0.000**	**1.750**	**0.000**
Findings					
Strength					
AON					
Suggestion					
Program Integrity Score			**0.0%**	**17.750**	**0.000**

DBM CA Standards Tool

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Access and Availability of Services					
1. Delivery Network 42 CFR 438.206(b)(1), 42 CFR 438.206(c)(3)	The DBM must maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Geographic Access DSC 3-2-3	The DBM must provide geographical access as follows: - Primary care dental providers experienced in child dental health within 20 minutes of driving time from residence to provider - Specialty dental services, ancillary services, and hospital services within 60 minutes of driving time from residence to provider	☐ Primary care within 20 minutes of driving time ☐ Specialty care within 60 minutes of driving time	**1.000** **1.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Second Opinion 42 CFR 438.206(b)(3)	The DBM must provide for a second opinion from a qualified healthcare professional within the network or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength**					

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Access and Availability of Services					
AON					
Suggestion					
4. Out-of-Network Services 42 CFR 438.206(b)(4)	If the network is unable to provide necessary and covered services, the DBM must adequately and timely cover these services for the enrollee outside of the network.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
5. Out-of-Network Providers DSC 3-31-1	The DBM must provide enrollees with timely approval or denial of authorization for out-of-network services through the assignment of a prior authorization number or similar process approved by Florida Healthy Kids Corporation (FHKC). If the DBM has granted prior authorization for covered and out-of-network services, or in the case of emergency services, the DBM is responsible for the payment of claims incurred as a result of those services.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
6. Out-of-Network Provider Payment	The DBM must require all out-of-network providers to coordinate with the DBM for payment and ensure the cost to the enrollee is no greater than it would be if the services were furnished within network.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Access and Availability of Services					
42 CFR 438.206(b)(5)					
Findings					
Strength					
AON					
Suggestion					
7. Timely Access—Appointment Standards 42 CFR 438.206(c), DSC 3-2-4	The DBM must provide timely treatment for enrollees in accordance with the following standards: a. Emergency care must be provided immediately b. Urgently needed care must be provided within 24 hours c. Routine care of enrollees who do not require emergency or urgent care must be provided within seven calendar days of the enrollee's request for services d. Routine physical examinations must be provided within four weeks of the enrollee's request e. Follow-up care must be provided as medically appropriate	☐ a. Emergency care provided immediately ☐ b. Urgently needed care provided within 24 hours ☐ c. Routine care provided within seven calendar days ☐ d. Routine physical examinations provided within four weeks ☐ e. Follow-up care provided as medically appropriate	**0.600** **0.600** **0.600** **0.600** **0.600**	**3.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
8. Timely Access—Other Requirements 42 CFR 438.206(c)(1)	The DBM must meet the following requirements: a. Ensure that network providers offer hours of operation that are no less than hours of operation offered to commercial enrollees or comparable Medicaid fee-for-service, if the provider serves only Medicaid enrollees b. Make services included in the contract available 24 hours a day, seven days a week, when medically necessary c. Establish mechanisms to ensure compliance by providers	☐ a. Hours of operation similar to commercial or Medicaid fee-for-service ☐ b. Services available 24 hours a day, seven days a week ☐ c. Mechanisms to ensure compliance in place ☐ d. Providers monitored for compliance regularly	**0.600** **0.600** **0.600** **0.600**	**3.000**	**0.000**

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Access and Availability of Services					
	d. Monitor providers regularly to determine compliance e. Take corrective action if there is a failure to comply	☐ e. Corrective action taken if failure to comply	**0.600**		
Findings					
Strength					
AON					
Suggestion					
9. Timely Access—Cultural Considerations 42 CFR 438.206(c), DSC 3-19-2A	The DBM must have a comprehensive written Cultural Competency Plan describing how the DBM will ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
Access and Availability of Services Score			**0.0%**	**14.000**	**0.000**

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
1. Grievance and Appeal System 42 CFR 438.402(a)	The DBM must have a system in place for enrollees that includes - a grievance process; and - an appeals process.	☐ Grievance process ☐ Appeals process	**1.000** **1.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Level of Appeals 42 CFR 438.402(b)	The DBM must have only one level of appeal for enrollees.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Authority and Timing to File—Enrollee 42 CFR 438.402(c)(2)	An enrollee may - file a grievance at any time; and - request an appeal up to 60 days from the date on the adverse benefit determination notice.	☐ File a grievance ☐ Request an appeal	**0.750** **0.750**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2018 Annual Compliance Assessment: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance System						
4. Authority to File—Authorized Representative 42 CFR 438.402(c)(1)(ii)	With written consent of the enrollee, a provider or authorized representative may request an appeal or file a grievance, or request a State review, on behalf of an enrollee.	☐ ☐	Yes No	**0.500** **0.000**	**0.500**	**0.000**
Findings **Strength** **AON** **Suggestion**						
5. Deemed Exhaustion of Appeals Process 42 CFR 438.402(c)(1)(i)(A), 42 CFR 438.408(c)(3)	If the DBM fails to adhere to the notice and timing requirements for an appeal, the enrollee is deemed to have exhausted the DBM's appeal process and may initiate State review.	☐ ☐	Yes No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**						
6. Procedures to File Grievance and Appeal 42 CFR 438.402(c)(3)	The enrollee may - file a grievance either orally or in writing with the DBM; and - request an appeal either orally or in writing.	☐ ☐	File a grievance either orally or in writing Request an appeal either orally or in writing	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON**						

