Florida External Quality Review Organization

February 2020

2019 Annual

EQRO Technical Report

HealthyKids™

Qsource

Table of Contents

List of Tables

Acknowledgements, Acronyms, and Initialisms*

A..... All
ACA.....Annual Compliance Assessment
ADD.....Follow-Up Care for Children Prescribed ADHD Medication
ADHD.....Attention-Deficit/Hyperactivity Disorder
ADV.....Annual Dental Visit
AHCA ..... Agency for Health Care Administration
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
APM .. Metabolic Monitoring for Children and Adolescents on Antipsychotics
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
C&M ..... Continuation and Maintenance
CAP .....Corrective Action Plan (ACA)
CAP .... Children and Adolescents' Access to Primary Care Practitioners (PMV)
CCO ..... Clinical Compliance and Outcomes
CFR ..... *Code of Federal Regulations*
CHIP..... Children's Health Insurance Program
CHL .....Chlamydia Screening in Women
CMS ..... Centers for Medicare & Medicaid Services
CWP ..... Appropriate Testing for Children with Pharyngitis
DBM ..... Dental Benefit Manager
Den..... Denominator
DentalTrac™ ..... a trademarked Managed Care of North America, Inc. system
DSC..... Dental Services Contract
E .....Expedited
ED ..... Emergency Department
EDV ..... Encounter Data Validation
EDW .....Enterprise Data Warehouse
ENT ..... Otolaryngology (ear, nose, and throat)
EPC ..... Envolve People Care
EQR/EQRO ..... External Quality Review/EQR Organization
F .....Female

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FAR ..... Final Audit Report
FFS ..... Fee for Service
FHKC ..... Florida Healthy Kids Corporation
FHM ..... Follow-Up After Hospitalization for Mental Illness: Ages 6 and Older
FUA ..... Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence
FUM ..... Follow-Up After Emergency Department Visit for Mental Illness
HEDIS® ..... Healthcare Effectiveness Data and Information Set, a registered trademark of the NCQA
HHS..... U.S. Department of Health and Human Services
HPV..... Human Papillomavirus
HRA..... Health Risk Assessment
IAD ..... Identification of Alcohol and Other Drug Services
IBNR..... Incurred But Not Reported
ID..... Identification
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
IPSD..... Index Prescription Start Date
IRO..... Independent Review Organization
IRR..... Inter-Rater Reliability
IS..... Information System(s)
ISCAT..... Information Systems Capability Assessment Tool
M ..... Male
MCG ..... Milliman Criteria Guidelines
MCO ..... Managed Care Organization
MMA ..... Managed Medical Assistance/Medication Management for People with Asthma
MPT ..... Mental Health Utilization
MRR ..... Medical Record Review
MSC ..... Medical Services Contract
MY ..... Measurement Year
N..... No/Number
NA ..... Not Applicable (ACA)
NA ..... Small Denominator (PMV)
NA ..... Not Assessed (PIP)
NABD ..... Notice of Adverse Benefit Determination
NCQA ..... National Committee for Quality Assurance
NCQA HEDIS Compliance Audit™.. a trademark of NCQA
No. ..... Number
NPI ..... National Provider Identifier
NR ..... Non-Reportable Rate
Num. ..... Numerator
OB/GYN ..... Obstetrician/Gynecologist
P&P ..... Policy and Procedure
PCP ..... Primary Care Provider/Physician
PDENT ..... Dental Preventive Services
PDP ..... Primary Dental Provider
PDSA..... Plan-Do-Study-Act
PIE..... Performance Improvement and Enhancement
PIHP ..... Prepaid Inpatient Health Plan

PIP .....Performance Improvement Project
PMV ..... Performance Measure Validation
PPC.....Prenatal and Postpartum Care
Q .....Quarter
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 Panel
SAS® .....a registered trademark of SAS Institute, Inc.*
SCP.....Specialty Care Provider
SEA.....Enrolled Children Receiving Dental Sealants on Permanent Molars
SHCN .....Special Health Care Needs
Td ..... Tetanus and Diphtheria Toxoids Vaccine
Tdap ..... Tetanus, Diphtheria Toxoids, and Acellular Pertussis Vaccine
TDENT .....Dental Treatment Services
UB-04 .....Uniform Bill (CMS-1450 form)
UM..... Utilization Management
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

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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 2019.

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 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, Florida Healthy Kids became one of three state programs grandfathered into the original Children's Health 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. Florida Healthy Kids includes subsidized health and dental insurance for children ages five through 18 years whose families exceed the income eligibility threshold for Medicaid but whose income does not exceed 200% of the federal poverty level. Florida Healthy Kids also includes a full-pay option that is not part of CHIP and is available to Florida children whose family income exceeds 200% of the federal poverty level. In 2019, the Florida State Legislature allotted funding for a proposal submitted by FHKC to lower payments for families in the Florida Healthy Kids full-pay program, predicted to eliminate medical and pharmacy annual deductibles as well as the 25-percent coinsurance requirement. In addition to the 15,000 Florida children ages 5 to 18 years already enrolled in this program, approximately 146,000 more children, who are currently uninsured, could benefit from this new option.

In 2019, five managed care organizations (MCOs) and three dental benefit managers (DBMs) operated in Florida. The MCOs included Aetna Better Health of Florida (Aetna), Simply Healthcare Plans, Inc. (Simply Healthcare; formerly Amerigroup Community Care [Amerigroup] in the *2018 Annual EQRO Technical Report*), WellCare Health Plans, Inc., doing business as Staywell Kids (Staywell), Sunshine Health Plan (Sunshine), and UnitedHealthcare of Florida, Inc. (UnitedHealthcare). The DBMs were Argus Dental Plan (Argus), DentaQuest of Florida, Inc. (DentaQuest), and Managed Care of North America, Inc., doing business as MCNA Dental Plans (MCNA). As of December 2019, more than 209,000 children were enrolled in the Florida Healthy Kids program.

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 Florida Healthy Kids population:

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

Using their vision and mission statements, FHKC developed six primary goals. These goals helped shape FHKC's approach to improving the quality 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 includes 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 2019, according to Centers for Medicare & Medicaid Services (CMS) protocols for EQR activities.

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 MCOs and DBMs:

- 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)

While the full-pay option for families who exceed the income eligibility threshold for CHIP (administered by Sunshine) is not

part of the CHIP and therefore not subject to federal requirements, FHKC elected to conduct EQR activities for this MCO based on standards included in its contract with FHKC. As such, the scope of the ANA and ACA reviews was limited to Sunshine's compliance with specific provisions in its contract with FHKC. PMV and PIP requirements for Sunshine were identical to those for the subsidized MCOs.

Qsource is responsible for the creation and production of this *2019 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 2019 to determine each MCO's and DBM's compliance with federally mandated activities.

This report includes the following results of these 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 Florida Healthy Kids 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. 2019 Survey and Review Periods for Mandated EQR Activities

Activity	Audit Period	Period Under Review
ANA	February 2019	January 1–December 31, 2018
ACA	April–May 2019	January 1–December 31, 2018
PMV	May–June 2019	October 1, 2017 – September 30, 2018 (HEDIS)
		January 1–December 31, 2018 (CMS-416)
PIP	July–August 2019	January 1–December 31, 2018

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

- 2019 ANA Reports
- 2019 ACA Reports
- 2019 PMV Reports
- 2019 PIP Validation Reports

This *2019 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. Comparative analysis from last year, the first year Qsource served as FHKC's EQRO, to this year is included in this report where possible.

ANA

Per 42 CFR § 438.68, incorporated by 42 § CFR 457.1218, FHKC must develop and enforce required network adequacy standards for contracted MCOs and DBMs. Time and distance standards must be developed for specified provider types. ANA reviews are designed to evaluate both the geographic adequacy of each MCO's and DBM's provider network and the completeness of its enrollee and provider communication regarding FHKC appointment access standards applicable during the review year. The multiple measures used to assess each are listed in the ANA section of this report.

ACA

Federal ACA requirements are generally defined in 42 CFR §438.358, with specific standards provided in 438 Subpart D. These are incorporated for CHIP by 42 CFR § 457 Subpart L. In addition, standards set forth in each MCO's and DBM's contract with FHKC and additional quality standards established by FHKC are included in the ACA as appropriate.

Qsource evaluated MCO and DBM compliance using customized CA standard and utilization management denial 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.

In addition to evaluating documentation provided directly by the MCOs and DBMs, FHKC also allowed certain elements of ACA standards to be considered as deemed compliant based on MCO or DBM compliance scores from an acceptable accrediting body. Qsource developed a deeming crosswalk based on National Committee for Quality Assurance (NCQA) accreditation standards to identify those elements that would be considered compliant based on accreditation standards. 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 performance measures. The primary aims of PMV are 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 § 438.330(c), 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™, and one Agency for Health Care Administration (AHCA) Medicaid Managed Medical Assistance measure. DBMs were evaluated using six CMS-416 dental measures, one modified CMS-416 measure, and the HEDIS Annual Dental Visit measure—all selected by FHKC for validation. 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 § 438.330(d). MCOs and DBMs must conduct PIPs that are designed to achieve, through ongoing measurements and interventions, significant and sustained improvement in clinical and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. PIP study topics must reflect Florida Healthy Kids 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 completion, each MCO and DBM was expected to implement rapid-cycle improvement activities using the Institute for Healthcare Improvement (IHI) Model for Improvement's Plan-Do-Study-Act (PDSA) model as appropriate for each PIP.

PIPs are further defined in 42 CFR § 438.330(d) 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 2019 PIP validation process evaluated one clinical and one nonclinical PIP for each MCO and DBM. 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 nonclinical services at a point in time

Qsource performs one of these optional activities, EDV, under its current contract with FHKC, 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

Prior to the initiation of EDV analysis, Qsource collaborated with FHKC to prepare separate *Data Submission Guidelines* for the Florida Healthy Kids MCOs and DBMs. Fulfilling EDV Activity 1 requirements, the guidelines included definitions, data layouts, and formats. For EDV Activity 2, assessment of the capacity of the MCOs and DBMs to produce accurate and complete claims and encounter data, each MCO underwent an annual NCQA HEDIS Compliance Audit during 2019, examining encounter and claims processing for measurement year 2018. 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 Information Systems Capabilities Assessment Tools (ISCATs) submitted.

For EDV Activity 3, Qsource analyzed data submissions to determine the extent of data completeness in the appropriate fields, the validity of the values of the data, and the volume and consistency of the data. Activity 4, medical record review of encounter data, was completed for Q1 dates of service in 2019. A separate report, *2019 Quarter 1 Dates of Service Encounter Data Validation Medical Record Review Report Addendum*, was provided to FHKC. Three of the five MCOs reported encounter data based on capitated provider payment arrangements. None of the DBMs utilized capitation; therefore, no encounters were reported. Qsource reviewed medical records for a statistically valid random sample of statewide encounters to confirm that key electronic encounter data were supported by the appropriate medical record.

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 All-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 2019 meetings featured seminars about 2019 EQRO activities, featuring a presentation on the ANA analysis; medical−dental collaboration; advancing the rights of children with medical complexities to healthcare; PDSA best practices; state strategies for promoting improvement in oral health; a pediatric and adolescent perspective on the opioid crisis; and vaccinating adolescents against the human papilloma virus. 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 *2019 Annual EQRO Technical Report*, which—in addition to this Overview—includes the following sections:

- ANA
- ACA
- PMV
- PIP Validation
- PDSA
- 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 Florida Healthy Kids 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 for the MCOs were done for primary care providers, but beginning in 2018, the network validation process expanded to include certain pediatric and adult specialists as well as hospitals. For the DBMs, the 2018 review included certain dental specialists in addition to primary care providers. The 2019 review included further changes, as contracts between FHKC and the MCOs and DBMs were amended effective July 1, 2018. This amendment included changes in provider and specialty type requirements in addition to separate time and distance standards for urban and rural areas by provider/specialty type.

Geographical access to MCO services—with the exception of Sunshine—was determined for both urban and rural enrollees by calculating the travel time and distance between MCO enrollees and the following provider types, as specified in the MCO contracts:

- Pediatric and family physician primary care providers (PCPs)
- Certain high-volume specialty care providers (SCPs), including allergists and immunologists, dermatologists, obstetricians/gynecologists, optometrists, and otolaryngologists
- Categories of behavioral health – pediatric, behavioral health – other providers, specialist – pediatric, and specialist – other providers
- Hospitals and pharmacies

After the enrollee and provider data were standardized and geocoded, county-level (urban and rural) calculations established the travel time and distance from each enrollee location to each of the provider types identified above. If the enrollee location had at least one provider location within the established criteria, that enrollee was factored into the percentage-with-access category. The access percentages for provider categories that included multiple provider types, such as behavioral health – pediatric, reflect the percentage of enrollees who had access to any provider within the category. In addition, access to individual specialties in the categories referenced above as well as freestanding psychiatric facilities and laboratories was determined for informational purposes only, as FHKC did not define time and distance standards for these provider types in the MCO contracts.

Sunshine, the sole MCO providing Florida Healthy Kids full-pay health coverage, was accountable to its FHKC contract but

not to CFR requirements. Sunshine's contract included geographical access time standards for primary care medical providers and specialty care medical providers, including specialty medical services, ancillary services, and hospital services, as well as appointment availability standards to ensure timely enrollee access to services. Geographical access to services was determined by calculating the travel time between Sunshine enrollees and these provider categories. In addition, access to individual provider types/specialties in the categories referenced above was included in the analysis for informational purposes only, as FHKC did not define access standards for these individual provider types/specialties in Sunshine's contract. Enrollees were not separated into rural and urban categories as the MCO's contract did not specify this analysis.

For DBM enrollees, geographical access to services was determined by calculating the travel time and distance from each enrollee—in both urban and rural categories—to each of the primary care dentist, specialty dentist, and orthodontist provider types, as specified in the DBM contracts. The access percentages for provider categories that included multiple provider types, such as dental specialists, reflect the percentage of enrollees who had access to any provider within that category.

Qsource also reviewed each MCO's and DBM's policies and procedures (P&Ps), provider manual, and enrollee handbook to ensure that appointment availability standards were in place during 2018 and consistent with contract standards.

The ANA reviews were conducted in February 2019.

Technical Methods of Data Collection

The 2019 ANA evaluation included MCO and DBM provider networks as of December 2018. MCO and DBM relevant P&Ps and provider and enrollee communication materials were assessed. The surveyors focused on the following areas:

- Analyses of the geographic distribution and availability of providers to Florida Healthy Kids enrollees
- Appointment availability and accessibility 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 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 *2019 Annual Network Adequacy Report*.

Comparative Findings

All four MCOs achieved over 90.0% compliance scores for urban enrollees to 11 of the 13 required provider/specialty type categories according to both time and distance standards. Access for rural enrollees was more limited, with the MCOs achieving over 90.0% compliance scores for access to nine of the 13 required provider/specialty type categories according to time standards and over 90.0% for six of the required 13 categories. The DBM networks demonstrated over 90.0% compliance scores for time and distance standards for urban and enrollee access to primary care dentists. All three DBMs also achieved over 90.0% compliance for urban enrollee access to orthodontists and dental specialists according to both time and distance standards. Access to these dental provider types was more limited for rural enrollees for time and distance standards. Plan-specific results for Sunshine, the other MCOs, and the DBMs are presented in Appendix A. Because of contract amendments during the year under review, comparisons from last year to this year are not possible; however, they will be included in the *2019 Annual EQRO Technical Report* where possible.

MCO Network Adequacy

For the 2019 evaluation, all five MCOs were deemed compliant. Results for Sunshine, whose network adequacy standards differed from those of the remaining four MCOs, were high, with 99.82% of enrollees having access to a primary care medical provider and 100% having access to a specialty care medical provider. More than 90.0% of Aetna's Florida Healthy Kids urban population had access to 11 of 13 required provider types for time standards and 12 of the 13 for distance standards, while over 90.0% of enrollees in rural areas had access to 9 of the 13 provider types for time standards and 6 of the 13 for distance standards. Simply and Staywell access results were similar, with over 90.0% of urban enrollees in each of the two MCOs having access to all 13 required provider types for both time and distance standards, over 90.0% of rural enrollees in each MCO having access to 11 of the 13 provider types for time standards, and over 90.0% of rural enrollees having access to 10 of the 13 provider types for distance standards.

For the review of appointment availability standards, Qsource concluded that all five MCOs' provider manuals and enrollee handbooks included appropriate standards and Simply Healthcare's P&Ps provided also included appropriate standards. However, Aetna's applicable P&P was not clear in its most recent revision updates, Staywell's P&P did not include the state approval date specific to Florida Healthy Kids, and UnitedHealthcare's P&P did not include an effective date. Finally, Sunshine's P&P included a timeframe that differed from the required standard for routine physical exams.

DBM Network Adequacy

All three DBMs also were deemed compliant for Network Adequacy. Over 90.0% of urban and rural enrollees in each of

the three DBMs Florida Healthy Kids population had access to a primary care dentist according to both time and distance standards. The DBMs demonstrated that over 90.0% of their urban enrollees also had access to dental specialists and orthodontists for time and distance standards. Only one DBM, Argus, offered rural enrollees over 90.0% access to orthodontists (according to the time standard), and none of the DBMs' rural enrollee populations had over 90.0% access to dental specialists.

In addition, the three DBMs all submitted provider manuals and enrollee handbooks that included appropriate appointment availability standards. Argus and MCNA also provided P&Ps with appropriate appointment availability standards, while the P&P provided by DentaQuest did not include all appropriate standards.

Strengths and Recommendations

Strengths

The MCOs were all deemed compliant for this year's ANA, and the four assessed according to updated contract standards demonstrated overall high access percentages for urban enrollees across time and distance standards to most of the 13 required provider types. Two of the MCOs also demonstrated high percentages of access for rural enrollees with only a few category exceptions.

The DBMs also were all deemed compliant for the 2019 ANA and demonstrated high access percentages for urban enrollees to all three categories of dental providers.

Recommendations

Qsource recommended evaluating the potential and taking appropriate action to improve access to certain provider type categories for four MCOs:

- Aetna, allergy and immunology specialists and pharmacy providers in rural areas
- Simply Healthcare, allergy and immunology and dermatology specialists in rural areas
- Staywell, allergy and immunology specialists and otolaryngologists in rural areas
- UnitedHealthcare, pediatric specialists and pediatric behavioral health providers in both urban and rural areas and to hospitals in rural areas

In addition, Qsource suggested that all MCOs continue to monitor their provider network and implement corrective action for identified deficiencies. Qsource also recommended that Aetna, Staywell, and UnitedHealthcare examine the provider categories of Behavioral Health – Pediatric and Specialist – Pediatric, particularly in rural areas, to determine if additional providers are available in these areas to improve access. Simply Healthcare was encouraged to examine accessibility to pediatric specialists.

For the appointment availability P&Ps, Qsource recommended that Aetna consider adding a detailed revision history, Staywell consider including the approval dates specifically for Florida Healthy Kids, and UnitedHealthcare consider including an effective date and a more detailed revision history.

Qsource recommended that Sunshine consider updating its appointment availability P&P to include all appropriate required standards.

Qsource made a recommendation to all three DBMs to evaluate the potential and take appropriate action to improve access to the following provider/specialty types:

- Argus, orthodontists for rural enrollees for distance standards and dental specialists for rural enrollees for both time and distance standards
- DentaQuest, dental specialists and orthodontists for rural enrollees
- MCNA, dental specialists and orthodontists for rural enrollees

Just as with the MCOs, Qsource also suggested that all of the DBMs continue to monitor their provider network and implement corrective action for identified deficiencies. Finally, Qsource recommended that DentaQuest consider updating its P&P to include all four appointment availability standards.

Annual Compliance Assessment (ACA)

Assessment Background

Qsource conducted the ACA reviews pursuant to the requirements in (1) 42 CFR § 438, Subparts D and E, as incorporated by 42 CFR § 457 Subpart L; (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 medical services contracts (MSCs) and dental services contracts (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 the MCOs for 2019 include Coverage and Authorization of Services, Coordination and Continuity of Care, and Subcontractual Relationships and Delegation. The DBMs were not evaluated for the Subcontractual Relationships and Delegation standard as they did not delegate any activities related to Florida Healthy Kids enrollees; they were assessed for the remaining two standards.

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 D and E, as incorporated by 42 CFR § 457, Subpart L. Sunshine, the sole MCO providing Florida Healthy Kids full-pay health coverage, was accountable to its FHKC contract but not to CFR requirements. 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 (with the exception of Sunshine) 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 2019 onsite surveys took place April through May 2019.

In addition to compliance standards, the ACA included reviews of a random sample of utilization management (UM) denial cases to evaluate how the MCO or DBM applied 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 2019 UM denial files, from which Qsource abstracted a random sample and an oversample using SAS® software. Files in this selection included 15 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 regulatory (with the exception of Sunshine) and contractual standards through a review of P&Ps, committee minutes, quality studies, reports, medical records/files, and other related MCO and DBM documentation. Each standard element has an assigned point value, and Qsource analyzed every element in the survey tools. Qsource determined MCO and DBM performance scores by dividing the total points earned for each standard element by the sum of possible points for each element. Scores for each standard were calculated by dividing the total points earned for all elements in the standard by the total points possible for all elements in the standard.

Comparative Findings

Overall ACA Compliance

All of the MCOs and DBMs achieved overall compliance for the 2019 ACA. Overall scores among the four MCOs other than Sunshine ranged from 85.0% to 99.0%, while overall scores across the DBMs ranged from 75.4% to 91.2%. Compliance scores were fairly consistent for the individual compliance assessment standards for Aetna, Simply Healthcare, Staywell, and UnitedHealthcare, with a range from 93.0% to 98.2% for Coverage and Authorization of Services, from 75.0% to 100% for Coordination and Continuity of Care, and from 73.7% to 100% for Subcontractual Relationships and Delegation. The range in scores from 80.8% to 100% for the UM denials file reviews was attributable to one MCO not achieving 100% compliance. Sunshine, which was assessed on different contract standards than the other four MCOs, achieved 100% compliance for all three standards and the file review. The DBMs' scores ranged more widely, mostly due to the Coordination and Continuity of Care standard having only one element for the DBMs. Scores ranged from 81.1% to 98.1% for Coverage and Authorization of Services and from 0% to 50.0% for Coordination and Continuity of Care, while the UM denial file review scores ranged from 80.0% to 100%.

MCO CA Standard Compliance

For the MCOs (excluding Sunshine), Aetna had the highest overall compliance standard score at 99.0%. Two of the three remaining MCOs achieved compliance of 94.0% or greater, with UnitedHealthcare achieving 94.0% and Staywell achieving 96.5%. Simply Healthcare's overall compliance score was 85.0%.

The MCOs achieved the highest scores overall for the Coverage and Authorization of Services standard; Aetna achieved 98.2% compliance, Staywell achieved 97.4%, and Simply Healthcare and UnitedHealthcare both achieved 93.0%. The Subcontractual Relationships and Delegation standard also had mostly high scores among the MCOs—100% for Aetna, Staywell, and UnitedHealthcare. Simply Healthcare's score was significantly lower, at 75.0%, mostly a result of P&Ps and delegated entity contracts not including all regulatory language. Most of the

MCOs not achieving full compliance indicated in their responses to their individual 2019 ACA Report that they had already incorporated the required language or announced their intentions to do so. The overall average compliance score (89.6%) among the four MCOs evaluated on the same contract standards was the lowest for the Coordination and Continuity of Care standard, with Aetna achieving 100%, Staywell and UnitedHealthcare achieving 91.7%, and Simply Healthcare achieving 75.0%.

Sunshine earned 100% compliance for all three standards evaluated and had an overall score of 100%.

DBM CA Standard Compliance

For the DBMs, Argus's overall score was the highest at 91.2%, while MCNA's overall score was 87.7% and DentaQuest's was 75.4%. Coverage and Authorization of Services scores were mostly high, with Argus achieving 98.1%, MCNA achieving 90.6%, and DentaQuest achieving 81.1%. DentaQuest's lower score for this standard is mostly a result of missing regulatory language in P&Ps and other DBM materials. Scores for the Coordination and Continuity of Care standard were low for all three DBMs, at 50.0% for MCNA and 0% for Argus and DentaQuest. The Coordination and Continuity of Care standard included only one element—Appropriate Source of Care. This element, based on a new provision in the FHKC-DBM contract effective on July 1, 2018, included only two criteria. MCNA demonstrated appropriate documentation of processes for this element, but actual implementation of the processes was incomplete. Argus's enrollee handbook included general information relevant to this element but did not provide documentation that demonstrated compliance with the intent of this element. While DentaQuest provided documentation to demonstrate part of the requirements for this element, it did not provide evidence in support of full compliance with requirements nor did it provide evidence of implementation of the requirements in operational practice.

MCO File Review Compliance

For the file review, Aetna, Simply Healthcare, and UnitedHealthcare achieved 100% compliance, while Staywell achieved 80.8%. Staywell's Notice of Adverse Benefit Determination letters reviewed onsite not including all required language resulted in the lower score; they were missing the notification to the enrollee that they had the right free of charge to information relevant to the adverse benefit determination and the right to request a Subscriber Assistance Panel, or Independent Review Organization (after July 1, 2018), hearing.

DBM File Review Compliance

Argus also had the highest score for the UM denial file review of all the DBMs, 100%. MCNA was very close to Argus's score, at 98.0%. DentaQuest achieved 80.0% compliance for the file review, attributable to the DBM's Notice of Adverse Benefit Determination letters reviewed onsite not including all required language. They were missing the notification to the enrollee that they had the right free of charge to information relevant to the adverse benefit determination.

Strengths and Opportunities for Improvement

Strengths

The MCOs had 37 strengths combined—seven for Aetna, eight for Simply Healthcare, 10 for Staywell, one for Sunshine, and 11 for UnitedHealthcare. Qsource noted the individual MCO strengths presented in **Table 2**.

Table 2. 2019 ACA Strengths for All MCOs

MCO	Coverage and Authorization of Services	Coordination and Continuity of Care	Subcontractual Relationships and Delegation
Aetna	**Element 5, Application of Review Criteria:** Quarterly IRR [inter-rater reliability] was conducted on 1% of all Florida Healthy Kids cases.	**Element 3, Initial Screening:** The MCO's standard timeframe to complete the initial screening of enrollee needs was 30 days, which is stricter than the required timeframe.	**Element 2, Delegation of Activities:** The MCO's Florida Medicaid and Florida Healthy Kids Compliance Addendum – Subcontractor and the Regulatory Amendment to Aetna Delegated Agreement documents were well organized with detailed, individual descriptions of expectations for vendor oversight functions for the MCO's delegated activities.
	Element 6, Appropriate Reviewer Expertise: The MCO demonstrated a comprehensive training	**Element 8, Treatment or Service Plan:** The MCO's 30- and 90-day interval	**Element 3, Regulatory Compliance:** The Florida Medicaid and Florida Healthy Kids Compliance Addendum –

Table 2. 2019 ACA Strengths for All MCOs			
MCO	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**	**Subcontractual Relationships and Delegation**
	program for its medical directors, including detailed documentation of that training.	assessments exceed timeframe requirements.	Subcontractor document included numerous references to the applicable governing body or document, including the MCO's contract with FHKC, and Florida statutes among other state and federal regulations. This document clearly communicated required provisions that governed subcontractor activities for the MCO.
Aetna			**Element 4, Subcontractor Audit:** The MCO's requirement for record retention, as explained in the Florida Medicaid and Florida Healthy Kids Compliance Addendum – Subcontractor document, was for subcontractors to maintain records in electronic form for three years in live systems and for an additional seven years in archival systems. The specific requirement for record preservation in live systems for three years exceeded the 10-year overall requirement.

Table 2. 2019 ACA Strengths for All MCOs			
MCO	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**	**Subcontractual Relationships and Delegation**
Simply Healthcare	**Element 5, Application of Review Criteria:** The MCO described its Performance Improvement and Enhancement (PIE) program onsite, which included monthly review of five cases per reviewer to validate clinical decisions.	**Element 5, Enrollee Health Record:** The MCO's annual medical record review provides a more robust accountability for providers to maintain enrollee health records in accordance with professional standards.	**Element 3, Regulatory Compliance:** The MCO's vendor oversight program is a best practice as it includes tools to guide the process as well as a local team to oversee Florida Healthy Kids vendors in Florida and collaborate with the MCO's national vendor oversight team.
	Element 7, Notice of Adverse Benefit Determination: A review of a sample of denial letters demonstrated that denial rationale language was very clear and understandable.	**Element 8, Treatment or Service Plan:** The MCO exceeded the review requirement for treatment or service plans of every 12 months, indicating in its P&P that care plans and treatment plans were updated at least every six months when there were significant changes in the enrollee's condition. The MCO also demonstrated review of complex cases every month.	

Table 2. 2019 ACA Strengths for All MCOs			
MCO	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**	**Subcontractual Relationships and Delegation**
Simply Healthcare	**Element 8, Timeframe for Standard Authorization Decisions:** The MCO adheres to a seven-day timeframe, which is stricter than the required 14-day standard. In addition, the MCO used a priority processing system for enrollees with complex conditions.		
	Element 9, Timeframe for Expedited Authorization Decisions: The MCO adheres to a 48-hour timeframe, which is stricter than the required 72-hour standard.		
	Element 10, Extension of Decision Timeframe: The MCO adheres to a seven-day timeframe, which is stricter than the required 14-day standard.		

Table 2. 2019 ACA Strengths for All MCOs			
MCO	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**	**Subcontractual Relationships and Delegation**
Staywell	**Element 5, Application of Review Criteria:** The MCO noted during the onsite that monthly audits of reviewer phone calls and three randomly selected cases were completed to identify areas of opportunity for consistent determination of authorization decisions.	**Element 2, Service Coordination:** The MCO described its Community Connection program, which offers an electronic warehouse of community resources for enrollees. The MCO uses a tracking system to generate monthly reports of the percentage of enrollees referred to a service who utilized that service and of total utilization for each service.	**Element 3, Regulatory Compliance:** The MCO's vendor oversight program is a best practice as it includes the C360 audit tool as well as a local team to oversee Florida Healthy Kids vendors in Florida and collaborate with the MCO's national vendor oversight team.
	Element 6, Appropriate Reviewer Expertise: The MCO described onsite a very comprehensive medical director training program, including shadowing a care manager and clinician.	**Element 3, Initial Screening:** The MCO's policy is to make a best effort to conduct an HRA [health risk assessment] within 30 days of new enrollment, which is stricter than the 90-day requirement.	
	Element 7, Notice of Adverse Benefit Determination: A review of a sample of MCO Notices of Adverse Benefit Determination (NABDs) demonstrated very clear and understandable denial rationale language.	**Element 5, Enrollee Health Record:** The MCO conducts an annual medical record review, with a threshold of 85% and education opportunities for providers who do not meet that threshold.	

Table 2. 2019 ACA Strengths for All MCOs			
MCO	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**	**Subcontractual Relationships and Delegation**
Staywell	**Element 11, Covered Outpatient Drug Decisions:** The MCO described onsite that an automated daily dashboard is used to monitor turnaround times.	**Element 8, Treatment or Service Plan:** As stated in Procedure #FL-18-HS-CM-010-PR-001, the MCO reviews and revises an enrollee's treatment or service plan every six months, which is stricter than the 12-month requirement. In addition, the MCO demonstrated its care management system, which incorporated the Virtual Health dashboard of all the enrollee's information on one access site.	
	Element 12, Compensation for Utilization Management Activities: The MCO described onsite that an annual attestation reflecting this criterion was signed by all reviewers.		

