Florida Healthy Kids Children's Health Insurance Program

2021 Annual

External Quality Review Technical Report

For Review Period January 1, 2020–December 31, 2020

HealthyKids™

Qsource

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List of Tables and Charts

Acknowledgements, Acronyms, and Initialisms[1]

AAAHC...Accreditation Association for Ambulatory Health Care
ACA.....Annual Compliance Assessment
ADD.....Follow-Up Care for Children Prescribed ADHD Medication
ADHD.....Attention-Deficit/Hyperactivity Disorder
ADV.....Annual Dental Visit
AHCA..... Agency for Health Care Administration
AHRQ..... Agency for Healthcare Research and Quality
AMB-ED ..... Ambulatory Care: Emergency Department Visits
AMR ..... Asthma Medication Ratio
ANA.....Annual Network Adequacy
AOD .....Alcohol and Other Drug
AON .....Area of Noncompliance
APM .. Metabolic Monitoring for Children and Adolescents on Antipsychotics
APP.....Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
AWC.....Adolescent Well-Care Visits
B..... Baseline
BMI.....Body Mass Index
BR .....Biased Rate
CAHPS® .Consumer Assessment of Healthcare Providers and Systems, a registered trademark of NCQA
CAP ..... Corrective Action Plan
CCP..... Contraceptive Care – Postpartum Women Ages 15−20
CCW.....Contraceptive Care – All Women Ages 15−20
CDF..... Screening for Depression and Follow-Up Plan: Ages 12−17
CFR ..... *Code of Federal Regulations*
CHIP..... Children's Health Insurance Program
CHL .....Chlamydia Screening in Women
CMS ..... Centers for Medicare & Medicaid Services
CPC..... CAHPS Health Plan Survey 5.0H, Child Version
CPT .....Current Procedural Terminology
CWP ..... Appropriate Testing for Children with Pharyngitis
DBM ..... Dental Benefit Manager
DD ..... Day
Den. ..... Denominator
DSC..... Dental Services Contract
E .....Expedited
ED .....Emergency Department
EDV..... Encounter Data Validation
ENT ..... Otolaryngology (ear, nose, and throat)

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

EQR/EQRO ..... External Quality Review/ EQR Organization
FAR ..... Final Audit Report
FFS ..... Fee for Service
FHKC ..... Florida Healthy Kids Corporation
FUA ..... Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence
FUH ..... Follow-Up After Hospitalization for Mental Illness
FUM ..... Follow-Up After Emergency Department Visit for Mental Illness
HEDIS® ..... Healthcare Effectiveness Data and Information Set, a registered trademark of NCQA
HHS ..... U.S. Department of Health and Human Services
HPV ..... Human Papillomavirus
IAD ..... Identification of Alcohol and Other Drug Services
ICD ..... International Classification of Diseases
ID ..... Identification
IDSS ..... Interactive Data Submission System
IET ..... Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment
IHCP ..... Indian Healthcare Provider
IHI ..... Institute for Healthcare Improvement
IMA ..... Immunizations for Adolescents
IRO ..... Independent Review Organization
IS ..... Information System(s)
ISCAT ..... Information Systems Capability Assessment Tool
MCO ..... Managed Care Organization
MCP/Plan ..... Managed Care Plan
MM ..... Month
MPT ..... Mental Health Utilization
MRR ..... Medical Record Review
MSC ..... Medical Services Contract
N ..... No/Number
NA ..... Not Applicable (ACA/PIP)
NA ..... Small Denominator (PMV)
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
OPA ..... U.S. Office of Population Affairs
P&P ..... Policy and Procedure
PC-02 ..... Cesarean Birth
PCP ..... Primary Care Provider/Physician
PDENT ..... Dental Preventive Services
PDP ..... Primary Dental Provider
PDSA ..... Plan-Do-Study-Act
PIP ..... Performance Improvement Project
PMV ..... Performance Measure Validation
PPC ..... Prenatal and Postpartum Care
Q ..... Quarter
QAPI ..... Quality Assessment and Performance Improvement

QIC ..... Quality Improvement Committee
QIP ..... Quality Improvement Plan
Qsource® ..... a registered trademark
R ..... Reportable Rate
R1/R2/R3 ..... Remeasurement Year 1/ Remeasurement Year 2/Remeasurement Year 3
Roadmap ..... Record of Administrative Data Management and Processes
S ..... Standard
SCP ..... Specialty Care Provider
SEA ..... Enrolled Children Receiving Dental Sealants on Permanent Molars
SQL ..... Structured Query Language
Td ..... Tetanus and Diphtheria Toxoids Vaccine
Tdap ..... Tetanus, Diphtheria Toxoids, and Acellular Pertussis Vaccine
TDENT ..... Dental Treatment Services
TJC ..... The Joint Commission
TTY/TTD ..... Text-Based Telecommunications
UB-04 ..... Uniform Bill (CMS-1450 form)
URAC® ..... a registered trademark
URI ..... Appropriate Treatment for Children with Upper Respiratory Infection
WCC .. Weight Assessment and Counseling for Nutrition & Physical Activity for Children/Adolescents
WCV ..... Child and Adolescent Well-Care Visits
Y ..... Yes
YYYY ..... Year

Overview

In accordance with Title 42 *Code of Federal Regulations* (CFR) § 438.364, Qsource has produced this *2021 Annual EQRO Technical Report* to summarize the quality, timeliness, and accessibility of care furnished to enrollees in the Florida Healthy Kids program by the managed care organizations (MCOs) and dental benefit managers (DBMs) contracted by the Florida Healthy Kids Corporation (FHKC). Title 42 of the CFR governs U.S. public health services. States that provide Children's Health Insurance Program (CHIP) services through contracts with MCOs/DBMs are required by federal mandate (42 CFR §§ 438.310–438.370, incorporated in § 457.1250) to conduct external quality review activities and ensure that the results of those activities are used to perform an external, independent assessment and produce an annual report. Qsource serves as FHKC's external quality review organization (EQRO) and prepared this *2021 Annual EQRO Technical Report* to document Florida Healthy Kids MCO and DBM performance in providing services to enrollees and to identify areas for improvement and recommend interventions to improve the process and outcomes of care. This section provides a brief history of FHKC, the organization's strategy for the Florida Healthy Kids program, EQR activities conducted in 2021, the guidelines for this report, and intended uses for this report.

Florida Healthy Kids Background

Created in 1990 by the Florida legislature, FHKC aims to improve access to medical and dental health insurance for the state's uninsured children, ages five to 18 years. In 1997, Florida Healthy Kids became one of three state programs grandfathered into the original CHIP legislation created through Title XXI of the *Social Security Act* and reauthorized in 2009. 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 2020, the measurement year under review, three MCOs and three DBMs operated in Florida:

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

- Simply Healthcare Plans, Inc. (Simply Healthcare), MCO

These entities, also known as managed care plans (MCPs) are referred to as Plans as well as MCOs and DBMs in this report.

As of August 2021, illustrated in **Chart 1**, more than 145,000 children were enrolled in the Florida Healthy Kids program, close to 125,000 in the subsidized program and over 21,000 in the full-pay option. In December 2020, nearly 170,000 children were enrolled in the program.