2018 Annual Compliance Assessment: <DBM>						
Evaluation Elements		**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
					Value	**Score**
Grievance System						
	Suggestion					
7.	Procedures—Oral Appeal 42 CFR 438.402(c)(3)	Unless the enrollee requests an expedited appeal, an oral appeal must be followed by a written, signed appeal.	☐ Yes ☐ No	**0.500** **0.000**	**0.500**	**0.000**
	Findings					
	Strength					
	AON					
	Suggestion					
8.	Assistance with Grievances and Appeals 42 CFR 438.406(a)	The DBM must give enrollees reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
	Findings					
	Strength					
	AON					
	Suggestion					
9.	Acknowledgement of Grievances and Appeals 42 CFR 438.406(b)(1)	The DBM must acknowledge receipt of each - grievance; and - appeal.	☐ Acknowledge receipt of grievances ☐ Acknowledge receipt of appeals	**0.500** **0.500**	**1.000**	**0.000**
	Findings					
	Strength					
	AON					
	Suggestion					

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
10. Individuals Who Make Grievance and Appeal Decisions 42 CFR 438.406(b)(2)(i-iii)	The DBM must ensure that individuals who make decisions on grievances and appeals a. were not involved in any previous level of review or decision-making nor a subordinate of any such individual; b. have the appropriate clinical expertise in treating the enrollee's condition or disease for an appeal of a denial based on lack of medical necessity, a grievance regarding denial of an expedited resolution of an appeal, or a grievance or appeal that involves clinical issues; and c. take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.	☐ a. Were not involved in previous level of review or decision-making nor a subordinate of any such individual ☐ b. Have the appropriate clinical expertise in treating the enrollee's condition or disease ☐ c. Take into account all information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination	**1.000** **1.000** **1.000**	**3.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
11. Oral Appeals 42 CFR 438.406(b)(3)	The DBM must provide that oral inquiries seeking to appeal an adverse benefit determination are - treated as appeals to establish the earliest possible filing date for the appeal; and - confirmed in writing, unless the enrollee or provider requests expedited resolution.	☐ Treated as appeals to establish earliest filing date ☐ Confirmed in writing, unless enrollee or provider requests expedited resolution	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON**					

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
Suggestion					
12. Opportunity to Present Evidence and Allegations of Fact or Law in Appeals 42 CFR 438.406(b)(4)	The process for appeals must - provide the enrollee a reasonable opportunity to present evidence and testimony and make legal and factual arguments; and - inform the enrollee of the limited timeframe available to do so in the case of expedited resolution.	☐ Provide enrollee a reasonable opportunity to present evidence and allegations of fact or law in person and in writing ☐ Inform the enrollee of limited timeframe to do so with expedited resolution	**0.500** **0.500**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
13. Opportunity to Examine Enrollee's Case File in Appeals 42 CFR 438.406(b)(5)	The process for appeals must provide the enrollee and their representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the DBM in connection with the appeal of the adverse benefit determination free of charge and sufficiently in advance of the resolution timeframe for appeals.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
14. Parties to the Appeal 42 CFR 438.406(b)(6)	As parties to the appeal, the appeal process must include - the enrollee and their representative; or - the legal representative of a deceased enrollee's estate.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
Strength					
AON					
Suggestion					
15. Resolution of Grievance 42 CFR 438.408(a-b)	The DBM must dispose of each grievance and provide notice - as expeditiously as the enrollee's health condition requires; and - not to exceed 90 calendar days from the day the DBM receives the grievance.	☐ As expeditiously as the enrollee's health condition requires ☐ Not to exceed 90 calendar days from the day the DBM receives the grievance	**1.000** **1.000**	**2.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
16. Resolution of Appeal 42 CFR 438.408(b)(2-3)	The DBM must resolve each appeal and provide notice to affected parties a. as expeditiously as the enrollee's health condition requires, b. no longer than 30 calendar days from the day the DBM receives the appeal for standard appeals, and c. no longer than 72 hours after the DBM receives the appeal for expedited appeals.	☐ a. As expeditiously as the enrollee's health condition requires ☐ b. For standard resolution, no longer than 30 calendar days from the day the DBM receives the appeal ☐ c. For expedited resolution, no longer than72 hours after the DBM receives the appeal	**1.000** **1.000** **1.000**	**3.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
17. Extension of Timeframes 42 CFR 438.408(c)(1)	The DBM may extend the timeframe to resolve grievances and appeals by up to 14 calendar days if - the enrollee requests the extension; or - the DBM shows to the satisfaction of FHKC (upon its request) that there is a need for additional information and how the delay is in the enrollee's interest.	☐ Enrollee requests the extension ☐ DBM shows need for additional information and delay is in enrollee's interest	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
18. Requirements Following Extension 42 CFR 438.408(c)(2)	If the DBM extends the timeframe for appeal not at the request of the enrollee, the DBM must a. make reasonable efforts to give the enrollee prompt oral notice of the delay; b. within two calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if they disagree; and c. resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.	☐ a. Make reasonable efforts to give prompt oral notice ☐ b. Give written notice within two calendar days and inform the enrollee of the right to file a grievance ☐ c. Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires	**0.500** **0.500** **0.500**	**1.500**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
19. Format of Appeal Notice 42 CFR 438.408(d)(2)(i)	For all appeals, the DBM must provide written notice of resolution.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
20. Format of Appeal Notice—Expedited Appeals 42 CFR 438.408(d)(2)(ii)	For notice of an expedited resolution, the DBM must make reasonable efforts to provide oral notice.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
21. Content of Appeal Notice 42 CFR 438.408(e)(1)	The written notice of appeal resolution must include the - the results of the resolution process; and - the date the appeal was completed.	☐ Results of the resolution process ☐ Date the resolution was completed	**1.000** **1.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
22. Content of Appeal Notice—Adverse Decision 42 CF 438.408(e)(2)	For appeals not wholly resolved in favor of the enrollee, the written notice of appeal resolution must include the right to request a State review and how to do so.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
23. Requirements for State Review 42 CFR 438.408(f)(1)	An enrollee may request a State review only after receiving notice that the DBM is upholding the adverse benefit determination.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
24. Expedited Resolution of Appeals 42 CFR 438.410(a)	The DBM must establish and maintain an expedited review process for appeals when the DBM determines (from an enrollee's request) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
25. Punitive Action for Expedited Appeal 42 CFR 438.410(b)	The DBM must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
26. Denial of Request for Expedited Resolution 42 CFR 438.410(c)	If the DBM denies a request for expedited resolution of an appeal, it must - transfer the appeal to the timeframe for standard resolution in accordance with §438.408(b)(2); and - follow the requirements in §438.408(c)(2).	☐ Transfer the appeal to the timeframe for standard resolution ☐ Follow the requirements in §438.408(c)(2)	**1.000** **1.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
27. Information about Grievance System to Providers 42 CFR 438.414	The DBM must provide the information specified at §438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON**					