Table 2. 2019 ACA Strengths for All MCOs			
MCO	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**	**Subcontractual Relationships and Delegation**
Sunshine	**Element 1, Timeframe for Standard Authorization Decisions:** The MCO's standard for completion of standard authorizations was noted as seven days, which is stricter than the 14-day requirement. The MCO indicated onsite that supervisors monitored cases through system business logic based on appropriate standards daily. The MCO also indicated that aggregated reports were monitored and presented to the appropriate committee on a monthly basis for accountability.		
UnitedHealthcare	**Element 5, Application of Review Criteria:** The MCO required that inpatient authorization staff attain and maintain Milliman Criteria Guidelines (MCG) certification.	**Element 2, Service Coordination:** The transitions of care language in the member handbook clearly described enrollee transition rights.	**Element 1, Contract Compliance:** The Delegated Entity Compliance and Oversight Program Toolkit demonstrated the MCO's commitment to maintaining ultimate responsibility for ensuring subcontractors' compliance with FHKC contract requirements and provided an infrastructure of people,

Table 2. 2019 ACA Strengths for All MCOs			
MCO	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**	**Subcontractual Relationships and Delegation**
			processes, guidelines, and templates to enable consistent monitoring of delegated entities.
UnitedHealthcare	**Element 8, Timeframe for Standard Authorization Decisions:** The MCO's standard timeframe for a decision notice on standard authorizations was seven days, which is stricter than the required 14-day timeframe.	**Element 5, Enrollee Health Record:** The 2018 Administrative Guide included a very comprehensive section on professional standards for medical records.	**Element 3, Regulatory Compliance:** The Delegated Entity Compliance and Oversight Program Toolkit addressed the importance of communicating and documenting clear contractual expectations to delegated entities to ensure compliance with all applicable laws and regulations.
	Element 9, Timeframe for Expedited Authorization Decisions: The MCO's standard timeframe for a decision on expedited authorizations was 48 hours, which is stricter than the required 72-hour timeframe.	**Element 6, Enrollee Privacy:** Policy #HS MMA 014 addressed the responsibility of the case manager specifically to protect enrollee privacy in the process of coordinating care.	

Table 2. 2019 ACA Strengths for All MCOs			
MCO	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**	**Subcontractual Relationships and Delegation**
UnitedHealthcare	**Element 10, Extension of Decision Timeframe:** The MCO's standard timeframe for a decision on extended authorizations was seven days, which is stricter than the required 14-day timeframe.	**Element 8, Treatment or Service Plan:** The MCO reviewed and revised the plan of care monthly or more frequently, which is considerably more often than the required standard.	
	Element 12, Compensation for Utilization Management Activities: Annual UM staff attestation regarding incentives is a best practice for this element.		

Qsource identified 10 strengths among the three DBMs—five for Argus, four for DentaQuest, and one for MCNA—all of which were for the Coverage and Authorization of Services standard. No strengths were identified for the DBMs for the Coordination and Continuity of Care standard, and the DBMs were not evaluated for the Subcontractual Relationships and Delegation standard as they had no delegated entities. Individual DBM strengths are presented in **Table 3**.

Table 3. 2019 ACA Strengths for All DBMs	
DBM	**Coverage and Authorization of Services**
Argus	**Element 5, Application of Review Criteria:** The DBM's threshold score for IRR testing is 95%. The DBM described onsite a practice of informal gathering of UM staff for ad hoc training by the dental director on unusual or infrequently seen situations.

Table 3. 2019 ACA Strengths for All DBMs	
DBM	**Coverage and Authorization of Services**
	Element 6, Appropriate Reviewer Expertise: The DBM described onsite additional comprehensive formal training for dental reviewers and ad hoc training whenever any criteria changes occur.
	Element 8, Timeframe for Standard Authorization Decisions: During the onsite, the DBM noted an internal timeframe goal for notice was 10 days. The DBM also described that weekly turnaround time reports were provided to the Vice President of Operations and to the Compliance Department. In addition, the DBM stated that monthly and quarterly reports were provided to the Quality and Compliance departments and to Executive Leadership staff.
	Element 9, Timeframe for Expedited Authorization Decisions: The DBM provided notice to providers and enrollees within 48 hours, which is stricter than the 72-hour requirement.
	Element 11, Compensation for Utilization Management Activities: An annual attestation regarding incentives was signed by all UM staff.
DentaQuest	**Element 5, Application of Review Criteria:** The DBM conducted quarterly IRR for all UM staff with a passing threshold of 90%.
	Element 6, Appropriate Reviewer Expertise: The DBM provided a comprehensive training program for dental consultants.
	Element 8, Timeframe for Standard Authorization Decisions: The internal timeframe for standard authorization decisions is seven days, stricter than the 14-calendar-day requirement.
	Element 11, Compensation for Utilization Management Activities: UM staff is required to sign an annual attestation regarding incentives.
MCNA	**Element 5, Application of Review Criteria:** The DBM described the position of a Clinical Review Analyst, a dentist who worked with the Quality Department on an ongoing basis to review and update medical necessity criteria.

Suggestions

The MCOs had 27 suggestions combined—four for Aetna, 12 for Simply Healthcare, three for Staywell, three for Sunshine, and five for UnitedHealthcare. Qsource noted the individual MCO suggestions presented in **Table 4**.

Table 4. 2019 ACA Suggestions for All MCOs

MCO	Coverage and Authorization of Services	Coordination and Continuity of Care	Subcontractual Relationships and Delegation
Aetna	**Element 2, Service Limitations:** The MCO could strengthen Policy #7100.05 by adding a specific reference to the provision of services supporting individuals with ongoing or chronic conditions.		
	Element 8, Timeframe for Standard Authorization Decisions: The MCO could update Policy #7100.05 to indicate that notice would be provided as expeditiously as the enrollee's health condition requires, to be completely consistent with the regulatory and contract requirements.		
	Element 9, Timeframe for Expedited Authorization Decisions: The MCO could update Policy #7100.05 to indicate that notice would be provided as expeditiously as the enrollee's health condition		

Table 4. 2019 ACA Suggestions for All MCOs			
MCO	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**	**Subcontractual Relationships and Delegation**
	requires, to be completely consistent with the regulatory and contract requirements.		
	Element 10, Extension of Decision Timeframe: The MCO could update Policy #7100.05 to indicate that notice would be provided as expeditiously as the enrollee's health condition requires, to be completely consistent with the regulatory and contract requirements.		
Simply Healthcare	**Element 2, Service Limitations:** The MCO could update P&P: Health Care Management – Utilization Management to specifically address the requirements for authorization of services to reflect ongoing needs of individuals with ongoing or chronic conditions.	**Element 2, Service Coordination:** The MCO could strengthen P&P #FL-CM: Care Coordination and Case Management by including a reference to applicable regulations in the policy purpose statement and clarifying which procedures in the P&P apply directly to the Florida Healthy Kids population.	**Element 1, Contract Compliance:** The MCO could strengthen its vendor contracts for Florida Healthy Kids delegated activities by including language specific to Florida Healthy Kids enrollees rather than only Medicaid.

Table 4. 2019 ACA Suggestions for All MCOs			
MCO	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**	**Subcontractual Relationships and Delegation**
	Element 5, Application of Review Criteria: P&P: Pre-Certification of Requested Services – Core Process could be updated to specifically address medical director consultation with the requesting provider.		**Element 2, Delegation of Activities:** The MCO could update the Compliance with Laws section in its Delegated Services Addendum to Network Provider Agreement with one vendor to reference Medicaid in addition to Medicare.
	Element 6, Appropriate Reviewer Expertise: The MCO could update the appropriate P&P to specifically address training for reviewers who deny or authorize services less than requested.		**Element 3, Regulatory Compliance:** The MCO could improve its delegate contracts by including specific references to CHIP, Medicaid, or the CFR.
	Element 8, Timeframe for Standard Authorization Decisions: The MCO could update Operating Procedures/Guidelines: Processing a Denial to specifically indicate that the notice is sent within 14 calendar days of the receipt of the request for services.		**Element 4, Subcontractor Audit:** The MCO could strengthen its vendor contracts for Florida Healthy Kids delegated activities by including language specific to Florida Healthy Kids enrollees rather than only Medicaid.

Table 4. 2019 ACA Suggestions for All MCOs			
MCO	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**	**Subcontractual Relationships and Delegation**
	Element 10, Extension of Decision Timeframe: The MCO could update P&P: Health Care Management Denial – Core Process to indicate that notice is provided in seven calendar days and as expeditiously as the enrollee's health condition requires and to include the enrollee's right to file a grievance, to be completely consistent with the regulatory and contract requirements.		**Element 5, Notification of Agreement Termination:** The MCO could specify that for FHKC, termination of agreement notice, instead of a "change in subcontractors," is provided to FHKC on a timely basis.
	Element 16, Elements of Adverse Benefit Determination Notice: The MCO could update P&P: Health Care Management Denial – Core Process to specifically list the required elements for the NABD for Florida Healthy Kids enrollees.		

Table 4. 2019 ACA Suggestions for All MCOs			
MCO	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**	**Subcontractual Relationships and Delegation**
Staywell	**Element 13, Termination, Suspension, or Reduction of Services:** The MCO could update Policy #FL-18-HS-UM-019 to indicate that the notice is mailed no later than 10 calendar days before the date of action, to be completely consistent with requirements.		**Element 4, Subcontractor Audit:** The MCO could update its Florida Healthy Kids Requirements Addendum to include that authorized entities have the right to audit the MCO's computer and electronic systems to be completely consistent with requirements.
	Element 16, Elements of Adverse Benefit Determination Notice: The MCO could review Policy #FL-18-HS-UM-019 to ensure that all required components of the NABD specifically apply to Florida Healthy Kids enrollees.		

Table 4. 2019 ACA Suggestions for All MCOs			
MCO	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**	**Subcontractual Relationships and Delegation**
Sunshine			**Element 1, Delegation of Activities:** The MCO could consider developing a P&P or other appropriate documentation of the required response timeline for FHKC requests for delegate agreements to include in the vendor oversight manual.
			Element 4, Notification of Agreement Termination: The MCO could consider including quarterly requirements for network adequacy attestations in an appropriate P&P to include in the vendor oversight manual.
			Element 5, Notice of Intent to Subcontract: The MCO could consider developing a P&P or update P&P #CC.COMP.21: Third Party Oversight Program Description to include documentation of required notification to FHKC for new subcontractors or affiliates for inclusion in the vendor oversight manual.

Table 4. 2019 ACA Suggestions for All MCOs			
MCO	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**	**Subcontractual Relationships and Delegation**
UnitedHealthcare	**Element 6, Appropriate Reviewer Expertise:** The MCO could develop a P&P or other appropriate written documentation of the training programs required for UM reviewers.		
	Element 9, Timeframe for Expedited Authorization Decisions: The MCO could update P&P #HS MMA 007 to indicate that the decision must be made and notice provided as expeditiously as the enrollee's health condition requires, to be completely consistent with the regulatory and contract requirements.		
	Element 10, Extension of Decision Timeframe: The MCO could update P&P #HS MMA 007 to indicate that the decision must be made and notice provided as expeditiously as the enrollee's health condition requires, to be completely consistent with the		

Table 4. 2019 ACA Suggestions for All MCOs			
MCO	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**	**Subcontractual Relationships and Delegation**
	regulatory and contract requirements.		
	Element 13, Termination, Suspension, or Reduction of Services: The MCO could update P&P #HS MMA 007 to specifically indicate 10 calendar days as the timeframe for providing notice.		
	Element 16, Elements of Adverse Benefit Determination Notice: The MCO could consider updating the appropriate P&P to include the required components of the notice of adverse benefit determination.		

Qsource noted 11 suggestions for all three DBMs—five for Argus, three for DentaQuest, and three for MCNA—all of which were for the Coverage and Authorization of Services standard.

No suggestions were identified for the DBMs for the Coordination and Continuity of Care standard, and the DBMs were not evaluated for the Subcontractual Relationships and Delegation standard as they had no delegated entities. Individual DBM suggestions are presented in Table 5.

Table 5. 2019 ACA Suggestions for All DBMs	
DBM	**Coverage and Authorization of Services**
Argus	**Element 7, Notice of Adverse Benefit Determination:** The DBM could add the word "provider" in the first sentence under section (K) of this process standard to clearly reflect that notice is provided to both providers and enrollees.
	Element 8, Timeframe for Standard Authorization Decisions: The DBM could update Authorization Process Standard FHK #UM59dAPS03 to indicate that notice is provided as expeditiously as the enrollee's health condition requires, to be completely consistent with the regulatory and contract requirements.
	Element 9, Timeframe for Expedited Authorization Decisions: The DBM could update Authorization Process Standard FHK #UM59dAPS03 to indicate that notice is provided as expeditiously as the enrollee's health condition requires, to be completely consistent with the regulatory and contract requirements.
	Element 14, Decisions Exceeding Timeframes: The DBM could update Authorization Process Standard FHK #UM59dAPS03 to include that notice is provided (in addition to the decision being made) on the date the required timeframe expires for authorization decisions not reached within the required timeframe.
	Element 15, Elements of Adverse Benefit Determination Notice: The DBM could update Authorization Process Standard FHK #UM59dAPS03 to include the enrollee's right to be provided access to documents and records related to the adverse benefit determination free of charge.
DentaQuest	**Element 2, Service Limitations:** The DBM could more specifically address that the chronic or ongoing needs of enrollees are supported in its documentation.
	Element 8, Timeframe for Standard Authorization Decisions: The DBM could update P&P #UM08-INS to indicate that notice of standard authorization decisions is provided within 14 calendar days of receipt of the request or indicate that the internal timeframe for standard decisions is seven days.
	Element 9, Timeframe for Expedited Authorization Decisions: The DBM could update P&P #UM08-INS to indicate that notice of expedited authorization decisions is provided within 72 hours of receipt of the request.

Table 5. 2019 ACA Suggestions for All DBMs	
DBM	**Coverage and Authorization of Services**
MCNA	**Element 6, Appropriate Reviewer Expertise:** The DBM could develop a P&P to formally document its reviewer training program.
	Element 7, Timeframe for Standard Authorization Decisions: The DBM could update P&P #3.203 to indicate that notice is provided as expeditiously as the enrollee's health condition requires, to be completely consistent with the regulatory and contract requirements.
	Element 10, Extension of Decision Timeframe: The DBM could update P&P #3.203 to indicate that notice is provided as expeditiously as the enrollee's health condition requires, to be completely consistent with the regulatory and contract requirements.

Areas of Noncompliance (AONs)

Qsource identified 15 areas of noncompliance (AONs) among the MCOs—one for Aetna, eight for Simply Healthcare, three for Staywell, and three for UnitedHealthcare. Sunshine had no AONs for the 2019 ACA. Qsource noted the individual MCO deficiencies for this year's ACA presented in **Table 6**.

Table 6. 2019 ACA AONs for All MCOs			
MCO	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**	**Subcontractual Relationships and Delegation**
Aetna	**Element 3, Medically Necessary Services:** The MCO should update Policy #7100.05 to include the services that address the ability for an enrollee to achieve age-appropriate growth and development and the ability for an enrollee to attain, maintain, or regain		

Table 6. 2019 ACA AONs for All MCOs			
MCO	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**	**Subcontractual Relationships and Delegation**
	functional ability in its definition of medically necessary services.		
Simply Healthcare	**Element 3, Medically Necessary Services:** The MCO should specifically include the three conditions under criterion b.2 in its definition of medical necessity.	**Element 3, Initial Screening:** The MCO should ensure that relevant P&Ps are effective for the entire review period and that they are specific to the Florida Healthy Kids population.	**Element 1, Contract Compliance:** The MCO should ensure all vendor contracts related to Florida Healthy Kids delegated activities include the requirement that the MCO will maintain responsibility for complying with its contract with FHKC.
	Element 11, Covered Outpatient Drug Decisions: P&P #A08: Pharmacy Prior Authorization should be updated to specifically indicate that enrollees and providers receive denial notification by telephone or other telecommunication device within 24 hours of a request for prior authorization. In addition, the definition of 24 hours as a business day or non-holiday should be removed.	**Element 8, Treatment or Service Plan:** The MCO should update P&P #FL-CM: Care Coordination and Case Management to include that plans of care are reviewed and revised at the request of the enrollee.	**Element 2, Delegation of Activities:** The MCO should ensure all contracts and amendments with all vendors that provide services for Florida Healthy Kids are effective for the entire review year.

Table 6. 2019 ACA AONs for All MCOs			
MCO	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**	**Subcontractual Relationships and Delegation**
	Element 14, Denial of Payment: P&P: Health Care Management Denial – Core Process should be updated to ensure that this provision is applicable to Florida Healthy Kids enrollees.		**Element 4, Subcontractor Audit:** The MCO should include a description of the right to inspect, evaluate, and audit if possible fraud were determined by FHKC, CMS, or the HHS [Department of Health and Human Services] Inspector General in all of its vendor contracts.
Staywell	**Element 2, Service Limitations:** The MCO should update Policy #FL-18-HS-UM-018 to indicate that services are authorized to reflect needs of enrollees with ongoing or chronic conditions.	**Element 8, Treatment or Service Plan:** The MCO should update appropriate P&Ps to include the requirement that it would change a care or treatment plan at the enrollee's request.	
	Element 3, Medically Necessary Services: The MCO should update Policy #FL-18-HS-UM-018 to include the requirements under criterion b for this element.		
UnitedHealthcare	**Element 3, Medically Necessary Services:** The MCO should update P&P #HS MMA 007 to include the components of medically	**Element 8, Treatment or Service Plan:** The MCO should update Policy #HS MMA 014 to include that plans of care are reviewed and revised with a	

Table 6. 2019 ACA AONs for All MCOs			
MCO	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**	**Subcontractual Relationships and Delegation**
	necessary services listed under criteria b for this element.	significant change in enrollee needs or circumstances or at the request of the enrollee.	
	Element 9, Timeframe for Expedited Authorization Services: The MCO should update P&P #HS MMA 007 to include that notice will be provided within the required timeframe.		

Qsource identified 13 AONs among the DBMs—three for Argus, seven for DentaQuest, and three for MCNA—and noted the individual DBM deficiencies for this year's ACA presented in **Table 7**. The DBMs were not evaluated for the Subcontractual Relationships and Delegation standard as they had no delegated entities.

Table 7. 2019 ACA AONs for All DBMs		
DBM	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**
Argus	**Element 1, Service Protections:** The DBM should ensure that the appropriate document includes the provision that the DBM does not deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee.	**Element 1, Appropriate Source of Care:** The DBM should develop procedures and processes to ensure each enrollee has an ongoing source of primary dental care and communicate how enrollees can contact this source of care.
	Element 2, Service Limitations: The DBM should ensure that the appropriate document	

Table 7. 2019 ACA AONs for All DBMs		
DBM	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**
	reflects that services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services.	
DentaQuest	**Element 1, Service Protections:** While the UM Program Description 2018 indicated that the DBM complied with all federal and state regulations, the requirements of the applicable regulations and contract provisions should be specifically documented in the appropriate policy or program document.	**Element 1, Appropriate Source of Care:** The DBM should implement P&Ps to fulfill the four required activities as agreed upon with FHKC to ensure each enrollee has an ongoing source of care and care coordination and as well as information on how to contact the designated provider.
	Element 2, Service Limitations: The DBM should include specific evidence that the UM process ensures that services furnished can reasonably achieve their purpose in its documentation.	
	Element 3, Medically Necessary Services: The DBM should update its definition of medical necessity to include the ability to achieve age-appropriate growth and development and the ability to attain, maintain, or regain functional capacity.	
	Element 10, Extension of Decision Timeframe: The DBM should update P&P #UM08-INS to indicate an extension timeframe of 14 calendar days and document written notice to the enrollee of the reason for the extension and the right to file a grievance.	

Table 7. 2019 ACA AONs for All DBMs		
DBM	**Coverage and Authorization of Services**	**Coordination and Continuity of Care**
	Element 14, Decisions Exceeding Timeframes: For denial authorization decisions not reached within required timeframes, the DBM should provide notice on the date the timeframe expires.	
	Element 15, Elements of Adverse Benefit Determination Notice: The DBM should update P&P #UM04-INS and the NABD template to include the enrollee's right to information relevant to the decision free of charge.	
MCNA	**Element 10, Extension of Decision Timeframe:** The DBM should update P&P #3.203 to indicate that, for the Florida Healthy Kids program, the extension period is 14 calendar days and that the determination must be carried out by the date the extension expires.	**Element 1, Appropriate Source of Care:** While the process of assigning a PDP [primary dental provider] for enrollees was implemented, the DBM should provide the enrollee with the assigned PDP name and contact information.
	Element 15, Elements of Adverse Benefit Determination Notice: The DBM should update P&P #3.203a to include that all documents relevant to the adverse benefit determination are available to the enrollee free of charge and should also update the denial letter template to include similar language.	

Improvements Since the 2018 ACA

As part of the ACA, Qsource documents the quality improvements the MCOs and DBMs have made since the previous year's survey. Table 8 summarizes the AONs identified during the 2018 ACA and the corrective actions accomplished

to address the AONs by ACA standard and MCO/DBM, including the MCO/DBM's planned action as described in its corrective action plans (CAPs) in its own words, and whether those actions satisfied the element associated with the AON. Standards assessed as part of the 2018 ACA included Access and Availability of Services, Grievance System, Quality Assessment and Performance Improvement, and Program Integrity. MCNA was not required to submit any CAPs for the 2018 ACA. Sunshine, evaluated for compliance with its contract with FHKC, was not accountable for completing CAPs for AONs identified during the 2018 ACA. For the Grievance System standard AONs identified for DentaQuest, the DBM disputed the CAPs. The basis for the disputed CAPs was in regard to requirement effective dates. While formal CAPs were not submitted, DentaQuest was required to address the 2018 AONs and provided all required documentation to confirm compliance.

Table 8. Improvements Since the 2018 ACA for all MCOs and DBMs by ACA Standard

MCO/DBM	2018 AON	MCO/DBM's Planned Action	Action Accomplished
Access and Availability of Services			
UnitedHealthcare	**Element 1, Delivery Network:** 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.	This policy and procedure was updated on 03/01/2018 to reflect FHKC.	This action satisfied the 2018 CAP.
	Element 5, Out-of-Network Services: P&P #MMA LTC NM 11 should be effective for the review period. In addition, the policy 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.	This policy and procedure was updated on 03/01/2018 to reflect FHKC. This policy and procedure was updated on 03/01/2018 removed reference stating enrollees responsibility for up to 40% of costs of services provided out of network as requested by FHKC; however, please note that Florida Statute 610.51(5)(c) allows MCOs	These actions satisfied the 2018 CAP.

Table 8. Improvements Since the 2018 ACA for all MCOs and DBMs by ACA Standard			
MCO/DBM	**2018 AON**	**MCO/DBM's Planned Action**	**Action Accomplished**
		to require subscribers to pay up to 40% if the physician is out of network. We'd like clarification from FHKC regarding this matter. [Clarification provided by FHKC]	
	Element 6, Out-of-Network Providers: P&P #MMA LTC NM 11 should be effective for the review period.	This policy and procedure was updated on 03/01/2018 to reflect FHKC.	This action satisfied the 2018 CAP.
	Element 7, Out-of-Network Provider Payment: P&P #MMA LTC NM 11 should be effective for the review period.	This policy and procedure was updated on 03/01/2018 to reflect FHKC.	This action satisfied the 2018 CAP.
	Element 9, Suspension of Payment to Network Providers: The MCO should ensure P&P #HP (SIU) 004 is effective for the review period.	This policy and procedure was updated on 3/30/2018 as a result of FHK [Florida Healthy Kids] Contract amendment #5, which specified these requirements.	This action satisfied the 2018 CAP.

Table 8. Improvements Since the 2018 ACA for all MCOs and DBMs by ACA Standard			
MCO/DBM	**2018 AON**	**MCO/DBM's Planned Action**	**Action Accomplished**
Grievance System			
DentaQuest	**Element 3, Authority and Timing to File – Enrollee:** The DBM should update P&P #200.016 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.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.
	Element 4, Authority to File – Authorized Representative: The DBM should update the Member Handbook and applicable P&Ps to reflect that an enrollee's representative may initiate a State review on the enrollee's behalf.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.
	Element 5, Deemed Exhaustion of Appeals Process: P&P #200.016 should 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.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.

Table 8. Improvements Since the 2018 ACA for all MCOs and DBMs by ACA Standard			
MCO/DBM	**2018 AON**	**MCO/DBM's Planned Action**	**Action Accomplished**
	Element 7, Procedures – Oral Appeal: The DBM should update P&P #200.016 and the Member Handbook to indicate that an expedited appeal does not need to be filed in writing.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.
	Element 9, Acknowledgement of Grievances and Appeals: P&P #200.016 should indicate that all grievances and appeals, whether filed orally or in writing, will be acknowledged.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.
	Element 11, Oral Appeals: P&P #200.016 should indicate that the date of the oral appeal will be treated as the appeal initiation date to establish the earliest possible filing date and that oral appeals will be confirmed in writing.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.
	Element 12, Opportunity to Present Evidence and Allegations of Fact or Law in Appeals: The enrollee letter for an expedited appeal should indicate the limited timeframe available for the enrollee to provide additional information.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.

Table 8. Improvements Since the 2018 ACA for all MCOs and DBMs by ACA Standard			
MCO/DBM	**2018 AON**	**MCO/DBM's Planned Action**	**Action Accomplished**
	Element 13, Opportunity to Examine Enrollee's Case File in Appeals: The DBM should update P&P #200.016 to indicate that the information will be provided to the enrollee or their representative free of charge.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.
	Element 15, Resolution of Grievance: The DBM should update P&P #200.016 to indicate that notice will be provided to the enrollee or their representative as expeditiously as the enrollee's health requires.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.
	Element 16, Resolution of Appeal: P&P #200.016 should include 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.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.

Table 8. Improvements Since the 2018 ACA for all MCOs and DBMs by ACA Standard			
MCO/DBM	**2018 AON**	**MCO/DBM's Planned Action**	**Action Accomplished**
	Element 17, Extension of Timeframes: P&P #200.016 should include the timeframe extension for appeals in this section, and it should include the standard grievance timeframe as well.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.
	Element 18, Requirements Following Extension: P&P #200.016 should indicate that 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.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.
	Element 20, Format of Appeal Notice – Expedited Appeals: P&P #200.016 should indicate that, for expedited appeals, the DBM makes reasonable efforts to provide oral notice to both the enrollee and the provider.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.

Table 8. Improvements Since the 2018 ACA for all MCOs and DBMs by ACA Standard			
MCO/DBM	**2018 AON**	**MCO/DBM's Planned Action**	**Action Accomplished**
	Element 25, Punitive Action for Expedited Appeal: The DBM should update P&P #200.016 and 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.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.
	Element 26, Denial of Request for Expedited Resolution: The DBM should update P&P #200.016 to indicate that if an expedited appeal is denied, the appeal will be resolved within 30 days.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.
	Element 29, Services Not Furnished While the Appeal Is Pending: P&P #200.016 should explain that 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.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.

Table 8. Improvements Since the 2018 ACA for all MCOs and DBMs by ACA Standard			
MCO/DBM	**2018 AON**	**MCO/DBM's Planned Action**	**Action Accomplished**
	Element 30, Services Furnished While the Appeal Is Pending: P&P #200.016 should explain that in the event of a reversal of the 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.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.
Simply Healthcare	**Element 8, Assistance with Grievances and Appeals:** 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.	Update, approve and finalize P&P Member Complaints and Grievances – FL. Update, approve and finalize P&P Member Appeals – FL.	These actions satisfied the 2018 CAP.

Table 8. Improvements Since the 2018 ACA for all MCOs and DBMs by ACA Standard			
MCO/DBM	**2018 AON**	**MCO/DBM's Planned Action**	**Action Accomplished**
	Element 10, Individuals Who Make Grievance and Appeal Decisions: 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.	Update, approve and finalize P&P Member Complaints and Grievances – FL.	This action satisfied the 2018 CAP.
	Element 17, Extension of Timeframes: 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.	Update, approve and finalize P&P Member Complaints and Grievances – FL. Update, approve and finalize P&P Member Appeals – FL.	These actions satisfied the 2018 CAP.
Quality Assessment and Performance Improvement			
Argus	**Element 2, Dissemination of Guidelines:** The DBM should update P&P#UM_62 to include the provision for dissemination of guidelines to enrollees and potential enrollees on request.	Verbiage update to P&P UM_62 for dissemination of guidelines to members/enrollees or potential enrollees upon request.	This action satisfied the 2018 CAP.

Table 8. Improvements Since the 2018 ACA for all MCOs and DBMs by ACA Standard			
MCO/DBM	**2018 AON**	**MCO/DBM's Planned Action**	**Action Accomplished**
	Element 3, Application of Guidelines: The DBM should update P&P#UM_62 to include provisions to ensure guidelines are consistent with enrollee education, coverage of services, and other areas to which guidelines apply.	Verbiage update to P&P UM_62 for consistency in coverage of services, member/enrollee education and other areas to which the clinical guidelines apply.	This action satisfied the 2018 CAP.
DentaQuest	**Element 1, Adoption of Practice Guidelines:** The DBM should adopt appropriate practice guidelines for dental services and conditions.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.
	Element 2, Dissemination of Guidelines: Once adopted, practice guidelines should be disseminated to all affected providers and enrollees and potential enrollees upon request.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.
	Element 3, Application of Guidelines: 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.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.

Table 8. Improvements Since the 2018 ACA for all MCOs and DBMs by ACA Standard			
MCO/DBM	**2018 AON**	**MCO/DBM's Planned Action**	**Action Accomplished**
Program Integrity			
Aetna	**Element 7, Overpayments – Providers:** 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.	1) Healthy Kids Provider Manual was updated to include the language on Overpayments – Providers – Refer to Section 14 – Overpayments. 2) Policy # FL-3000.01 reflects the process on FWA which includes guidance on Overpayments – Providers Page 10, Section: Suspected/Confirmed Fraud and Abuse Reporting/ The health plan will promptly report……	These actions satisfied the 2018 CAP.
Argus	**Element 7, Overpayments – Providers:** 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.	Verbiage update to the Managed Care Provider Agreement to include the requirement that providers must submit written notification of the reason for overpayments.	This action satisfied the 2018 CAP.
DentaQuest	**Element 5, Services Delivered to Enrollees:** The DBM should implement a formal process to regularly verify if services billed have been received by enrollees.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.

Table 8. Improvements Since the 2018 ACA for all MCOs and DBMs by ACA Standard			
MCO/DBM	**2018 AON**	**MCO/DBM's Planned Action**	**Action Accomplished**
	Element 7, Overpayments – Providers: The DBM should 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.		Documentation including appropriate information was provided as evidence of updates that met 2018 ACA requirements as of 3/11/19.
Staywell	**Element 7, Overpayments – Providers:** The MCO should update the provider manual to indicate that overpayments must be returned within 60 days.	Update provider manual to include information on how providers must return overpayments within 60 days of the date the overpayment is identified.	A review of the provider manual began in June 2018 and the overpayment detail was incorporated during the review. The updated provider manual was finalized and published on 9/19/2018. This action satisfied the 2018 CAP.
UnitedHealthcare	**Element 6, Timely Access – Other Requirements:** The policy (NM MMA LTC 23) was not effective for the review period. The Practitioner Agreement or the Provider Manual was not updated to include hours of operation requirements specifically for Florida Healthy Kids enrollees.	We've submitted a request to update the Provider Manual with the hours of operation requirements specifically for FHK [Florida Healthy Kids] enrollees. The manual with implemented changes should be posted by Friday October 12, 2018. This policy and procedure was	These actions satisfied the 2018 CAP.

Table 8. Improvements Since the 2018 ACA for all MCOs and DBMs by ACA Standard			
MCO/DBM	**2018 AON**	**MCO/DBM's Planned Action**	**Action Accomplished**
		updated on 04/2018 to reflect FHKC.	

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 and one AHCA Managed Medical Assistance (MMA) measure 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 ISCAT, and all MCOs used NCQA HEDIS-certified software for measure calculation. As a result of the MCOs' successful completion of the HEDIS audit process, onsite audits and source code review (also components of the protocol) by Qsource were not necessary.

Based on all validation activities, results were determined for each performance measure. For the MCOs, NCQA's HEDIS Compliance Audit protocol was followed. For the 2019 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 eight dental performance measures to be calculated and reported by the contracted DBMs. Six 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

2019 Validated Measures

Although some selected measures changed for both the MCOs and the DBMs, trending analysis is included where possible. Trending for these measures is the addition of a green or red arrow to this year's result for each measure (in tables 11 and 14) to indicate an increase (⬆) or decrease (⬇) from the previous year's rate. Trending is not included for two MCO measures (in tables 12 and 13), because the measure results are generally very small (less than one percent).

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 9 provides a description of the audited measures for MCOs, and Table 10 provides a description of the audited measures for DBMs. Some measure definition age stratifications that do not apply to the Florida Healthy Kids population (ages 5–18 years) have been omitted. In the case that a measure has an overlapping age stratification that does apply to Florida Healthy Kids enrollees, data for that category will be reported. However, due to enrollment data aberrations, total rates reported for measures that include overlapping age stratifications may include a minimal number of enrollees outside the Florida Healthy Kids population age range of 5–18 years.