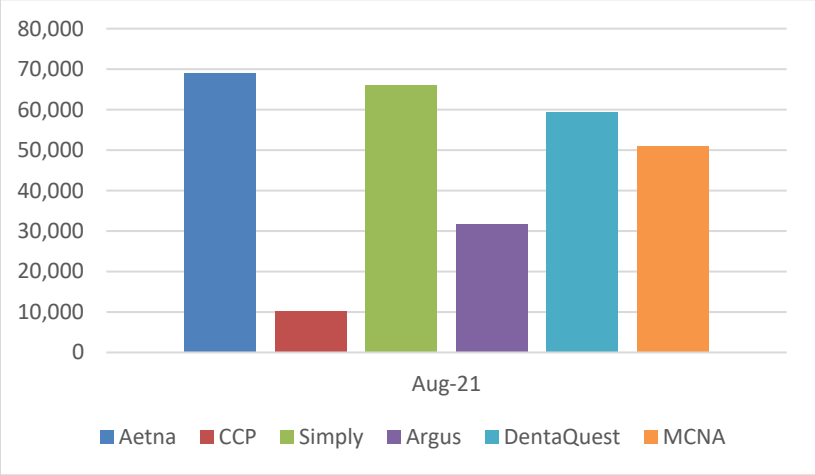

Chart 1. Florida Healthy Kids Enrollment by MCO/DBM

Community Care provides services for Florida Healthy Kids enrollees in eight counties (Broward, Indian River, Martin, Miami-Dade, Monroe, Okeechobee, Palm Beach, and St. Lucie). The remaining MCOs and DBMs provide services in all 67 Florida counties.

FHKC Quality Strategy Plan

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

The Quality Strategy Plan is implemented through the ongoing comprehensive quality assessment and performance improvement programs (QAPIs) that the MCOs and DBMs must have in place. Each MCO/DBM's QAPI includes performance improvement projects and performance measures as determined by FHKC and evaluated by Qsource to foster alignment among QAPI requirements, the Quality Strategy Plan, and the annual EQR activities.

Figure 1. Quality Strategy Plan Goals

FHKC's goals and vision and mission statements align with the three aims of the National Quality Strategy: better care, improved health for people and communities, and affordable healthcare. FHKC's 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. Using its vision and mission statements, FHKC developed the six primary goals listed included in **Figure 1**. These goals helped shape FHKC's approach to improving the quality, timeliness, and accessibility of healthcare for its enrollees. The Quality Strategy Plan includes two primary areas of focus, access to quality care and quality assurance.

Access to Quality Care

Three primary challenges affect the provision of care for Florida Healthy Kids enrollees: the rural nature of the state, physician hesitancy to contract with publicly funded insurance programs or acceptance of fewer patients with publicly funded insurance coverage than those with private insurance, and the insufficient number of pediatric subspecialists currently in the workforce.

To mitigate these threats to providing access to care, FHKC requires its MCOs and DBMs to meet network adequacy time and distance standards it established in the Quality Strategy Plan and the MCO and DBM contracts. FHKC also requires each MCO/DBM to demonstrate its capacity to service the expected

population of Florida Healthy Kids enrollees and to adhere to time standards for providing services. Other areas monitored toward achieving access to quality care include provider information accuracy and provider quality, care for children with special healthcare needs, transition of care, benefit decisions, and reducing health disparities.

Quality Assurance

FHKC monitors quality assurance for the Florida Healthy Kids program through continuous quality improvement requirements for the MCOs and DBMs as well as the annual EQR activities described in this report.

EQR Activities

As set forth in 42 CFR § 438.358, incorporated by 42 CFR § 457.1250, four mandatory EQR activities must be conducted to assess the performance of the MCOs and DBMs in regard to the quality of, timeliness of, and access to care provided for Florida Healthy Kids enrollees. In addition, 42 CFR § 438.358 outlines six optional EQR activities that may be conducted at the state agency's discretion. Each state agency (in this case, FHKC) may also assign other responsibilities to its designated EQRO, such as the provision of ongoing technical assistance. As outlined in Title 42 CFR § 438.352, the Centers for Medicare & Medicaid Services (CMS) is required to develop protocols to guide and support the completion of EQR-related activities. As CHIPs are required to undergo EQR activities also, the protocols apply to the Florida Healthy Kids program as well. This section summarizes the activities that Qsource performed for FHKC in 2021, according to CMS EQR Protocols published in October 2019. No protocol had yet been published at the time of conducting network adequacy activities for 2021, so Qsource, in cooperation with its subcontractor, Quest Analytics, followed internally developed standards.

Quality of Care

While quality of care has numerous applications, CMS describes it as the degree to which preferred enrollee health outcomes are likely to be increased through the efforts of the MCOs and DBMs providing enrollee services, including the Plans' organization and operations. Part of each Plan's provision of care to enrollees involves clinical practice guidelines, which are required to be based on valid and reliable clinical evidence or a consensus of providers in the relevant field. The review of each Plan's compliance with these types of federal, state, and contractual regulations governing managed care (compliance assessment) contributes to the monitoring of quality of care for Florida Healthy Kids enrollees. The Plans' required QAPI plans, which include performance improvement projects and aim to improve quality performance measure results for the Florida Healthy Kids population, allow for quality planning and management.

Enrollee experience of care—evaluated in part through CAHPS [Consumer Assessment of Healthcare Providers and Systems (CAHPS®)] Health Plan Survey 5.0H, Child Version (CPC) overall satisfaction and composite scores for key areas—is

another indicator of quality of care. Enrollee experience is also measured through the annual network adequacy validation, encompassing access to and timeliness of care, which also are quality of care measurements.

In addition, encounter data validation serves to measure healthcare quality by identifying the degree to which accurate and complete service utilization data are reported by the MCOs and DBMs, helping to ensure effective operation and oversight of the Plans serving Florida Healthy Kids enrollees.

To assess each Plan's quality of care, Qsource conducted the following EQR activities:

- Review of compliance with Medicaid and CHIP managed care regulations (annual compliance assessment, ACA)
- Validation of performance improvement projects (PIPs)
- Validation of performance measures (PMV)
- Validation of network adequacy (ANA)
- Validation of encounter data (EDV), one of the optional CMS EQR activities

Timeliness of Care

For quality care to be effective, it has to be provided in an appropriately timely manner. Thus, various standards for timely care are monitored through Plan compliance with federal, state, and contractual regulations; the Plans' network adequacy to deliver services timely; and Plan timeliness in processing prior authorization requests, claims, grievances, and appeals.

To assess each Plan's timeliness of care, Qsource conducted the following EQR activities:

- ACA
- ANA
- EDV

Access to Care

Just as quality of care is critical for enrollee health outcomes, so is access to care when it is needed. Each FHKC Plan must attest annually to its ability to provide Florida Healthy Kids enrollees with adequate access to the care they need. The Plans' provider capacity is also monitored through network adequacy evaluation, which assesses the availability of critical provider specialties by time and distance and how quickly enrollees can obtain needed appointments. Compliance with applicable federal, state, and contractual regulations also addresses access to care requirements, ensuring accessibility for all enrollees, including those with limited English proficiency and physical or mental disabilities. Access to care also may be measured through focused Plan efforts via PIPs that address the availability of services needed by enrollees and the degree to which enrollees may access those services. Plan performance on various quality measures helps enable monitoring of enrollee access to care as well.

To assess each Plan's access to care, Qsource conducted the following EQR activities:

- ANA
- ACA
- PIPs
- PMV

As part of its EQRO role beyond the CMS EQR Protocol activities, Qsource provided FHKC and its MCOs and DBMs with technical assistance—an EQR-related activity also defined by 42 CFR § 438.358 and incorporated by 42 CFR § 457.1250. In this capacity, Qsource maintained ongoing, collaborative communication with FHKC and supported the MCOs and DBMs in their EQR activities. Most notably, Qsource provided PIP technical assistance to all the Plans to assist them in understanding requirements associated with the revised CMS EQR protocol and in completing the PIP Summary Form, which changed significantly from the prior-year PIP validation. Qsource met individually with Plan staff responsible for overseeing PIP efforts. In addition, Qsource developed an example PIP designed to guide Plan staff as they completed their own 2021 PIP Summary Form as well as a sample Plan-Do-Study-Act (PDSA) worksheet to enhance Plan rapid-cycle implementation and reporting. One other guide, instructing Plans how to conduct the Chi-Square test to assess the fit between the Plans' actual results and expected values for the PIP, was provided to the Plans in response to their questions related to statistical testing.