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
Suggestion					
28. Recordkeeping Requirements DSC 3-14, 42 CFR 438.416(b)	The DBM must maintain records of grievances and appeals that contain the following information: a. A general description of the reason for the appeal or grievance b. The date received c. The date of each review or, if applicable, review meeting d. Resolution at each level of the appeal or grievance, if applicable e. Date of resolution at each level f. Name of the covered person for whom the appeal or grievance was filed	☐ a. General description of reason for the grievance or appeal ☐ b. Date received ☐ c. Date of each review or review meeting ☐ d. Resolution of each level ☐ e. Date of resolution at each level ☐ f. Name of covered person	**0.500** **0.500** **0.500** **0.500** **0.500** **0.500**	**3.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
29. Services Not Furnished While Appeal is Pending 42 CFR 438.424(a)	If the DBM or State review office reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the DBM must authorize or provide the disputed services as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.	☐ Yes ☐ No	**1.500** **0.000**	**1.500**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance System					
30. Services Furnished While Appeal is Pending 42 CFR 438.424(b)	If the DBM or the State review office reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, the DBM must pay for those services in accordance with State policy and regulations.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
Grievance System Score			**0.0%**	**41.500**	**0.000**

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement					
1. Adoption of Practice Guidelines 42 CFR 438.236(b)	The DBM must adopt practice guidelines that a. are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field; b. consider the needs of the DBM's enrollees; c. are adopted in consultation with contracting healthcare professionals; and d. are reviewed and updated periodically as appropriate.	☐ a. Based on valid and reliable clinical evidence or consensus of healthcare professionals ☐ b. Consider the needs of DBM enrollees ☐ c. Adopted in consultation with contracting healthcare professionals ☐ d. Reviewed and updated periodically as appropriate	**0.500** **0.500** **0.500** **0.500**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Dissemination of Guidelines 42 CFR 438.236(c)	The DBM must disseminate the practice guidelines to - all affected providers; and - enrollees and potential enrollees upon request.	☐ All affected providers ☐ Enrollees and potential enrollees upon request	**0.500** **0.500**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Application of Guidelines 42 CFR 438.236(d)	The following must be consistent with the guidelines: a. Decisions for utilization management b. Enrollee education c. Coverage of services	☐ a. Decisions for utilization management ☐ b. Enrollee education ☐ c. Coverage of services	**0.250** **0.250** **0.250**	**1.000**	**0.000**