Table 9. 2019 PMV: MCO HEDIS Performance Measures	
Measure Name	**Measure Definition**
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 (MY), and enrollees 7 to 19 years of age who had a visit with a PCP during the MY or the year prior. MCOs report four separate percentages (only three apply to the Florida Healthy Kids population): ♦ 25 months – 6 years ♦ 7–11 years ♦ 12–19 years
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	IET assesses the percentage of adolescent and adult enrollees 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 treatment within 14 days of the diagnosis ♦ Engagement of AOD Treatment—Initial treatment and two or more additional AOD services or medication treatment within 34 days of the initiation visit MCOs report a total rate and two age stratifications for each: ♦ 13–17 years ♦ ≥ 18 years

Table 9. 2019 PMV: MCO HEDIS Performance Measures	
Measure Name	**Measure Definition**
Prenatal and Postpartum Care (PPC)	PPC measures the percentage of live birth deliveries on or between November 6 of the year prior to the MY and November 5 of the MY. 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 and who had one or more well-child visits with a PCP during the MY.
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 MY.
Ambulatory Care: Emergency Department Visits (AMB-ED)	AMB-ED summarizes utilization of ambulatory care for enrollees in the category of emergency department (ED) visits.

Table 9. 2019 PMV: MCO HEDIS Performance Measures	
Measure Name	**Measure Definition**
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 MY: ♦ Any services (includes all stratifications below) ♦ Inpatient ♦ Intensive outpatient or partial hospitalization ♦ Outpatient or medication treatment ♦ ED ♦ Telehealth
Mental Health Utilization (MPT)	MPT summarizes the number and percentage of enrollees receiving the following mental health services during the MY: ♦ Any services (includes all stratifications below) ♦ Inpatient ♦ Intensive outpatient or partial hospitalization ♦ Outpatient ♦ ED ♦ Telehealth
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 MY. This measure calculates a total rate as well as two age stratifications (only one applies to the Florida Healthy Kids population): ♦ Women ages 16–20

Table 9. 2019 PMV: MCO HEDIS Performance Measures	
Measure Name	**Measure Definition**
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, counseling for nutrition, and counseling for physical activity—during the MY. For WCC, a total rate and two age stratifications are reported for each indicator: ♦ 3–11 years ♦ 12–17 years
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, dispensed an antibiotic, 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 MY and June 30 of the MY. A higher rate represents better performance (i.e., appropriate testing).

Table 9. 2019 PMV: MCO HEDIS Performance Measures	
Measure Name	**Measure Definition**
Medication Management for People with Asthma (MMA)	MMA records the percentage of enrollees 5 to 64 years of age during the MY 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 Florida Healthy Kids population): ♦ 5–11 years ♦ 12–18 years
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 MY. This measure calculates a total rate as well as four age stratifications (only two apply to the Florida Healthy Kids population): ♦ 5–11 years ♦ 12–18 years

Table 9. 2019 PMV: MCO HEDIS Performance Measures	
Measure Name	**Measure Definition**
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 within 270 days (nine months) of the end of the Initiation Phase
Follow-Up After Hospitalization for Mental Illness: Ages 6 and Older (FHM)**	FHM examines continuity of care for mental illness through the percentage of discharges for enrollees 6 years of age and older who were hospitalized for treatment of selected mental health 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 had a follow-up visit within the following: ♦ 7 days of discharge ♦ 30 days of discharge For FHM, a total rate and two age stratifications are reported: ♦ 6–17 years ♦ 18–64 years

Table 9. 2019 PMV: MCO HEDIS Performance Measures	
Measure Name	**Measure Definition**
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 For FUM, a total rate and three age stratifications are reported (only two apply to the Florida Healthy Kids population): ♦ 6–17 years ♦ 18–64 years
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
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	APM is the percentage of enrollees ages 1 to 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. For APM, a total rate and three age stratifications are reported: ♦ 1–5 years ♦ 6–11 years ♦ 12–17 years

Table 9. 2019 PMV: MCO HEDIS Performance Measures	
Measure Name	**Measure Definition**
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 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 treated with antipsychotic medications and were on two or more concurrent antipsychotic medications for at least 90 consecutive days during the MY. For this measure, a lower rate indicates better performance (i.e., low rates of concurrent antipsychotics indicate better care). This measure calculates a total rate as well as three age stratifications: ♦ 1–5 years ♦ 6–11 years ♦ 12–17 years

** IMA aligns with Advisory Committee on Immunization Practices 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 rather than an absolute BMI value.

*** FHM is not a HEDIS measure; it is an AHCA-defined measure.*

Table 10. 2019 PMV: DBM Performance Measures		
Measure Name	**Source**	**Measure Definition**
Enrolled Children Receiving Any Dental Services	CMS-416	The percentage of enrollees who received at least one dental service during the federal fiscal year
Enrolled Children Receiving Dental Preventive Services (PDENT)	CMS-416	The percentage of enrollees who received at least one preventive dental service during the federal fiscal year
Enrolled Children Receiving Dental Treatment Services (TDENT)	CMS-416	The percentage of enrollees who received at least one dental treatment service during the federal fiscal year
Enrolled Children Receiving Dental Sealants on Permanent Molars (SEA)	CMS-416	The percentage of enrollees in age categories 6–9 and 10–14 years who received a sealant on a permanent molar tooth during the federal fiscal year
Enrolled Children Receiving Dental Sealants on Permanent Molars – With Exclusions (SEA – With Exclusions)*	CMS-416	The percentage of enrollees in age categories 6–9 and 10–14 years who received a sealant on a permanent molar tooth during the federal fiscal year, excluding from the denominator any enrollees who had molars previously sealed, restored, or extracted
Enrolled Children Receiving Diagnostic Dental Services	CMS-416	The percentage of enrollees who received at least one diagnostic dental service during the federal fiscal year
Enrolled Children Receiving Any Dental or Oral Health Service	CMS-416	The percentage of enrollees who received either a dental service by or under the supervision of a dentist or an oral health service by a qualified healthcare practitioner who is neither a dentist nor providing services under the supervision of a dentist
Annual Dental Visit (ADV)	HEDIS	The percentage of enrollees 2–20 years of age who had at least one dental visit during the measurement year

** Modified CMS-416 measure: enrollees who have had molars previously sealed, restored, or extracted have been excluded from the denominator.*

MCO-specific results appear in tables **11**, 12, and 13. The green and red arrows in **Table 11** indicate an increase (⬆) or decrease (⬇) from the previous year's rate. Trending for some measures is not possible, as measures reported for the 2018 PMV are not all the same as those reported for 2019. Others are not able to be trended due to different designations from year to year; for example, a measure with a percentage result one year has an NA (small denominator) designation the other year. Where measure results appear without green or red arrows, trending was not possible.

Table 11. 2019 PMV Performance Measure Rate Results: MCOs

Measure	Aetna	Simply Healthcare	Staywell	Sunshine	United Healthcare
Access and Availability of Care					
Children and Adolescents' Access to Primary Care Practitioners (CAP)					
25 Months – 6 Years	90.25%⬆	93.54%⬆	91.88%⬇	90.17%⬇	90.80%⬇
7–11 Years	93.11%⬆	96.15%⬇	96.08%⬇	96.11%⬇	94.53%⬆
12–19 Years	90.50%⬇	94.67%⬆	94.21%⬇	94.08%⬆	91.34%⬆
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
Opioid Abuse or Dependence: Engagement of AOD Treatment: 13–17 Years	NA	NA	NA	NA	NA

Table 11. 2019 PMV Performance Measure Rate Results: MCOs					
Measure	**Aetna**	**Simply Healthcare**	**Staywell**	**Sunshine**	**United Healthcare**
Other Drug Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	57.14%↑	48.15%	45.74%↑	NA	NA
Other Drug Abuse or Dependence: Engagement of AOD Treatment: 13–17 Years	4.76%↓	11.11%	4.26%↓	NA	NA
Initiation of AOD Treatment: 13–17 Years Total	52.17%↑	48.21%↑	44.64%↑	NA	NA
Engagement of AOD Treatment: 13–17 Years Total	4.35%↓	10.71%↑	3.57%↓	NA	NA
Alcohol Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	NA	NA	NA	NA	NA
Alcohol Abuse or Dependence: Engagement of AOD Treatment: 18+ Years	NA	NA	NA	NA	NA
Opioid Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	NA	NA	NA	NA	NA
Opioid Abuse or Dependence: Engagement of AOD Treatment: 18+ Years	NA	NA	NA	NA	NA

Table 11. 2019 PMV Performance Measure Rate Results: MCOs					
Measure	**Aetna**	**Simply Healthcare**	**Staywell**	**Sunshine**	**United Healthcare**
Other Drug Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	NA	NA	29.55%↓	NA	NA
Other Drug Abuse or Dependence: Engagement of AOD Treatment: 18+ Years	NA	NA	4.55%↑	NA	NA
Initiation of AOD Treatment: 18+ Years Total	NA	NA	30.19%↑	NA	NA
Engagement of AOD Treatment: 18+ Years Total	NA	NA	3.77%↑	NA	NA
Alcohol Abuse or Dependence: Initiation of AOD Treatment Total	NA	NA	42.86%	NA	NA
Alcohol Abuse or Dependence: Engagement of AOD Treatment Total	NA	NA	0%	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	54.39%↑	42.31%↑	40.58%↑	61.29%	NA

Table 11. 2019 PMV Performance Measure Rate Results: MCOs					
Measure	**Aetna**	**Simply Healthcare**	**Staywell**	**Sunshine**	**United Healthcare**
Other Drug Abuse or Dependence: Engagement of AOD Treatment Total	5.26%↓	11.54%↑	4.35%↓	16.13%	NA
Initiation of AOD Treatment Total	47.69%↑	41.18%↑	40.00%↑	57.89%	NA
Engagement of AOD Treatment Total	4.62%↓	10.59%↑	3.64%↓	13.16%	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	NA	NA	NA	NA	NA
6–11 Years	NA	NA	NA	NA	NA
12–17 Years	34.43%↑	66.67%↑	63.27%↑	NA	NA
Total	34.21%	63.41%	63.64%	NA	NA
Utilization					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	74.45%↑	82.97%↑	77.31%↓	75.10%↑	75.18%↑
Adolescent Well-Care Visits (AWC)	66.91%↑	73.48%↓	70.40%↑	67.16%↑	63.50%↑
Ambulatory Care: Emergency Department Visits (AMB-ED) – Visits / 1,000 Enrollee Months					

Table 11. 2019 PMV Performance Measure Rate Results: MCOs					
Measure	**Aetna**	**Simply Healthcare**	**Staywell**	**Sunshine**	**United Healthcare**
1–9 Years	29.98↑	30.70↑	30.01↑	21.88↑	34.60↑
10–19 Years	24.42↑	24.46↓	26.35↑	20.57↓	29.27↑
Effectiveness of Care – Prevention and Screening					
Chlamydia Screening in Women (CHL)					
16–20 Years	54.76%↑	62.60%↑	53.65%↑	49.73%↓	44.91%↑
Immunizations for Adolescents (IMA)					
Meningococcal	72.99%↑	84.18%↑	81.75%↑	76.40%↓	71.53%↑
Tdap/Td	92.70%↑	94.40%↑	91.97%↓	94.95%↑	93.43%↑
HPV	32.85%↑	39.17%↑	37.47%↑	26.49%↑	30.66%↑
Combination #1 (Meningococcal and Tdap/Td)	72.26%↑	82.48%↑	80.54%↑	75.14%↓	71.05%↑
Combination #2 (Meningococcal, Tdap/Td, and HPV)	27.49%↑	36.25%↑	35.52%↑	23.96%↑	28.95%↑
Weight Assessment and Counseling for Nutrition & Physical Activity for Children/Adolescents (WCC)					
BMI Percentile 3–11 Years	84.04%↑	95.96%↑	85.00%↑	76.34%↑	90.40%↑
Counseling for Nutrition 3–11 Years	78.72%↑	84.34%↑	77.50%↑	73.41%↑	71.72%↑
Counseling for Physical Activity 3–11 Years	77.13%↑	82.83%↑	76.00%↑	66.95%↑	70.20%↑
BMI Percentile 12–17 Years	86.55%↑	94.84%↑	89.10%↑	76.58%↑	82.63%↑

Table 11. 2019 PMV Performance Measure Rate Results: MCOs					
Measure	**Aetna**	**Simply Healthcare**	**Staywell**	**Sunshine**	**United Healthcare**
Counseling for Nutrition 12–17 Years	80.72%↑	89.20%↑	79.62%↑	74.27%↑	69.95%↑
Counseling for Physical Activity 12–17 Years	78.03%↑	88.73%↑	78.20%↑	67.66%↑	67.61%↑
BMI Percentile Total	85.40%↑	95.38%↑	87.10%↑	76.45%↑	86.37%↑
Counseling for Nutrition Total	79.81%↑	86.86%↑	78.59%↑	73.81%↑	70.80%↑
Counseling for Physical Activity Total	77.62%↑	85.89%↑	77.13%↑	67.28%↑	68.86%↑
Effectiveness of Care – Respiratory Condition					
Appropriate Testing for Children with Pharyngitis (CWP)	84.46%↑	82.41%↑	82.58%↓	83.55%↑	61.68%↑
Medication Management for People with Asthma (MMA)					
Medication Compliance 50% 5–11 Years	51.46%↑	55.78%↓	54.74%↓	65.63%↑	47.22%↓
Medication Compliance 75% 5–11 Years	27.18%↑	34.32%↑	27.37%↑	43.75%↑	16.67%↓
Medication Compliance 50% 12–18 Years	43.42%↓	51.57%↓	53.94%↑	65.63%↑	NA
Medication Compliance 75% 12–18 Years	18.42%↓	27.35%↑	27.17%↑	46.88%↑	NA
Medication Compliance 50% Total	48.04%	53.99%	54.39%	65.63%	46.67%

Table 11. 2019 PMV Performance Measure Rate Results: MCOs					
Measure	**Aetna**	**Simply Healthcare**	**Staywell**	**Sunshine**	**United Healthcare**
Medication Compliance 75% Total	23.46%	31.37%	27.43%	45.31%	18.33%
Asthma Medication Ratio (AMR)					
5–11 Years	84.55%↑	91.03%↑	88.43%↑	87.88%↑	72.97%↑
12–18 Years	80.72%↑	76.67%↑	77.50%↑	77.78%↓	NA
Total	82.90%	84.78%	83.68%	82.61%	64.62%
Effectiveness of Care – Behavioral Health					
Follow-Up Care for Children Prescribed ADHD Medication (ADD)					
Initiation Phase	42.20%↓	42.26%↓	41.91%↓	45.61%↑	44.83%↑
Continuation and Maintenance Phase	61.11%↑	59.21%↓	54.55%↓	NA	NA
Follow-Up After Hospitalization for Mental Illness: Ages 6 and Older (FHM [MMA])					
7-Day Follow-Up 6–17 Years	34.40%	39.15%	42.56%	45.71%	42.59%
30-Day Follow-Up 6–17 Years	63.76%	59.79%	68.19%	68.57%	62.96%
7-Day Follow-Up 18–64 Years	NA	35.71%	24.32%	NA	NA
30-Day Follow-Up 18–64 Years	NA	71.43%	40.54%	NA	NA
7-Day Follow-Up Total	33.77%	38.98%	41.14%	44.74%	39.66%
30-Day Follow-Up Total	62.28%	60.34%	66.03%	67.11%	60.34%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)					
7-Day Follow-Up 6–17 Years	23.33%	23.68%	40.00%	NA	NA

Table 11. 2019 PMV Performance Measure Rate Results: MCOs					
Measure	**Aetna**	**Simply Healthcare**	**Staywell**	**Sunshine**	**United Healthcare**
30-Day Follow-Up 6–17 Years	36.67%	42.11%	65.00%	NA	NA
7-Day Follow-Up 18–64 Years	NA	NA	NA	NA	NA
30-Day Follow-Up 18–64 Years	NA	NA	NA	NA	NA
7-Day Follow-Up Total	25.00%	22.50%	40.32%	NA	NA
30-Day Follow-Up Total	37.50%	40.00%	64.52%	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)					
7-Day Follow-Up 13–17 Years	NA	NA	3.23%	NA	NA
30-Day Follow-Up 13–17 Years	NA	NA	3.23%	NA	NA
7-Day Follow-Up 18+ Years	NA	NA	NA	NA	NA
30-Day Follow-Up 18+Years	NA	NA	NA	NA	NA
7-Day Follow-Up Total	NA	NA	2.50%	NA	NA
30-Day Follow-Up Total	NA	NA	2.50%	NA	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)					
1–5 Years	NA	NA	NA	NA	NA
6–11 Years	NA	NA	32.69%	NA	NA
12–17 Years	42.25%	46.38%	42.20%	50.00%	NA
Total	40.86%	40.70%	40.00%	43.14%	38.24%

Table 11. 2019 PMV Performance Measure Rate Results: MCOs					
Measure	**Aetna**	**Simply Healthcare**	**Staywell**	**Sunshine**	**United Healthcare**
Overuse/Appropriateness					
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	88.47%↑	92.45%↑	89.49%↑	88.71%↑	75.72%↑
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)					
1–5 Years	NA	NA	NA	NA	NA
6–11 Years	NA	NA	0%	NA	NA
12–17 Years	2.13%↑	0%	0.76%↓	3.13%↑	NA
Total	1.61%	0%	0.57%	2.44%	NA

** 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.*

Table 12 provides the MCOs' PMV results for the IAD measure. Because the results for this measure are typically less than one percent of the MCOs' enrollees, trending is not included.

Table 12. 2019 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Alcohol										
Any Services: Male										
0–12 Years	0	0%	0	0%	1	0.01%	0	0%	0	0%

Table 12. 2019 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
13–17 Years	6	0.07%	6	0.06%	20	0.16%	3	0.12%	1	0.06%
18–24 Years	2	0.13%	2	0.12%	5	0.23%	4	0.94%	0	0%
Any Services: Female										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	7	0.08%	10	0.11%	23	0.19%	8	0.35%	3	0.20%
18–24 Years	3	0.20%	4	0.24%	7	0.31%	2	0.54%	1	0.37%
Any Services: Total										
0–12 Years	0	0%	0	0%	1	0%	0	0%	0	0%
13–17 Years	13	0.08%	16	0.09%	43	0.17%	11	0.23%	4	0.13%
18–24 Years	5	0.16%	6	0.18%	12	0.27%	6	0.75%	1	0.18%
Inpatient: Male										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	1	0.01%	1	0.01%	8	0.06%	0	0%	0	0%
18–24 Years	0	0%	0	0%	2	0.09%	3	0.71%	0	0%
Inpatient: Female										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	0	0%	4	0.04%	8	0.06%	3	0.13%	1	0.07%
18–24 Years	1	0.07%	1	0.06%	1	0.04%	0	0%	0	0%

Table 12. 2019 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Inpatient: Total										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	1	0.01%	5	0.03%	16	0.06%	3	0.06%	1	0.03%
18–24 Years	1	0.03%	1	0.03%	3	0.07%	3	0.38%	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%	1	0.05%	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%	1	0.07%
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%	1	0.02%	0	0%	0	0%
Outpatient/Medication Treatment: Male										
0–12 Years	0	0%	0	0%	1	0.01%	0	0%	0	0%
13–17 Years	0	0%	2	0.02%	6	0.05%	1	0.04%	0	0%

Table 12. 2019 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
18–24 Years	1	0.07%	0	0%	1	0.05%	0	0%	0	0%
Outpatient/Medication Treatment: Female										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	1	0.01%	4	0.04%	12	0.10%	1	0.04%	2	0.13%
18–24 Years	2	0.13%	0	0%	1	0.04%	1	0.27%	1	0.37%
Outpatient/Medication Treatment: Total										
0–12 Years	0	0%	0	0%	1	0%	0	0%	0	0%
13–17 Years	1	0.01%	6	0.03%	18	0.07%	2	0.04%	2	0.06%
18–24 Years	3	0.10%	0	0%	2	0.05%	1	0.13%	1	0.18%
Emergency Department: Male										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	5	0.06%	4	0.04%	8	0.06%	2	0.08%	1	0.06%
18–24 Years	1	0.07%	2	0.12%	1	0.05%	1	0.24%	0	0%
Emergency Department: Female										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	6	0.07%	3	0.03%	7	0.06%	5	0.22%	3	0.20%
18–24 Years	1	0.07%	3	0.18%	6	0.27%	1	0.27%	0	0%
Emergency Department: Total										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%

Table 12. 2019 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
13–17 Years	11	0.06%	7	0.04%	15	0.06%	7	0.15%	4	0.13%
18–24 Years	2	0.07%	5	0.15%	7	0.16%	2	0.25%	0	0%
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%	1	0.24%	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%	1	0.13%	0	0%
Opioid										
Any Services: Male										
0–12 Years	0	0%	2	0.01%	1	0.01%	0	0%	0	0%
13–17 Years	1	0.01%	1	0.01%	7	0.06%	3	0.12%	1	0.06%
18–24 Years	0	0%	0	0%	2	0.09%	0	0%	0	0%

Table 12. 2019 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Any Services: Female										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	4	0.05%	2	0.02%	6	0.05%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%	1	0.27%	1	0.37%
Any Services: Total										
0–12 Years	0	0%	2	0.01%	1	0%	0	0%	0	0%
13–17 Years	5	0.03%	3	0.02%	13	0.05%	3	0.06%	1	0.03%
18–24 Years	0	0%	0	0%	2	0.05%	1	0.13%	1	0.18%
Inpatient: Male										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	0	0%	0	0%	5	0.04%	1	0.04%	0	0%
18–24 Years	0	0%	0	0%	1	0.05%	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%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%
Inpatient: Total										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	0	0%	0	0%	7	0.03%	1	0.02%	0	0%

Table 12. 2019 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
18–24 Years	0	0%	0	0%	1	0.02%	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%	1	0.05%	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%	1	0.02%	0	0%	0	0%
Outpatient/Medication Treatment: Male										
0–12 Years	0	0%	2	0.01%	1	0.01%	0	0%	0	0%
13–17 Years	0	0%	1	0.01%	3	0.02%	2	0.08%	1	0.06%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%
Outpatient/Medication Treatment: Female										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%

Table 12. 2019 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
13–17 Years	3	0.04%	2	0.02%	4	0.03%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%	1	0.27%	1	0.37%
Outpatient/Medication Treatment: Total										
0–12 Years	0	0%	2	0.01%	1	0%	0	0%	0	0%
13–17 Years	3	0.02%	3	0.02%	7	0.03%	2	0.04%	1	0.03%
18–24 Years	0	0%	0	0%	0	0%	1	0.13%	1	0.18%
Emergency Department: Male										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	1	0.01%	0	0%	0	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%
Emergency Department: Female										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	1	0.01%	0	0%	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	2	0.01%	0	0%	0	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%

Table 12. 2019 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**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%
Other										
Any Services: Male										
0–12 Years	1	0.01%	3	0.02%	3	0.02%	0	0%	0	0%
13–17 Years	58	0.68%	70	0.74%	127	1.00%	23	0.94%	13	0.79%
18–24 Years	16	1.05%	18	1.10%	33	1.53%	9	2.12%	7	2.47%
Any Services: Female										
0–12 Years	2	0.02%	2	0.01%	1	0.01%	0	0%	0	0%

Table 12. 2019 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
13–17 Years	41	0.49%	43	0.47%	81	0.65%	16	0.71%	14	0.92%
18–24 Years	6	0.39%	16	0.97%	31	1.39%	7	1.88%	3	1.12%
Any Services: Total										
0–12 Years	3	0.01%	5	0.02%	4	0.01%	0	0%	0	0%
13–17 Years	99	0.58%	113	0.60%	208	0.83%	39	0.83%	27	0.85%
18–24 Years	22	0.72%	34	1.04%	64	1.46%	16	2.01%	10	1.82%
Inpatient: Male										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	14	0.16%	16	0.17%	36	0.28%	7	0.29%	5	0.30%
18–24 Years	2	0.13%	4	0.24%	7	0.32%	5	1.18%	0	0%
Inpatient: Female										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	10	0.12%	12	0.13%	30	0.24%	7	0.31%	7	0.46%
18–24 Years	1	0.07%	3	0.18%	7	0.31%	3	0.81%	2	0.75%
Inpatient: Total										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	24	0.14%	28	0.15%	66	0.26%	14	0.30%	12	0.38%
18–24 Years	3	0.10%	7	0.21%	14	0.32%	8	1.00%	2	0.36%

Table 12. 2019 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Intensive Outpatient/Partial Hospitalization: Male										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	3	0.04%	5	0.05%	3	0.02%	0	0%	1	0.06%
18–24 Years	2	0.13%	1	0.06%	1	0.05%	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	5	0.06%	3	0.03%	0	0%	0	0%	1	0.07%
18–24 Years	0	0%	0	0%	1	0.04%	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	8	0.05%	8	0.04%	3	0.01%	0	0%	2	0.06%
18–24 Years	2	0.07%	1	0.03%	2	0.05%	0	0%	0	0%
Outpatient/Medication Treatment: Male										
0–12 Years	1	0.01%	3	0.02%	3	0.02%	0	0%	0	0%
13–17 Years	24	0.28%	46	0.49%	83	0.65%	14	0.57%	6	0.37%
18–24 Years	6	0.40%	11	0.67%	17	0.79%	2	0.47%	5	1.77%
Outpatient/Medication Treatment: Female										
0–12 Years	1	0.01%	2	0.01%	1	0.01%	0	0%	0	0%
13–17 Years	24	0.29%	23	0.25%	34	0.27%	7	0.31%	7	0.46%

Table 12. 2019 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
18–24 Years	4	0.26%	8	0.49%	13	0.58%	2	0.54%	0	0%
Outpatient/Medication Treatment: Total										
0–12 Years	2	0.01%	5	0.02%	4	0.01%	0	0%	0	0%
13–17 Years	48	0.28%	69	0.37%	117	0.47%	21	0.45%	13	0.41%
18–24 Years	10	0.33%	19	0.58%	30	0.68%	4	0.50%	5	0.91%
Emergency Department: Male										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	28	0.33%	19	0.20%	32	0.25%	5	0.20%	4	0.24%
18–24 Years	12	0.79%	8	0.49%	16	0.74%	3	0.71%	2	0.71%
Emergency Department: Female										
0–12 Years	1	0.01%	0	0%	0	0%	0	0%	0	0%
13–17 Years	15	0.18%	18	0.19%	25	0.20%	3	0.13%	2	0.13%
18–24 Years	2	0.13%	6	0.36%	14	0.63%	3	0.81%	2	0.75%
Emergency Department: Total										
0–12 Years	1	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	43	0.25%	37	0.20%	57	0.23%	8	0.17%	6	0.19%
18–24 Years	14	0.46%	14	0.43%	30	0.68%	6	0.75%	4	0.73%
Telehealth: Male										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%

Table 12. 2019 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
13–17 Years	0	0%	0	0%	0	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%	1	0.24%	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%	1	0.13%	0	0%

Table 13 provides the MCOs' PMV results for the MPT measure. Because the results for this measure are typically small compared to the number of enrollees for each MCO, trending is not included.

Table 13. 2019 PMV Results: MCOs – Audited Mental Health Utilization (MPT) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Any Services: Male										
0–12 Years	874	6.52%	917	6.43%	1,834	9.32%	342	7.56%	159	6.47%

Table 13. 2019 PMV Results: MCOs – Audited Mental Health Utilization (MPT) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
13–17 Years	538	6.29%	641	6.77%	1,187	9.34%	214	8.75%	138	8.42%
18–24 Years	53	3.49%	74	4.51%	120	5.56%	28	6.59%	11	3.89%
Any Services: Female										
0–12 Years	571	4.29%	648	4.67%	1,300	6.80%	201	4.81%	107	4.57%
13–17 Years	671	7.99%	856	9.26%	1,555	12.52%	281	12.41%	154	10.14%
18–24 Years	90	5.89%	87	5.29%	206	9.23%	41	11.01%	14	5.21%
Any Services: Total										
0–12 Years	1,445	5.41%	1,565	5.56%	3,134	8.08%	543	6.23%	266	5.54%
13–17 Years	1,209	7.13%	1,497	8.00%	2,742	10.91%	495	10.51%	292	9.24%
18–24 Years	143	4.70%	161	4.90%	326	7.42%	69	8.66%	25	4.53%
Inpatient: Male										
0–12 Years	23	0.17%	39	0.27%	55	0.28%	4	0.09%	5	0.20%
13–17 Years	56	0.65%	65	0.69%	120	0.94%	17	0.70%	17	1.04%
18–24 Years	2	0.13%	10	0.61%	17	0.79%	2	0.47%	0	0%
Inpatient: Female										
0–12 Years	33	0.25%	38	0.27%	59	0.31%	9	0.22%	6	0.26%
13–17 Years	85	1.01%	111	1.20%	213	1.72%	24	1.06%	23	1.51%
18–24 Years	6	0.39%	9	0.55%	26	1.16%	5	1.34%	1	0.37%
Inpatient: Total										
0–12 Years	56	0.21%	77	0.27%	114	0.29%	13	0.15%	11	0.23%

Table 13. 2019 PMV Results: MCOs – Audited Mental Health Utilization (MPT) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
13–17 Years	141	0.83%	176	0.94%	333	1.33%	41	0.87%	40	1.27%
18–24 Years	8	0.26%	19	0.58%	43	0.98%	7	0.88%	1	0.18%
Intensive Outpatient/Partial Hospitalization: Male										
0–12 Years	142	1.06%	117	0.82%	140	0.71%	0	0%	7	0.28%
13–17 Years	80	0.94%	101	1.07%	72	0.57%	0	0%	17	1.04%
18–24 Years	6	0.40%	9	0.55%	6	0.28%	0	0%	0	0%
Intensive Outpatient/Partial Hospitalization: Female										
0–12 Years	82	0.62%	89	0.64%	67	0.35%	0	0%	11	0.47%
13–17 Years	110	1.31%	118	1.28%	114	0.92%	0	0%	23	1.51%
18–24 Years	15	0.98%	8	0.49%	15	0.67%	1	0.27%	1	0.37%
Intensive Outpatient/Partial Hospitalization: Total										
0–12 Years	224	0.84%	206	0.73%	207	0.53%	0	0%	18	0.38%
13–17 Years	190	1.12%	219	1.17%	186	0.74%	0	0%	40	1.27%
18–24 Years	21	0.69%	17	0.52%	21	0.48%	1	0.13%	1	0.18%
Outpatient: Male										
0–12 Years	872	6.50%	903	6.33%	1,821	9.26%	340	7.51%	159	6.47%
13–17 Years	520	6.08%	614	6.49%	1,160	9.13%	211	8.63%	127	7.75%
18–24 Years	52	3.43%	67	4.09%	111	5.14%	28	6.59%	12	4.24%
Outpatient: Female										
0–12 Years	563	4.23%	634	4.57%	1,284	6.72%	197	4.71%	103	4.40%

Table 13. 2019 PMV Results: MCOs – Audited Mental Health Utilization (MPT) Performance Measure										
Measure	Aetna		Simply Healthcare		Staywell		Sunshine		UnitedHealthcare	
	No.	%	No.	%	No.	%	No.	%	No.	%
13–17 Years	640	7.62%	823	8.90%	1,515	12.20%	270	11.92%	148	9.74%
18–24 Years	86	5.63%	81	4.93%	191	8.55%	39	10.47%	14	5.21%
Outpatient: Total										
0–12 Years	1,435	5.37%	1,537	5.46%	3,105	8.01%	537	6.17%	262	5.46%
13–17 Years	1,160	6.84%	1,437	7.68%	2,675	10.65%	481	10.21%	275	8.71%
18–24 Years	138	4.53%	148	4.51%	302	6.87%	67	8.41%	26	4.71%
Emergency Department: Male										
0–12 Years	143	1.07%	116	0.81%	140	0.71%	0	0%	8	0.33%
13–17 Years	80	0.94%	99	1.05%	71	0.56%	0	0%	19	1.16%
18–24 Years	6	0.40%	9	0.55%	6	0.28%	0	0%	1	0.35%
Emergency Department: Female										
0–12 Years	81	0.61%	89	0.64%	65	0.34%	0	0%	11	0.47%
13–17 Years	110	1.31%	113	1.22%	116	0.93%	2	0.09%	19	1.25%
18–24 Years	15	0.98%	7	0.43%	16	0.72%	1	0.27%	1	0.37%
Emergency Department: Total										
0–12 Years	224	0.84%	205	0.73%	205	0.53%	0	0%	19	0.40%
13–17 Years	190	1.12%	212	1.13%	187	0.74%	2	0.04%	38	1.20%
18–24 Years	21	0.69%	16	0.49%	22	0.50%	1	0.13%	2	0.36%
Telehealth: Male										
0–12 Years	1	0.01%	7	0.05%	1	0.01%	1	0.02%	1	0.04%

Table 13. 2019 PMV Results: MCOs – Audited Mental Health Utilization (MPT) Performance Measure										
Measure	Aetna		Simply Healthcare		Staywell		Sunshine		UnitedHealthcare	
	No.	%	No.	%	No.	%	No.	%	No.	%
13–17 Years	1	0.01%	8	0.08%	1	0.01%	1	0.04%	0	0%
18–24 Years	0	0%	1	0.06%	0	0%	1	0.24%	0	0%
Telehealth: Female										
0–12 Years	2	0.02%	0	0%	0	0%	0	0%	0	0%
13–17 Years	3	0.04%	9	0.10%	4	0.03%	2	0.09%	0	0%
18–24 Years	1	0.07%	0	0%	1	0.04%	0	0%	0	0%
Telehealth: Total										
0–12 Years	3	0.01%	7	0.02%	1	0%	1	0.01%	1	0.02%
13–17 Years	4	0.02%	17	0.09%	5	0.02%	3	0.06%	0	0%
18–24 Years	1	0.03%	1	0.03%	1	0.02%	1	0.13%	0	0%

DBM-specific PMV results appear in **Table 14**. The green and red arrows indicate an increase (⬆) or decrease (⬇) from the previous year's rate. The All Enrollees category was not included in last year's report; thus, no trending for this category is provided for any of the measures. The Any Dental or Oral Health Service measure also was not included in last year's analysis. In addition, for the ADV measure, the age category of 5 to 6 years was 4 to 6 years for 2018 reporting, so comparisons should be made with caution. Finally, DentaQuest did not report results for two measures last year: Dental Sealants and Dental Sealants – With Exclusions.