Qsource also continued to work closely with the Plans to assist them as they assessed their claims and encounter data collection and reporting systems following FHKC's collaboration with the Agency for Healthcare Administration (AHCA) to develop new data submission guidelines effective January 1, 2020. These efforts aimed to create more standardized reporting between the two agencies. Qsource and FHKC met virtually on multiple occasions with individual MCOs and DBMs in 2020 to help staff determine capacity to meet the new guidelines with existing systems and transition to the new layout in an effort to reduce potential errors on initial data submission. This technical assistance continued into 2021.

Finally, Qsource conducted three health and dental All-Plan meeting(s) that were attended by FHKC, MCO, and DBM staff. The three virtual 2021 meeting(s) featured the following topics:

- Integrated Care for Patients with Addictions – From Adolescence to Adulthood
- COVID-19, Social Media, and the Adolescent Brain
- Oral Health Equity in Florida: We Are Not Doing a Good Job!
- Cultural and Linguistic Competency
- Performance Improvement Project Best Practices
- 2022 Compliance Assessment Update – New CMS Protocol Requirements
- The Role of Life Experiences in Shaping Brain Development
- 2022 External Quality Review Activities
- Improving Oral Health Outcomes Through Use of Quality

The virtual meetings were held in June, September, and December.

Technical Report Guidelines

To assist both EQROs and state agencies, CMS supplemented the requirements of 42 CFR § 438.364, as incorporated by 42 CFR § 457.1250, and provided guidelines in the 2019 EQR Protocols for producing annual technical reports. Qsource revised the *Annual EQRO Technical Report* to reflect the guidelines, including aiming for a 50-page or less count for the primary report body. Requirements for report content also were followed.

Qsource is responsible for the creation and production of this *2021 Annual EQRO Technical Report*, which compiles the results of the EQR activities conducted in 2021 to determine each MCO's and DBM's compliance with federally mandated activities. Qsource's efforts are a primary means of assessing the quality, timeliness, and accessibility of services provided by FHKC's MCOs and DBMs.

This report includes the following results of these activities:

- Technical methods for data collection and analysis, data description, and conclusions drawn from data analysis for each of the EQR compliance activities
- Strengths and weaknesses demonstrated by each MCO and DBM in providing healthcare services to Florida Healthy Kids enrollees
- Recommendations for improving the quality of these services, including how FHKC can target goals and objectives in the Quality Strategy Plan to better support improvement
- Methodologically appropriate, comparative information about all FHKC's MCOs and DBMs, consistent with CMS EQR protocol guidance
- The degree to which each MCO/DBM has effectively addressed the recommendations for quality improvement made during the 2020 EQR

This *2021 Annual EQRO Technical Report* is based on detailed findings that can be examined in the individual EQR activity reports provided to FHKC as well as the MCOs and DBMs. Comparative analyses from EQR reviews conducted in 2019, 2020, and 2021 are included in this report where possible.

In addition to this Overview, this year's technical report includes the following EQR-activity-specific sections, followed by an overall Conclusions and Recommendations section:

- Performance Improvement Project (PIP) Validation
- Performance Measure Validation (PMV)
- Annual Compliance Assessment (ACA)
- Annual Network Adequacy (ANA)
- Encounter Data Validation (EDV)

The appendices provide additional EQR activity information:

- Appendix A includes more detailed, MCO/DBM-specific results.
- Appendix B provides the tools used to conduct the 2021 EQR activities.

FHKC Utilization of the EQRO Technical Report

The *Annual EQRO Technical Report* provides FHKC with substantive, unbiased data for the MCOs and DBMs as well as recommendations for action toward far-reaching performance improvement. As mandated by 42 CFR § 438.364, these data enable benchmarking of 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 and better support improvement in the quality and timeliness of, and access to healthcare services provided for Florida Healthy Kids enrollees.

Performance Improvement Project (PIP) Validation

Assessment Background

PIPs help the MCOs and DBMs evaluate performance in relevant areas of clinical care and nonclinical services, as well as improve areas of deficiency, areas benefiting from targeted improvement, and areas identified as a priority according to the Quality Strategy Plan. PIPs are intended to promote actual, significant, and sustained improvement in Medicaid enrollee health status through clinical and nonclinical service enhancement, quality of life, and provider and enrollee satisfaction. The primary objective of PIP validation is to determine the compliance of each MCO and DBM with the requirements set forth in 42 CFR § 438.330(d), as incorporated by 42 CFR § 457.1240(b).

PIP 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. 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 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
- Implementation of interventions to achieve improvement in the access to and quality of care
- Evaluation of intervention effectiveness
- Planning and initiation of activities to increase or sustain improvement

The 2021 PIP validation process evaluated one clinical and one nonclinical PIP each for three MCOs (Aetna, Community Care, and Simply Healthcare) and three DBMs (Argus, DentaQuest, and MCNA). The clinical PIP topics were selected by FHKC; the nonclinical topics were proposed by the MCOs/DBMs and approved by FHKC. Qsource's PIP validation team of experienced clinicians specializing in quality improvement and a healthcare data analyst with expertise in statistics reviewed each PIP's design and approach, evaluated each PIP's compliance with the data analysis plan described by the MCO/DBM, and assessed the effectiveness of MCO and DBM interventions.

Technical Methods for Data Collection and Analysis

Each MCO and DBM is contractually required to submit its PIP studies annually to FHKC as requested. They must include the necessary documentation for data collection, data analysis plans, and an interpretation of all results. They also should address threats to validity regarding data analysis and include an interpretation of PIP results.

The 2021 PIP validation was based on CMS's *EQR Protocol 1: Validation of Performance Improvement Projects* released in 2019. Qsource developed a PIP Summary Form and a PIP Validation Tool to standardize the process by which each MCO and DBM provided PIP information to FHKC and how that information was assessed. Using Qsource's PIP Summary Form, each MCO and DBM submitted its PIPs and supplemental information in July 2021.

Each PIP validation assessed MCO and DBM performance on nine steps through two activities: (1) assess the PIP methodology, and (2) perform overall validation and reporting of PIP results. The actual number of steps validated for each PIP varied depending on how far the MCO or DBM had progressed with an individual PIP or whether the step was applicable to the PIP's methodology. For example, *Step 4: Describe the Sampling Method* was not validated when a PIP did not use sampling or used HEDIS Technical Specifications for sampling.

For the completion of Activity 1, the elements within each step were scored as Met, Not Met, or Not Applicable. Qsource's scoring methodology was based on the percentage of elements met of all elements assessed across the nine steps. Overall validation rating was determined by the percentage score of all elements met, as guided in EQR Protocol 1 Activity 2. PIPs in the baseline year only had the first six steps validated, as performance measure data were not yet available. In these instances, scores were based on the percentage score of all elements met for these first six steps. All PIPs received an overall validation rating indicating high, moderate, low, or no confidence, as outlined in the protocol and listed in **Table 1**. More specific information on validation methodology is available in the individual *2021 PIP Validation Report* for each MCO and DBM.

Table 1. PIP Validation Rating Criteria	
Status	**Criteria**
High Confidence	Of all elements assessed, 90–100% are **met** across all activities.
Moderate Confidence	Of all elements assessed, 80–89.99% are **met** across all activities.
Low Confidence	Of all elements assessed, 70–79.99% are **met** across all activities.
No Confidence	Less than 70% of all elements are **met**.

Description of Data Obtained

Table 2 summarizes the nine CMS protocol steps the MCOs and DBMs addressed in their PIP Summary Forms.

Table 2. CMS PIP Protocol Steps	
Step #	**Step Description**
1	State the selected PIP topic.
2	State the PIP aim statement.
3	Identify the PIP population.
4	Describe the sampling methodology.
5	Describe selected PIP variables and performance measures.
6	Describe valid and reliable data collection procedures.
7	Analyze data and interpret PIP results.
8	Describe improvement strategies.
9	Assess for significant and sustained improvement.