2018 Annual Compliance Assessment: <DBM>						
Evaluation Elements		**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
					Value	**Score**
Quality Assessment and Performance Improvement						
		d. Other areas to which guidelines apply	☐ d. Other areas to which guidelines apply	**0.250**		
	Findings					
	Strength					
	AON					
	Suggestion					
4.	Quality Improvement Plans—General 42 CFR 438.330(a), DSC 3-24-1	The DBM must have an ongoing Quality Improvement Plan (QIP) that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes in service performance for its enrollees.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**0.000**
	Findings					
	Strength					
	AON					
	Suggestion					
5.	Quality Improvement Plans—Policies and Procedures DSC 3-24-1(B)	QIPs must include written policies and procedures that address components of effective healthcare management including, but not limited to, anticipation, identification, monitoring, measurement, evaluation of enrollees' healthcare needs, and effective action to promote quality of care.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**0.000**
	Findings					
	Strength					
	AON					
	Suggestion					

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement					
6. Quality Improvement Plans—Process Improvement DSC 3-24-1(C)	QIPs must define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management to achieve the highest level of success possible.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
7. Quality Improvement Plans—Care Management DSC 3-24-1(D)	Each QIP must include specific interventions for care management to improve care and promote healthier enrollee outcomes.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
8. Quality Improvement Plan Committee DSC 3-24-2	The DBM must have a QIP Committee with the Medical Director serving as either the Chairman or Co-Chairman.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON**					

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement					
Suggestion					
9. Quality Improvement Plan Committee—Membership DSC 3-24-2	The QIP Committee must include the following members: a. Quality Director b. Grievance Coordinator c. Utilization Review Manager d. Credentialing Manager e. Risk Manager/Infection Control Professional (if applicable) f. Advocate representation (if applicable) g. Provider representation, either through providers serving on the Committee or through a provider liaison position such as a representative from the network management department	☐ a. Quality Director ☐ b. Grievance Coordinator ☐ c. Utilization Review Manager ☐ d. Credentialing Manager ☐ e. Risk Manager/Infection Control Professional (if applicable) ☐ f. Advocate representation (if applicable) ☐ g. Provider representation	**0.250** **0.250** **0.250** **0.250** **0.250** **0.250** **0.250**	**1.750**	**0.000**
Findings					
Strength					
AON					
Suggestion					
10. Quality Improvement Plan Committee—Meeting Frequency DSC 3-24-2	The Committee must meet at least quarterly.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement					
Suggestion					
11. Performance Improvement Projects 42 CFR 438.330(d)(1)	The DBM must conduct performance improvement projects that focus on both clinical and non-clinical areas.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
12. Performance Improvement Projects—Requirements 42 CFR 438.330(d)(2)	Each performance improvement project must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and must include the following elements: a. Measurement of performance using objective quality measures b. Implementation of interventions to achieve improvement in access to and quality of care c. Evaluation of effectiveness of interventions based on the performance measures described in paragraph (d)(2)(i) of this section d. Planning and initiation of activities for increasing or sustaining improvement	☐ a. Performance measurement using objective quality indicators ☐ b. Implementation of interventions to achieve improvement in access to and quality of care ☐ c. Evaluation of intervention effectiveness ☐ d. Planning and initiation of activities for increasing or sustaining improvement	**0.500** **0.500** **0.500** **0.500**	**2.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement					
13. Performance Improvement Projects—Reporting 42 CFR 438.330(d)(3)	The DBM must report the status and results of each project conducted as requested, but not less than once per year.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
14. Performance Measurement 42 CFR 438.330(c)(2)(i)	The DBM must annually measure and report on its performance using standard measures required by FHKC.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
15. Utilization of Services 42 CFR 438.330(b)(3)	The DBM must have mechanisms in effect to detect both under- and over-utilization of services.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings **Strength** **AON**					

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement					
Suggestion					
16. Enrollees with Special Healthcare Needs 42 CFR 438.330(b)(4)	The DBM must have mechanisms in effect to assess the quality and appropriateness of care furnished to enrollees with special healthcare needs.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
17. Health Information Systems—General 42 CFR 438.242(a)	The DBM must maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this subpart.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
18. Health Information Systems—Required Information 42 CFR 438.242(a)	The health information system must provide information on areas including but not limited to a. utilization; b. grievances and appeals; and c. disenrollments for other than loss of Medicaid eligibility.	☐ a. Utilization ☐ b. Grievances and appeals ☐ c. Disenrollments	**0.500** **0.500** **0.500**	**1.500**	**0.000**

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement					
Findings					
Strength					
AON					
Suggestion					
19. Health Information Systems—Basic Elements 42 CFR 438.242(b)(1)	The DBM must collect data on - enrollee and provider characteristics as specified by FHKC; and - services furnished to enrollees through an encounter system.	☐ Enrollee and provider characteristics ☐ Services furnished to enrollees	**0.500** **0.500**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
20. Health Information Systems—Data Received from Providers 42 CFR 438.242(b)(2)	The DBM must ensure that data received from providers are accurate and complete by a. verifying the accuracy and timeliness of reported data, including data from network providers the DBM is compensating on the basis of capitation payments; b. screening the data for completeness, logic, and consistency; and c. collecting service information in standardized formats to the extent feasible and appropriate.	☐ a. Verifying data accuracy and completeness ☐ b. Screening data for completeness, logic, and consistency ☐ c. Collecting information in standardized formats	**0.500** **0.500** **0.500**	**1.500**	**0.000**
Findings					
Strength					
AON					