Table 14. 2019 PMV Results: DBMs									
Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Annual Dental Visit									
All Enrollees	58.23%	21,594	12,575	62.92%	49,780	31,320	59.21%	47,371	28,050

Table 14. 2019 PMV Results: DBMs									
Measure	**Argus**			**DentaQuest**			**MCNA**		
	Rate (%)	**Den.***	**Num.***	**Rate (%)**	**Den.**	**Num.**	**Rate (%)**	**Den.**	**Num.**
Enrollees Age 5 to 6†	57.14%↑	2,002	1,144	64.16%↑	2,779	1,783	59.21%↓	2,562	1,517
Enrollees Age 7 to 10	63.06%↑	7,918	4,993	69.26%↑	14,041	9,725	65.51%↑	12,663	8,296
Enrollees Age 11 to 14	59.67%↑	6,310	3,765	64.05%↑	16,939	10,850	60.93%↑	16,170	9,852
Enrollees Age 15 to 18	49.83%↓	5,364	2,673	55.94%↑	16,021	8,962	52.48%↑	15,976	8,385
Any Dental Service									
Enrolled at Least 1 Month: All Enrollees	41.63%	51,566	21,467	46.82%	107,836	50,487	43.14%	101,106	43,620
Enrolled at Least 1 Month: Age 5**	17.22%↑	1,167	201	27.11%↑	3,360	911	27.63%↑	4,379	1,210
Enrolled at Least 1 Month: Age 6–9	43.34%↑	18,479	8,009	50.14%↑	29,386	14,735	45.86%↓	26,682	12,237
Enrolled at Least 1 Month: Age 10–14	44.21%↑	19,509	8,624	49.23%↑	42,937	21,140	45.67%↓	39,998	18,268
Enrolled at Least 1 Month: Age 15–18	37.33%↑	12,411	4,633	42.61%↑	32,145	13,698	39.62%↓	30,047	11,905
Enrolled at Least 3 Months Continuously: All Enrollees	47.15%	43,449	20,485	53.07%	91,075	48,330	49.45%	84,789	41,931

Table 14. 2019 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 3 Months Continuously: Age 5	21.64%↓	684	148	38.24%↑	2,011	769	37.25%↑	2,897	1,079
Enrolled at Least 3 Months Continuously: Age 6–9	49.07%↑	15,562	7,637	57.33%↑	24,458	14,021	53.11%↑	22,007	11,688
Enrolled at Least 3 Months Continuously: Age 10–14	49.56%↑	16,628	8,241	55.30%↑	36,755	20,327	51.99%↑	33,879	17,614
Enrolled at Least 3 Months Continuously: Age 15–18	42.17%↑	10,575	4,459	47.44%↑	27,847	13,211	44.41%↑	26,006	11,550
Enrolled at Least 6 Months Continuously: All Enrollees	53.20%	32,827	17,464	58.74%	70,974	41,691	55.33%	66,295	36,678
Enrolled at Least 6 Months Continuously: Age 5	71.43%↑	7	5	49.08%↑	758	372	45.48%↑	1,517	690
Enrolled at Least 6 Months Continuously: Age 6–9	54.82%↑	11,809	6,474	63.76%↑	18,608	11,864	59.92%↑	16,800	10,067
Enrolled at Least 6 Months Continuously: Age 10–14	55.71%↑	12,769	7,113	60.88%↑	29,206	17,780	57.81%↑	26,957	15,585

Table 14. 2019 PMV Results: DBMs									
Measure	**Argus**			**DentaQuest**			**MCNA**		
	Rate (%)	**Den.***	**Num.***	**Rate (%)**	**Den.**	**Num.**	**Rate (%)**	**Den.**	**Num.**
Enrolled at Least 6 Months Continuously: Age 15–18	46.98%↓	8,242	3,872	52.11%↑	22,400	11,673	49.17%↑	21,021	10,336
Enrolled at Least 11 Months Continuously: All Enrollees	59.24%	19,746	11,698	63.69%	46,320	29,503	60.01%	43,568	26,144
Enrolled at Least 11 Months Continuously: Age 5	0%	0	0	50.00%	2	1	55.61%↑	196	109
Enrolled at Least 11 Months Continuously: Age 6–9	61.49%↑	6,596	4,056	68.79%↑	11,302	7,775	65.40%↑	10,419	6,814
Enrolled at Least 11 Months Continuously: Age 10–14	61.18%↑	8,013	4,902	65.99%↑	19,650	12,968	62.38%↑	18,316	11,426
Enrolled at Least 11 Months Continuously: Age 15–18	53.34%↑	5,137	2,740	57.00%↑	15,365	8,758	53.26%↓	14,637	7,795
Preventive Dental Services									
Enrolled at Least 1 Month: All Enrollees	36.75%	55,155	20,268	44.14%	107,836	47,603	40.50%	101,106	40,951
Enrolled at Least 1 Month: Age 5**	12.56%↓	1,592	200	25.15%↑	3,360	845	25.71%↑	4,379	1,126

Table 14. 2019 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 1 Month: Age 6–9	39.10%↑	19,697	7,702	48.17%↑	29,386	14,155	43.92%↓	26,682	11,720
Enrolled at Least 1 Month: Age 10–14	39.42%↑	20,749	8,180	46.87%↑	42,937	20,123	43.49%↓	39,998	17,394
Enrolled at Least 1 Month: Age 15–18	31.91%↓	13,117	4,186	38.82%↑	32,145	12,479	35.65%↑	30,047	10,711
Enrolled at Least 3 Months Continuously: All Enrollees	43.99%	43,925	19,324	50.30%	91,075	45,809	46.65%	84,789	39,558
Enrolled at Least 3 Months Continuously: Age 5	19.54%↓	701	137	36.00%↑	2,011	724	35.21%↑	2,897	1,020
Enrolled at Least 3 Months Continuously: Age 6–9	46.61%↑	15,747	7,339	55.33%↑	24,458	13,533	51.14%↑	22,007	11,254
Enrolled at Least 3 Months Continuously: Age 10–14	46.47%↑	16,812	7,813	52.89%↑	36,755	19,441	49.72%↑	33,879	16,845
Enrolled at Least 3 Months Continuously: Age 15–18	37.83%↓	10,665	4,035	43.49%↑	27,847	12,110	40.14%↑	26,006	10,439

Table 14. 2019 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 6 Months Continuously: All Enrollees	50.26%	33,083	16,626	56.11%	70,974	39,824	52.54%	66,295	34,834
Enrolled at Least 6 Months Continuously: Age 5	62.50%↑	8	5	47.63%↑	758	361	43.38%↑	1,517	658
Enrolled at Least 6 Months Continuously: Age 6–9	52.68%↑	11,913	6,276	61.97%↑	18,608	11,531	58.05%↑	16,800	9,753
Enrolled at Least 6 Months Continuously: Age 10–14	52.81%↑	12,856	6,789	58.67%↑	29,206	17,134	55.62%↑	26,957	14,993
Enrolled at Least 6 Months Continuously: Age 15–18	42.81%↓	8,306	3,556	48.20%↑	22,400	10,797	44.86%↑	21,021	9,430
Enrolled at Least 11 Months Continuously: All Enrollees	56.47%	19,832	11,199	61.13%	46,320	28,317	57.41%	43,568	25,012
Enrolled at Least 11 Months Continuously: Age 5	0%	0	0	50.00%	2	1	55.10%↑	196	108
Enrolled at Least 11 Months Continuously: Age 6–9	59.63%↑	6,623	3,949	67.16%↑	11,302	7,590	63.79%↑	10,419	6,646

Table 14. 2019 PMV Results: DBMs									
Measure	**Argus**			**DentaQuest**			**MCNA**		
	Rate (%)	**Den.***	**Num.***	**Rate (%)**	**Den.**	**Num.**	**Rate (%)**	**Den.**	**Num.**
Enrolled at Least 11 Months Continuously: Age 10–14	58.58%↑	8,046	4,713	63.90%↑	19,650	12,557	60.44%↑	18,316	11,071
Enrolled at Least 11 Months Continuously: Age 15–18	49.14%↑	5,163	2,537	53.17%↑	15,365	8,169	49.10%↑	14,637	7,187
Dental Treatment Services									
Enrolled at Least 1 Month: All Enrollees	16.32%	51,566	8,413	17.41%	107,836	18,769	15.09%	101,106	15,260
Enrolled at Least 1 Month: Age 5**	4.80%↑	1,167	56	6.82%↓	3,360	229	7.79%↑	4,379	341
Enrolled at Least 1 Month: Age 6–9	17.22%↑	18,479	3,182	19.72%↑	29,386	5,796	17.10%↓	26,682	4,562
Enrolled at Least 1 Month: Age 10–14	16.54%↑	19,509	3,227	17.40%↑	42,937	7,469	14.67%↓	39,998	5,868
Enrolled at Least 1 Month: Age 15–18	15.70%↑	12,411	1,948	16.41%↓	32,145	5,274	14.94%↓	30,047	4,489
Enrolled at Least 3 Months Continuously: All Enrollees	18.61%	43,449	8,086	19.86%	91,075	18,090	17.43%	84,789	14,778

Table 14. 2019 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 3 Months Continuously: Age 5	6.58%↓	684	45	9.55%↓	2,011	192	10.46%↑	2,897	303
Enrolled at Least 3 Months Continuously: Age 6–9	19.64%↑	15,562	3,056	22.80%↑	24,458	5,576	20.02%↓	22,007	4,405
Enrolled at Least 3 Months Continuously: Age 10–14	18.63%↑	16,628	3,097	19.65%↑	36,755	7,221	16.80%↓	33,879	5,690
Enrolled at Least 3 Months Continuously: Age 15–18	17.85%↓	10,575	1,888	18.31%↓	27,847	5,100	16.84%↓	26,006	4,380
Enrolled at Least 6 Months Continuously: All Enrollees	21.50%	32,827	7,058	22.38%	70,974	15,883	19.87%	66,295	13,173
Enrolled at Least 6 Months Continuously: Age 5	14.29%↑	7	1	12.80%↑	758	97	14.17%↑	1,517	215
Enrolled at Least 6 Months Continuously: Age 6–9	22.52%↑	11,809	2,659	26.02%↑	18,608	4,841	23.11%↑	16,800	3,882
Enrolled at Least 6 Months Continuously: Age 10–14	21.29%↑	12,769	2,718	21.84%↑	29,206	6,380	18.96%↓	26,957	5,111

Table 14. 2019 PMV Results: DBMs									
Measure	**Argus**			**DentaQuest**			**MCNA**		
	Rate (%)	**Den.***	**Num.***	**Rate (%)**	**Den.**	**Num.**	**Rate (%)**	**Den.**	**Num.**
Enrolled at Least 6 Months Continuously: Age 15–18	20.38%↓	8,242	1,680	20.38%↑	22,400	4,564	18.86%↓	21,021	3,965
Enrolled at Least 11 Months Continuously: All Enrollees	24.19%	19,746	4,776	24.58%	46,320	11,384	21.86%	43,568	9,524
Enrolled at Least 11 Months Continuously: Age 5	0%	0	0	0%	2	0	20.41%↑	196	40
Enrolled at Least 11 Months Continuously: Age 6–9	25.99%↑	6,596	1,714	28.73%↑	11,302	3,247	25.70%↑	10,419	2,678
Enrolled at Least 11 Months Continuously: Age 10–14	23.55%↑	8,013	1,887	24.01%↑	19,650	4,718	20.66%↓	18,316	3,784
Enrolled at Least 11 Months Continuously: Age 15–18	22.87%↑	5,137	1,175	22.25%↑	15,365	3,419	20.65%↓	14,637	3,022
Dental Sealants (The age 5 and age 15–18 stratifications do not apply to this measure.)									
Enrolled at Least 1 Month: All Enrollees	10.97%	40,446	4,436	12.55%	72,323	9,074	11.14%	66,680	7,427
Enrolled at Least 1 Month: Age 6–9	11.53%↓	19,697	2,271	14.20%↑	29,389	4,174	12.42%↑	26,682	3,315

Table 14. 2019 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 1 Month: Age 10–14	10.43%↓	20,749	2,165	11.41%↑	42,934	4,900	10.28%↓	39,998	4,112
Enrolled at Least 3 Months Continuously: All Enrollees	13.03%	32,559	4,244	14.33%	61,212	8,771	12.89%	55,886	7,204
Enrolled at Least 3 Months Continuously: Age 6–9	13.81%↓	15,747	2,175	16.39%↑	24,460	4,009	14.58%↑	22,007	3,209
Enrolled at Least 3 Months Continuously: Age 10–14	12.31%↓	16,812	2,069	12.96%↑	36,752	4,762	11.79%↓	33,879	3,995
Enrolled at Least 6 Months Continuously: All Enrollees	14.84%	24,769	3,675	16.22%	47,813	7,755	14.57%	43,757	6,375
Enrolled at Least 6 Months Continuously: Age 6–9	15.57%↓	11,913	1,855	18.74%↑	18,611	3,487	16.79%↑	16,800	2,820
Enrolled at Least 6 Months Continuously: Age 10–14	14.16%↓	12,856	1,820	14.62%↑	29,202	4,268	13.19%↓	26,957	3,555
Enrolled at Least 11 Months Continuously: All Enrollees	17.06%	14,669	2,502	17.57%	30,951	5,439	15.80%	28,735	4,540

Table 14. 2019 PMV Results: DBMs									
Measure	**Argus**			**DentaQuest**			**MCNA**		
	Rate (%)	**Den.***	**Num.***	**Rate (%)**	**Den.**	**Num.**	**Rate (%)**	**Den.**	**Num.**
Enrolled at Least 11 Months Continuously: Age 6–9	19.09%↑	6,623	1,264	21.06%↑	11,304	2,381	18.60%↑	10,419	1,938
Enrolled at Least 11 Months Continuously: Age 10–14	15.39%↑	8,046	1,238	15.56%↑	19,647	3,058	14.21%↓	18,316	2,602
Dental Sealants – With Exclusions (The age 5 and age 15–18 stratifications do not apply to this measure.)									
Enrolled at Least 1 Month: All Enrollees	11.82%	36,505	4,315	14.18%	63,993	9,075	11.52%	62,818	7,238
Enrolled at Least 1 Month: Age 6–9	12.63%↑	17,315	2,187	17.55%	23,788	4,174	13.23%↑	24,177	3,198
Enrolled at Least 1 Month: Age 10–14	11.09%↑	19,190	2,128	12.19%	40,205	4,901	10.46%↓	38,641	4,040
Enrolled at Least 3 Months Continuously: All Enrollees	13.44%	30,814	4,140	16.47%	53,247	8,772	13.43%	52,282	7,019
Enrolled at Least 3 Months Continuously: Age 6–9	14.47%↑	14,483	2,095	20.96%	19,124	4,009	15.73%↑	19,681	3,096
Enrolled at Least 3 Months Continuously: Age 10–14	12.52%↓	16,331	2,045	13.96%	34,123	4,763	12.03%↓	32,601	3,923

Table 14. 2019 PMV Results: DBMs									
Measure	**Argus**			**DentaQuest**			**MCNA**		
	Rate (%)	**Den.***	**Num.***	**Rate (%)**	**Den.**	**Num.**	**Rate (%)**	**Den.**	**Num.**
Enrolled at Least 6 Months Continuously: All Enrollees	15.28%	23,364	3,571	19.01%	40,793	7,755	15.29%	40,609	6,208
Enrolled at Least 6 Months Continuously: Age 6–9	16.39%↓	10,860	1,780	25.02%	13,938	3,487	18.39%↑	14,776	2718
Enrolled at Least 6 Months Continuously: Age 10–14	14.32%↓	12,504	1,791	15.89%	26,855	4,268	13.51%↓	25,833	3490
Enrolled at Least 11 Months Continuously: All Enrollees	17.78%	13,637	2,425	21.16%	25,709	5,439	16.75%	26,276	4,402
Enrolled at Least 11 Months Continuously: Age 6–9	20.69%↑	5,838	1,208	30.44%	7,854	2,391	20.95%↑	8,860	1,856
Enrolled at Least 11 Months Continuously: Age 10–14	15.60%↑	7,799	1,217	17.13%	17,855	3,058	14.62%↓	17,416	2,546
Diagnostic Dental Services									
Enrolled at Least 1 Month: All Enrollees	39.68%	51,566	20,461	46.00%	107,836	49,608	40.79%	101,106	41,239
Enrolled at Least 1 Month: Age 5**	16.37%↑	1,167	191	26.49%↑	3,360	890	26.76%↑	4,379	1,172

Table 14. 2019 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 1 Month: Age 6–9	42.08%↑	18,479	7,776	49.57%↑	29,386	14,566	44.56%↓	26,682	11,890
Enrolled at Least 1 Month: Age 10–14	42.03%↑	19,509	8,200	48.37%↑	42,937	20,769	43.39%↑	39,998	17,355
Enrolled at Least 1 Month: Age 15–18	34.60%↑	12,411	4,294	41.62%↑	32,145	13,380	36.02%↓	30,047	10,822
Enrolled at Least 3 Months Continuously: All Enrollees	45.06%	43,449	19,578	52.29%	91,075	47,619	46.88%	84,789	39,749
Enrolled at Least 3 Months Continuously: Age 5	20.76%↓	684	142	37.64%↑	2,011	757	36.49%↑	2,897	1,057
Enrolled at Least 3 Months Continuously: Age 6–9	47.74%↑	15,562	7,430	56.79%↑	24,458	13,890	51.75%↑	22,007	11,388
Enrolled at Least 3 Months Continuously: Age 10–14	47.26%↑	16,628	7,859	54.48%↑	36,755	20,024	49.52%↑	33,879	16,778
Enrolled at Least 3 Months Continuously: Age 15–18	39.22%↑	10,575	4,147	46.49%↑	27,847	12,946	40.48%↑	26,006	10,526

Table 14. 2019 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 6 Months Continuously: All Enrollees	51.06%	32,827	16,762	58.08%	70,974	41,220	52.67%	66,295	34,917
Enrolled at Least 6 Months Continuously: Age 5	71.43%↑	7	5	49.08%↑	758	372	45.09%↑	1,517	684
Enrolled at Least 6 Months Continuously: Age 6–9	53.59%↑	11,809	6,329	63.37%↑	18,608	11,792	58.71%↑	16,800	9,863
Enrolled at Least 6 Months Continuously: Age 10–14	53.39%↑	12,769	6,817	60.18%↑	29,206	17,575	55.28%↑	26,957	14,903
Enrolled at Least 6 Months Continuously: Age 15–18	43.81%↓	8,242	3,611	51.25%↑	22,400	11,479	45.04%↑	21,021	9,467
Enrolled at Least 11 Months Continuously: All Enrollees	57.03%	19,746	11,261	63.03%	46,320	29,194	57.17%	43,568	24,908
Enrolled at Least 11 Months Continuously: Age 5	0%	0	0	50.00%	2	1	55.10%↑	196	108
Enrolled at Least 11 Months Continuously: Age 6–9	60.29%↑	6,596	3,977	68.46%↑	11,302	7,737	64.28%↑	10,419	6,697

Table 14. 2019 PMV Results: DBMs									
Measure	**Argus**			**DentaQuest**			**MCNA**		
	Rate (%)	**Den.***	**Num.***	**Rate (%)**	**Den.**	**Num.**	**Rate (%)**	**Den.**	**Num.**
Enrolled at Least 11 Months Continuously: Age 10–14	58.84%↑	8,013	4,715	65.27%↑	19,650	12,825	59.77%↑	18,316	10,948
Enrolled at Least 11 Months Continuously: Age 15–18	50.01%↑	5,137	2,569	56.17%↑	15,365	8,630	48.88%↓	14,637	7,155
Any Dental or Oral Health Service									
Enrolled at Least 1 Month: All Enrollees	16.32%	51,566	8,413	46.82%	107,836	50,487	43.14%	101,106	43,620
Enrolled at Least 1 Month: Age 5**	4.80%	1,167	56	27.11%	3,360	911	27.63%	4,379	1,210
Enrolled at Least 1 Month: Age 6–9	17.22%	18,479	3,182	50.14%	29,386	14,735	45.86%	26,682	12,237
Enrolled at Least 1 Month: Age 10–14	16.54%	19,509	3,227	49.23%	42,937	21,140	45.67%	39,998	18,268
Enrolled at Least 1 Month: Age 15–18	15.70%	12,411	1,948	42.61%	32,145	13,698	39.62%	30,047	11,905
Enrolled at Least 3 Months Continuously: All Enrollees	18.61%	43,449	8,086	53.07%	91,075	48,330	49.45%	84,789	41,931

Table 14. 2019 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 3 Months Continuously: Age 5	6.58%	684	45	38.24%	2,011	769	37.25%	2,897	1,079
Enrolled at Least 3 Months Continuously: Age 6–9	19.64%	15,562	3,056	57.33%	24,458	14,021	53.11%	22,007	11,688
Enrolled at Least 3 Months Continuously: Age 10–14	18.63%	16,628	3,097	55.30%	36,755	20,327	51.99%	33,879	17,614
Enrolled at Least 3 Months Continuously: Age 15–18	17.85%	10,575	1,888	47.44%	27,847	13,211	44.41%	26,006	11,550
Enrolled at Least 6 Months Continuously: All Enrollees	21.50%	32,827	7,058	58.74%	70,974	41,691	55.33%	66,295	36,678
Enrolled at Least 6 Months Continuously: Age 5	14.29%	7	1	49.08%	758	372	45.48%	1,517	690
Enrolled at Least 6 Months Continuously: Age 6–9	22.52%	11,809	2,659	63.76%	18,608	11,864	59.92%	16,800	10,067
Enrolled at Least 6 Months Continuously: Age 10–14	21.29%	12,769	2,718	60.88%	29,206	17,780	57.81%	26,957	15,585

Table 14. 2019 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 6 Months Continuously: Age 15–18	20.38%	8,242	1,680	52.11%	22,400	11,673	49.17%	21,021	10,336
Enrolled at Least 11 Months Continuously: All Enrollees	24.19%	19,746	4,776	63.69%	46,320	29,503	60.01%	43,568	26,144
Enrolled at Least 11 Months Continuously: Age 5	0%	0	0	50.00%	2	1	55.61%	196	109
Enrolled at Least 11 Months Continuously: Age 6–9	25.99%	6,596	1,714	68.79%	11,302	7,775	65.40%	10,419	6,814
Enrolled at Least 11 Months Continuously: Age 10–14	23.55%	8,013	1,887	65.99%	19,650	12,968	62.38%	18,316	11,426
Enrolled at Least 11 Months Continuously: Age 15–18	22.87%	5,137	1,175	57.00%	15,365	8,758	53.26%	14,637	7,795

** Den.=Denominator; Num.=Numerator*

† The age range for this stratification is 4–6 years; as age 4 years does not apply to the Florida Healthy Kids population, the stratification has been renamed Age 5–6 for this report.

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

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 appropriate technical specifications—HEDIS or AHCA MMA.

Qsource noted several strengths for the DBMs. Argus demonstrated being well prepared for the onsite review through ISCA documentation and making subject-matter experts available for the review team. Argus's consistent performance across required dental measures and from the 2018 to the 2019 PMV also were commended, especially given the MCO's growth during the review year as well as network changes to meet statewide network adequacy standards.

Likewise, Qsource did not note any areas of improvement for the DBMs for the 2019 PMV.

In addition, Qsource highlighted DentaQuest's robust, routinely updated Windward system capabilities for data collection and reporting as well as pointed out the DBM's organizational reporting process and each department's staff having an understanding of its role and contribution to the measure production process. Finally, Qsource identified MCNA's DentalTrac™ as an excellent internally developed system and noted its uniqueness and comprehensiveness, recognizing it as a best practice.

Areas for Improvement

No areas of improvement were noted for the MCOs for the 2019 PMV, just as for the 2018 PMV.

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 2019 PIP validation cycle, there were two PIP topics for each MCO and DBM, one clinical selected by FHKC and one nonclinical proposed by the MCO/DBM and approved by FHKC. As shown in **Table 15**, all five MCOs and two of the three DBMs achieved a Met status for both of their PIP studies. The two PIPs for one of the DBMs both received a Not Met status.

Table 15. 2019 PIP Validation Status by MCO/DBM

MCO/DBM	PIP Type	Met/Not Met
Aetna	Clinical	Met
	Nonclinical	Met
Argus	Clinical	Met
	Nonclinical	Met
DentaQuest	Clinical	Not Met
	Nonclinical	Not Met
MCNA	Clinical	Met
	Nonclinical	Met
Simply	Clinical	Met
Healthcare	Nonclinical	Met
Staywell	Clinical	Met
	Nonclinical	Met
Sunshine	Clinical	Met
	Nonclinical	Met
UnitedHealthcare	Clinical	Met
	Nonclinical	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 2019.

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 *2019 PIP Validation Report* for each MCO and DBM.

Following Qsource's initial validation of the PIPs, the draft *2019 PIP Validation Report* for each PIP was shared with its corresponding MCO/DBM for an opportunity to correct any identified deficiencies as well as address Qsource's suggestions for an improved PIP study. The MCOs and DBMs resubmitted their revised PIP studies and supplemental information, and Qsource revalidated the PIPs. The scores from this second validation are included in PIP findings.

Description of Data Obtained

Table 16 summarizes the 10 CMS protocol activity requirements and the 13 critical elements addressed in the PIP Summary Form.

Table 16. 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

Table 16. CMS PIP Activities and Critical Elements

PIP Activities	Critical Elements
	♦ Have available data that can be collected on each indicator
V. Use Sound Sampling Methods	♦ Ensure a representative sample of the eligible population
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

Table 16. CMS PIP Activities and Critical Elements

PIP Activities	Critical Elements
IX. Assess for Real Improvement	♦ No critical elements
X. Assess for Sustained Improvement	♦ No critical elements

Findings

Table 17 presents a summary of each MCO's and DBM's PIPs and includes each PIP's title, validation status, type, populations affected, study indicators, interventions, summary of performance, any decrease or increase in measurement results, and discussion points. This information is useful for determining whether to continue or retire a specific PIP. Florida Healthy Kids MCO and DBM PIPs for 2019 were clinical and nonclinical. Italicized text in **Table 17** was taken directly from MCO and DBM materials and has not been edited by Qsource. For the 2019 PIP review, 14 of the 16 PIP studies received a Met Status.

One DBM's clinical PIP and nonclinical PIP both received a Not Met status due to a critical element score below 100%.

Table 17. Performance Summary for 2019 PIPs	
MCOs	
Aetna: Well-Child Visits in the 5th and 6th Years of Life (W34)	
Validation Status	Met
PIP Type	Clinical
Study Population	*This study will include a sample of the eligible population: all continuously enrolled FHK* [Florida Healthy Kids] *members (children) who are 5 and 6 years of age (as of December 31) of the measurement year, with no more than one gap of up to 45 days who meet the HEDIS Technical Specifications for the W34 measure. The study population represents a subgroup of the FHK* [Florida Healthy Kids] *population to which this PIP indicator (W34) applies. The study will not exclude members based on health status or special health care needs.*
Study Indicator(s)	*Well-Child Visits in the 5th and 6th Years of Life (W34)*
Interventions*	*Live Telephonic Outreach to Members to remind members of importance of well-child visits and appointment scheduling assistance. 11/27/19 – Throughout 2018, Plan-Do-Study-Act processes were applied to this intervention, resulting in a larger proportion of members reached and an increase is the study indicator over the prior year.*
Summary of Performance	Aetna achieved overall validation and critical element scores of 97.8% and 100%, respectively.
Measurement Results	Results have fluctuated across the nine years of this PIP. For the 2018 reporting year, the remeasurement result was 74.50%, compared to the baseline goal of 69.70% and result of 65.20% and the remeasurement result of 72.50% for the 2017 reporting year.
EQRO Discussion	Qsource identified two strengths and one AON for this PIP study. Strengths were related to detailed information in activities VI and VII, and the AON involved providing the study description to data abstractors in Activity VI.

Table 17. Performance Summary for 2019 PIPs	
Aetna: Timely follow-up for patients after they have been hospitalized for mental illness (FUH 7-day)	
Validation Status	Met
PIP Type	Nonclinical
Study Population	*This study will include the FHK* [Florida Healthy Kids] *membership eligible for the FUH 7-day measure: all continuously enrolled FHK* [Florida Healthy Kids] *members (children) at least 6 years of age or older as of the date of discharge with no gaps in enrollment during the measurement year, who meet the HEDIS Technical Specifications for the FUH 7-day measure and who had the recommended follow-up with a mental health practitioner within 7 days of discharge from hospital. The study population represents the eligible FHK* [Florida Healthy Kids] *members to which this PIP indicator (FUH 7-day) applies. The study will not exclude members based on health status or special health care needs.*
Study Indicator(s)	*Follow-Up After Hospitalization for Mental Illness (FUH 7-day)*
Interventions*	As this is the baseline year for this PIP, no interventions were included.
Summary of Performance	Aetna achieved overall validation and critical element scores of 100%.
Measurement Results	The baseline goal was 36.54%, and the baseline result was 33.77%.
EQRO Discussion	Qsource identified no strengths, suggestions, or AONs for this PIP study.
Simply Healthcare: Improving Well-Child Visits in the 5th and 6th Years of Life	
Validation Status	Met
PIP Type	Clinical
Study Population	- *Overall FHK* [Florida Healthy Kids] *Membership (# enrollees) in December 31, 2018: 52102* - *Number of members in population addressed by PIP (children between 5 and 6 years of age) in December 31, 2018: 5536* - *When: Jan 1, 2018 – Dec 31, 2018*

Table 17. Performance Summary for 2019 PIPs	
	- *Where: Region 6,7,10,11* - *Population (who): The Plan followed the HEDIS 2018 technical specifications for the W34 measure (for FHK* [Florida Healthy Kids] *members 5 to 6 years of age only) for all member criteria, per the embedded document below.* - *Numerator: The percentage of children 5 to 6 years of age during the measurement year that received one or more Well-Child Visits with a PCP.* - *Denominator: Eligible children 5 to 6 years of age during the measurement year.* - *Allowable gap: No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).* - *Anchor date: December 31 of the measurement year.* - *Specific Exclusion criteria: Members in hospice are excluded from the eligible population.* - *Continuous enrollment requirements: The measurement year.*
Study Indicator(s)	*Well-Child Visits in the 5th and 6th Years of Life (W34): HEDIS*
Interventions*	♦ *Clinic Day Program: designed to provide easily accessible medical services, member education, and confirm members' contact information.* ♦ *Live Outbound Calls: Health Promotions outreach team conducts outbound calls to members not compliant for the W34 measure. Calls are made in two different ways: 1) the outreach team calls non-compliant members and invites them to an outreach event linked to the Plan's Clinic Day Program, and 2) the outreach team makes calls to members from selected providers' offices and schedules their appointments with the providers.* ♦ *Member Contact Information Verification: The Plan piloted an intervention that may potentially impact the ability to communicate with members across all Lines of Business and products, including FHK. The Plan contracted with a vendor who*

Table 17. Performance Summary for 2019 PIPs	
	was able to review and match member contact information using various proprietary means. The Plan 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 was done in order to determine the rate of incorrect contact information. Vendor information was verified with the members who will also be encouraged to report their correct contact information to the State. The Plan would document the correct contact information in a separate database that will not be overridden by the State.
Summary of Performance	Simply Healthcare achieved overall validation and critical element scores of 100%.
Measurement Results	Results have fluctuated across the nine years of this PIP. For the 2018 reporting year, the remeasurement result was 80.90%, compared to the baseline goal of 77.70% and result of 72.80% and the remeasurement result of 75.90% for the 2017 reporting year.
EQRO Discussion	Qsource identified four strengths and four suggestions for this PIP study. Strengths were related to detailed descriptions in activities I, VI, and VIII, and suggestions were to include information in all appropriate activities and to address Plan-Do-Study-Act (PDSA) activities in Activity VIII.
Simply Healthcare: Care Coordination to Improve Follow-up Care for Children Prescribed ADHD Medication (ADD)	
Validation Status	Met
PIP Type	Nonclinical
Study Population	- *Overall FHK* [Florida Healthy Kids] *Membership (# enrollees) in December 31, 2018: 52102* - *Number of members in population addressed by PIP in December 31, 2018: 1441* - *Number of members in population addressed by ADD measure (FHK* [Florida Healthy Kids] *enrollees) as on Dec 31, 2018: 300* - *When: Jan 1, 2019 – Dec 31, 2019*

Table 17. Performance Summary for 2019 PIPs	
	- *Where: Region 6,7,10,11* - *Population (who): The Plan followed the HEDIS 2019 technical specifications for the ADD measure (for FHK* [Florida Healthy Kids] *members) for all member criteria, per the embedded document.* - *Ages - Six years as of March 1 of the year prior to the measurement year to 12 years as of the last calendar day of February of the measurement year.* - *Continuous enrollment - 120 days (4 months) prior to the IPSD through 30 days after the IPSD for initiation phase and 120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD for maintenance phase.* - *Allowable gap – None for initiation phase. One 45-day gap in enrollment between 31 days and 300 days (10 months) after the IPSD for maintenance phase. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).* - *Anchor date – None* - *Exclusions (optional) - Exclude from the denominator for both rates, members with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year. Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.*
Study Indicator(s)	1. *Follow-Up Care for Children Prescribed ADHD Medication (ADD) Initiation Phase* 2. *Follow-Up Care for Children Prescribed ADHD Medication (ADD) Continuation and Maintenance (C&M) Phase*
Interventions*	As this is the baseline year for this PIP, no interventions were included.
Summary of Performance	Simply Healthcare achieved overall validation and critical element scores of 100%.