Comparative Findings

Table 3 presents the type, topic, overall validation rating, and overall score of each MCO's and DBM's PIPs in addition to the primary area of care impacted by the PIP—quality, access, or timeliness. The MCOs' clinical PIP, *Screening for Depression and Follow-Up: Ages 12–17*, was selected by FHKC in 2019. MCO nonclinical PIPs focused on behavioral health topics. The DBMs' clinical PIP focused on preventive dental services, while the nonclinical PIP focused on access and availability of services.

For the 2021 PIP review, six PIPs achieved an overall validation rating of High Confidence, five received a rating of Moderate Confidence, and one received a rating of Low Confidence. No PIPs received a No Confidence rating. Additional details about each PIP are provided in Appendix A.

Table 3. 2021 PIP Validation Rating and Performance Score by MCO/DBM							
MCO/DBM	**PIP Type**	**PIP Topic**	**Quality**	**Timeliness**	**Access**	**Overall Validation Rating**	**Overall Score**
Aetna	Clinical	**Screening for Depression and Follow-Up: Ages 12-17 (CDF-CH)**	✓	✓		High Confidence	**100%**
	Nonclinical	**Follow-Up After Hospitalization for Mental Illness – 7-Day (FUH – 7-Day)**	✓	✓		High Confidence	**95.6%**
Argus	Clinical	**Preventive Dental Services**	✓	✓	✓	Moderate Confidence	**82.9%**
	Nonclinical	**Access – Enrollee Satisfaction and Treatment Dental Services**	✓		✓	Low Confidence	**70.0%**
Community Care	Clinical	**Screening for Depression and Follow-Up Ages 12-17 (CDF-CH)**	✓	✓		High Confidence	**92.3%**
	Nonclinical	**Health Risk Assessment (HRA) Response Rate**	✓	✓		Moderate Confidence	**86.2%**
DentaQuest	Clinical	**Preventative Dental**	✓	✓	✓	High Confidence	**100%**
	Nonclinical	**Access – Percentage of Enrollees Utilizing Any Dental Service**	✓		✓	Moderate Confidence	**84.8%**
MCNA	Clinical	**Preventive Dental Visits**	✓	✓	✓	High Confidence	**97.8%**
	Nonclinical	**Access – Annual Dental Visit (ADV)**	✓	✓	✓	High Confidence	**97.8%**
Simply Healthcare	Clinical	**Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)**	✓	✓		Moderate Confidence	**88.1%**
	Nonclinical	**Follow-Up Care for Children Prescribed ADHD Medication (ADD)**	✓	✓		Moderate Confidence	**86.7%**

Strengths, Weaknesses, and Improvements

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. Areas of noncompliance (AONs), or weaknesses, arise from evaluation elements that receive a Not Met score, indicating that those elements are not in full compliance with CMS protocols. AONs are expressed in terms of what the MCO/DBM should do to meet all requirements. This information

is useful for determining whether to continue or retire a specific PIP. Qsource also identifies suggestions where an element is fully compliant but a revision or update could further strengthen that element's compliance. Because the MCOs and DBMs are not held accountable for addressing suggestions, suggestions are not monitored or included in this report.

Strengths

Strengths were identified in seven of the nine validation steps for the 2021 PIP validation. More Plans received recognition for Step 1 than any other step, with seven PIPs commended for including detailed analyses of enrollee needs, care, and services related to the PIP topic. Six PIPs had strengths noted for Step 6, with several MCOs and DBMs applauded for describing the data collection design and plan in comprehensive detail; describing a comprehensive, externally audited process for estimating data completeness; and providing a thorough discussion of the process by which appropriate data are made available. Six PIPs also received strengths for Step 8, for which MCOs and DBMs were recognized for including very detailed driver diagrams to address barriers; including a detailed and comprehensive description and in-depth analysis of PDSA cycles for each improvement strategy; and addressing all elements of the step in comprehensive detail.

The number and content of the strengths identified during the 2021 PIP validation demonstrated that the MCOs and DBMs are committed to achieving Quality Strategy Plan goals 1, 2, 3, and 6—quality, satisfaction, growth, and advancement—in providing a robust provider and specialist network to provide services for Florida Healthy Kids enrollees. Detailed strengths by Plan are provided in Appendix A.

Weaknesses

Six PIPs had weaknesses identified for Step 2 during the 2021 PIP Validation, with several MCOs and DBMs reminded that the PIP aim statement must specify the PIP time period and include a realistic, clear, and unambiguous goal. Weaknesses were also identified for six PIPs for Step 6, for which several Plans were urged to fully define, describe, and address performance measures and variables. For Step 9, several MCOs and DBMs were told to address quantitative evidence of improvement, statistical evidence of improvement, the likelihood that any improvement is the result of the improvement strategy, and whether any sustained improvement occurred over time.

Collectively, the MCOs and DBMs demonstrated an understanding of the components of a valid PIP, but did not consistently address each of the steps required for PIP validation. Qsource will continue working with the plans to ensure that each PIP's methodology is thorough and valid. Detailed weaknesses by Plan are provided in Appendix A.

Improvements

Due to the large changes in PIP validation methodology necessitated by the shift from CMS's 2012 protocol to the 2019 protocol this year, comparisons between 2020 and this year's validation are not possible. They will be included in next year's report.

Performance Measure Validation (PMV)

Assessment Background

Performance measures enable monitoring individual MCOs/DBMs at a point in time, tracking performance over time, comparing performance among MCOs and DBMs, and informing selection and evaluation of quality improvement activities. The primary aims of PMV are to evaluate the accuracy of MCO- and DBM-reported performance measures and to determine whether those measures were calculated according to required technical specifications. To satisfy CMS protocol for MCOs/DBMs and to meet the requirements set forth in 42 CFR § 438.330(c), as incorporated by 42 CFR § 457.1250, FHKC selected a process for an objective, comparative review of quality measures.

The 2021 PMV included validation of performance measures for the three MCOs—Aetna, Community Care, and Simply Healthcare—and the three DBMs—Argus, DentaQuest, and MCNA—providing care services for Florida Healthy Kids enrollees in 2020. 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 and Description of Data Obtained for MCOs

FHKC identified for validation 18 Healthcare Effectiveness Data and Information Set (HEDIS®) measures, defined by the National Committee for Quality Assurance (NCQA) and validated through an NCQA HEDIS Compliance Audit™; one CMS measure; one measure from The Joint Commission (TJC), two U.S. Office of Population Affairs (OPA) measures, and one Agency for Healthcare Research and Quality (AHRQ) measure to be calculated and reported by the contracted MCOs. The CMS, TJC, OPA, and AHRQ measures were new to the MCOs for the 2021 PMV, while some measures reported in previous years were retired. Of the 23 total measures included in the 2021 PMV, 15 were part of the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set). Audited measures and their technical descriptions for the MCOs are provided in Appendix A.

Each of the MCOs underwent a full NCQA HEDIS Compliance Audit by an NCQA-certified HEDIS auditor, including completion of a HEDIS Record of Administrative Data Management and Processes (Roadmap), validation of performance measure rates, submission of rates to NCQA through the Interactive Data Submission System (IDSS), and the production of a Final Audit Report (FAR). The five new non-HEDIS measures required to be reported by FHKC in 2021 were all included under the scope of the formal HEDIS audit. CMS's *Protocol 2: Validation of Performance Measures* (2019) outlines activities for validation of performance measures. The HEDIS Compliance Audit information is recorded in each MCO's Information Systems Capability Assessment Tool (ISCAT). Per

the protocol, if the MCO recently had a comprehensive, independent assessment of its information systems, the EQRO may review those results. All of FHKC's 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 2021 PMV, this entailed a report of preliminary findings; a review of the final rates; and the production of a final report stating whether the MCO had a Reportable Rate (R), Biased Rate (BR), or Small Denominator (NA).