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Quality Assessment and Performance Improvement					
Suggestion					
Quality Assessment and Performance Improvement Score			**0.0%**	**26.750**	**0.000**

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
1. Program Integrity General Requirements 42 CFR 438.608(a)	The DBM must implement and maintain arrangements or procedures that are designed to guard against fraud and abuse.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Compliance Program 42 CFR 438.608(a)(1)	The program integrity arrangements or procedures must include a compliance program that includes, at a minimum: a. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards; b. The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices and who reports directly to the Chief Executive Officer and the board of directors; c. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program; d. A system for training and education for the compliance officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the contract; e. Effective lines of communication between the compliance officer and the organization's employees;	☐ a. Written policies, procedures, and standards ☐ b. Designation of compliance officer ☐ c. Establishment of Regulatory Compliance Committee ☐ d. System for training and education ☐ e. Effective lines of communication ☐ f. Enforcement of standards through disciplinary guidelines ☐ g. Provision for routine internal monitoring and auditing	**0.500** **0.500** **0.500** **0.500** **0.500** **0.500** **0.500**	**3.500**	**0.000**

2018 Annual Compliance Assessment: <DBM>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Program Integrity						
	f. Enforcement of standards through well-publicized disciplinary guidelines; and g. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, and correction of such problems promptly and thoroughly to reduce the potential for recurrence.					
	Findings **Strength** **AON** **Suggestion**					
3. Fraud Prevention DSC 3-13-2	At a minimum, the DBM fraud and abuse program must include the following: a. A compliance officer with sufficient experience in healthcare and has the responsibility and authority for carrying out the provisions of the DBM's fraud and abuse policies and procedures b. Adequate staffing and resources to investigate unusual incidents and develop corrective action plans to assist the DBM with preventing and detecting potential fraud and abuse activities c. Internal controls and policies and procedures that are designed to prevent, detect, and report known or suspected fraud and abuse activities d. Provisions for the investigation and follow-up of any notifications to FHKC of, including but not limited to, any fraud by subcontractors, applicants, or enrollees e. Cooperation in any investigation by FHKC, state, or federal entities or any subsequent legal action that may result from such an investigation	☐	a. Compliance officer with sufficient experience in healthcare	**0.500**	**3.500**	**0.000**
		☐	b. Adequate staffing and resources to investigate unusual incidents and develop corrective action plans	**0.500**		
		☐	c. Internal controls and policies and procedures to prevent, detect, and report fraud and abuse activities	**0.500**		
		☐	d. Provisions for investigation and follow-up of any notifications to FHKC	**0.500**		
		☐	e. Cooperation in any investigation	**0.500**		
		☐	f. Non-retaliation policies against any individual that reports violations	**0.500**		
		☐	g. Distribute written policies to employees	**0.500**		

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
	f. Non-retaliation policies against any individual that reports violations of the DBM's fraud and abuse policies and procedures or suspected fraud and abuse g. Distribution of written fraud and abuse policies to the DBM's employees in accordance with Section 6032 of the federal Deficit Reduction Act of 2005, including the rights of employees to be protected as whistleblowers				
	Findings **Strength** **AON** **Suggestion**				
4. Changes in Network Provider Circumstances 42 CFR 438.608(a)(4)	The DBM must have a provision for notification to FHKC when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the DBM.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
	Findings **Strength** **AON** **Suggestion**				
5. Services Delivered to Enrollees 42 CFR 438.608(a)(5)	The DBM must have a provision for a method to verify, by sampling or other methods, whether services that have been represented have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
	Findings				

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
Strength					
AON					
Suggestion					
6. Suspension of Payments to Network Providers 42 CFR 438.608(a)(8)	The DBM must have a provision for suspension of payment to a network provider for which FHKC determines there is a credible allegation of fraud.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
7. Overpayments —Providers 42 CFR 438.608(d)(2)	The DBM must require and have a mechanism for a network provider to report to the DBM when it has received an overpayment, to return the overpayment to the DBM within 60 calendar days after the date on which the overpayment was identified, and to notify the DBM in writing of the reason for the overpayment.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**0.000**
Findings					
Strength					
AON					
Suggestion					
8. Prohibited Affiliations	The DBM may not knowingly have a relationship with the following: - An individual who is debarred, suspended, or otherwise excluded from participating under the Federal Acquisition	☐ Individual who is debarred, suspended, or otherwise excluded from participating under the Federal Acquisition Regulation	**1.000**	**2.000**	**0.000**

2018 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
42 CFR 438.610(a), DSC 3-23-1	Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 - An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above	☐ Individual who is an affiliate of person described above	**1.000**		
Findings					
Strength					
AON					
Suggestion					
9. Prohibited Affiliations—Federal Healthcare Programs 42 CFR 438.610(b)	The DBM may not have a relationship with an individual or entity that is excluded from participation in any federal healthcare program.	☐ Yes ☐ No	**1.750** **0.000**	**1.750**	**0.000**
Findings					
Strength					
AON					
Suggestion					
Program Integrity Score			**0.0%**	**17.750**	**0.000**