Table 17. Performance Summary for 2019 PIPs	
Measurement Results	For study indicator 1, the baseline goal was 50.82%, and the baseline result was 42.28%. For study indicator 2, the baseline goal was 63.77%, and the baseline result was 58.54%.
EQRO Discussion	Qsource identified one strength related to analysis of ethnicity of the MCO's membership for this PIP study.
Staywell: Improving Rate of Well Child Care Visits for 5 and 6 year olds	
Validation Status	Met
PIP Type	Clinical
Study Population	*The study population is defined by the 2019 HEDIS® measure W34 – Well Visits for Children in the 3rd, 4th, 5th and 6th Years of Life. Sampling will not be used. All members that meet the criteria will be in the study.*
Study Indicator(s)	*Well Child Visits in the 5th and 6th Years of Life*
Interventions*	*Periodicity letters are sent to members/parents/caregivers reminding them of the recommended preventive services based on the member's age. Letters are sent to all members in their birthday month and if they have not seen their primary care physician within 45 days of joining the plan.*
Summary of Performance	Staywell achieved overall validation and critical element scores of 94.7% and 100%, respectively.
Measurement Results	Results have fluctuated across the nine years of this PIP. For the 2018 reporting year, the remeasurement result was 77.31%, compared to the baseline goal of 71.83% and result of 65.73% and the remeasurement result of 81.20% for the 2017 reporting year.
EQRO Discussion	Qsource identified two suggestions and two AONs for this PIP study. Suggestions were related to presentation of interventions in Activity VIII. AONs involved the MCO's need to include missing required information in Activity VII.
Staywell: Metabolic Monitoring for Children and Adolescents on Anti-Psychotics	
Validation Status	Met

Table 17. Performance Summary for 2019 PIPs	
PIP Type	Nonclinical
Study Population	*The study population is defined by the 2019 HEDIS® measure APM - Metabolic Measurement for Children and Adolescents on Antipsychotics. Sampling will not be used. All members that meet the criteria will be in the study. In coverage year 2018, there were 214 children and adolescents in the denominator for this measure. This should be an adequate population as the non-reportable threshold for NCQA is less than 30 members. This includes the number of children and adolescents, ages 6-17 years who have been prescribed two or more anti-psychotics and have had at least one test for blood glucose or an HBA1C, and at least one test for LDL-C or cholesterol performed in the measurement year.*
Study Indicator(s)	*Metabolic Measurement for Children and Adolescents on Antipsychotics*
Interventions*	As this is the baseline year for this PIP, no interventions were included.
Summary of Performance	Staywell achieved overall validation and critical element scores of 100%.
Measurement Results	The baseline goal was 39.15%, and the baseline result was 40.00%.
EQRO Discussion	Qsource did not identify any strengths, suggestions, or AONs for this PIP study.
Sunshine: Well-Child Visits in the Fifth and Sixth Years of Life	
Validation Status	Met
PIP Type	Clinical
Study Population	*The eligible population includes all children ages 5 and 6 years of age 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. To determine continuous enrollment for an enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage. There are no subgroups of children excluded from this study. Enrollees with special needs will be included.*
Study Indicator(s)	*Well-Child Visits for Enrollees Ages 5 and 6*

Table 17. Performance Summary for 2019 PIPs	
Interventions*	1. *Welcome calls are placed by Envolve People Care (EPC) following a member's enrollment to complete a health screening, answer questions and provide information on member services, important contact numbers, primary care providers, making appointments and transportation benefits. Envolve People Care provides monthly scorecards on outreach efforts. During the PDSA cycle, a revision of the Welcome Calls script was completed. It was determined that the script should be revised to include messaging giving the web address for the member handbook, more specific information about the well-child benefits and a reminder to make an appointment for annual well-child visits.* 2. *Pay for Performance Incentive program gives participating providers a per-member reimbursement based on their attributed population performance. Utilization and payments are tracked monthly with results posted to the provider portal.* ***Intervention Update:*** *The provider pay for performance program was revised in RY2019 to include childhood immunizations and additional provider training. Marketing initiatives were conducted to increase awareness and utilization of the program.* ***PDSA:*** *During the PDSA cycle, we discovered tracking improvements in incentive payments to providers presented some challenges. The Pay for Performance utilization report did not accurately reflect the amount of incentives being paid on a quarterly basis. Due to the claims submissions process and a lag in the reporting system we were unable to assess if there was improvement each quarter. We are currently working on a reporting resolution to capture the accurate amount of incentives being paid to providers for the well child measure.* 3. *Routine onsite visits to providers by PPM and the Clinical Compliance and Outcomes (CCO) Team for education on accessing the provider portal, Availity, billing, coding, a review of gaps in care and Pay for Performance results. During the PDSA cycle, It was determined that a new methodology was needed to target practices with the highest percentage of gaps in each measure. The targeted provider list was revised to include an additional 160 practices throughout the State. To better track progress of individual practices in specific measures, the QI department partnered with the Sunshine Health analytics team to develop a*

Table 17. Performance Summary for 2019 PIPs	
	dashboard that interfaces with the Centene enterprise data warehouse (EDW) enabling the most current data to be viewed by measure, Coordinator, region, TIN, provider, and member.
Summary of Performance	Sunshine achieved overall validation and critical element scores of 84.6% and 100%, 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. For the 2018 reporting year, the remeasurement result was 75.10%, compared to the baseline goal of 72.02% and result of 71.45% and the remeasurement result of 71.84% for the 2017 reporting year.
EQRO Discussion	Qsource identified two suggestions and six AONs for this PIP study. The AONs involved the MCO's need to include missing required information in activities VII, IX, and X.
Sunshine: Follow up after hospitalization for mental illness	
Validation Status	Met
PIP Type	Nonclinical
Study Population	*The study population includes all children ages 5 through 18 years of age enrolled in Sunshine Healthy Kids from the date of discharge through 30 days after discharge. Members in hospice are excluded from the eligible population. Enrollees with special needs will be included. The population will include members with a follow-up visit with a mental health practitioner within 7 days after discharge. Visits that occur on the date of discharge will not be included.*
Study Indicator(s)	The MCO did not provide the title or description of the study indicator.
Interventions*	As this is the baseline year for this PIP, no interventions were included.
Summary of Performance	Sunshine achieved overall validation and critical element scores of 91.3% and 100%, respectively.

Table 17. Performance Summary for 2019 PIPs	
Measurement Results	The baseline goal was 46.46%, and the baseline result was 43.64%.
EQRO Discussion	Qsource identified eight suggestions and two AONs for this PIP study. The suggestions were to include information in all appropriate activities, add more historical data for the topic in Activity I, rephrasing the study question in Activity II, and addressing estimated degree of data completeness in Activity VI. The AONs involved the MCO's need to include missing required information in activities IV and VI.
UnitedHealthcare: Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34)	
Validation Status	Met
PIP Type	Clinical
Study Population	*As instructed by FHK* [Florida Healthy Kids]*, this study will include all of the children in the targeted population of 5-6 year old FHK* [Florida Healthy Kids] *members enrolled with UHC FL, as the Florida Healthy Kids enrollment is limited to children ages 5 through 18. There are no children 3 and 4 years old in the FHK* [Florida Healthy Kids] *program to include in the study; and no subgroups of children will be consistently excluded. The entire population of FHK* [Florida Healthy Kids] *children eligible for the study will be used (no sampling). This study will include all FHK* [Florida Healthy Kids] *members in the eligible population and does not exclude recipients with special health care needs.*
Study Indicator(s)	*Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34)*
Interventions*	♦ *Quality Performance Incentive Program (QPIP)* Results: Low provider engagement. Only a few providers earned incentive (top performers). Model will be revise/modified for next measurement year. ♦ *Welcome Calls/ Welcome Packets- PDSA implemented: added educational line to welcome calls script in regards to the importance of well visits. Test of change was unsuccessful due to low number of members called using the new script. Change in script did not trigger members to make appointment.* ♦ *CPC Program and Gap Detail Reports- PDSA Implemented: FHK* [Florida Healthy

Table 17. Performance Summary for 2019 PIPs	
	Kids] *member gaps in the W34 were given to providers separate from the overall list of gaps containing both MMA and FHK* [Florida Healthy Kids] *members. Regions 4 CPC emphasized the importance of reaching out and engaging the FHK* [Florida Healthy Kids] *membership in well visits as part of this PIP for providers. Test of change revealed important information in regards to the processes PCPs have in place when reaching out to members for well visits. The change was adopted; CPCs continued to share a separate list for the FHK* [Florida Healthy Kids] *W34 population with providers throughout the year. This initiative to be tested again in the following measurement year though another PDSA to understand better impact in the overall W34 measure.* ♦ *Telephone Outreach (IVR) Results: Year over year data analysis shows members who received an IVR to have a higher compliance rate in the W34 measure than members who did not get an IVR call. Missing or incorrect contact information limits outreach to only a group of the W34 population. The health plan will continue to explore other available channels of communication with members.* ♦ *Annual Well-Visit Member E-mail Reminder (PDSA Implemented): In addition to phone calls, UHC sent out well visit reminders via e-mail to members' parents. Campaign was deployed during month of July. This was a onetime campaign. E-mail opening rate for this campaign was higher than the benchmark (24% compared to 17% for the insurance market). The initiative has been adapted and will be retested in remeasurement 4.* ♦ *End of Year Well Visit Member Reminder Live Calls: non-compliant members were reached out through live calls during December 2018 to encourage member to visit their doctor for a well visit before the end of the year. (no PDSA). Results: The campaign included a total of 122 members. Only 9 members were reached by a live agent. Out of the 9 members reached, only 1 visited the doctor. The campaign included a total of 122 members.*
Summary of Performance	UnitedHealthcare achieved overall validation and critical element scores of 97.8% and 100%, respectively.
Measurement Results	Results were reported from 2015 through 2018 of this nine-year study, and the

Table 17. Performance Summary for 2019 PIPs	
	baseline result and goal were redefined as the 2015 values, as allowed due to the length of the study. The redefined baseline goal was 75.00%, and the baseline result was 68.20%. Results for remeasurement years six through eight increased, from 68.70% to 69.35% and finally to 75.18%.
EQRO Discussion	Qsource identified six strengths and one AON for this PIP study. Strengths were related to detailed descriptions in activities I, III, VI, VII, and VIII as well as graphical presentation of results in Activity VII. The AON involved the MCO's need to include missing required information in Activity VI.
UnitedHealthcare: Improving Follow-Up Care for Children Prescribed ADHD Medication (ADD): Initiation Phase	
Validation Status	Met
PIP Type	Nonclinical
Study Population	*The study population for this project follows criteria from the HEDIS® 2019 Technical Specifications for the ADD (Initiation phase) measure. Population includes FHK* [Florida Healthy Kids] *members six years of age as of March 1 of the year prior to the measurement year to 12 years as of the last calendar day of February of the measurement year. Members must be continuously enrolled for 120 days (4 months) prior to the Index Prescription Start Date (IPSD) through 30 days after the IPSD.* *Exclusions:* 1. *Members in hospice are excluded from the eligible population* 2. *Members who had a positive ADHD medication history within period of 120 days prior to the IPSD.* 3. *Members who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the IPSD.*
Study Indicator(s)	*ADDI: Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase*
Interventions*	As this is the baseline year for this PIP, no interventions were included.
Summary of Performance	UnitedHealthcare achieved overall validation and critical element scores of 100%.

Table 17. Performance Summary for 2019 PIPs	
Measurement Results	The baseline goal was 55.91%, and the baseline result was 40.86%.
EQRO Discussion	Qsource identified one strength related to detailed research in Activity I for this PIP study.
DBMs	
Argus: Children Receiving Preventive Dental Services	
Validation Status	Met
PIP Type	Clinical
Study Population	*This 100% of the total FHK* [Florida Healthy Kids] *enrollees/members in 67 Florida Counties are affected and the total membership falls within the target population. All members should receive preventive dental services. The American Academy of Pediatric Dentistry recommends that children visit a dentist once every six months (or more often for high-risk children) for routine and preventive care. This PIP includes all children in the age group 6-18 as the measurement outcome, but all age-groups are to be included in the outreach and intervention processes. The study population is based on the FHK* [Florida Healthy Kids] *Argus membership and will run through the length of the PIP.*
Study Indicator(s)	1. *The percent of Florida Healthy Kids 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 six months in the dental plan, who receive dental preventive services (per CMS Form-416 specifications)*
Interventions*	As this PIP was rebaselined this year, no interventions were included.
Summary of Performance	Argus achieved overall validation and critical element scores of 100%.
Measurement Results	For study indicator 1, the baseline goal was 41.00%, and the baseline result was

Table 17. Performance Summary for 2019 PIPs	
	36.68%. For study indicator 2, the baseline goal was 43.00%, and the baseline result was 49.45%. Remeasurement results were not included as the study was rebaselined this year.
EQRO Discussion	Qsource identified one strength related to comprehensive research in Activity I for this PIP study.
Argus: Access and Availability of Services – Enrollee Satisfaction	
Validation Status	Met
PIP Type	Nonclinical
Study Population	*The study population includes FHK* [Florida Healthy Kids] *enrollees who are active at the time of the survey, includes new enrollees, those with continuous coverage as of 01/01/2019, those who have not had more than a 30-day lapse in coverage, are between the ages of 6-18 at the time the survey population pool is pulled, and who reside in any of the 67 Florida Counties. The targeted study population will not exclude CSHCNs, nor will exclude any of the total population due to their ethnicity, household language preference, health condition, etc. The study population will also include those who have received services as well as those in need of services (no claim history that is aligned with the ADA recommended dental care). Therefore, those in need and those having received services are included in the study population.* *The study population is based on the FHK* [Florida Healthy Kids] *Argus membership and will run through the length of the PIP. A member satisfaction survey will be sent to 2.5% of the total membership and is a representative sample size with a margin of error of 5%, confidence level of 95%, and estimated response rate of 20%. Surveys will be sent quarterly. The data collection cycle was initially established with the expectation to issue a survey quarterly to 2.5% of the total membership at the end of the month prior to when the quarterly survey is published. It was decided that for the first survey run, those who were effective on 01/01/2019 or before and had not received dental care within the ADA recommended standards for routine dental services would be included in the initial pool. This and all following survey pools*

Table 17. Performance Summary for 2019 PIPs	
	included those in need of dental services, those new to the plan, and those who had received services. This was to identify interventions to help those who had not utilized dental services and may be at risk for dental disease as well as those who have received appropriate dental care.
Study Indicator(s)	The DBM did not provide the title or description of the study indicator.
Interventions*	As this is the baseline year for this PIP, no interventions were included.
Summary of Performance	Argus achieved overall validation and critical element scores of 96.6% and 100%, respectively.
Measurement Results	Remeasurement results are not included as this is the baseline year of the study. In addition, as this study is based on an internally developed enrollee satisfaction survey that has not yet been administered, the DBM indicated that the baseline goal and result will be determined based on results of the first quarterly administration of the survey.
EQRO Discussion	Qsource identified two suggestions and one AON for this PIP study. The suggestions involved the study questions in Activity II and missing required information in Activity IV. The AON involved missing required information in Activity VI.
DentaQuest: Preventive Dental Services for 13- to 18-Year-Olds	
Validation Status	Not Met
PIP Type	Clinical
Study Population	*All FHKC eligible members are included in the study populations. Study Populations for Study Indicator: The populations are DQ's FHKC members under the age of 21 with at least 90 days continuous enrollment during the federal fiscal year who received one preventive dental service.*
Study Indicator(s)	*PDENT*
Interventions*	As this PIP was rebaselined this year, no interventions were included.
Summary of Performance	DentaQuest achieved overall validation and critical element scores of 95.8% and

Table 17. Performance Summary for 2019 PIPs	
	87.5%, respectively.
Measurement Results	The baseline goal was to increase measure results by two percentage points, and the baseline result was 48.94%. Remeasurement results were not included as the study was rebaselined this year.
EQRO Discussion	Qsource identified one strength, one suggestion, and one AON for this PIP study. The strength was related to comprehensive research in Activity I, and the suggestion was to use incurred but not reported (IBNR) methodology to calculate the estimated data completeness rate. The AON involved the need to include the available data source in Activity IV.
DentaQuest: Access & Availability/Non-Compliant Geo Directory	
Validation Status	Not Met
PIP Type	Nonclinical
Study Population	*Study population for Extended Hours Dental Care* *Extended hours include provider offices that offer dental services during non-standard hours and non-standard times. Non-standard hours include providers that offer dental services outside of 8:00am-5:00pm. Non-standard days include providers that offer services on Saturdays and/or Sundays.* *Study population for Any Dental Visit* *All FHKC members are included in the study populations. The populations are DQ's FHKC members meeting the CMS-416 Any dental visit measure which includes members under age 21 with 90 days continuous enrollment during the FFY who received at least one dental service.*
Study Indicator(s)	1. *Providers offering care after hours* 2. *Any dental visit*
Interventions*	As this is the baseline year for this PIP, no interventions were included.
Summary of Performance	DentaQuest achieved overall validation and critical element scores of 91.7% and

Table 17. Performance Summary for 2019 PIPs	
	87.5%, respectively.
Measurement Results	For study indicator 1, the baseline goal was 50.50%, and the baseline result was 45.50%. For study indicator 2, the baseline goal was 53.70%, and the baseline result was 51.70%.
EQRO Discussion	Qsource identified three suggestions and two AONs for this PIP study. Suggestions were to include information in all appropriate activities and to ensure consistency in the baseline rate in activities I and VI. The AONs involved the MCO's need to include missing required information in activities IV and VI.
MCNA: Preventive Dental Services	
Validation Status	Met
PIP Type	Clinical
Study Population	*Indicator #1: Preventive dental services* *Numerator: Members from the denominator who received at least one preventive dental service during the reporting year as evidenced by a claim on file with any CDT 1000 – D1999.* *Denominator: Members ages 5-18 as of 12/31 of the reporting year, continuously enrolled at least 90 days during the reporting year.* *Indicator #2: Dental Sealants ages 6-9 (with exclusions)* *Numerator: Members from the denominator who received at least one dental sealant during the reporting year as evidenced by a claim on file with CDT code 1351* *Denominator: Members ages 6-9 as of 12/31 of the reporting year, continuously enrolled at least 90 days during the reporting year.* *Indicator #3: Dental Sealants ages 10-14 (with exclusions)* *Numerator: Members from the denominator who received at least one dental sealant during the reporting year as evidenced by a claim on file with CDT code 1351*

Table 17. Performance Summary for 2019 PIPs	
	Denominator: Members ages 10-14 as of 12/31 of the reporting year, continuously enrolled at least 90 days during the reporting year.
Study Indicator(s)	1. *Preventive Dental Services* 2. *Dental Sealants, ages 6-9 with exclusions* 3. *Dental Sealants, ages 10-14 with exclusions*
Interventions*	As this PIP was rebaselined this year, no interventions were included.
Summary of Performance	MCNA achieved overall validation and critical element scores of 100%.
Measurement Results	For study indicator 1, the baseline goal was 48.91%, and the baseline result was 46.91%. For study indicator 2, the baseline goal was 18.34%, and the baseline result was 16.34%. For study indicator 3, the baseline goal was 14.33%, and the baseline result was 12.33%. Remeasurement results were not included as the study was rebaselined this year.
EQRO Discussion	Qsource identified three strengths related to comprehensive information included in activities I, IV, and VI for this PIP study.
MCNA: Annual Dental Visit (ADV)	
Validation Status	Met
PIP Type	Nonclinical
Study Population	*The study population is enrollees, including those with special health care needs (SHCNs), who meet the following criteria listed below:* - *Member age criteria: Members ages 5-18 years old as of 12/31 of the reporting year* - *Inclusion and or exclusion criteria: N/A* - *Diagnosis, procedure, and/or system codes criteria: N/A* - *Continuous enrollment, new enrollment, and allowable gaps: Members continuously enrolled 12 months during the reporting year with no more than a one month break in coverage. Members must also be actively enrolled on 12/31.*

Table 17. Performance Summary for 2019 PIPs	
Study Indicator(s)	*Annual dental visit (ADV)*
Interventions*	As this is the baseline year for this PIP, no interventions were included.
Summary of Performance	MCNA achieved overall validation and critical element scores of 100%.
Measurement Results	The baseline goal was 61.31%, and the baseline result was 59.31%.
EQRO Discussion	Qsource identified three strengths related to comprehensive information included in activities I, IV, and VI for this PIP study.

** Interventions are provided for the most recent remeasurement year. Further interventions can be found in the individual 2019 PIP Validation Report for each MCO and DBM.*

Strengths and Opportunities for Improvement

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. 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. AONs arise from evaluation elements that receive a Not Met score, indicating that those elements are not in full compliance with CMS protocols. Identified strengths, suggestions, and AONs are provided in **Table 18**.

Table 18. PIP Strengths, Suggestions, and AONs by MCO/DBM			
MCO/DBM	**PIP Title**	**PIP Activity / Element**	**Strength, Suggestion, or AON**
Strengths			
Aetna	Well-Child Visits in the 5th and 6th Years of Life (W34)	Activity VI. Use Valid and Reliable Data Collection Procedures	The MCO provided a flowchart describing administrative data algorithms.

Table 18. PIP Strengths, Suggestions, and AONs by MCO/DBM			
MCO/DBM	**PIP Title**	**PIP Activity / Element**	**Strength, Suggestion, or AON**
		Activity VII. Analyze Data and Interpret Study Results	The MCO had a very detailed data analysis plan and demonstrated awareness of factors that could have impacted results.
Argus	Children Receiving Preventive Dental Services	Activity I. Choose the Selected Study Topic(s)	The DBM provided comprehensive, relevant research on the study topic, along with national- and state-level data analysis.
DentaQuest	Preventive Dental Services	Activity I. Choose the Selected Study Topic(s)	The DBM provided comprehensive, relevant research on the study topic.
MCNA	Preventive Dental Services	Activity I. Choose the Selected Study Topic(s)	The DBM provided comprehensive, relevant research on the study topic.
		Activity IV. Select the Study Indicators	The DBM addressed most elements of this activity comprehensively.
		Activity VI. Use Valid and Reliable Data Collection Procedures	The DBM addressed each element of this activity in appropriate and comprehensive detail.

Table 18. PIP Strengths, Suggestions, and AONs by MCO/DBM			
MCO/DBM	**PIP Title**	**PIP Activity / Element**	**Strength, Suggestion, or AON**
	Annual Dental Visit (ADV)	Activity I. Choose the Selected Study Topic(s)	The DBM provided comprehensive, relevant research on the study topic.
		Activity IV. Select the Study Indicators	The DBM addressed most elements of this activity comprehensively.
		Activity VI. Use Valid and Reliable Data Collection Procedures	The DBM addressed the elements of this activity in appropriate and comprehensive detail.
Simply Healthcare	Improving Well-Child Visits in the 5th and 6th Years of Life	Activity I. Choose the Selected Study Topic(s)	The potential impact of the study topic on enrollee health and functional status was clearly described.
		Activity VI. Use Valid and Reliable Data Collection Procedures	The MCO addressed the majority of this activity in detail and provided comprehensive supporting documentation. The MCO provided its HEDIS Record of Administrative Data Management and Processes (Roadmap), which included administrative data algorithms.

Table 18. PIP Strengths, Suggestions, and AONs by MCO/DBM			
MCO/DBM	**PIP Title**	**PIP Activity / Element**	**Strength, Suggestion, or AON**
		Activity VIII. Include Improvement Strategies	The MCO addressed most of this activity in detail and provided comprehensive supporting documentation.
	Care Coordination to Improve Follow-up Care for Children Prescribed ADHD Medication (ADD)	Activity I. Choose the Selected Study Topic(s)	The MCO included an analysis of the ethnic distribution of its membership to address any racial and cultural impacts on the study topic in the future.
UnitedHealthcare	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34)	Activity I. Choose the Selected Study Topic(s)	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.
		Activity III. Use a Representative and Generalizable Study Population	The study population was described in detail and included appropriate HEDIS Technical Specifications for the W34 measure.

Table 18. PIP Strengths, Suggestions, and AONs by MCO/DBM			
MCO/DBM	**PIP Title**	**PIP Activity / Element**	**Strength, Suggestion, or AON**
		Activity VI. Use Valid and Reliable Data Collection Procedures	The MCO addressed the majority of this activity in detail and provided comprehensive supporting documentation.
		Activity VII. Analyze Data and Interpret Study Results	The data analysis plan and its implementation were comprehensive. Demographic subgroup analysis addressed the dynamics of the measurements. Graphical presentation of results was exceptional and facilitated interpretation.
		Activity VIII. Include Improvement Strategies	The MCO's description of improvement strategies and analysis of results was exceptionally well documented.
	Improving Follow-Up Care for Children Prescribed ADHD Medication (ADD): Initiation Phase	Activity I. Choose the Selected Study Topic(s)	The MCO included detailed, comprehensive research to support the relevance of the study topic.

Table 18. PIP Strengths, Suggestions, and AONs by MCO/DBM			
MCO/DBM	**PIP Title**	**PIP Activity / Element**	**Strength, Suggestion, or AON**
Suggestions			
Argus	Access and Availability of Services – Enrollee Satisfaction	Activity II: Define the Study Question(s)	The DBM could combine the two study questions into one question.
		Activity IV: Select the Study Indicators	The DBM could include the claims/encounter data availability for the Any Dental Services measure in this activity.
DentaQuest	Preventive Dental Services	Activity VI. Use Valid and Reliable Data Collection Procedures	For a more specific rate, the DBM could substantiate the estimated data completeness rate using incurred but not reported (IBNR) methodology.
	Access & Availability/Non-Compliant Geo Directory	Activity I. Choose the Selected Study Topic(s)	The DBM could include information about eligible populations that meet the study criteria in this activity.
		Activity IV. Select the Study Indicators	The DBM could ensure that the baseline rate cited in Activity 1 (51.86%) is consistent with the baseline rate in this activity (51.7%) and include the data source

Table 18. PIP Strengths, Suggestions, and AONs by MCO/DBM			
MCO/DBM	**PIP Title**	**PIP Activity / Element**	**Strength, Suggestion, or AON**
			for each indicator in this activity.
Simply Healthcare	Improving Well-Child Visits in the 5th and 6th Years of Life	Activity IV. Select the Study Indicators	The MCO could describe how the study indicator measures changes in health or functional status in this activity.
		Activity VII. Analyze Data and Interpret Study Results	While it was described in activities IV and VI, the MCO could document how the study indicator would be calculated (i.e., HEDIS-certified software) in this activity.
		Activity VIII. Include Improvement Strategies	The MCO could have included the driver diagram from Activity IV in this activity as it relates to barriers to interventions. The MCO also could include a description of PDSA processes and results for intervention(s) for which PDSA was conducted.
		Activity X. Assess for Sustained Improvement	The MCO could address statistically significant improvement over

Table 18. PIP Strengths, Suggestions, and AONs by MCO/DBM			
MCO/DBM	**PIP Title**	**PIP Activity / Element**	**Strength, Suggestion, or AON**
			remeasurement periods, variations between time periods, and statistical testing between remeasurement periods in this activity.
Staywell	Improving Rate of Well Child Care Visits for 5 and 6 year olds	Activity VIII. Include Improvement Strategies	The MCO could confirm that all interventions implemented over the life of the PIP through 2018 are included in this activity. The MCO could include a description of PDSA processes and results for intervention(s) for which PDSA activities were conducted.
Sunshine	Well-Child Visits in the Fifth and Sixth Years of Life	Activity IV. Select the Study Indicators	The MCO could describe how the study indicator measures changes in enrollee health and functional status and include the claims/encounter data available for collection in this activity.
		Activity I. Choose the Selected Study Topic(s)	The MCO could include more historical data prior to

Table 18. PIP Strengths, Suggestions, and AONs by MCO/DBM

MCO/DBM	PIP Title	PIP Activity / Element	Strength, Suggestion, or AON
	Follow up after hospitalization for mental illness		the HEDIS 2018 rate for the indicator to strengthen support of the study topic's relevance. The MCO also could explain the criteria for enrollees' inclusion in the study and state that enrollees with special healthcare needs are not excluded from the study in this activity.
		Activity II. Define the Study Question(s)	The MCO could consider referring only to "targeted interventions" in the study question instead of naming specific interventions, as interventions can change over the life of the PIP.
		Activity III. Use a Representative and Generalizable Study Population	The MCO could define requirements for continuous enrollment, new enrollment, and allowable gaps in enrollment in the MCO in this activity.
		Activity IV. Select the Study Indicators	The MCO could include the study indicator title and description as well as explain the

Table 18. PIP Strengths, Suggestions, and AONs by MCO/DBM			
MCO/DBM	**PIP Title**	**PIP Activity / Element**	**Strength, Suggestion, or AON**
			claims/encounter data available for collection in this activity.
		Activity VI. Use Valid and Reliable Data Collection Procedures	The MCO could address the relatively low estimated degree of data completeness.
AONs			
Aetna	Well-Child Visits in the 5th and 6th Years of Life (W34)	Activity VI. Use Valid and Reliable Data Collection Procedures	The MCO should provide an overview of the study itself in the written instructions or as an attachment to the instructions for manual data abstraction.
Argus	Access and Availability of Services – Enrollee Satisfaction	Activity VI: Use Valid and Reliable Data Collection Procedures	The DBM should include the basis for the Any Dental Services data completeness estimate.
DentaQuest	Preventive Dental Services	Activity IV. Select the Study Indicators	The DBM should address the source of data available for measurement of each study indicator (e.g., dental administrative claims data include all necessary elements to calculate the indicator).