Technical Methods of Data Assessment and Description of Data Obtained for DBMs

The PMV for FHKC's DBMs normally includes pre-onsite reviews, an onsite visit, and post-onsite analyses. Due to the COVID-19 pandemic, all regularly scheduled onsite reviews were migrated to virtual reviews through the use of online meeting software. All other protocols for the PMV review remained the same.

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. Of the eight total measures included in the 2021 PMV, two were part of the Child Core Set. Audited measures and their technical descriptions for the DBMs are provided in Appendix A.

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

- **ISCATs:** Completed ISCATs received from the DBMs were reviewed to ensure all sections were complete and all attachments were available. The validation team reviewed all ISCAT documents, noting issues or items needing follow-up.
- **Source Code (Programming Language) for Performance Measures:** For the CMS-416 measures and HEDIS ADV measure, 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.
- **Supportive Documentation:** Qsource reviewed additional information to complete the validation process, including, but not limited to, policies and procedures (P&Ps), file layouts, system flow diagrams, system log files, and data collection process descriptions. Issues or areas needing 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 virtual 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-review 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. **Reviews:** The virtual review lasted one day and included the following:
   - Opening session
   - Evaluation of system compliance, specifically the processing of claim, encounter, and enrollment data where applicable
   - Review of data integration and primary data sources, including discussion and observation of source code logic where applicable as well as discussion and observation of how all data sources were combined and the method used to produce the analytical file for performance measure reporting
   - Closing session summarizing preliminary findings and recommendations

Description of Data Obtained

Table 4 lists the audited measures for MCOs, and Table 6 lists 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 are reported. However, due to enrollment data aberrations, total rates reported for measures that include overlapping age stratifications may include a minimal number of enrollees outside the Florida Healthy Kids population age range of 5–18 years. Measures are organized by categories of care defined by FHKC and based on the CMS Child Core Set categories. They are labeled according to the aspect of care they assess: quality, timeliness, or access.

Table 4. 2021 PMV: MCO Performance Measures

Quality	Timeliness	Access	Measure
Primary Care Access and Preventive Care			
✓	✓	✓	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
✓	✓		Chlamydia Screening in Women (CHL)
✓	✓		Immunizations for Adolescents (IMA)
✓	✓	✓	Child and Adolescent Well-Care Visits (WCV)
✓	✓		Screening for Depression and Follow-Up Plan: Ages 12−17 (CDF)
Maternal and Perinatal Health			
✓	✓	✓	Prenatal and Postpartum Care (PPC)

Table 4. 2021 PMV: MCO Performance Measures			
Quality	**Timeliness**	**Access**	**Measure**
✓			Cesarean Birth (PC-02)
✓	✓	✓	Contraceptive Care – Postpartum Women Ages 15−20 (CCP)
✓	✓	✓	Contraceptive Care – All Women Ages 15−20 (CCW)
Care of Acute and Chronic Conditions			
✓			Asthma Medication Ratio (AMR)
✓	✓		Appropriate Testing for Pharyngitis (CWP)
✓			Appropriate Treatment for Upper Respiratory Infection (URI)
✓	✓		Ambulatory Care: Emergency Department Visits (AMB-ED)
Behavioral Healthcare			
✓	✓		Follow-Up Care for Children Prescribed ADHD Medication (ADD)
✓	✓		Follow-Up After Hospitalization for Mental Illness (FUH)
✓	✓		Follow-Up After Emergency Department Visit for Mental Illness (FUM)
✓	✓		Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

Table 4. 2021 PMV: MCO Performance Measures

Quality	Timeliness	Access	Measure
✓		✓	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
✓	✓		Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
✓	✓	✓	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
✓			Identification of Alcohol and Other Drug Services (IAD)
✓			Mental Health Utilization (MPT)
Experience of Care			
✓		✓	CAHPS Health Plan Survey 5.0H, Child Version (CPC)

Table 5 includes the dental performance measures for the 2021 PMV. They are labeled according to the aspect of care they assess: quality, timeliness, or access.

Table 5. 2021 PMV: DBM Performance Measures			
Quality	Timeliness	Access	Measure
✓	✓	✓	Enrolled Children Receiving Dental Sealants on Permanent Molars (SEA)
✓	✓	✓	Enrolled Children Receiving Dental Sealants on Permanent Molars – With Exclusions (SEA – With Exclusions)
✓	✓	✓	Enrolled Children Receiving Preventive Dental Services (PDENT)
✓	✓	✓	Enrolled Children Receiving Any Dental Services
✓	✓	✓	Enrolled Children Receiving Dental Treatment Services (TDENT)
✓	✓	✓	Enrolled Children Receiving Diagnostic Dental Services
✓	✓	✓	Enrolled Children Receiving Any Preventive Dental or Oral Health Service
✓	✓	✓	Annual Dental Visit (ADV)

Comparative Findings

Although some selected measures changed for both the MCOs and the DBMs over the 2018–2020 measurement years, trending analysis is included where possible from the 2020 PMV to the 2021 PMV, provided in Appendix A. Trending for these measures is the addition of a green or red arrow to this year's result for each measure (in tables A-4 and A-7) to indicate an increase (⬆) or decrease (⬇) from the previous year's rate. Trending is not included for two MCO measures (in tables A-5 and A-6), because the measure results are generally very small (less than one percent).

Charts 2 and 3 present overall trending for the MCOs and DBMs, respectively, by including the total number of performance measures for which rates increased (or decreased positively when lower measure rates are better), decreased, or remained the same from the 2020 PMV to the 2021 PMV. Because Community Care is a new Plan in 2021, trending is not available. MCO measures overwhelmingly increased in 2021, with only 34 measures declining (16 for Aetna and 18 for Simply Healthcare).

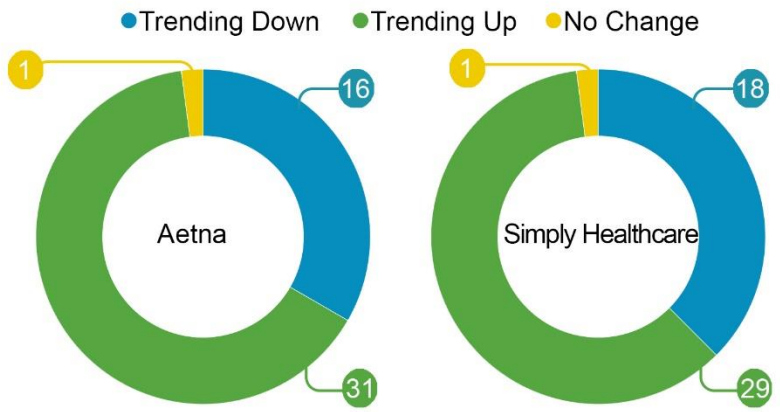

Chart 2. 2021 PMV MCO Measure Trending from 2020 to 2021

The DBMs experienced the opposite trend, with the majority of performance measures earning lower rates this year compared to last year. There were only five measure rate improvements overall for DBMs (one for Argus and four for DentaQuest).