MCO and DBM File Review Tools

Appeal File Review Tool

<MCO/DBM>: <MCO/DBM Name>			Time Standard Calculation: Calendar Days											<XX/XX/XX>	
1	2	3	4			5			6		7	8	9	10	11	
File #	Case ID*	Date Appeal Received	Acknowledgment of Appeal			Appropriate Clinical Reviewer			Appeal Investigation Documented		E/S**	Date Written Notification of Decision to Member	Number of Days for Resolution	Resolution Time Standard	Resolution Time Standard Met	
			Y	N	NA	Y	N	NA	Y	N					Y	N
1																
2																
3																
4																
5																
6																
7																
8																
9																
10																
Compliant Answers			<#>			<#>			<#>						<#>	
Applicable Answers			<#>			<#>			<#>						<#>	

Total Compliant:	<#>
Total Applicable:	<#>
Percent Compliant:	<%>

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

*** Expedited or standard*

Grievance File Review Tool

<MCO/DBM: <MCO/DBM Name>					Time Standard Calculation: Calendar Days							<XX/XX/XX>
1	2	3	4		5		6	7	8	9		10	
File #	Case ID*	Grievance Rcvd. Date	Grievance Acknowledged		Investigation of Grievance Documented		Date Resolved	Number of Days to Resolve	Time Standard	Timeliness Standard Met		Notification of Resolution	
			Y	N	Y	N				Y	N	Y	N
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
Compliant Answers			<#>		<#>					<#>		<#>	
Applicable Answers			<#>		<#>					<#>		<#>	

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

Total Compliant:	<#>
Total Applicable:	<#>
Percent Compliant:	<%>

PIP Validation

The FHKC 2018 PIP Validation Tool was used to assess applicable MCO and DBM PIPs in accordance with CMS protocol.

2018 PIP Validation Tool—<MCO/DBM> <PIP Title>					
Activity I: Choose the Study Topic(s)					
Topics selected for the study should reflect the Medicaid-enrolled population in terms of demographic characteristics, prevalence of disease, and the potential consequences (risks) of disease. Topics could also address the need for a specific service. The goal of the project should be to improve processes and outcomes of healthcare. The topic may be specified by FHKC or based on input from FHK enrollees.					
Element #	**C***	**Study topic(s):**	**Met**	**Not Met**	**NA****
1	☐	Reflects high-volume or high-risk conditions	☐	☐	☐
2	☐	Is selected following collection and analysis of data	☐	☐	☐
3	☐	Addresses a broad spectrum of care and services	☐	☐	☐
4	☐	Includes all eligible populations that meet the study criteria	☐	☐	☐
5	☐	Does not exclude enrollees with special healthcare needs	☐	☐	☐
6	☑	Has the potential to affect enrollee health, functional status, or satisfaction	☐	☐	☐
Activity I Results:			**Total**	**Met**	**Not Met**	**NA**
All Elements			6			
Critical Elements			1			
Comment:						
Strength:						
AON:						
Suggestion:						

* *C = Critical Element*

** *NA = Not Assessed*

2018 PIP Validation Tool—<MCO/DBM> <PIP Title>					
Activity II: Define the Study Question(s)					
Stating the study question(s) helps to maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.					
Element #	**C***	**The study question(s):**		**Met**	**Not Met**	**NA****
1	☑	States the problem to be studied in simple terms		☐	☐	☐
2	☑	Is answerable		☐	☐	☐
Activity II Results:			**Total**	**Met**	**Not Met**	**NA**
All Elements			2			
Critical Elements			2			
Comment:						
Strength:						
AON:						
Suggestion:						

* *C = Critical Element*
** *NA = Not Assessed*

2018 PIP Validation Tool—<MCO/DBM> <PIP Title>					
Activity III: Use a Representative and Generalizable Study Population					
The selected topic should represent the entire eligible FHK-enrolled population, with system-wide measurement and improvement efforts to which the study indicators apply.					
Element #	**C***	**The representative and generalizable study population:**	**Met**	**Not Met**	**NA****
1	☑	Is accurately and completely defined	☐	☐	☐
2	☐	Includes requirements for the length of an enrollee's enrollment in the MCO or DBM	☐	☐	☐
3	☑	Captures all enrollees to whom the study question applies	☐	☐	☐

Activity III Results:	**Total**	**Met**	**Not Met**	**NA**
All Elements	3			
Critical Elements	2			
Comment:				
Strength:				
AON:				
Suggestion:				

* *C = Critical Element*
** *NA = Not Assessed*

2018 PIP Validation Tool—<MCO/DBM>
<PIP Title>

Activity IV: Select the Study Indicators

A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event (e.g., a child has not received a recommended vaccination) or a status (e.g., a child has not had a weight assessment) that is to be measured. The selected indicators should track performance or improvement over time. The indicators should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research.