Table 18. PIP Strengths, Suggestions, and AONs by MCO/DBM			
MCO/DBM	**PIP Title**	**PIP Activity / Element**	**Strength, Suggestion, or AON**
	Access & Availability/Non-Compliant Geo Directory	Activity IV. Select the Study Indicators	The DBM should specifically define the benchmark rate (noted as the national benchmark).
		Activity VI. Use Valid and Reliable Data Collection Procedures	The DBM should include the appropriate systematic process for data collection for the Any Dental Services study indicator.
Staywell	Improving Rate of Well Child Care Visits for 5 and 6 year olds	Activity VII. Analyze Data and Interpret Study Results	The MCO should identify factors that threaten internal or external validity of findings and those that could affect the ability to compare the initial measurement with the remeasurement.
Sunshine	Well-Child Visits in the Fifth and Sixth Years of Life	Activity VII. Analyze Data and Interpret Study Results	The MCO should address any factors that affect the ability to compare the initial measurement with remeasurements. The MCO also should address an interpretation of the study's success to date.
		Activity IX. Assess for Real Improvement	The MCO should assess improvements in processes

Table 18. PIP Strengths, Suggestions, and AONs by MCO/DBM

MCO/DBM	PIP Title	PIP Activity / Element	Strength, Suggestion, or AON
			or outcomes of care, determine if improvements appear to be the result of interventions, and provide statistical evidence that observed improvement is true improvement.
		Activity X. Assess for Sustained Improvement	The MCO should assess whether repeated measurements over comparable time periods are indicative of sustained improvement.
	Follow up after hospitalization for mental illness	Activity IV. Select the Study Indicators	The MCO should explain how the study indicator measures changes in enrollee health or functional status.
		Activity VI. Use Valid and Reliable Data Collection Procedures	The MCO should specifically describe an appropriate method for the estimation of data completeness.
UnitedHealthcare	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34)	Activity VI. Use Valid and Reliable Data Collection Procedures	The MCO should provide evidence that an overview of the PIP study is included in the training for medical record abstractors.

Plan-Do-Study-Act

Assessment Background

In addition to the 10-step PIP evaluation and validation outlined in CMS's *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. For Q2, the Plan-Do activities were reevaluated with the Study-Act submissions, and the reports included all four PDSA cycles. Evaluation included scoring elements for each activity as Met, Opportunity, or Not Assessed (NA).

Description of Data Obtained

Table 19 summarizes the four PDSA activities and elements.

Table 19. 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 ♦ 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 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. 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. Identified strengths and suggestions by individual MCO/DBM and by PIP study for Q1 and Q2 combined are provided in **Table 20**.

Table 20. PDSA Strengths and Suggestions by MCO/DBM

MCO/DBM	PIP Title	PDSA Activity	Strength or Suggestion
Strengths			
Aetna	Follow-Up After Hospitalization for Mental Illness (FUH)	Plan	The project plan included a process measure to drive improvement interventions. The driver diagram was very comprehensive and resulted in a number of relevant change ideas. The change ideas were described in detail, are provider focused, and address critical issues in driving improvement for this measure.
		Do	The test of change was implemented in a limited geographic area, which allows for analysis of the change's success and potential spread to other areas.
Argus	Preventive Dental Services	Plan	The project plan demonstrated principles of continuous, rapid-cycle improvement.
		Do	The outreach call campaign was revised to target all new enrollees within five days of receipt of enrollment files (rather than only those with gaps in

Table 20. PDSA Strengths and Suggestions by MCO/DBM			
MCO/DBM	**PIP Title**	**PDSA Activity**	**Strength or Suggestion**
			care) and was implemented to improve the potential success of the intervention.
		Study	Outcome measure results were provided in graphical format for ease of interpretation.
	Enrollee Satisfaction with Access	Plan	The survey-based study is an innovative approach to address enrollee satisfaction as it relates to access to services.
DentaQuest	Preventive Dental Services	Plan	The selected change idea applied to a select number of counties, allowing for testing on a limited basis and potential future spread of the intervention based on results of the initial test.
		Study	PDSA principles were incorporated well, with a limited change test implemented quickly and monitored promptly, resulting in a rapid-cycle decision to abandon an ineffective intervention.
	Access and Availability	Plan	The selected change idea applied to a select number of counties, allowing for testing on a limited basis and potential future spread of the intervention based on results of the initial test.
		Study	PDSA principles were incorporated well, with a limited change test implemented quickly and monitored promptly, resulting in a rapid-cycle decision to abandon an ineffective intervention.

Table 20. PDSA Strengths and Suggestions by MCO/DBM			
MCO/DBM	**PIP Title**	**PDSA Activity**	**Strength or Suggestion**
MCNA	Preventive Dental Services	Plan	The description of the aim and measures was very comprehensive. Planning for this quarter 1 PDSA cycle was evident. The test was appropriately implemented, and result data were collected for this quarter 1 PDSA cycle.
		Study	The graphs of rate results over time were exceptional and very informative.
	Annual Dental Visit	Plan	Planning for this quarter 1 PDSA cycle was evident.
		Do	The test was appropriately implemented, and result data were collected for this quarter 1 PDSA cycle.
		Study	The graphs of rate results over time were exceptional and very informative.
Simply Healthcare	Well-Child Visits (W34)	Plan	The driver diagram demonstrated a clear understanding of the variables impacting the study aim and resulted in identification of appropriate change ideas.
	Follow-up Care for Children Prescribed ADHD Medication (ADD)	Plan	The driver diagram demonstrated a clear understanding of the variables impacting the study aim and resulted in identification of appropriate change ideas. The change idea selected is innovative and provider focused.
		Study	Measure results were presented by provider, in addition to the overall results. The observations and lessons learned were comprehensive and

Table 20. PDSA Strengths and Suggestions by MCO/DBM			
MCO/DBM	**PIP Title**	**PDSA Activity**	**Strength or Suggestion**
			reflected an improved understanding of the study overall.
Sunshine	Well-Child Visits (W34)	Plan	The driver diagram was very comprehensive and relevant to the project topic.
	Follow-Up After Hospitalization for Mental Illness (FUH)	Plan	The driver diagram was very comprehensive and relevant to the project topic. The selected change idea is innovative. The project plan demonstrated a clear understanding of PDSA principles and how to put them into practice.
		Do	Both elements in this activity were addressed concisely and included the required components. A clear understanding of PDSA principles and how to put these into practice was evident in this activity.
		Study	Further follow-up to determine factors affecting success of the intervention was completed.
		Act	The plan for the next PDSA cycle included relevant tasks from lessons learned from the test.
UnitedHealthcare	Well-Child Visits (W34)	Plan	A clear understanding of PDSA principles was noted in the following: the aim of the project included a short-term goal; the change idea selected was limited to one region, allowing for evaluation of success of the intervention and potential spread based on test results; and collection of data on process measures was well described.

Table 20. PDSA Strengths and Suggestions by MCO/DBM			
MCO/DBM	**PIP Title**	**PDSA Activity**	**Strength or Suggestion**
		Study	The graphs of rate results over time were exceptional and very informative.
	Follow-up Care for Children Prescribed ADHD Medication (ADD)	Plan	A clear understanding of PDSA principles was noted in the following: the aim of the project included a short-term goal, the change idea selected was innovative in terms of using pharmacy data to identify behavioral health prescribers, and collection of data on process measures was well described.
		Do	A clear understanding of PDSA principles was noted in this activity.
		Study	The graphs of rate results over time were exceptional and very informative. Lessons learned were valuable for adapting the change test.
		Act	Adaptations to the change test were clearly developed from lessons learned.
Suggestions			
Aetna	Well-Child Visits (W34)	Plan	Monthly monitoring of the number and status of outreach calls (described in element 5) should be specifically referenced as a process measure in element 2.
		Study	Since the change test was implemented in May 2019, it may have been possible to provide results from the months of May and June, particularly results of the process measure (outreach success and lessons learned).

Table 20. PDSA Strengths and Suggestions by MCO/DBM			
MCO/DBM	**PIP Title**	**PDSA Activity**	**Strength or Suggestion**
Argus	Preventive Dental Services	Plan	Factors that influence indicator rates should be included in the primary and secondary driver section of the driver diagram. Element 5 should only include the actual change idea implemented and the rationale for selection of this change idea. Monitoring of outreach call completion rates, a process measure, should be defined under element 2 of this activity. The sustainability plan should reference all required components.
		Do	Additional detail on how the change tests were actually implemented should be included.
		Act	The sustainability plan should reference all required components.
	Enrollee Satisfaction with Access	Plan	For the aim, a numeric rate for the desired outcome (enrollee satisfaction) and timeframe for achievement based on survey question (indicator) scores should be developed. For the study measures, how improvement will be demonstrated (change in survey question scores) should be discussed. In addition, using the survey response rate as a process measure should be considered. The driver diagram should be updated to include appropriate information for the aim, primary and secondary drivers, and change ideas. The data collection process description should include the survey method and the number of survey attempts

Table 20. PDSA Strengths and Suggestions by MCO/DBM			
MCO/DBM	**PIP Title**	**PDSA Activity**	**Strength or Suggestion**
			planned. The sustainability plan should reference all required components.
		Act	The sustainability plan should reference all required components.
MCNA	Preventive Dental Services	Plan	The sustainability plan should reference all required components.
		Study	General observations regarding the implementation of the change test could be useful, e.g. successful components of the change test and whether any barriers were encountered.
		Act	The sustainability plan should reference all required components.
	Annual Dental Visit	Plan	The sustainability plan should reference all required components.
		Study	General observations regarding the implementation of the change test could be useful, e.g. successful components of the change test and whether any barriers were encountered.
		Act	The sustainability plan should reference all required components.
Simply Healthcare	Well-Child Visits (W34)	Plan	The sustainability plan should reference all required components.
		Study	The low volume of participation in the Clinic Day Program should be addressed.

Table 20. PDSA Strengths and Suggestions by MCO/DBM			
MCO/DBM	**PIP Title**	**PDSA Activity**	**Strength or Suggestion**
		Act	If change tests were to be adapted, those modifications should be discussed. The sustainability plan should reference all required components. The plan for the next cycle should also include test modifications.
	Follow-up Care for Children Prescribed ADHD Medication (ADD)	Plan	The sustainability plan should reference all required components.
		Act	Potential adaptations to the change test should be considered, based on the lessons learned and observations from the study phase. The sustainability plan should reference all required components.
Staywell	Well-Child Visits (W34)	Plan	The aim of the project should be updated to include an achievable goal, numeric rate for outcome, and specific timeframe for achievement. Process results being tracked should be defined as process measures in element 2. The number of change ideas selected should be more limited to better focus on PDSA activities. The sustainability plan should reference all required components.
		Do	The changes for this PDSA cycle should have been implemented in the first quarter of 2019 and should have been based on an analysis of the prior year intervention results with appropriate revisions to the interventions, as necessary. Similarly, results should be based on first quarter 2019 interventions.

Table 20. PDSA Strengths and Suggestions by MCO/DBM			
MCO/DBM	**PIP Title**	**PDSA Activity**	**Strength or Suggestion**
		Study	Process measure results should be reported and analyzed.
		Act	The sustainability plan should reference all required components.
	Monitoring for Children and Adolescents on Anti-Psychotics	Plan	The aim of the project should be updated to include an achievable goal, numeric rate for outcome, and specific timeframe for achievement. The number of change ideas selected should be more limited to better focus on PDSA activities. The sustainability plan should reference all required components.
		Do	The changes for this PDSA project should have been implemented in the first quarter of 2019. Similarly, results should be based on first quarter 2019 interventions.
		Study	Both outcome and process measure results should be analyzed. Lessons learned from the implementation of the intervention should be described.
		Act	The action to be taken should be directly related to measure results and lessons learned. The sustainability plan should reference all required components. A general plan for the next PDSA cycle should be described.
Sunshine	Well-Child Visits (W34)	Plan	The process measures described in element 6 should be identified in element 2 as well. The

Table 20. PDSA Strengths and Suggestions by MCO/DBM

MCO/DBM	PIP Title	PDSA Activity	Strength or Suggestion
			sustainability plan should reference all required components.
		Do	The implementation and results of the Provider Education test for the first quarter of 2019 should be addressed. If the test was not conducted during this Plan-Do cycle, it should be deleted from element 5 under the "Plan" activity.
		Study	Process and outcome measures should be presented graphically to enhance analysis. Resolution of outcome measure reporting issues should be discussed in the lessons learned.
		Act	Actions to resolve outcome reporting issues should be included. The sustainability plan should reference all required components. The plan for the next PDSA cycle should include additional detail based on experience with this PDSA cycle.
	Follow-Up After Hospitalization for Mental Illness (FUH)	Plan	The sustainability plan should reference all required components.
		Act	The sustainability plan should reference all required components.
UnitedHealthcare	Well-Child Visits (W34)	Plan	The process measures noted in element 6 should also be defined in element 2. The outcome measure should be included in element 6. The sustainability plan should reference all required components.

Table 20. PDSA Strengths and Suggestions by MCO/DBM			
MCO/DBM	**PIP Title**	**PDSA Activity**	**Strength or Suggestion**
		Act	The sustainability plan should reference all required components.
	Follow-up Care for Children Prescribed ADHD Medication (ADD)	Plan	The process measure noted in element 6 should also be defined in element 2. The outcome measure should be included in element 6. The sustainability plan should reference all required components.
		Act	The sustainability plan should reference all required components.

Validation of Encounter Data (EDV)

Assessment Background

FHKC contracted with Qsource to conduct one optional activity, Validation of Encounter Data. CMS encourages the use of EQROs to validate encounter data to ensure that data used for activities related to payments and delivery of care are valid and reliable. 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

The 2019 quarter 1 (Q1) EDV report submission addressed claims and encounter data with service dates between October 1 and December 31, 2018, for all claims and encounters adjudicated between October 1, 2018, and March 31, 2019 (to address claim payment lag). The Q2 report submission included claims and encounter data with service dates between January 1 and March 31, for all claims and encounters adjudicated between January 1 and June 30, 2019 (to address claim payment lag). The Q3 report addressed claims and encounter data with service dates between April 1 and June 30, 2019, for all claims and encounters adjudicated between April 1 and September 30, 2019 (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-facility 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 2019, examining encounter and claims processing for measurement year 2018. 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 facility 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" (CMS's *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 21**.

Table 21. 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
Billed Units	Numbers
Admission Date (Facility Only)	Valid date
Service Start Date (Professional Only)	Valid date
Billing Provider National Provider Identifier (NPI)	Valid length, numbers
DBMs	
Recipient ID	Valid length, numbers
Plan ID	Plan's ID

Table 21. Validation Techniques for MCO and DBM Claims and Encounter Data	
Field	**Data Test for Validity**
Billing Provider NPI	Valid length, numbers
Service Date	Valid date
Procedure Code	Valid code
Tooth ID or Area ID	Valid ID

Findings

For EDV Activity 2, review of data production capacity, all five MCOs and all three 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.

Completeness and Validity

Table 22 includes completeness and validity rates of medical facility claims for all MCOs in aggregate for 2018 Q4, 2019 Q1, and 2019 Q2 dates of service. Scores between 90.0% and 99.99% are identified in **green**; there were no scores below 90.0%.

Table 22. Completeness and Validity Rates for All MCOs—Medical Facility Claims						
	2018 Q4 Dates of Service		2019 Q1 Dates of Service		2019 Q2 Dates of Service	
Field	**Completeness Rate**	**Validity Rate***	**Completeness Rate**	**Validity Rate***	**Completeness Rate**	**Validity Rate***
	N=177,316		N=159,390		N=175,287	
Recipient ID	**99.94%**	**97.12%**	**99.87%**	**96.05%**	100%	**97.12%**
Gender	100%	100%	100%	100%	100%	100%
Plan ID	100%	100%	100%	100%	100%	**99.99%**
Principal Diagnosis	100%	100%	100%	100%	**99.99%**	100%
Billed Units	100%	100%	100%	100%	100%	100%
Admission Date	**92.02%**	100%	**91.12%**	100%	**90.37%**	100%
Billing Provider NPI	**98.55%**	100%	**98.32%**	100%	**98.33%**	100%

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

Table 23 includes completeness and validity rates of medical professional claims for all MCOs in aggregate for 2018 Q4, 2019 Q1, and 2019, Q2, and Q3 dates of service. Scores between 90.0% and 99.99% are identified in **green**; there were no scores below 90.0%.

Table 23. Completeness and Validity Rates for All MCOs—Medical Professional Claims

	2018 Q4 Dates of Service		2019 Q1 Dates of Service		2019 Q2 Dates of Service	
Field	**Completeness Rate**	**Validity Rate***	**Completeness Rate**	**Validity Rate***	**Completeness Rate**	**Validity Rate***
	N=705,593		**N=727,293**		**N=720,965**	
Recipient ID	**99.87%**	**95.86%**	**99.78%**	**95.45%**	**99.49%**	**96.21%**
Gender	100%	100%	100%	**99.99%**	100%	**99.99%**
Plan ID	100%	**99.99%**	100%	100%	100%	100%
Principal Diagnosis	100%	**99.99%**	100%	100%	100%	100%
Billed Units	100%	100%	100%	100%	100%	100%
Service Start Date	100%	100%	100%	100%	100%	100%
Billing Provider NPI	**94.05%**	100%	**93.27%**	100%	**94.55%**	**99.99%**

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

Table 24 includes completeness and validity rates of medical professional encounters for all MCOs in aggregate for 2018 Q4, 2019 Q1, and 2019 Q2 dates of service. Scores between 90.0% and 99.99% are identified in **green**; there were no scores below 90.0%.

Table 24. Completeness and Validity Rates for All MCOs—Medical Professional Encounters

	2018 Q4 Dates of Service		2019 Q1 Dates of Service		2019 Q2 Dates of Service	
Field	**Completeness Rate**	**Validity Rate***	**Completeness Rate**	**Validity Rate***	**Completeness Rate**	**Validity Rate***
	N=115,071		**N=103,761**		**N=83,222**	
Recipient ID	**99.87%**	**99.99%**	**99.83%**	100%	**99.50%**	100%

Table 24. Completeness and Validity Rates for All MCOs—Medical Professional Encounters						
	2018 Q4 Dates of Service		2019 Q1 Dates of Service		2019 Q2 Dates of Service	
Field	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
	N=115,071		N=103,761		N=83,222	
Gender	100%	100%	100%	100%	100%	100%
Plan ID	100%	100%	100%	100%	100%	**99.99%**
Principal Diagnosis	100%	100%	100%	100%	100%	100%
Billed Units	100%	100%	100%	100%	100%	100%
Service Start Date	100%	100%	100%	100%	100%	100%
Billing Provider NPI	**94.65%**	100%	**99.78%**	100%	**99.17%**	100%

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

As demonstrated in **tables 22** through **24**, MCO rates were very consistent across 2018 Q4, 2019 Q1, and 2019 Q2 dates of service, with Admission Date for medical facility claims being the least completed data field. The validity rates for Recipient ID for medical facility and professional claims were also consistently lower than those for other data fields across all three quarters. In addition, Billing Provider NPI data were not complete for medical facility claims, medical professional claims, and medical professional encounters.

Table 25 includes completeness and validity rates for all DBMs in aggregate for 2018 Q4, 2019 Q1, and 2019 Q2 dates of service. Scores between 90.0% and 99.99% are identified in **green**; there were no scores below 90.0%.

Table 25. Completeness and Validity Rates for All DBMs						
	2018 Q4 Dates of Service		2019 Q1 Dates of Service		2019 Q2 Dates of Service	
Field	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
	N=384,854		N=363,369		N=362,396	
Recipient ID	**99.45%**	**99.99%**	**99.36%**	**99.99%**	**99.42%**	**99.99%**
Plan ID	100%	100%	100%	100%	100%	100%
Billing Provider NPI	**99.95%**	100%	**99.95%**	100%	**99.86%**	100%
Service Date	100%	100%	100%	100%	100%	100%
Procedure Code	**99.82%**	100%	**99.88%**	100%	**99.86%**	100%
Tooth ID or Area ID**	**60.33%**	NA	**60.48%**	NA	**60.42%**	NA

** Valid Rates are those deemed accurate of records determined complete.*
*** Not Applicable: The Tooth ID or Area ID is not required for all dental procedure codes; thus, the validity rate was not calculated.*

As shown in **Table 25**, DBM rates were very consistent across 2018 Q4, 2019 Q1, and 2019 Q2 dates of service, with completeness and validity rates above 99.0% for all fields except Tooth ID or Area ID, which is not required for all dental procedure codes. A lower rate would be expected for this data field, and the validity rate was not calculated.

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 26) and volume of records relative to MCO/DBM enrollment (Table 27), 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, and average time for claims processing based on claim receipt date (Table 28), average lines per claim (Table 29), and average number of claims/encounter lines per enrollee who received services (Table 30). Table 26 includes total claims and encounters submitted by all MCOs and DBMs for 2018 Q4, 2019 Q1, and 2019 Q2 dates of service.

Table 26. Total Claims and Encounters Submitted by MCOs and DBMs				
Total Records (N=1,320,030)				
2018 Q4 Dates of Service	**Claims** N (% of MCO Total)		**Encounters**	**Total**
	Facility	**Professional**	**Professional**	
Total MCOs	177,316 (20.08%)	705,593 (79.92%)	115,071	997,994
Total DBMs				322,036
Total Records (N=1,353,813)				
2019 Q1 Dates of Service	**Claims** N (% of MCO Total)		**Encounters**	**Total**
	Facility	**Professional**	**Professional**	
Total MCOs	159,390 (17.98%)	727,293 (82.02%)	103,761	990,444
Total DBMs				363,369
Total Records (N=1,341,890)				
2019 Q2 Dates of Service	**Claims** N (% of MCO Total)		**Encounters**	**Total**
	Facility	**Professional**	**Professional**	
Total MCOs	175,287 (19.56%)	720,965 (80.44%)	83,222	979,494
Total DBMs				362,396

As would be expected, consistency was a key finding across all three quarters, both in total records between MCOs and DBMs, and in the percentage of facility and professional claims for the MCOs. Table 27 includes the percentage of enrollment versus claims and encounter data by MCO and DBM for 2018 Q4, 2019 Q1, and 2019 Q2 dates of service.

Table 27. Percentage of Enrollment Versus Claims and Encounter Data by MCO/DBM						
MCO	**2018 Q4 Dates of Service**		**2019 Q1 Dates of Service**		**2019 Q2 Dates of Service**	
	% Enrollment	**% Claims & Encounters**	**% Enrollment**	**% Claims & Encounters**	**% Enrollment**	**% Claims & Encounters**
Aetna	23.11%	22.61%	25.35%	24.53%	25.30%	22.25%
Simply Healthcare	25.35%	23.52%	25.83%	23.39%	25.62%	23.24%
Staywell	37.58%	41.50%	37.15%	39.63%	37.17%	41.06%
Sunshine	9.80%	9.14%	7.39%	9.20%	7.67%	10.16%
UnitedHealthcare	4.16%	3.23%	4.28%	3.26%	4.24%	3.29%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
DBM	**% Enrollment**	**% Claims & Encounters**	**% Enrollment**	**% Claims & Encounters**	**% Enrollment**	**% Claims & Encounters**
Argus	19.00%	19.03%	21.06%	18.78%	21.24%	18.61%
DentaQuest	45.79%	44.08%	41.91%	42.88%	42.22%	43.33%
MCNA	35.20%	36.89%	37.03%	38.34%	36.53%	38.06%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

As demonstrated in **Table 27**, and as would be expected, percentages of enrollment and claims and encounters were consistent for individual MCOs and DBMs across all three quarters as well as among the MCOs and DBMs for each quarter.

Table 28 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 2018 Q4, 2019 Q1, and 2019 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. While the average number of days until payment for MCO professional and facility claims and DBM claims fluctuated somewhat from quarter to quarter, the rates were consistent with expectations for time between dates of service, discharge, or claim receipt and date of payment.

Table 28. Total Average Number of Days from Date of Service/Date of Discharge/Date of Claim Receipt 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	25	26
Q2 Dates of Service	28	22
Q3 Dates of Service	21	30
DBMs	Avg. Days from Date of Claim Receipt to Date of Payment	
Q1 Dates of Service	14	
Q2 Dates of Service	13	
Q3 Dates of Service	9	

Table 29 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 for 2018 Q4, 2019 Q1, and 2019 Q2 dates of service. Again, consistency across quarters was a key finding for MCO facility and professional claims, DBM claims, and MCO encounters.

Table 29. 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	125,442	30,627	4.10	613,835	275,152	2.23
Q2 Dates of Service	159,390	33,154	4.72	727,293	307,231	2.43
Q3 Dates of Service	175,287	35,010	4.86	720,965	293,843	2.50

Table 29. Average Number of Lines per Claim—MCOs and DBMs and Average Number of Lines per Encounter—MCOs			
DBMs	Lines	Claims	Average Lines per Claim
Q1 Dates of Service	306,308	66,033	4.67
Q2 Dates of Service	363,369	74,560	4.90
Q3 Dates of Service	362,396	75,644	4.82
Encounters			
MCOs	Lines	Claims	Average Lines per Claim
Q1 Dates of Service	93,406	19,878	4.70
Q2 Dates of Service	103,761	18,627	4.79
Q3 Dates of Service	83,222	15,552	4.99

Table 30 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 for 2018 Q4, 2019 Q1, and 2019 Q2 dates of service. Aside from some slight fluctuation between quarters for the MCO facility and professional claims, average lines per enrollee who received services were consistent and within expectations.

Table 30. 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	125,442	21,003	5.97	613,835	102,546	5.99

Table 30. 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						
Q2 Dates of Service	159,390	22,007	7.30	727,293	101,780	7.17
Q3 Dates of Service	175,287	21,918	7.86	720,965	101,318	7.19

DBMs	Claim Lines	Enrollees	Average Lines per Enrollee Who Received Services
Q1 Dates of Service	306,308	46,752	6.58
Q2 Dates of Service	363,369	50,962	7.17
Q3 Dates of Service	362,396	50,742	7.20
Encounters			
MCOs	Encounter Lines	Enrollees	Average Lines per Enrollee Who Received Services
Q1 Dates of Service	93,406	14,575	6.41
Q2 Dates of Service	103,761	12,940	6.86
Q3 Dates of Service	83,222	11,325	6.71

Conclusions and Recommendations

Strengths

Overall, FHKC's MCOs and DBMs continued to demonstrate dedication to providing Florida Healthy Kids enrollees high-quality services by complying with regulatory and contractual standards, adhering to requirements for reporting national and state performance measures, and designing studies with the aim of achieving significant and sustained improvement in clinical and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

ANA

For the 2019 ANA, the four MCOs that were accountable to both FHKC contract and CFR provisions demonstrated a strength in providing required access to 11 of 13 provider/specialty types for over 90.0% of their urban enrollees. The DBMs exhibited a shared strength as well, providing access to primary care dentists according to required standards for over 90.0% of their urban and rural enrollees. In addition, the majority of DBM urban enrollees had access to orthodontists and dental specialists. Held accountable to access standards in its FHKC contract but not those in CFR provisions, Sunshine provided access to primary medical providers for 99.82% of its enrollees and to specialty care medical providers for 100% of its enrollees. Finally, all MCOs and DBMs demonstrated provider manuals and enrollee handbooks that included appropriate appointment availability standards. No other strengths were identified for the MCOs and DBMs.

ACA

For the 2019 ACA, Qsource evaluated three ACA standards: Coverage and Authorization of Services, Coordination and Continuity of Care, and Subcontractual Relationships and Delegation. In addition, UM denial file reviews were conducted. The MCOs and DBMs demonstrated the following:

Aetna

Qsource noted strengths for seven elements for Aetna across all three standards, some of which highlighted the MCO's internal timeframes that were stricter than timeframes required by CFR and/or FHKC contract provisions.

Simply Healthcare

Qsource noted strengths for eight elements for Simply Healthcare across all three standards, including several highlighting the MCO's internal timeframes that were stricter than timeframes required by CFR and/or FHKC contract provisions, robust processes, and a best-practice vendor oversight program.

Staywell

Qsource noted strengths for 10 elements for Staywell across all three standards, including several highlighting the MCO's internal timeframes that were stricter than timeframes required by CFR and/or FHKC contract provisions, robust processes, and a best-practice vendor oversight program.

Sunshine

Qsource noted one strength for Sunshine, the MCO evaluated by FHKC contract provisions only. One of its timeframes related to authorization decisions well exceeded the contract requirement.

UnitedHealthcare

Qsource noted strengths for 11 elements for UnitedHealthcare across all three standards, including several highlighting the MCO's internal timeframes that were stricter than timeframes required by CFR and/or FHKC contract provisions, comprehensive information, and an internal toolkit for vendor oversight.

Argus

In the Coverage and Authorization of Services standard, Qsource noted strengths for five elements for Argus, including several highlighting the DBM's internal timeframes that were stricter than timeframes required by CFR and/or FHKC contract provisions and comprehensive staff training.

DentaQuest

In the Coverage and Authorization of Services standard, Coverage and Authorization of Services, Qsource noted strengths for four elements for DentaQuest, including a couple highlighting comprehensive staff training and the DBM's internal timeframes that were stricter than timeframes required by CFR and/or FHKC contract provisions.

MCNA

Qsource noted one strength for MCNA. The DBM's Clinical Review Analyst dentist collaborated with the Quality Department on an ongoing basis to ensure the most up-to-date medical necessity criteria were used.

PMV

The MCOs and DBMs demonstrated the following for the 2019 PMV:

MCOs

While no individual MCO strengths were noted by Qsource, the MCOs were compliant with all NCQA-defined IS Standards for HEDIS-applied data and processes and prepared performance measures in accordance with appropriate HEDIS and AHCA MMA technical specifications.

Argus

Argus was noted as being well prepared for the onsite review and commended for its consistent performance across required dental measures.

DentaQuest

DentaQuest's Windward system capabilities for data collection and reporting, its organizational reporting process, and its staff knowledge were all highlighted as strengths.

MCNA

MCNA's DentalTrac system was noted as an excellent, unique, comprehensive internally developed system.

PIPs

Sixteen PIPs were selected for validation for 2019, with 14 of them achieving a Met validation status and two achieving a Not Met validation status. The MCOs and DBMs demonstrated the following:

Aetna

Qsource identified strengths for two activities for Aetna's clinical PIP: Activity VI, Use Valid and Reliable Data Collection Procedures; and Activity VII, Analyze Data and Interpret Study Results.

Simply Healthcare

Simply demonstrated strengths for both its clinical and its nonclinical PIP for Activity I, Choose the Selected Study Topic(s). The MCO also had strengths for Activity VI, Use Valid and Reliable Data Collection Procedures; and Activity VIII, Include Improvement Strategies, for its clinical PIP.

UnitedHealthcare

UnitedHealthcare demonstrated strengths for both its clinical and its nonclinical PIP for Activity I, Choose the Selected Study Topic(s). The MCO also had strengths for Activity III, Use a Representative and Generalizable Study Population; Activity VI, Use Valid and Reliable Data Collection Procedures; Activity VII, Analyze Data and Interpret Study Results; and Activity VIII, Include Improvement Strategies, for its clinical PIP.

Argus

Qsource identified a strength for one activity for Argus' clinical PIP: Activity I, Choose the Selected Study Topic(s).

DentaQuest

Qsource identified a strength for one activity for DentaQuest's clinical PIP: Activity I, Choose the Selected Study Topic(s).

MCNA

MCNA demonstrated strengths for both its clinical and its nonclinical PIP for Activity I, Choose the Selected Study Topic(s); Activity IV: Select the Study Indicators; and Activity VI, Use Valid and Reliable Data Collection Procedures.

PDSAs

For the 2019 PDSA rapid-cycle evaluations, Qsource identified strengths for four of the MCOs and all three DBMs:

Aetna

Aetna's nonclinical PIP was noted for strengths in its project plan, driver diagram, and tests of change across Plan and Do activities.

Simply Healthcare

The clinical PIP for Simply Healthcare was noted for strengths in its driver diagram in the Plan activity, and the nonclinical PIP was noted for strengths in the driver diagram, comprehensive observations, lessons learned, and measure results across Plan and Study activities.

Sunshine

Sunshine's clinical PIP was noted for strengths in its driver diagram in the Plan activity, and the nonclinical PIP was noted for strengths in its driver diagram, project plan, demonstration of a clear understanding of PDSA principles, analysis of intervention success, and plan for the next PDSA cycle across Plan, Do, Study, and Act activities.

UnitedHealthcare

The clinical PIP for UnitedHealthcare was noted for strengths in its demonstration of a clear understanding of PDSA principles and rate results graphs across Plan and Study activities, and the nonclinical PIP was noted for strengths in its demonstration of a clear understanding of PDSA principles, rate results graphs, lessons learned, and change test adaptations across Plan, Do, Study, and Act activities.

Argus

Argus' clinical PIP was noted for strengths in its project plan, outreach campaign revision, and rate results graphs across Plan, Do, and Study activities. The nonclinical PIP was noted for a strength in its survey-based study in the Plan activity.