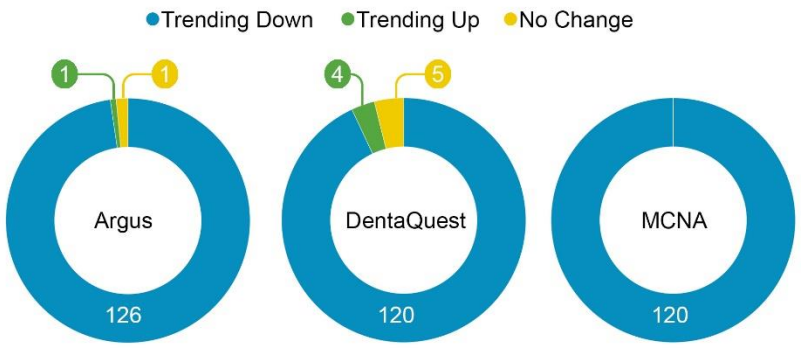

Chart 3. 2021 PMV DBM Measure Trending from 2020 to 2021

Strengths, Weaknesses, and Improvements

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

Strengths and Weaknesses

No strengths or weaknesses were noted among MCOs, as all were deemed fully compliant with all NCQA-defined Information System 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. Likewise, Qsource did not identify any areas for improvement related to any of the DBMs' processes for data collection and performance measure reporting during the 2021 PMV, as with the 2020 and 2019 PMV activities.

Improvements

As no weaknesses were identified for the MCOs or DBMs in the 2020 PMV, there are no improvements to report for 2021. However, Qsource has included in Table 6 significant improvements (more than 10%) in MCO/DBM measure results and has provided trending for the individual MCOs' and DBMs' performance measure results in Tables A.4 and A.7 in Appendix A.

Table 6. Improvements Since the 2020 PMV by MCO/DBM						
MCO/DBM	**Measure**	**Quality**	**Timeliness**	**Access**	**2020 Measure Result**	**2021 Measure Result**
Aetna	Follow-Up After Hospitalization for Mental Illness (FUH): 7-Day Follow-Up: 6–17 Years	✓	✓		36.73%	52.09%
	FUH: 30-Day Follow-Up: 6–17 Years	✓	✓		55.10%	74.42%
	Follow-Up After Emergency Department Visit for Mental Illness (FUM): 7-Day Follow-Up: 6–17 Years	✓	✓		26.67%	39.68%
	FUM: 30-Day Follow-Up: 6–17 Years	✓	✓		45.00%	58.73%
	FUM: 30-Day Follow-Up Total	✓	✓		26.09%	60.00%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Other Drug Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	✓	✓	✓	25.93%	39.02%
	IET: Initiation of AOD Treatment: 13–17 Years Total	✓	✓	✓	26.56%	36.56%
	IET: Other Drug Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	✓	✓	✓	30.56%	57.58%
	IET: Initiation of AOD Treatment: 18+ Years Total	✓	✓	✓	32.61%	51.06%
	IET: Other Drug Abuse or Dependence: Initiation of AOD Treatment Total	✓	✓	✓	27.78%	44.35%
	IET: Initiation of AOD Treatment Total	✓	✓	✓	29.09%	41.43%
Simply Healthcare	Follow-Up After Hospitalization for Mental Illness (FUH): 7-Day Follow-Up: 6–17 Years	✓	✓	✓	8.76%	41.49%
	FUH: 30-Day Follow-Up: 6–17 Years	✓	✓	✓	18.98%	67.66%

Table 6. Improvements Since the 2020 PMV by MCO/DBM						
MCO/DBM	**Measure**	**Quality**	**Timeliness**	**Access**	**2020 Measure Result**	**2021 Measure Result**
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Other Drug Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	✓	✓	✓	33.33%	56.38%
	IET Initiation of AOD Treatment: 13–17 Years Total	✓	✓	✓	36.67%	56.36%
	IET Other Drug Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	✓	✓	✓	34.21%	48.78%
	IET Initiation of AOD Treatment: 18+ Years Total	✓	✓	✓	34.09%	48.84%
	IET Other Drug Abuse or Dependence: Initiation of AOD Treatment Total	✓	✓	✓	33.70%	54.07%
	IET Initiation of AOD Treatment Total	✓	✓	✓	35.58%	54..25%

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 *EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations* (2019); and (3) FHKC medical service contracts (MSCs) and dental services contracts (DSCs). The survey team consisted of staff with expertise in program evaluation and 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, as noted in **Table 7**. The standards are categorized according to aspect of care: quality, timeliness, or access. Standards reviewed for the MCOs for 2021 include Availability of Services, Assurances of Adequate Capacity and Services, Grievance and Appeals System, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement (QAPI). This year's ACA also included grievance and appeal file reviews.

Table 7. Compliance Assessment Standards

Standard	Quality	Timeliness	Access	Review Year
Availability of Services		✓	✓	2021
Assurances of Adequate Capacity and Services	✓	✓	✓	2021
Grievance and Appeals System			✓	2021
Practice Guidelines	✓			2021
Health Information Systems	✓	✓	✓	2021
Quality Assessment and Performance Improvement (QAPI)	✓	✓	✓	2021
Coordination and Continuity of Care	✓	✓	✓	2022
Coverage and Authorization of Services		✓	✓	2022
Subcontractual Relationships and Delegation	✓	✓	✓	2022
Provider Selection (Credentialing/ Recredentialing)	✓			2023
Confidentiality	✓		✓	2023

The overall results for the compliance assessments for 2021, the first year in the new three-year review cycle, are included for each MCO and DBM in the Comparative Findings section, where discussion of results from the 2021 ACA is also provided.

More detailed results from the 2021 ACA are included in Appendix A.

Technical Methods for Data Collection and Analysis

For each MCO and DBM, the ACA normally includes pre-onsite reviews, an onsite visit, and post-onsite analyses. Due to the COVID-19 pandemic, however, all regularly scheduled onsite reviews were migrated to virtual reviews through the use of online meeting software. All other protocols for the ACA review remained the same. Qsource developed evidence-based oversight assessment 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. Qsource provided the ACA tools and a list of documents needed to support compliance to each MCO and DBM prior to pre-assessment, giving the MCOs and DBMs opportunities to ask questions, gather supporting documentation, and prepare for the virtual review. Qsource also distributed an ACA Process Overview document to explain the process to each MCO and DBM. Prior to the review, Qsource surveyors completed desktop reviews of all documentation provided by the MCOs and DBMs. During the review, MCO and DBM staff answered questions and provided information to help surveyors determine the MCO/DBM's degree of compliance with federal and contract requirements, explore any issues not fully addressed in the document review, and increase overall understanding of the MCO/DBM's operations. Qsource surveyors used the tools, along with personal observations, interviews with MCO/DBM staff, virtual system demonstrations, and file/document reviews to facilitate analyses and compilation of findings. The MCOs and DBMs also provided additional P&Ps and other relevant documents for surveyors during the virtual review. The virtual reviews took place in April 2021.

To reduce duplication of assessment activities, FHKC chose to allow certain standard elements to be deemed compliant in cases where an MCO/DBM, accredited by a nationally recognized accreditation organization—NCQA, the Accreditation Association for Ambulatory Health Care (AAAHC), or URAC®—has achieved a full score on an element with similar requirements to the regulatory or contractual element. Aetna, Argus, and MCNA elected to provide full documentation for all elements for the 2021 review. For Community Care, three full elements were deemed compliant based on NCQA accreditation, and two full elements and one partial element were deemed compliant based on AAAHC accreditation. For DentaQuest, no deeming opportunities were available; as such, the DBM provided full documentation for all elements. For Simply Healthcare, one full element and one partial element were deemed compliant based on NCQA accreditation.

In addition to compliance standards, the ACA included reviews of a random sample of enrollee grievance and appeal cases to evaluate how the MCO or DBM applied the processes and procedures required in 42 CFR § 438, Subpart D in its operational practice. Qsource asked that MCOs and DBMs provide the universe of 2020 grievance and appeal files, from which Qsource abstracted a random sample and an oversample. Files in this selection included 15 grievance files and 15 appeal files (10 sample and 5 oversample).

Description of Data Obtained

Throughout the documentation review and virtual assessment processes, Qsource reviewers used the survey tools to collect information and document findings regarding each MCO's and DBM's compliance with regulatory and contractual standards through a review of P&Ps, quality studies, reports, medical records/files, and other related MCO and DBM documentation. Each standard element had an assigned point value of 1, and Qsource analyzed every element in the survey tools.