Element #	C*	Study indicators:	Met	Not Met	NA**
1	☑	Are well-defined, objective and measurable	☐	☐	☐
2	☐	Are based on current, evidence-based practice guidelines, pertinent peer-reviewed literature, or consensus of expert panels	☐	☐	☐
3	☑	Allow for the study questions to be answered	☐	☐	☐
4	☐	Measure changes (outcomes) in health or functional status, enrollee satisfaction, or valid process alternatives	☐	☐	☐
5	☑	Have available data that can be collected on each indicator	☐	☐	☐
6	☐	Are nationally recognized measures, such as HEDIS Technical Specifications, when appropriate	☐	☐	☐
7	☐	Include the basis on which the indicators were adopted, if internally developed	☐	☐	☐

Activity IV Results:	Total	Met	Not Met	NA
All Elements	7			
Critical Elements	3			

Comment:
Strength:

* *C = Critical Element*
** *NA = Not Assessed*

AON:
Suggestion:

2018 PIP Validation Tool—<MCO/DBM>
<PIP Title>

Activity V: Use Sound Sampling Methods

(This activity is only scored if sampling is used.) If sampling is used to select enrollees of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. The true prevalence or incidence rate for the event in the population may not be known the first time a topic is studied.

Element #	C*	Sampling methods:	Met	Not Met	NA**
1	☐	Consider and specify the true or estimated frequency of occurrence	☐	☐	☐
2	☐	Identify the sample size	☐	☐	☐
3	☐	Specify the confidence level	☐	☐	☐
4	☐	Specify the acceptable margin of error	☐	☐	☐
5	☑	Ensure a representative sample of the eligible population	☐	☐	☐
6	☐	Are in accordance with generally accepted principles of research design and statistical analysis	☐	☐	☐

Activity V Results:	Total	Met	Not Met	NA
All Elements	6			
Critical Elements	1			

Comment:
Strength:
AON:
Suggestion:

* *C = Critical Element*
** *NA = Not Assessed*

2018 PIP Validation Tool—<MCO/DBM>
<PIP Title>

Activity VI: Use Valid and Reliable Data Collection Procedures

Data collection must ensure that the data collected on the study indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement.

Element #	C*	Data collection procedures include:	Met	Not Met	NA**
1	☐	The identification of data elements to be collected	☐	☐	☐
2	☐	The identification of specified sources of data	☐	☐	☐
3	☐	A defined and systematic process for collecting baseline and remeasurement data	☐	☐	☐
4	☐	A timeline for the collection of baseline and remeasurement data	☐	☐	☐
5	☐	Qualified staff and personnel to abstract manual data	☐	☐	☐
6	☑	A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications	☐	☐	☐
7	☐	A manual data collection tool that supports inter-rater reliability	☐	☐	☐
8	☐	Clear and concise written instructions for completing the manual data collection tool	☐	☐	☐
9	☐	An overview of the study in written instructions	☐	☐	☐
10	☐	Administrative data collection algorithms/flow charts that show activities in the production of indicators	☐	☐	☐
11	☐	An estimated degree of administrative completeness	☐	☐	☐

Activity VI Results:	Total	Met	Not Met	NA
All Elements	11			

* *C = Critical Element*
** *NA = Not Assessed*

Critical Elements	1
Comment:	
Strength:	
AON:	
Suggestion:	

2018 PIP Validation Tool—<MCO/DBM> <PIP Title>					
Activity VII: Analyze Data and Interpret Study Results					
Review the data analysis process for the selected clinical or non-clinical study indicators. Review appropriateness of and adherence to the statistical analysis techniques used.					
Element #	**C***	**Study results:**	**Met**	**Not Met**	**NA****
1	☑	Are conducted according to the data analysis plan in the study design	☐	☐	☐
2	☑	Allow for the generalization of results to the study population if a sample was selected	☐	☐	☐
3	☐	Identify factors that threaten internal or external validity of findings	☐	☐	☐
4	☐	Include an interpretation of findings	☐	☐	☐
5	☐	Are presented in a way that provides accurate, clear, and easily understood information	☐	☐	☐
6	☐	Identify the initial measurement and remeasurement of study indicators	☐	☐	☐
7	☐	Identify statistical differences between the initial measurement and the remeasurement	☐	☐	☐
8	☐	Identify factors that affect the ability to compare the initial measurement with the remeasurement	☐	☐	☐
9	☐	Include an interpretation of the extent to which the study was successful	☐	☐	☐
Activity VII Results:			**Total**	**Met**	**Not Met**	**NA**
All Elements			9			
Critical Elements			2			

* *C = Critical Element*

** *NA = Not Assessed*

Comment:
Strength:
AON:
Suggestion:

2018 PIP Validation Tool—<MCO/DBM> <PIP Title>					
Activity VIII: Include Improvement Strategies					
Real, sustained improvements in care result from a continuous cycle of measuring and analyzing performance, as well as developing and implementing system-wide improvements in care. Interventions are designed to change behavior at an institutional, practitioner, or enrollee level.					
Element #	**C***	**Improvement strategies are:**	**Met**	**Not Met**	**NA****
1	☑	Related to causes/barriers identified through data analysis and quality improvement processes	☐	☐	☐
2	☐	System changes that are likely to induce permanent change	☐	☐	☐
3	☐	Revised if the original interventions were not successful	☐	☐	☐
4	☐	Standardized and monitored if interventions were successful	☐	☐	☐
Activity VIII Results:			**Total**	**Met**	**Not Met**	**NA**
All Elements			4			
Critical Elements			1			
Comment: **Strength:** **AON:** **Suggestion:**						

* *C = Critical Element*

** *NA = Not Assessed*

2018 PIP Validation Tool—<MCO/DBM> <PIP Title>					
Activity IX: Assess for Real Improvement					
Through repeated measurement of the quality indicators selected for the project, meaningful change in performance relative to the performance observed during baseline measurement must be demonstrated. Assess for any random, year-to-year variations, population changes, or sampling errors that may have occurred during the measurement process.					
Element #	**C***	**Assessments for real improvement strategies indicate that:**	**Met**	**Not Met**	**NA****
1	☐	The remeasurement methodology is the same as the baseline methodology	☐	☐	☐
2	☐	There are documented improvements in processes or outcomes of care	☐	☐	☐
3	☐	The improvements appear to be the result of planned intervention(s)	☐	☐	☐
4	☐	There is statistical evidence that observed improvement is true improvement	☐	☐	☐
Activity IX Results:			**Total**	**Met**	**Not Met**	**NA**
All Elements			4			
Critical Elements			0			
Comment:						
Strength:						
AON:						
Suggestion:						

* *C = Critical Element*

** *NA = Not Assessed*

2018 PIP Validation Tool—<MCO/DBM> <PIP Title>					
Activity X: Assess for Sustained Improvement					
Describe any demonstrated improvement through repeated measurements over comparable time periods. Discuss any random, year-to-year variation, population changes or sampling errors that may have occurred during the remeasurement process.					
Element #	**C***	**Sustained improvement strategies indicate that:**	**Met**	**Not Met**	**NA****
1	☐	Repeated measurements over comparable time periods demonstrate sustained improvement or that a decline in improvement is not statistically significant	☐	☐	☐
Activity X Results:			**Total**	**Met**	**Not Met**	**NA**
All Elements			1			
Critical Elements			0			
Comment: **Strength:** **AON:** **Suggestion:**						
Overall Results for PIP Study						
Overall Results:			**Total**	**Met**	**Not Met**	**NA**
All Elements			53			
Critical Elements			13			

* *C = Critical Element*

** *NA = Not Assessed*

APPENDIX C | 2018 All-Plan Meeting Information

Qsource conducts meetings three times a year attended by FHKC and its MCOs and DBMs that feature keynote presentations and group participation activities, as detailed in **Table C-1**. The meetings held in 2018—one face to face and two virtual—offered an introduction to Qsource, the EQRO team, and the federally mandated annual EQR activities; a focus on using digital resources to better communicate with providers and enrollees as well as legal concerns when communicating with minors; and a PIP and PDSA quality improvement session followed by best practices on telehealth from one of two National Centers of Excellence for Telehealth.

Table C-1. 2018 FHKC All-Plan Meetings

Presentation Title	Presenter
February 1, 2018	
Qsource Background	♦ Dawn FitzGerald, Chief Executive Officer, Qsource
EQRO Activities Requirements	♦ John Couzins, EQRO Director, Qsource
Protocol 1: Assessment of Compliance	♦ Lois Heffernan, EQRO Program Manager, Qsource
Network Adequacy Analysis	♦ James Lamb, Regional Sales Director, Quest Analytics
Protocol 2: Validation of Performance Measures	♦ John Couzins, Qsource
Protocol 3: Validation of Performance Improvement Projects (PIPs)	♦ Dawn FitzGerald, Qsource ♦ Lois Heffernan, Qsource
Protocol 4: Validation of Encounter Data	♦ John Couzins, Qsource
Annual EQR Technical Report	♦ Lois Heffernan, Qsource

Table C-1. 2018 FHKC All-Plan Meetings	
Presentation Title	**Presenter**
August 22, 2018	
Smarter Communications, Better Outcomes: Using Digital Communication Effectively to Produce Better Results for Your Plan	♦ Steve Kindl, Senior Director, Enterprise Sales, HealthCrowd
Legal Aspects of Enrollee/Parent/Guardian Outreach	♦ Melissa Goldman, Esq., Associate, Baker Donelson
November 8, 2018	
Performance Improvement Project (PIP) and Plan-Do-Study-Act (PDSA) Quality Tips	♦ Lois Heffernan, Qsource
Building a Foundation of Telehealth Quality Through Research and Education	♦ Jillian Harvey, Director, Doctor of Health Administration Division, Medical University of South Carolina ♦ Ragan DuBose-Morris, Telehealth Education Manager, Center for Telehealth, Medical University of South Carolina