DentaQuest

Both the clinical PIP and the nonclinical PIP for DentaQuest were noted for strengths in their change ideas and appropriately implemented change tests across Plan and Study activities.

MCNA

MCNA's clinical PIP was noted for strengths in its aim and measure description, evident planning, appropriately implemented test, and result data across Plan and Study activities. The nonclinical PIP was noted for strengths in its evident planning, appropriately implemented test, result data, and rate result graphs across Plan, Do, and Study activities.

Opportunities and Recommendations

ANA

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

Aetna

Recommendations included evaluating the potential and taking appropriate action to improve access to allergy and immunology specialists and pharmacy providers in rural areas as well as continuing to monitor its provider network and implement

corrective action for identified deficiencies. Qsource also recommended that Aetna examine the provider categories of Behavioral Health – Pediatric and Specialist – Pediatric, particularly in rural areas, to determine if additional providers are available in these areas to improve access and consider adding a detailed revision history to its appointment availability P&Ps.

Simply Healthcare

Recommendations included evaluating the potential and taking appropriate action to improve access to allergy and immunology and dermatology specialists in rural areas as well as continuing to monitor its provider network and implement corrective action for identified deficiencies. Qsource also recommended that Simply Healthcare examine pediatric specialists to determine if additional providers are available to improve access.

Staywell

Recommendations included evaluating the potential and taking appropriate action to improve access to allergy and immunology specialists and otolaryngologists in rural areas as well as continuing to monitor its provider network and implement corrective action for identified deficiencies. Qsource also recommended that Staywell examine the provider categories of Behavioral Health – Pediatric and Specialist – Pediatric, particularly in rural areas, to determine if additional providers are available in these areas to improve access and consider including approval dates specifically for Florida Healthy Kids in its appointment availability P&Ps.

Sunshine

Qsource recommended that Sunshine consider updating its appointment availability P&P to include all appropriate required standards.

UnitedHealthcare

Recommendations included evaluating the potential and taking appropriate action to improve access to pediatric specialists and pediatric behavioral health providers in both urban and rural areas and to hospitals in rural areas as well as continuing to monitor its provider network and implement corrective action for identified deficiencies. Qsource also recommended that UnitedHealthcare examine the provider categories of Behavioral Health – Pediatric and Specialist – Pediatric, particularly in rural areas, to determine if additional providers are available in these areas to improve access and consider including an effective date and a more detailed revision history in its appointment availability P&Ps

Argus

One recommendation was to evaluate the potential and take appropriate action to improve access to orthodontists for rural enrollees for distance standards and dental specialists for rural enrollees for both time and distance standards. The other was to continue to monitor its provider network and implement corrective action for identified deficiencies.

DentaQuest

One recommendation was to evaluate the potential and take appropriate action to improve access to dental specialists and orthodontists for rural enrollees. Another was to continue to monitor its provider network and implement corrective action for identified deficiencies. Qsource also recommended that DentaQuest consider updating its P&P to include all four appointment availability standards.

MCNA

One recommendation was to evaluate the potential and take appropriate action to improve access to dental specialists and orthodontists for rural enrollees. Another was to continue to monitor its provider network and implement corrective action for identified deficiencies.

ACA

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

Aetna

Four suggestions were made for Aetna in the Service Limitations, Timeframe for Standard Authorization Decisions, Timeframe for Expedited Authorization Decisions, and Extension of Decision Timeframe elements. An AON was noted for the Medically Necessary Services element. All recommendations made for Aetna were in the Coverage and Authorization of Services standard.

Simply Healthcare

Twelve suggestions were made for Simply Healthcare in the Service Limitations, Application of Review Criteria, Appropriate Reviewer Expertise, Timeframe for Standard Authorization Decisions, Extension of Decision Timeframe, and Elements of Adverse Benefit Determination Notice elements in the Coverage and Authorization of Services standard; the Service Coordination element in the Coordination and Continuity of Care standard; and the Contract Compliance, Delegation of Activities, Regulatory Compliance, Subcontractor Audit, and Notification of Agreement Termination elements in the Subcontractual Relationships and Delegation standard.

Eight AONs were noted for the Medically Necessary Services, Covered Outpatient Drug Decisions, and Denial of Payment elements in the Coverage and Authorization of Services standard; the Initial Screening and Treatment or Service Plan elements in the Coordination and Continuity of Care standard; and the Contract Compliance, Delegation of Activities, and Subcontractor Audit elements in the Subcontractual Relationships and Delegation standard.

Staywell

Three suggestions were made for Staywell in the Termination, Suspension, or Reduction of Services; and Elements of Adverse Benefit Determination Notice elements in the Coverage and Authorization of Services standard and in the Subcontractor

Audit element of the Subcontractual Relationships and Delegation standard.

Three AONs were noted for the Service Limitations and Medically Necessary Services elements in the Coverage and Authorization of Services standard; and the Treatment or Service Plan element in the Coordination and Continuity of Care standard.

Sunshine

Three suggestions were made for Sunshine in the Delegation of Activities, Notification of Agreement Termination, and Notice of Intent to Subcontract elements in the Subcontractual Relationships and Delegation standard.

UnitedHealthcare

Five suggestions were made for UnitedHealthcare in the Appropriate Reviewer Expertise; Timeframe for Expedited Authorization Decisions; Extension of Decision Timeframe; Termination, Suspension, or Reduction of Services; and Elements of Adverse Benefit Determination Notice elements in the Coverage and Authorization of Services standard.

Three AONs were noted for the Medically Necessary Services and Timeframe for Expedited Authorization Services elements in the Coverage and Authorization of Services standard; and the Treatment or Service Plan element in the Coordination and Continuity of Care standard.

Argus

Five suggestions were made for Argus for the Notice of Adverse Benefit Determination, Timeframe for Standard Authorization Decisions, Timeframe for Expedited Authorization Decisions, Decisions Exceeding Timeframes, and Elements of Adverse Benefit Determination Notice elements in the Coverage and Authorization of Services standard.

Three AONs were noted for the Service Protections and Service Limitations elements in the Coverage and Authorization of Services standard; and the Appropriate Source of Care element in the Coordination and Continuity of Care standard.

DentaQuest

Three suggestions were made for DentaQuest in the Service Limitations, Timeframe for Standard Authorization Decisions, and Timeframe for Expedited Authorization Decisions elements in the Coverage and Authorization of Services standard.

Seven AONs were noted for the Service Protections, Service Limitations, Medically Necessary Services, Extension of Decision Timeframe, Decisions Exceeding Timeframes, and Elements of Adverse Benefit Determination Notice elements in the Coverage and Authorization of Services standard; and the Appropriate Source of Care element in the Coordination and Continuity of Care standard.

MCNA

Three suggestions were made for MCNA in the Appropriate Reviewer Expertise, Timeframe for Standard Authorization Decisions, and Extension of Decision Timeframe elements in the Coverage and Authorization of Services standard.

Three AONs were noted in the Extension of Decision Timeframe and Elements of Adverse Benefit Determination Notice elements; and the Appropriate Source of Care element in the Coordination and Continuity of Care standard.

PMV

No areas of improvement were noted for the MCOs or the DBMs for the 2019 PMV.

PIPs

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

Aetna

Qsource noted one AON for Aetna's clinical PIP in Activity VI, Use Valid and Reliable Data Collection Procedures.

Simply Healthcare

Qsource noted five suggestions for Simply Healthcare's clinical PIP in Activity IV, Select the Study Indicators; Activity VII, Analyze Data and Interpret Study Results; Activity VIII, Include Improvement Strategies; and Activity X, Assess for Sustained Improvement.

Staywell

Qsource noted two suggestions for Staywell's clinical PIP in Activity VIII, Include Improvement Strategies; and one AON in Activity VII, Analyze Data and Interpret Study Results.

Sunshine

Qsource noted one suggestion for Sunshine's clinical PIP in Activity IV, Select the Study Indicators, and six suggestions for the nonclinical PIP in Activity I, Choose the Selected Study Topic(s); Activity II, Define the Study Question(s); Activity III, Use a Representative and Generalizable Study Population; Activity IV, Select the Study Indicators; and Activity VI, Use Valid and Reliable Data Collection Procedures.

Four AONs were noted for Sunshine's clinical PIP in Activity VII, Analyze Data and Interpret Study Results; Activity IX, Assess for Real Improvement; and Activity X, Assess for Sustained Improvement. Two AONs were identified for the nonclinical PIP in Activity IV, Select the Study Indicators, and Activity VI, Use Valid and Reliable Data Collection Procedures.

UnitedHealthcare

Qsource noted one AON for UnitedHealthcare's clinical PIP in Activity VI, Use Valid and Reliable Data Collection Procedures.

Argus

Qsource noted two suggestions for Argus' nonclinical PIP in Activity II, Define the Study Question(s), and Activity IV, Select

the Study Indicators; and one AON in Activity VI, Use Valid and Reliable Data Collection Procedures.

DentaQuest

Qsource noted one suggestion for DentaQuest's clinical PIP in Activity VI, Use Valid and Reliable Data Collection Procedures, and two suggestions for the nonclinical PIP in Activity I, Choose the Selected Study Topic(s), and Activity IV, Select the Study Indicators.

One AON was noted for DentaQuest's clinical PIP in Activity IV, Select the Study Indicators; and two AONs were identified for the nonclinical PIP in Activity IV, Select the Study Indicators, and Activity VI, Use Valid and Reliable Data Collection Procedures.

PDSAs

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

Aetna

Two suggestions were made for Aetna's clinical PIP for describing process measures in the Plan activity and providing all results possible in the Study activity.

Simply Healthcare

Five suggestions were made for Simply Healthcare's clinical PIP for including all required components in the sustainability plan in the Plan activity; addressing low participation in the Study activity; and discussing change test modifications, including all required components in the sustainability plan, and including test modifications for the next PDSA cycle in the Act activity.

Three suggestions were made for the nonclinical PIP for including all required components in the sustainability plan in the Plan activity; and considering potential change test adaptations and including all required components in the sustainability plan in the Act activity.

Staywell

Eight suggestions were made for Staywell's clinical PIP for including an achievable goal, outcome numeric rate, and achievement timeframe in the project aim; properly defining process measures; limiting change idea selection; and including all required components in the sustainability plan in the Plan activity; timely implementing changes and basing those changes on result analysis from the previous year, and basing results on correct interventions in the Do activity; reporting and analyzing process measures in the Study activity; and including all required components in the sustainability plan in the Act activity.

Ten suggestions were made for the nonclinical PIP for including an achievable goal, outcome numeric rate, and achievement timeframe in the project aim; limiting change idea selection; and including all required components in the sustainability plan in the Plan activity; timely implementing changes and basing those changes on result analysis from the previous year in the Do activity; analyzing both outcome and process measures, and describing lessons learned in the Study activity; and relating planned actions

to measure results and lessons learned, including all required components of the sustainability plan, and describing a general plan for the next PDSA cycle in the Act activity.

Sunshine

Nine suggestions were made for Sunshine's clinical PIP for describing process measures and including all required components in the sustainability plan in the Plan activity; addressing implementation and results of the change test in the Do activity; graphically presenting process and outcome measures and discussing resolution of outcome measure reporting issues in the Study activity; and including resolution of outcome reporting issues, including all required components in the sustainability plan, and including additional detail in the plan for the next PDSA cycle in the Act activity.

Two suggestions, both to include all required components in the sustainability plan, were made for the nonclinical PIP in the Plan and Act activities.

UnitedHealthcare

The same four suggestions were made for UnitedHealthcare's clinical PIP and nonclinical PIP: defining process measures, including outcome measures, and including all required components in the sustainability plan in the Plan activity; and including all required components in the sustainability plan in the Act activity.

Argus

Six suggestions were made for Argus' clinical PIP for including influencing factors in primary and secondary drivers, not including change ideas not implemented, defining process measures, and including all required components in the sustainability plan in the Plan activity; providing additional detail about change tests in the Do activity; and including all required components in the sustainability plan in the Act activity.

Six suggestions also were made for Argus' nonclinical PIP for developing a desired outcome numeric rate and achievement timeframe, discussing the demonstration of improvement, considering use of survey response rate as a process measure, updating the driver diagram, including survey method and number of attempts to administer the survey in the data collection process, and including all required components in the sustainability plan in the Plan activity and including all required components in the sustainability plan in the Act activity.

MCNA

The same three suggestions were made for MCNA's clinical PIP and nonclinical PIP: including all required components in the sustainability plan in the Plan activity, including general observations regarding change test implementation in the Study activity, and including all required components in the sustainability plan in the Act activity.

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 2019 ANA, ACA, and PIP Validation activities. The MCO- and DBM-specific results for the 2019 PMV can be found in the PMV section, and specific results for the 2019 EDV can be found in the EDV section.

ANA

The following evaluation activities were performed for four of the five MCOs and all three DBMs:

- Travel time analysis for urban and rural enrollees to provider types specified in the MCO/DBM's contract with FHKC
- Distance analysis for urban and rural enrollees to provider types specified in the MCO/DBM's contract with FHKC
- Appointment availability and accessibility

Evaluation activities performed for one MCO, Sunshine—the only MCO providing Florida Healthy Kids full-pay health coverage, included travel time analysis for primary care and specialty care medical providers and appointment availability and accessibility.

The network adequacy information in **tables A-1** through **A-5** was obtained from analyses performed on provider and enrollee data.

Table A-1. 2019 Network Adequacy Results: Travel Time Analysis by MCO and Provider/Specialty Type

Provider/Specialty Type	Aetna		Simply Healthcare		Staywell		UnitedHealthcare	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Allergy & Immunology	90.58%	76.39%	97.52%	43.37%	96.93%	89.20%	98.08%	100%
Dermatology	91.15%	95.15%	99.89%	94.27%	99.20%	99.08%	98.80%	100%
OB/GYN	99.98%	90.47%	100%	99.76%	99.91%	94.87%	99.63%	100%
Optometry	99.98%	100%	100%	92.83%	99.76%	100%	99.36%	100%
Otolaryngology (ENT)	88.47%	94.23%	99.97%	92.83%	94.06%	88.57%	98.84%	100%
PCP – Pediatrician	99.88%	99.18%	99.96%	94.86%	99.68%	90.80%	98.63%	100%
PCP – Family Physician	99.46%	96.62%	99.75%	99.64%	99.82%	91.29%	99.98%	100%

Table A-1. 2019 Network Adequacy Results: Travel Time Analysis by MCO and Provider/Specialty Type								
Provider/Specialty Type	**Aetna**		**Simply Healthcare**		**Staywell**		**UnitedHealthcare**	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Behavioral Health – Pediatric	81.98%	65.12%	99.87%	92.83%	99.71%	100%	20.15%	0%
Behavioral Health – Other	91.87%	90.30%	100%	100%	99.73%	100%	100%	100%
Specialist – Pediatric	95.11%	86.71%	99.51%	86.14%	99.14%	100%	85.12%	89.66%
Specialist – Other	99.85%	97.68%	100%	99.28%	99.84%	96.85%	99.45%	100%
Hospital	96.84%	90.23%	99.98%	94.03%	99.74%	94.60%	98.87%	42.53%
Pharmacy	98.82%	58.18%	99.87%	98.81%	99.87%	95.82%	99.97%	90.80%

Table A-2. 2019 Network Adequacy Results: Distance Analysis by MCO and Provider/Specialty Type								
Provider/Specialty Type	**Aetna**		**Simply Healthcare**		**Staywell**		**UnitedHealthcare**	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Allergy & Immunology	93.93%	66.04%	99.23%	23.42%	98.28%	79.47%	98.83%	100%
Dermatology	92.11%	81.00%	99.98%	72.52%	99.83%	98.44%	99.23%	100%
OB/GYN	100%	94.33%	100%	100%	99.96%	97.36%	99.80%	100%
Optometry	100%	99.49%	100%	92.83%	99.81%	99.33%	99.74%	100%
Otolaryngology (ENT)	91.32%	89.44%	99.99%	92.83%	97.66%	86.69%	99.26%	100%
PCP – Pediatrician	99.92%	99.21%	100%	94.98%	99.73%	93.66%	98.74%	100%
PCP – Family Physician	99.77%	97.30%	99.94%	99.64%	99.92%	92.90%	100%	100%
Behavioral Health – Pediatric	88.48%	59.86%	99.97%	92.83%	99.75%	100%	34.26%	0%
Behavioral Health – Other	95.26%	86.03%	100%	100%	99.89%	100%	100%	100%

Table A-2. 2019 Network Adequacy Results: Distance Analysis by MCO and Provider/Specialty Type								
Provider/Specialty Type	**Aetna**		**Simply Healthcare**		**Staywell**		**UnitedHealthcare**	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Specialist – Pediatric	96.37%	77.79%	99.91%	72.76%	99.36%	99.61%	88.23%	68.97%
Specialist – Other	99.92%	98.70%	100%	99.52%	99.88%	98.53%	99.61%	100%
Hospital	95.14%	93.88%	99.88%	94.62%	99.00%	97.03%	97.74%	75.86%
Pharmacy	97.84%	46.09%	99.81%	96.54%	99.51%	87.68%	99.60%	89.66%

Table A-3. 2019 Network Adequacy Results: Travel Time Analysis by Provider/Specialty Type for Sunshine	
Provider/Specialty Type	**Time Standard % of Enrollees with Access**
Primary Care Medical Provider	99.82%
Specialty Care Medical Provider	100%

Table A-4. 2019 Network Adequacy: Travel Time Analysis by DBM and Provider/Specialty Type						
Provider/Specialty Type	**Argus**		**DentaQuest**		**MCNA**	
	Urban	Rural	Urban	Rural	Urban	Rural
Primary Care Dentists	99.72%	99.74%	99.61%	95.93%	99.31%	93.86%
Dental Specialists	90.35%	51.99%	95.50%	64.83%	97.23%	61.84%
Orthodontists	99.26%	93.08%	99.44%	85.14%	99.41%	87.78%

Table A-5. 2019 Network Adequacy: Distance Analysis by DBM and Provider/Specialty Type						
Provider/Specialty Type	**Argus**		**DentaQuest**		**MCNA**	
	Urban	Rural	Urban	Rural	Urban	Rural
Primary Care Dentists	99.91%	99.83%	99.87%	97.68%	99.61%	95.14%
Dental Specialists	92.68%	38.06%	96.70%	55.10%	98.35%	53.49%
Orthodontists	97.78%	79.89%	98.04%	74.91%	97.63%	76.28%

ACA

ACA Standards

Table A-6 displays each MCO's and DBM's compliance with federal statutes (with the exception of Sunshine, which was not evaluated for compliance with federal statutes), its relative contract, and additional compliance standards established by FHKC. Individual results are presented for each ACA standard.

Table A-6. 2019 ACA Standard Results: MCOs and DBMs								
Standard	**MCOs**					**DBMs**		
	Aetna	Simply Healthcare	Staywell	Sunshine	United Healthcare	Argus	DentaQuest	MCNA
Coverage and Authorization of Services	98.2%	93.0%	97.4%	100%	93.0%	98.1%	81.1%	90.6%
Coordination and Continuity of Care	100%	75.0%	91.7%	100%	91.7%	0%	0%	50.0%
Subcontractual Relationships and Delegation	100%	73.7%	100%	100%	100%			

Table A-6. 2019 ACA Standard Results: MCOs and DBMs								
Standard	**MCOs**					**DBMs**		
	Aetna	Simply Healthcare	Staywell	Sunshine	United Healthcare	Argus	DentaQuest	MCNA
Overall Compliance Standard Score	**99.0%**	**85.0%**	**96.5%**	**100%**	**94.0%**	**91.2%**	**75.4%**	**87.7%**

File Review

The results in **Table A-7** present each MCO's and DBM's compliance with each file review.

Table A-7. 2019 ACA File Review Results: MCOs and DBMs								
File Review	**MCOs**					**DBMs**		
	Aetna	Simply Healthcare	Staywell	Sunshine	United Healthcare	Argus	DentaQuest	MCNA
UM Denials	100%	100%	80.8%	100%	100%	100%	80.0%	98.0%

PIP Validation

FHKC required that all PIPs submitted by MCOs and DBMs be validated for calendar year 2018. 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-8** through A-11 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-8** includes scores for the MCOs' clinical PIPs, Table A-9 includes scores for the MCOs' nonclinical PIPs, Table A-10 includes scores for the DBMs' clinical PIPs, and Table A-11 includes scores for the DBMs' nonclinical PIPs.

Table A-8. 2019 Clinical PIP Validation Scores by Review Activity: MCOs

Review Activities	All (A) and Critical (C) Elements Met/Assessed									
	Aetna		Simply Healthcare		Staywell		Sunshine		United Healthcare	
	A	C	A	C	A	C	A	C	A	C
I. Choose the Study Topic(s)	6/6	1/1	6/6	1/1	6/6	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	5/5	3/3	6/6	3/3	6/6	3/3
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

Table A-8. 2019 Clinical PIP Validation Scores by Review Activity: MCOs											
Review Activities		**All (A) and Critical (C) Elements Met/Assessed**									
		Aetna		**Simply Healthcare**		**Staywell**		**Sunshine**		**United Healthcare**	
		A	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**
VI. Use Valid and Reliable Data Collection Procedures		9/10	1/1	10/10	1/1	6/6	0/0	6/6	0/0	9/10	1/1
VII. Analyze and Interpret Study Results		9/9	2/2	9/9	2/2	6/8	1/1	6/8	1/1	9/9	2/2
VIII. Include Improvement Strategies		4/4	1/1	4/4	1/1	3/3	1/1	3/3	1/1	4/4	1/1
IX. Assess for Real Improvement		4/4	0/0	4/4	0/0	4/4	0/0	1/4	0/0	4/4	0/0
X. Assess for Sustained Improvement		1/1	0/0	1/1	0/0	1/1	0/0	0/1	0/0	1/1	0/0
Overall Score		**44/45**	**12/12**	**45/45**	**12/12**	**36/38**	**10/10**	**33/39**	**10/10**	**44/45**	**12/12**
Percentage of Elements Met	**Total**	**97.8%**		**100%**		**94.7%**		**84.6%**		**97.8%**	
	Critical	**100%**		**100%**		**100%**		**100%**		**100%**	
Validation Status		**Met**		**Met**		**Met**		**Met**		**Met**	

Table A-9. 2019 Nonclinical PIP Validation Scores by Review Activity: MCOs										
Review Activities	**All (A) and Critical (C) Elements Met/Assessed**									
	Aetna		**Simply Healthcare**		**Staywell**		**Sunshine**		**United Healthcare**	
	A	**C**	**A**	**C**	**A**	**C**	**A**	**C**	**A**	**C**
I. Choose the Study Topic(s)	6/6	1/1	6/6	1/1	6/6	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	5/6	3/3	6/6	3/3
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	6/6	0/0	6/6	0/0	6/6	0/0	5/6	0/0	6/6	0/0
VII. Analyze and Interpret Study Results	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
VIII. Include Improvement Strategies	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
IX. Assess for Real Improvement	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
X. Assess for Sustained Improvement	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
Overall Score	**23/23**	**8/8**	**23/23**	**8/8**	**23/23**	**8/8**	**21/23**	**8/8**	**23/23**	**8/8**

Table A-9. 2019 Nonclinical PIP Validation Scores by Review Activity: MCOs

Review Activities		All (A) and Critical (C) Elements Met/Assessed									
		Aetna		Simply Healthcare		Staywell		Sunshine		United Healthcare	
		A	C	A	C	A	C	A	C	A	C
Percentage of Elements Met	Total	100%		100%		100%		91.3%		100%	
	Critical	100%		100%		100%		100%		100%	
Validation Status		Met		Met		Met		Met		Met	

Table A-10. 2019 Clinical 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	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
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	6/7	2/3	7/7	3/3
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0
VI. Use Valid and Reliable	6/6	0/0	6/6	0/0	6/6	0/0

Table A-10. 2019 Clinical 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**
Data Collection Procedures							
VII. Analyze and Interpret Study Results		0/0	0/0	0/0	0/0	0/0	0/0
VIII. Include Improvement Strategies		0/0	0/0	0/0	0/0	0/0	0/0
IX. Assess for Real Improvement		0/0	0/0	0/0	0/0	0/0	0/0
X. Assess for Sustained Improvement		0/0	0/0	0/0	0/0	0/0	0/0
Overall Score		**23/23**	**8/8**	**23/24**	**7/8**	**24/24**	**8/8**
Percentage of Elements Met	**Total**	**100%**		**95.8%**		**100%**	
	Critical	**100%**		**87.5%**		**100%**	
Validation Status		**Met**		**Not Met**		**Met**	

Table A-11. 2019 Nonclinical 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	6/6	1/1	6/6	1/1

Table A-11. 2019 Nonclinical 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
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)		7/7	3/3	6/7	2/3	7/7	3/3
V. Use Sound Sampling Methods		6/6	1/1	0/0	0/0	0/0	0/0
VI. Use Valid and Reliable Data Collection Procedures		4/5	0/0	5/6	0/0	6/6	0/0
VII. Analyze and Interpret Study Results		0/0	0/0	0/0	0/0	0/0	0/0
VIII. Include Improvement Strategies		0/0	0/0	0/0	0/0	0/0	0/0
IX. Assess for Real Improvement		0/0	0/0	0/0	0/0	0/0	0/0
X. Assess for Sustained Improvement		0/0	0/0	0/0	0/0	0/0	0/0
Overall Score		**28/29**	**9/9**	**22/24**	**7/8**	**24/24**	**8/8**
Percentage of Elements Met	**Total**	**96.6%**		**91.7%**		**100%**	
	Critical	**100%**		**87.5%**		**100%**	

Table A-11. 2019 Nonclinical 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
Validation Status	Met		Not Met		Met	

APPENDIX B | 2019 Sample Assessment Tools

The assessment tools presented in this appendix represent a comprehensive sample of the tools used to evaluate performance for the ANA, ACA, PIP Validation, and PDSA EQR activities. 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 2019 ANA.

2019 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>	

2019 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 within seven calendar days of the enrollee's request for services.	<Yes or No>	<Yes or No>
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:

- 2019 CA Standards Survey Tools (MCO and DBM)
- Utilization Management Denials File Review Tool

MCO CA Standards Tool – Aetna, Simply Healthcare, Staywell, UnitedHealthcare

2019 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
1. Service Protections *42 Code of Federal Regulations* (CFR) 438.210(a)(3)(i)-(ii), Medical Services Contract (MSC) 3-5	The managed care organization (MCO): a. must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished; and b. may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee.	☐ a. Sufficient services to achieve purpose ☐ b. No arbitrary denial or reduction of services	**0.500** **0.500**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Service Limitations 42 CFR 438.210(a)(4)(i)-(ii), MSC 3-5	The MCO may place appropriate limits on a service on the basis of criteria applied under the Florida Healthy Kids Corporation (FHKC) plan, such as medical necessity, or for the purpose of utilization control, provided that: a. the services furnished can reasonably achieve their purpose, as required in 42 CFR 438.210(a)(3)(i); and b. the services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services.	☐ a. Services can achieve their purpose ☐ b. Services authorized in a manner that reflects enrollee's ongoing need	**0.500** **0.500**	**1.000**	**X.XXX**
Findings **Strength** **AON**					

2019 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Suggestion					
3. Medically Necessary Services 42 CFR 438.210(a)(5)(i)-(ii)	The MCO must specify what constitutes "medically necessary services" in a manner that: a. is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and b. addresses the extent to which the MCO is responsible for covering services that address: 1. the prevention, diagnosis, and treatment of an enrollee's disease, condition, and/or disorder that results in health impairments and/or disability; 2. the ability for an enrollee to achieve age-appropriate growth and development; and 3. the ability for an enrollee to attain, maintain, or regain functional capacity.	☐ a. Is no more restrictive than that used in the State Medicaid program ☐ b. Addresses the extent to which the MCO is responsible for covering services	**1.000** **1.000**	**2.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
4. Authorization of Services 42 CFR 438.210(b)(1), MSC 3-5	For the processing of requests for initial and continuing authorizations of services, the MCO and its subcontractors have in place, and follow, written policies and procedures.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**X.XXX**
Findings					
Strength					

2019 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
AON					
Suggestion					
5. Application of Review Criteria 42 CFR 438.210(b)(2)(i)-(ii), MSC 3-5	For the processing of requests for initial and continuing authorizations of services, the MCO must: a. have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and b. consult with the requesting provider for medical services when appropriate.	☐ a. Mechanisms to ensure consistent application of review criteria ☐ b. Requesting provider consultation	**3.000** **3.000**	**6.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
6. Appropriate Reviewer Expertise 42 CFR 438.210(b)(3), MSC 3-5	The MCO must ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual who has appropriate expertise in addressing the enrollee's medical or behavioral health needs. The process must include the training given to the reviewers.	☐ Reviewers with appropriate expertise and clinical background ☐ Reviewer training	**3.000** **3.000**	**6.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					

2019 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
7. Notice of Adverse Benefit Determination 42 CFR 438.210(c)	The MCO must notify the requesting provider, and give the enrollee written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The enrollee's notice must meet the requirements of 42 CFR 438.404.	☐ Written notice to enrollee ☐ Notice to provider	**3.000** **3.000**	**6.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
8. Timeframe for Standard Authorization Decisions 42 CFR 438.210(d)(1)(i)-(ii), MSC 3-5	For standard authorization decisions, the MCO must provide notice as expeditiously as the enrollee's condition requires and within FHKC-established timeframes that may not exceed 14 calendar days following receipt of the request for service.	☐ Yes ☐ No	**3.000** **0.000**	**3.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
9. Timeframe for Expedited Authorization Decisions 42 CFR 438.210(d)(2)(i)-(ii), MSC 3-5	For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.	☐ Yes ☐ No	**3.000** **0.000**	**3.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
10. Extension of Decision Timeframe 42 CFR 438.404(c)(4)(i)-(ii), MSC 3-5	The MCO may extend the timeframe up to 14 additional calendar days, if the enrollee, or the provider, requests an extension or the MCO justifies to FHKC, upon request, a need for additional information and how the extension is in the enrollee's interest, provided that: a. the MCO gives the enrollee written notice of the reason for the decision to extend the timeframe and informs the enrollee of the right to file a grievance; and b. the MCO issues and carries out the determination as expeditiously as the enrollee's health condition requires, but no later than the date the extension expires.	☐ a. Written notice to enrollee of reason for decision and right to file a grievance ☐ b. Determination carried out as expeditiously as the enrollee's health condition requires but no later than the date the extension expires	**3.000** **3.000**	**6.000**	**X.XXX**

2019 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Findings					
Strength					
AON					
Suggestion					
11. Covered Outpatient Drug Decisions 42 CFR 438.210(d)(3), MSC 3-5	For all covered outpatient drug authorization decisions, the MCO must provide notice by telephone or other telecommunication device within 24 hours of a request for prior authorization.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
12. Compensation for Utilization Management Activities 42 CFR 438.210(e), MSC 3-5	The MCO must ensure that compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**X.XXX**
Findings					
Strength					
AON					

2019 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Suggestion					
13. Termination, Suspension, or Reduction of Services CFR 438.404(c)(1), MSC 3-5	For termination, suspension, or reduction of previously approved services, the MCO must provide notice at least 10 calendar days before the date of action except when: a. the MCO has information concerning the death of the enrollee; b. the MCO receives a clear, written, signed statement from the enrollee stating that the enrollee no longer wishes to receive services or the enrollee gives information that requires termination or reduction of services and the enrollee indicates understanding that termination or reduction of services must be the outcome of providing such information; c. the enrollee has been admitted to an institution that causes ineligibility under the plan for further services; d. the enrollee's whereabouts are unknown and the U.S. Postal Service returns the MCO's mail directed toward the enrollee indicating no forwarding address; e. the MCO establishes that the enrollee is enrolled in the FHK program in another region; f. a change in the level of medical care is prescribed by the enrollee's physician; g. the notice involves an adverse benefit determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the *Social Security Act*; h. in accordance with 42 CFR 431.213(h); and i. the MCO has facts, verified through secondary sources when possible, indicating that action should be taken because of probable fraud by the enrollee, in which	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**X.XXX**

2019 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
	case the notice must be provided at least five calendar days before the date of action.				
Findings					
Strength					
AON					
Suggestion					
14. Denial of Payment CFR 438.404(c)(2), MSC 3-5	For denial of payment, the MCO must provide notice at the time of any action affecting the claim.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
15. Decisions Exceeding Timeframes CFR 438.404(c)(5), MSC 3-5	For service authorization decisions not reached within the timeframes required by 42 CFR 438.210(d), which constitutes a denial and is an adverse benefit determination, the MCO must provide the notice on the date the timeframe expires.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					