Qsource determined MCO and DBM performance scores by adding the total points earned for each standard element on a scale of 0 to 1. Scores for each standard were calculated by dividing the total points earned for all elements in the standard by the total points possible for all elements in the standard. **Table 8** includes the total number of elements met out of the number of elements possible for each standard for all the MCOs combined and for all the DBMs combined; a corresponding overall percentage of compliance is also included for each standard.

Table 8. 2021 ACA Overall Compliance Scores

Standard	Overall Compliance			
	MCOs		DBMs	
	# Met / # Possible	% Score	# Met / # Possible	% Score
Availability of Services	30.652 / 39	**78.6%**	21.668 / 27	**80.3%**
Assurances of Adequate Capacity and Services	11 / 12	**91.7%**	8 / 9	**88.9%**
Grievances and Appeals	107 / 114	**94.3%**	83.358 / 108	**77.2%**
Practice Guidelines	8.5 / 9	**94.4%**	8 / 9	**88.9%**
Health Information Systems	9 / 9	**100%**	10.3 / 12	**86.1%**
Quality Assessment and Performance Improvement (QAPI)	16 / 16	**100%**	15.6 / 18	**86.7%**
Total Overall Score	**182.152 / 199**		**146.926 / 183**	
	91.5%		**80.3%**	

Comparative Findings

Chart 4 includes overall compliance scores for all standards evaluated over the past three-year period (2019–2021), organized according to each element's relative care category: quality, timeliness, and access. Scores for each standard are

included for calculations for all care categories to which they apply. Detailed discussion of the 2021 review is included in this section. Additional results are provided in Appendix A.

While trending comparisons cannot be made due to different standards being reviewed each year of the three-year compliance assessment cycle, summative data indicate the MCOs and DBMs are demonstrating mostly acceptable performance across key metrics related to quality, timeliness, and access. Scores for quality standards in 2020 were impacted by the MCOs and DBMs lacking requirements in policies and procedures that were outlined in the Florida Healthy Kids Uniform Credentialing and Recredentialing Policy (UCRP) as well as lacking documentation of provider credentialing and recredentialing activities conducted by AHCA. The 2021 ACA overall compliance scores for timeliness and access were affected by the DBMs' combined lower score on the Grievances and Appeals standard and both the MCOs' and the DBMs' combined lower scores for the Availability of Services standard. While the MCOs' combined compliance score was 94.3% for Grievances and Appeals, the DBMs' combined score was 77.2%, due to missing CFR and DSC provisions in the DBMs' documentation. The Availability of Services standard's overall 79.3% compliance score was mostly attributable to one element with five criteria related to Indian healthcare providers. While most of the MCOs/DBMs demonstrated compliance in practice through quarterly attestations indicating they were not contracted with any Indian healthcare providers, the provisions were not evident in Plan policies and procedures. Some of the Plans' documentation included the required provisions but did not have the requirements in place for the entire review year, which they must be to earn a 100% compliance score. Even with these areas of noncompliance, scores for all three categories of quality, timeliness, and access were higher in 2021 than the prior year.

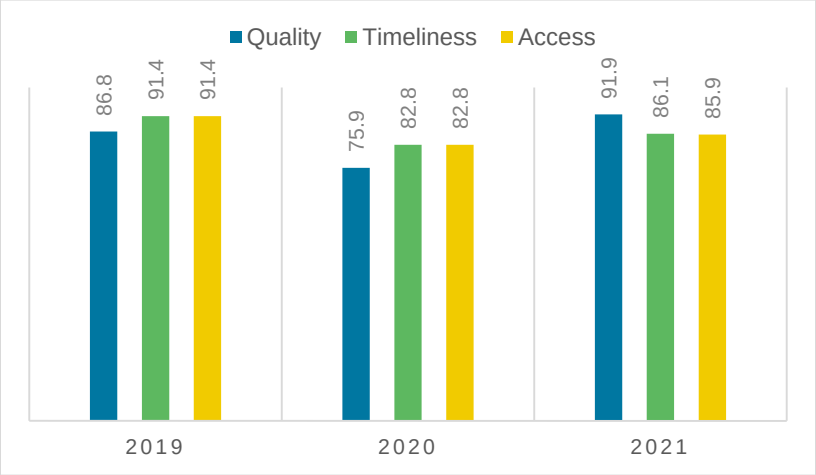

Chart 4. 2021 ACA MCO/DBM Overall Compliance Score Trending 2019–2021

Strengths, Weaknesses, and Improvements

The ACA assists FHKC, Qsource, and the MCOs/DBMs in identifying strengths and areas of noncompliance (AONs) in addition to compliance scores. Strengths indicate that the MCO/DBM demonstrated particular proficiency on a given standard and can be identified regardless of compliance score; the lack of an identified strength should not be interpreted as a

shortcoming on the part of the MCO/DBM. AONs are identified where the MCO/DBM achieved less than 100% compliance and reflect what the MCO/DBM should do to improve performance. Qsource also identifies suggestions where an element is fully compliant but a revision/update could further strengthen that element's compliance. The MCOs and DBMs are not held accountable for addressing suggestions; therefore, suggestions are not monitored or included in this report.

Chart 5 shows the volume of strengths and weaknesses for the 2021 ACA review by the three categories of quality, timeliness, and access. Since some standards apply to more than one category, some strengths and weaknesses are counted for multiple categories.

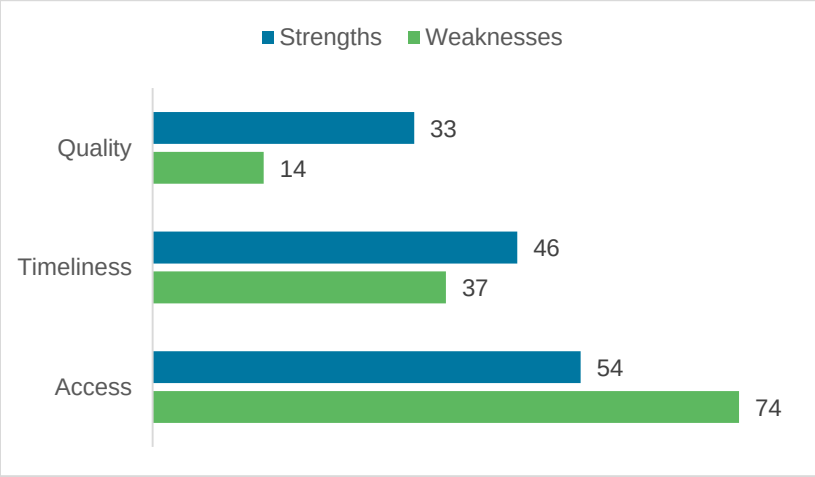

Chart 5. 2021 ACA MCO/DBM Combined Strengths and Weaknesses by Quality, Timeliness, and Access

Chart 6 shows the number of strengths and weaknesses by MCO/DBM. As with **Chart 5**, strengths and weaknesses can each be counted across multiple categories.