2019 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
16. Elements of Adverse Benefit Determination Notice CFR 438.404(a), MSC 3-5	A notice of adverse benefit determination must include: a. the adverse benefit determination the MCO has made; b. the reason for the adverse benefit determination; c. the enrollee's right to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse benefit determination, including medical necessity criteria and processes, strategies, or evidentiary standards used in setting coverage limits; d. the enrollee's right to request an appeal, including information on exhausting the appeal process, and the right to request a Subscriber Assistance Panel (SAP) hearing (prior to July 1, 2018) or use of an Independent Review Organization (IRO) or the federal review process (on or after July 1, 2018); e. the procedures for exercising these rights; and f. the circumstances under which an appeal can be expedited and how the enrollee can request an expedited appeal.	☐ a. Adverse benefit determination ☐ b. Reason for adverse benefit determination ☐ c. Enrollee's right free of charge to information relevant to the adverse benefit determination ☐ d. Enrollee's right to request an appeal ☐ e. Procedures for filing an appeal ☐ f. Process for requesting an expedited appeal	**2.000** **2.000** **2.000** **2.000** **2.000** **2.000**	**12.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
		Coverage and Authorization of Services	**0.0%**	**57.000**	**0.000**

2019 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
1. Appropriate Source of Care 42 CFR 438.208(b)(1), MSC 3-2-1	The MCO must ensure each enrollee has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee. The MCO must provide enrollees information on how to contact their designated person or entity.	☐ Primary care coordinator ☐ Designated entity contact information	**2.000** **2.000**	**4.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Service Coordination 42 CFR 438.208(b)(2)(i)-(v), MSC 3-2-6	The MCO must coordinate services it furnishes to the enrollee: a. between settings of care, including appropriate discharge planning for short- and long-term hospital and institutional stays; b. with the services the enrollee receives from any other MCO; and c. with the services the enrollee receives from community and social support providers.	☐ a. Services between settings of care ☐ b. Services from any other MCO ☐ c. Services from community and social support providers	**1.000** **1.000** **1.000**	**3.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
3. Initial Screening 42 CFR 438.208(b)(3)	The MCO must make a best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful.	☐ Initial screening conducted ☐ Within 90-day timeframe	**2.000** **2.000**	**4.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
4. Assessment of Enrollee Needs 42 CFR 438.208(b)(4)	The MCO must share with FHKC or other MCOs serving the enrollee the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
5. Enrollee Health Record 42 CFR 438.208(b)(5)	The MCO must ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON**					

2019 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
Suggestion					
6. Enrollee Privacy 42 CFR 438.208(b)(6)	The MCO must ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
7. Special Healthcare Needs Assessment 42 CFR 438.208(c)(2)	The MCO must implement mechanisms to comprehensively assess each FHK enrollee identified by FHKC as having special healthcare needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
8. Treatment or Service Plan 42 CFR 438.208(c)(3)(iv)-(v)	The MCO must produce a treatment or service plan meeting the criteria in 42 CFR 438.208(c)(3)(iv)-(v) for enrollees with special healthcare needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan must be reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or	☐ Treatment or service plan provided ☐ Reviewed and revised at least every 12 months, when the enrollee's needs significantly change, or at the enrollee's request	**2.000** **2.000**	**4.000**	**X.XXX**

2019 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
	needs change significantly, or at the request of the enrollee per 42 CFR 441.301(c)(3).				
Findings					
Strength					
AON					
Suggestion					
9. Enrollee Direct Access to Specialists 42 CFR 438.208(c)(4), MSC 3-5	The MCO must have mechanisms in place to provide enrollees determined to have special healthcare needs with direct access to a specialist in a manner that is appropriate for the enrollee's condition and identified needs. Direct access may include, but is not limited to, a standing referral or an approved number of visits. To prevent duplication of work, assessments related to an enrollee's special healthcare needs and direct access determinations must be provided to FHKC or another MCO. The MCO must accept such information as assessed by another MCO in the FHK program from FHKC.	☐ Direct enrollee access to specialists ☐ Assessments and direct access determinations provided to FHKC or another MCO ☐ Direct access determinations and assessments provided by another MCO accepted	**1.000** **1.000** **1.000**	**3.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
		Coordination and Continuity of Care	**0.0%**	**24.000**	**0.000**

2019 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
1. Contract Compliance 42 CFR 438.230(b)(1), MSC 3-30-C	The MCO must maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with FHKC, notwithstanding any relationship(s) the MCO may have with any subcontractor.	☐ Yes ☐ No	**2.000** **0.000**	**2.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Delegation of Activities 42 CFR 438.230(c)(1)(i)-(iii), MSC 3-30	If any of the MCO's activities or obligations under its contract with FHKC are delegated to a subcontractor: a. the delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement; b. the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's contract obligations; c. the contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where FHKC or the MCO determines that the subcontractor has not performed satisfactorily; and d. all such agreements shall also be available to FHKC within seven business days of request for production.	☐ a. Delegated activities specified in contract ☐ b. Subcontractor agreement ☐ c. Revocation of delegation of activities ☐ d. Agreements available within seven days of request	**2.000** **2.000** **2.000** **2.000**	**8.000**	**X.XXX**
Findings **Strength** **AON**					

2019 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
Suggestion					
3. Regulatory Compliance 42 CFR 438.230(c)(2)	The subcontractor must comply with all applicable Children's Health Insurance Program (CHIP) laws and regulations, including applicable subregulatory guidance and contract provisions.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
4. Subcontractor Audit 42 CFR 438.230(c)(3)(i)-(iv)	The subcontractor must agree that: a. FHKC, Centers for Medicare & Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCO's contract with FHKC; b. the subcontractor will make available, for purposes of an audit, evaluation, or inspection under 42 CFR 438.230(c)(3)(i) its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its FHK enrollees; c. the right to audit under 42 CFR 438.230(c)(3)(i) will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later; and	☐ a. Right to audit ☐ b. Subcontractor audit availability ☐ c. 10-year post-contract right to audit ☐ d. Right to audit at any time there is a possibility of fraud or similar risk	**1.0000** **1.0000** **1.0000** **1.0000**	**4.000**	**X.XXX**

2019 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
	d. if FHKC, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, FHKC, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.				
Findings **Strength** **AON** **Suggestion**					
5. Notification of Agreement Termination MSC 3-30-D	The MCO must provide FHKC with timely notice of termination of agreements with any subcontractor or affiliate. On a quarterly basis, the MCO must provide FHKC with an attestation as to the adequacy of the MCO's network.	☐ Termination notice ☐ Quarterly attestation	**1.000** **1.000**	**2.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
6. Notice of Intent to Subcontract MSC 3-30-E	The MCO must provide FHKC with timely notice of the MCO's intent to contract with any new subcontractors or affiliates for services covered. Prior to execution, the MCO must forward for FHKC's review and approval any proposed agreement for services with subcontractors or affiliates.	☐ Timely notice to FHKC ☐ Proposed agreement forwarded to FHKC for approval	**1.000** **1.000**	**2.000**	**X.XXX**
Findings **Strength** **AON**					

2019 Annual Compliance Assessment: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Subcontractual Relationships and Delegation					
Suggestion					
		Subcontractual Relationships and Delegation	**0.0%**	**19.000**	**0.000**

Sunshine CA Standards Tool

2019 Annual Compliance Assessment: Sunshine					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
1. Timeframe for Standard Authorization Decisions Medical Services Contract (MSC) Attachment D - Enrollee Benefit Schedule, Section IV	All requirements for prior authorizations must conform to federal and state regulations and must be completed within 14 days of request by the enrollee or enrollee's provider.	☐ Yes ☐ No	**5.000** **0.000**	**5.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
		Coverage and Authorization of Services	**XX.X%**	**5.000**	**X.XXX**

2019 Annual Compliance Assessment: Sunshine					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
1. Enrollee Health Record MSC 3-18	The MCO must require its providers to maintain medical records for each enrollee under the Florida Healthy Kids Corporation (FHKC) contract in accordance with applicable federal and state law.	☐ Yes ☐ No	**5.000** **0.000**	**5.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
		Coordination and Continuity of Care	**XX.X%**	**5.000**	**X.XXX**

2019 Annual Compliance Assessment: Sunshine					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
1. Delegation of Activities MSC 3-30	All agreements between the MCO and its subcontractors or affiliates to provide services under its contract with FHKC must be reduced to writing and executed by both parties. All such agreements must also be available to FHKC within seven business days of request for production.	☐ Subcontractor agreement ☐ Agreements available within seven days of request	**3.000** **2.000**	**5.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Regulatory Compliance MSC 3-30-C	The MCO's contract with a subcontractor or affiliate must fully comply with all terms and conditions of its contract with FHKC.	☐ Yes ☐ No	**3.000** **0.000**	**3.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
3. Subcontractor Audit MSC 3-25-B and 3-25-E	The MCO must have all records used or produced in the course of the performance of its contract with FHKC available at all reasonable times for inspection, review, audit, or copying to FHKC, any vendor contracted with FHKC, or any state or federal regulatory agency as authorized by law or FHKC. Access to such records must be during normal business hours and must be either through onsite review of records or through the mail. These records must be retained for at least five years following the term of the MCO's contract with FHKC, except if an audit is in progress or audit findings	☐ Records available for inspection, review, audit, or copying ☐ Record access during normal business hours via onsite review or mail ☐ Post-contract five-year record retention ☐ Records kept until all tasks of any applicable audits are complete	**1.0000** **1.0000** **1.0000** **1.0000**	**4.000**	**X.XXX**

2019 Annual Compliance Assessment: Sunshine					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
	are yet unresolved, in which case records must be kept until all tasks are completed.				
Findings **Strength** **AON** **Suggestion**					
4. Notification of Agreement Termination MSC 3-30-D	The MCO must provide FHKC with timely notice of termination of any agreements with any subcontractor or affiliate. On a quarterly basis, the MCO must provide FHKC with an attestation as to the adequacy of the MCO's network.	☐ Termination notice ☐ Quarterly attestation	**2.000** **2.000**	**4.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
5. Notice of Intent to Subcontract MSC 3-30-E	The MCO must provide FHKC with timely notice of the MCO's intent to contract with any new subcontractors or affiliates for services covered. Prior to execution, the MCO must forward for FHKC's review and approval any proposed agreement for services with subcontractors or affiliates.	☐ Timely notice to FHKC ☐ Proposed agreement forwarded to FHKC for approval	**2.000** **2.000**	**4.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
		Subcontractual Relationships and Delegation	**XX.X%**	**20.000**	**X.XXX**

DBM CA Standards Tool

2019 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
1. Service Protections 42 *Code of Federal Regulations* (CFR) 438.210(a)(3)(i)-(ii), Dental Services Contract (DSC) 3-5	The dental benefit manager (DBM): a. must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished; and b. may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee.	☐ a. Sufficient services to achieve purpose ☐ b. No arbitrary denial or reduction of services	**0.650** **0.650**	**1.300**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Service Limitations 42 CFR 438.210(a)(4)(i)-(ii), DSC 3-5	The DBM may place appropriate limits on a service on the basis of criteria applied under the Florida Healthy Kids Corporation (FHKC) plan, such as medical necessity, or for the purpose of utilization control, provided that: a. the services furnished can reasonably achieve their purpose, as required in 42 CFR 438.210(a)(3)(i); and b. the services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services.	☐ a. Services can achieve their purpose ☐ b. Services authorized in a manner that reflects enrollee's ongoing need	**0.650** **0.650**	**1.300**	**X.XXX**
Findings **Strength**					

2019 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
AON					
Suggestion					
3. Medically Necessary Services 42 CFR 438.210(a)(5)(i)-(ii)	The DBM must specify what constitutes "medically necessary services" in a manner that: a. is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and b. addresses the extent to which the DBM is responsible for covering services that address: 1. the prevention, diagnosis, and treatment of an enrollee's disease, condition, and/or disorder that results in health impairments and/or disability; 2. the ability for an enrollee to achieve age-appropriate growth and development; and 3. the ability for an enrollee to attain, maintain, or regain functional capacity.	☐ a. Is no more restrictive than that used in the State Medicaid program ☐ b. Addresses the extent to which the DBM is responsible for covering services	**1.300** **1.300**	**2.600**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
4. Authorization of Services 42 CFR 438.210(b)(1), DSC 3-5	For the processing of requests for initial and continuing authorizations of services, the DBM and its subcontractors have in place, and follow, written policies and procedures.	☐ Yes ☐ No	**2.600** **0.000**	**2.600**	**X.XXX**
Findings					

2019 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Strength					
AON					
Suggestion					
5. Application of Review Criteria 42 CFR 438.210(b)(2)(i)-(ii), DSC 3-5	For the processing of requests for initial and continuing authorizations of services, the DBM must: a. have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and b. consult with the requesting provider for dental services when appropriate.	☐ a. Mechanisms to ensure consistent application of review criteria ☐ b. Requesting provider consultation	**3.900** **3.900**	**7.800**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
6. Appropriate Reviewer Expertise 42 CFR 438.210(b)(3), DSC 3-5	The DBM must ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual who has appropriate expertise in addressing the enrollee's medical health needs. The process must include the training given to the reviewers.	☐ Reviewers with appropriate expertise and clinical background ☐ Reviewer training	**3.900** **3.900**	**7.800**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					

2019 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
7. Notice of Adverse Benefit Determination 42 CFR 438.210(c)	The DBM must notify the requesting provider, and give the enrollee written notice of any decision by the DBM to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The enrollee's notice must meet the requirements of 42 CFR 438.404.	☐ Written notice to enrollee ☐ Notice to provider	**3.900** **3.900**	**7.800**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
8. Timeframe for Standard Authorization Decisions 42 CFR 438.210(d)(1)(i)-(ii), DSC 3-5	For standard authorization decisions, the DBM must provide notice as expeditiously as the enrollee's condition requires and within FHKC-established timeframes that may not exceed 14 calendar days following receipt of the request for service.	☐ Yes ☐ No	**3.900** **0.000**	**3.900**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2019 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
9. Timeframe for Expedited Authorization Decisions 42 CFR 438.210(d)(2)(i)-(ii), DSC 3-5	For cases in which a provider indicates, or the DBM determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the DBM must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.	☐ Yes ☐ No	**3.900** **0.000**	**3.900**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
10. Extension of Decision Timeframe 42 CFR 438.404(c)(4)(i)-(ii), DSC 3-5	The DBM may extend the timeframe up to 14 additional calendar days, if the enrollee, or the provider, requests an extension or the DBM justifies to FHKC, upon request, a need for additional information and how the extension is in the enrollee's interest, provided that: a. the DBM gives the enrollee written notice of the reason for the decision to extend the timeframe and informs the enrollee of the right to file a grievance; and b. the DBM issues and carries out the determination as expeditiously as the enrollee's health condition requires, but no later than the date the extension expires.	☐ Written notice to enrollee of reason for decision and right to file a grievance ☐ Determination carried out as expeditiously as the enrollee's health condition requires but no later than the date the extension expires	**3.900** **3.900**	**7.800**	**X.XXX**

2019 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Findings					
Strength					
AON					
Suggestion					
11. Compensation for Utilization Management Activities 42 CFR 438.210(e), DSC 3-5	The DBM must ensure that compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.	☐ Yes ☐ No	**2.600** **0.000**	**2.600**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
12. Termination, Suspension, or Reduction of Services CFR 438.404(c)(1), DSC 3-5	For termination, suspension, or reduction of previously approved services, the DBM must provide notice at least 10 calendar days before the date of action except when: a. the DBM has information concerning the death of the enrollee; b. the DBM receives a clear, written, signed statement from the enrollee stating that the enrollee no longer wishes to receive services or the enrollee gives information that requires termination or reduction of services and the enrollee indicates understanding that termination or reduction of services must be the outcome of providing such information;	☐ Yes ☐ No	**2.600** **0.000**	**2.600**	**X.XXX**

2019 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
	c. the enrollee has been admitted to an institution that causes ineligibility under the plan for further services; d. the enrollee's whereabouts are unknown and the U.S. Postal Service returns the DBM's mail directed toward the enrollee indicating no forwarding address; e. the DBM establishes that the enrollee is enrolled in the FHK program in another region; f. a change in the level of medical care is prescribed by the enrollee's physician; g. the notice involves an adverse benefit determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the *Social Security Act*; h. in accordance with 42 CFR 431.213(h); and i. the DBM has facts, verified through secondary sources when possible, indicating that action should be taken because of probable fraud by the enrollee, in which case the notice must be provided at least five calendar days before the date of action.				
	Findings				
	Strength				
	AON				
	Suggestion				
13. Denial of Payment	For denial of payment, the DBM must provide notice at the time of any action affecting the claim.	☐ Yes ☐ No	**1.300** **0.000**	**1.300**	**X.XXX**

2019 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
CFR 438.404(c)(2), DSC 3-5					
Findings					
Strength					
AON					
Suggestion					
14. Decisions Exceeding Timeframes CFR 438.404(c)(5), DSC 3-5	For service authorization decisions not reached within the timeframes required by 42 CFR 438.210(d), which constitutes a denial and is an adverse benefit determination, the DBM must provide the notice on the date the timeframe expires.	☐ Yes ☐ No	**2.600** **0.000**	**2.600**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
15. Elements of Adverse Benefit Determination Notice CFR 438.404(a), DSC 3-5	A notice of adverse benefit determination must include: a. the adverse benefit determination the DBM has made; b. the reason for the adverse benefit determination; c. the enrollee's right to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse benefit determination, including medical necessity criteria and processes, strategies, or evidentiary standards used in setting coverage limits;	☐ a. Adverse benefit determination ☐ b. Reason for adverse benefit determination ☐ c. Enrollee's right free of charge to information relevant to the adverse benefit determination ☐ d. Enrollee's right to request an appeal ☐ e. Procedures for filing an appeal	**2.600** **2.600** **2.600** **2.600** **2.600**	**15.600**	**X.XXX**

2019 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
	d. the enrollee's right to request an appeal, including information on exhausting the appeal process, and the right to request a Subscriber Assistance Panel (SAP) hearing (prior to July 1, 2018) or use of an Independent Review Organization (IRO) or the federal review process (on or after July 1, 2018); e. the procedures for exercising these rights; and the circumstances under which an appeal can be expedited and how the enrollee can request an expedited appeal.	☐ f. Process for requesting an expedited appeal	**2.600**		
Findings					
Strength					
AON					
Suggestion					
		Coverage and Authorization of Services	**0.0%**	**71.500**	**0.000**

2019 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
1. Appropriate Source of Care 42 CFR 438.208(b)(1), DSC 3-2-1	The DBM must ensure each enrollee has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee. The DBM must provide enrollees information on how to contact their designated person or entity.	☐ Primary care coordinator ☐ Designated entity contact information	**2.600** **2.600**	**5.200**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
		Coordination and Continuity of Care	**0.0%**	**5.200**	**0.000**

2019 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
1. Contract Compliance 42 CFR 438.230(b)(1), DSC 3-30-C	The DBM must maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with FHKC, notwithstanding any relationship(s) the DBM may have with any subcontractor.	☐ Yes ☐ No	**2.600** **0.000**	**2.600**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Delegation of Activities 42 CFR 438.230(c)(1)(i)-(iii), DSC 3-30	If any of the DBM's activities or obligations under its contract with FHKC are delegated to a subcontractor: a. the delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement; b. the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the DBM's contract obligations; c. the contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where FHKC or the DBM determines that the subcontractor has not performed satisfactorily; and d. all such agreements shall also be available to FHKC within seven business days of request for production.	☐ a. Delegated activities specified in contract or written agreement ☐ b. Subcontractor agreement ☐ c. Revocation of delegation of activities ☐ d. Agreements available to FHKC within seven days of request	**2.600** **2.600** **2.600** **2.600**	**10.400**	**X.XXX**
Findings **Strength** **AON**					

2019 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
Suggestion					
3. Regulatory Compliance 42 CFR 438.230(c)(2)	The subcontractor must comply with all applicable Children's Health Insurance Program (CHIP) laws and regulations, including applicable subregulatory guidance and contract provisions.	☐ Yes ☐ No	**1.100** **0.000**	**1.100**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
4. Subcontractor Audit 42 CFR 438.230(c)(3)(i)-(iv)	The subcontractor must agree that: a. FHKC, Centers for Medicare & Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the DBM's contract with FHKC; b. the subcontractor will make available, for purposes of an audit, evaluation, or inspection under 42 CFR 438.230(c)(3)(i) its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its FHK enrollees; c. the right to audit under 42 CFR 438.230(c)(3)(i) will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later; and	☐ a. Right to audit ☐ b. Subcontractor audit availability ☐ c. 10-year post-contract right to audit ☐ d. Right to audit at any time there is a possibility of fraud or similar risk	**1.150** **1.150** **1.150** **1.150**	**4.600**	**X.XXX**

2019 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
	d. if FHKC, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, FHKC, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.				
Findings **Strength** **AON** **Suggestion**					
5. Notification of Agreement Termination DSC 3-30-D	The DBM must provide FHKC with timely notice of termination of agreements with any subcontractor or affiliate. On a quarterly basis, the DBM must provide FHKC with an attestation as to the adequacy of the DBM's network.	☐ Termination notice ☐ Quarterly attestation	**1.150** **1.150**	**2.300**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
6. Notice of Intent to Subcontract DSC 3-30-E	The DBM must provide FHKC with timely notice of the DBM's intent to contract with any new subcontractors or affiliates for services covered. Prior to execution, the DBM must forward for FHKC's review and approval any proposed agreement for services with subcontractors or affiliates.	☐ Timely notice to FHKC ☐ Proposed agreement forwarded to FHKC for approval	**1.150** **1.150**	**2.300**	**X.XXX**
Findings **Strength**					

2019 Annual Compliance Assessment: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Subcontractual Relationships and Delegation					
AON					
Suggestion					
		Subcontractual Relationships and Delegation	**0.0%**	**23.300**	**0.000**

MCO and DBM File Review Tool

UM Denials File Review Tool

MCO/DBM: <MCO/DBM Name> **XX/XX/XX**

1	2	3	4		5			6		7		8	9	10	11	12		13	
File #	Case ID*	Date Request Rec'd.	Appropriate Review Criteria Used		Requesting Provider Consulted			Final Denial Decision by Qualified Profes-sional		Decision NOT Arbitrary = Yes		E/S**	Date Notified	# of Days for Notifi-cation	Notification Time Standard	Notification Time Standard Met		NABD Content Complete	
			Y	N	Y	N	NA	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 enrollee information.*

***Expedited or Standard*

Total Compliant:	
Total Applicable:	
Percent Compliant:	

PIP Validation

The FHKC 2019 PIP Validation Tool was used to assess applicable MCO and DBM PIPs in accordance with CMS protocol.

2019 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>					
Activity I: Choose the Selected Study Topic(s)					
Topics selected for the study should reflect the Florida Healthy Kids 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 or services. The topic may be specified by Florida Healthy Kids Corporation (FHKC).					
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	☐	Addresses any exclusion of 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:	<Type comment here>.					
Strength:	<Type strength here>.					
AON:	<Type AON here>.					

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

2019 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>
Suggestion: <Type suggestion here>.

2019 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>					
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***	**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:	<Type comment here>.					
Strength:	<Type strength here>.					
AON:	<Type AON here>.					
Suggestion:	<Type suggestion here>.					

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

2019 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>					
Activity III: Use a Representative and Generalizable Study Population					
The selected topic should represent the entire eligible population of Florida Healthy Kids enrollees with system-wide measurement and improvement efforts to which the study indicator(s) applies.					
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/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:	<Type comment here>.					
Strength:	<Type strength here>.					
AON:	<Type AON here>.					
Suggestion:	<Type suggestion here>.					

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

2019 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>					
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 received a recommended vaccination) or a status (e.g., a child diagnosed with asthma is not prescribed a controller medication) 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:	<Type comment here>.					
Strength:	<Type strength here>.					
AON:	<Type AON here>.					
Suggestion:	<Type suggestion here>.					

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

2019 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>					
Activity V: Use Sound Sampling Methods					
If sampling is used to select enrollees in 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. This activity is only scored if sampling is used. **If sampling was not used, e.g. the entire eligible population was assessed, this activity is not scored.**					
Element #	**C***	**Sampling methods:**	**Met**	**Not Met**	**NA****
1	☐	Consider and specify the calculated administrative rate or estimated rate	☐	☐	☐
2	☐	Identify the sample size	☐	☐	☐
3	☐	Specify the confidence level to be used	☐	☐	☐
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:	<Type comment here>.					
Strength:	<Type strength here>.					
AON:	<Type AON here>.					
Suggestion:	<Type suggestion here>.					

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

2019 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>					
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:**	**Met**	**Not Met**	**NA****
1	☐	Identify data elements to be collected	☐	☐	☐
2	☐	Identify specified sources of data	☐	☐	☐
3	☐	Describe a defined and systematic process for collecting baseline and remeasurement data	☐	☐	☐
4	☐	Include data collection and analysis cycles	☐	☐	☐
5	☐	Describe qualified staff and personnel to abstract manual data	☐	☐	☐
6	☐	Describe the data collection tool that supports inter-rater reliability (IRR) and the IRR process	☐	☐	☐
7	☑	Include a manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications	☐	☐	☐
8	☐	Include clear and concise written instructions for completing the manual data collection tool	☐	☐	☐
9	☐	Include an overview of the study in written instructions	☐	☐	☐
10	☐	Include administrative data collection algorithms/flowcharts or narrative that shows activities in the production of indicators	☐	☐	☐
11	☐	Include an estimated degree of administrative data completeness	☐	☐	☐
Activity VI Results:			**Total**	**Met**	**Not Met**	**NA**
All Elements			11			
Critical Elements			1			
Comment: <Type comment here>.						

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

2019 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>	
Strength:	<Type strength here>.
AON:	<Type AON here>.
Suggestion:	<Type suggestion here>.

2019 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>					
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, and interpret the findings.					
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(s)	☐	☐	☐
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			
Comment:	<Type comment here>.					
Strength:	<Type strength here>.					
AON:	<Type AON here>.					
Suggestion:	<Type suggestion here>.					

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

2019 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>					
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:	<Type comment here>.					
Strength:	<Type strength here>.					
AON:	<Type AON here>.					
Suggestion:	<Type suggestion here>.					

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

2019 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>					
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 assessed/analyzed. Also address any random, year-to-year variations; population changes; or sampling errors that may have occurred during the measurement process. This activity is not assessed until a baseline measurement and a minimum of one annual remeasurement has been completed.					
Element #	**C***	**Assessments for real improvement indicate that:**	**Met**	**Not Met**	**NA****
1	☐	The remeasurement methodology is the same as the baseline methodology	☐	☐	☐
2	☐	Documented improvements in processes or outcomes of care are assessed	☐	☐	☐
3	☐	Improvements appear to be the result of planned intervention(s)	☐	☐	☐
4	☐	Statistical evidence that observed improvement is true improvement is addressed	☐	☐	☐
Activity IX Results:			**Total**	**Met**	**Not Met**	**NA**
All Elements			4			
Critical Elements			0			
Comment:	<Type comment here>.					
Strength:	<Type strength here>.					
AON:	<Type AON here>.					
Suggestion:	<Type suggestion here>.					

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

2019 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>					
Activity X: Assess for Sustained Improvement					
Describe any improvement demonstrated through repeated measurements over comparable time periods. Assess for any random, year-to-year variations; population changes; sampling errors; or statistically significant declines that may have occurred during the remeasurement process. This activity is not assessed until a baseline measurement and a minimum of two annual remeasurements have been completed.					
Element #	**C***	**Sustained improvement strategies indicate that:**	**Met**	**Not Met**	**NA****
1	☐	Repeated measurements over comparable time periods are assessed for sustained improvement.	☐	☐	☐
Activity X Results:			**Total**	**Met**	**Not Met**	**NA**
All Elements			1			
Critical Elements			0			
Comment:	<Type comment here>.					
Strength:	<Type strength here>.					
AON:	<Type AON here>.					
Suggestion:	<Type suggestion here>.					

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

PDSA

The FHKC 2019 PDSA Plan-Do Review Tool and the FHKC 2019 PDSA Study-Act Review Tool were used to assess MCO and DBM PDSAs.

Plan-Do

2019 PDSA—<MCO/DBM Name> <Clinical/Nonclinical> – <PIP Study Title>				
Activity I: Plan				
Element #		**Met**	**Opportunity**	**NA***
1	Set aim of the project	☐	☐	☐
2	Define measure	☐	☐	☐
3	State measure baseline	☐	☐	☐
4	Develop driver diagram	☐	☐	☐
5	Select specific change ideas and rationale for selection	☐	☐	☐
6	Describe planned data collection process	☐	☐	☐
7	Develop initial sustainability plan	☐	☐	☐
Activity I Results:	**Total**	**Met**	**Opportunity**	**NA**
All Elements	7			
Comment:				
Strength:				
Suggestion:				

* *Not applicable*

2019 PDSA—<MCO/DBM Name> <Clinical/Nonclinical> – <PIP Study Title>				
Activity II: Do				
Element #	**The study question(s):**	**Met**	**Opportunity**	**NA***
1	Describe the change implemented and the scale of the test	☐	☐	☐
2	Describe the results of the test	☐	☐	☐
Activity II Results:	**Total**	**Met**	**Opportunity**	**NA**
All Elements	2			
Comment:				
Strength:				
Suggestion:				

* *Not applicable*

Study-Act

2019 PDSA—<MCO/DBM Name> <Clinical/Nonclinical> – <PIP Study Title>				
Activity III: Study				
Element #		**Met**	**Opportunity**	**NA***
1	Analyze and compare results	☐	☐	☐
2	Describe what was learned from test of change	☐	☐	☐
Activity III Results:	**Total**	**Met**	**Opportunity**	**NA**
All Elements	2			
Comment:				
Strength:				
Suggestion:				

* *Not applicable*

2019 PDSA—<MCO/DBM Name> <Clinical/Nonclinical> – <PIP Study Title>				
Activity IV: Act				
Element #		**Met**	**Opportunity**	**NA***
1	Describe action to be taken	☐	☐	☐
2	Complete sustainability plan	☐	☐	☐
3	Describe plan for next PDSA cycle	☐	☐	☐
Activity IV Results:	**Total**	**Met**	**Opportunity**	**NA**
All Elements	3			
Comment:				
Strength:				
Suggestion:				

* *Not applicable*

APPENDIX C | 2019 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 2019—one face to face and two virtual—offered strategies for medical–dental collaboration from the American Dental Association; an overview of the Annual Network Adequacy activity analysis from Quest Analytics; an overview and timeline of annual EQRO activities for the year; a discussion of the right to health for children with medical complexities; two Plan samples of Plan-Do-Study-Act rapid improvement cycle best practices; state strategies for promoting improvement in oral health from the National Academy for State Health Policy; and one Plan's best practices for improving human papilloma virus vaccination rates for adolescents.

Table C-1. 2019 FHKC All-Plan Meetings

Presentation Title	Presenter
January 14, 2019	
Medical−Dental Collaboration: Strategies for Quality Improvement, Disease Prevention, and Cost Control	♦ Dr. Jane Grover, Director, Council on Advocacy for Access and Prevention, American Dental Association
Annual Network Adequacy Analysis	♦ James Lamb, Regional Sales Director, Quest Analytics
2019 EQRO Activities Overview and Timeline	♦ Lois Heffernan, EQRO Program Manager, Qsource
June 13, 2019	
Advancing the Right to Health of Children with Medical Complexity	♦ Jeffrey Goldhagen, President, International Society for Social Pediatrics and Child Health, and Professor and Chief, Division of Community and Societal Pediatrics University of Florida College of Medicine—Jacksonville
Plan-Do-Study-Act Best Practices	♦ Kathleen McKim, Senior Director, Quality Improvement, Sunshine Health Plan ♦ Diana Valderrama, Senior Clinical Data Analyst, UnitedHealthcare

Table C-1. 2019 FHKC All-Plan Meetings	
Presentation Title	**Presenter**
September 19, 2019	
State Strategies for Promoting Improvement in Oral Health	♦ Carrie Hanlon, Project Director, National Academy for State Health Policy
The Opioid Epidemic: A Pediatric and Adolescent Perspective	♦ Dr. Benjamin S. Heavrin, Chief Medical Officer, Qsource
Human Papilloma Virus (HPV): Vaccinate Adolescents Against Cancer	♦ Bushra Khan, Manager, Clinical Quality, Simply Healthcare Plans