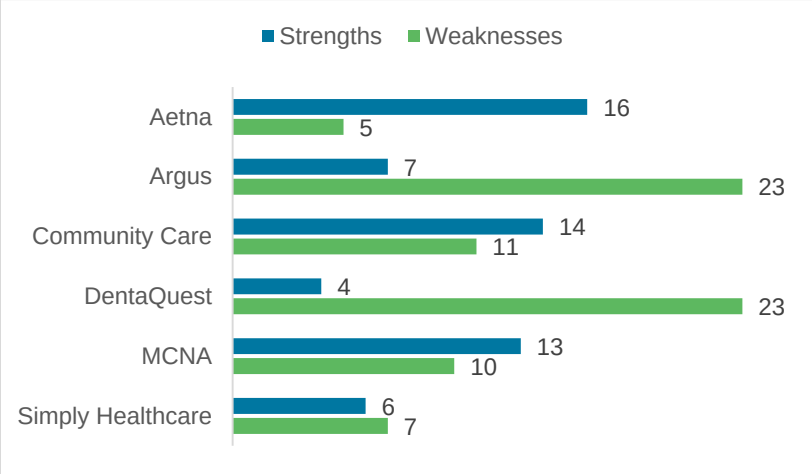

Chart 6. 2021 ACA Strengths and Weaknesses by MCO/DBM

Strengths

For the 2021 ACA, strengths were identified across all six standards assessed. Those noted for quality standards included particularly well-organized documentation, policy and procedures that referenced specific Florida Healthy Kids requirements, annotated clinical practice guidelines, system updates to capture the assignment of enrollees' primary providers, and additional internal provisions not required by the CFR or MSC/DSC. The majority of strengths related to timeliness were for specific references to CFR and MSC/DSC regulations as well as the Florida Healthy Kids program in Plan documentation. Other strengths were

noted for policies and procedures that included detailed review/revision histories that clearly indicated what requirements were in place during the review year, and for internal reporting turnaround times not required by the CFR or MSC/DSC. Most access-related strengths encompassed those previously mentioned, as all but one standard fall into the access category, as well as those specific to grievance and appeal processes, including detailed descriptions and assurances of enrollee understanding of both processes.

The overall strengths demonstrated that the MCOs and DBMs are committed to quality documentation and implementing processes in operational practice, supporting the Quality Strategy Plan's goal of effectiveness and the availability of child-centered Plans that provide comprehensive, quality healthcare services.

Detailed strengths by Plan are included in Appendix A.

Weaknesses

Similar to strengths for the 2021 ACA, weaknesses (AONs) were identified for all six standards. Those related to quality included not having required provisions in Plan documentation effective for the entire review year as well as missing requirements in P&Ps to share clinical practice guidelines, which are used to make utilization decisions, with enrollees and potential enrollees and to submit required documentation notifying FHKC of any significant changes in services as specified by FHKC. Another area lacking in some Plan P&Ps was ensuring provider data were accurate and complete, although the Plans demonstrated doing this in practice. Some of the Plans' Quality Improvement Plans were noted as missing collection and submission of performance measure data provisions and Florida Healthy Kids program results. The Quality Improvement Plan deficiencies also apply to timeliness and access.

Other areas for improvement identified for timeliness were mainly in the Availability of Services standard, noted for missing required provisions in Plan P&Ps and for provisions added to P&Ps during the review year, leading to the Plans being out of compliance for not having the provisions in place for all of 2021. Of note, half of the six Florida Healthy Kids Plans had five AONs recorded for one element in the Availability of Services standard related to enrollee access to Indian healthcare providers. This requirement was effective January 1, 2020, for the MCOs based on newly executed MSCs, and July 1, 2018, for the DBMs based on Amendment No. 3 to the DSCs. This provision had not previously been reviewed for compliance. Another commonality in AONs was related to incomplete language required in P&Ps to address the Plans' delivery of services in a culturally competent manner, regardless of gender, sexual orientation, or gender identity. Similarly, an AON for the missing provision of taking into account the urgency of an enrollee's need for services was shared by several Plans.

As access to care applies to all but one standard, most of the aforementioned AONs apply to this area as well. However, one of the MCOs and all of the DBMs had multiple deficiencies identified for elements in the Grievances and Appeals standard. These were noted for needed updates to Plan documentation, such as the enrollee handbook and P&Ps, to include all required provisions

from the CFR and the MSC/DSC. Some of the P&Ps covered required provisions for part but not all of the review year.

Collectively, the MCOs and DBMs demonstrated compliance with federal and contractual regulations in operational practice but did not consistently address the requirements in all P&Ps and other Plan documentation. The most impactful deficiency was related to the Quality Improvement Plan FHKC requires each Plan to maintain, as noted in the quality assurance portion of the FHKC Quality Strategy Plan. With some of the Quality Improvement Plans missing performance results specific to the Florida Healthy Kids program, the requirement for the MCOs and DBMs to objectively and systematically monitor and evaluate the quality and appropriateness of care and services rendered to Florida Healthy Kids enrollees was not fulfilled in some cases.

Detailed weaknesses by Plan are included in Appendix A.

Improvements

Where AONs are identified, corrective action plans, or CAPs, are required to address any deficiencies. **Table 9** includes the MCOs' and DBMs' improvements made based on last year's ACA analysis of AONs. Community Care's contract with FHKC was not effective until January 1, 2020. As such, Community Care was not evaluated in the 2020 ACA (2019 review period) and therefore had no CAPs to satisfy from the previous ACA. The three standards assessed as part of the 2020 ACA were Enrollee Information, Enrollee Rights and Protections, and Credentialing. Improvements are labeled according to their related aspects of care: quality, timeliness, or access. All CAPs were satisfied for all Plans for the 2020 ACA.

Table 9. Improvements Since the 2020 ACA by MCO/DBM

Standard and Element	2020 AON	MCO/DBM Corrective Action	Quality	Timeliness	Access
Aetna					
Enrollee Rights and Protections: Compliance with Federal and State Laws	The managed care organization (MCO) should revise Policy #1501.30 and its Cultural Competency Plan to include specific references to all applicable laws cited in 42 CFR 438.100(d).	Updated Policy 1501.30 and Cultural Competency Plan.		✓	✓

Table 9. Improvements Since the 2020 ACA by MCO/DBM					
Standard and Element	**2020 AON**	**MCO/DBM Corrective Action**	**Quality**	**Timeliness**	**Access**
Credentialing: At-Risk Providers – 2	The provider agreement or provider manual should be updated to include the requirement for access for unannounced site visits by the Centers for Medicare & Medicaid Services (CMS), Florida Healthy Kids Corporation (FHKC), their agents, and designated contractors.	1. The 2020 Florida Healthy Kids Provider Manual was updated to include the requirement for access for unannounced site visits by CMS, FHKC, their agents, and designated contractors and was submitted for website upload. 2. The updated 2020 Florida Healthy Kids Provider Manual has been uploaded to the MCO's Florida website.	✓		
Credentialing: Disclosures	The provider agreement should be updated to include a requirement for the provision of required disclosures within 35 days of the date of request by CMS, the Agency for Health Care Administration (AHCA), or FHKC.	The provider agreement regulatory compliance addendum was updated to include the requirement for the provision of required disclosures within 35 days of the date of request by CMS, AHCA, or FHKC.	✓		
Credentialing: Education and Training	Due to lack of access to the enterprise-level system, the MCO should ensure that documentation of all required primary source verification elements and copies of licenses are stored in its credentialing system.	1. Aetna Enterprise Credentials Verification Organization (CVO) is National Committee for Quality Assurance (NCQA) certified and Utilization Review Accreditation Commission (URAC) accredited. Their system of operation is the Aetna Enterprise Provider Credentialing Database (EPC). EPC tracks and stores provider credentialing data. To maintain the security of protected data, only CVO credentialing personnel have access to this database. Plan-level credentialing support staff have access to CVO portal in order to retrieve credentialing statuses and provider data obtained during primary source	✓		

Table 9. Improvements Since the 2020 ACA by MCO/DBM					
Standard and Element	**2020 AON**	**MCO/DBM Corrective Action**	**Quality**	**Timeliness**	**Access**
		verification process. For example, DEA license number, Board Certification/Specialty, Medical/Professional Education, etc. 2. Plan-level credentialing support staff have access to CAQH Proview to review and retrieve provider documentation, as needed or upon request.			
Argus					
Enrollee Information: Language and Format	The dental benefit manager (DBM) should update Quality – FHK Materials and Marketing Restrictions to include the requirement to include taglines in the prevalent non-English languages in the service area, as well as large print of no less than 18-point font size.	Updates to Member Handbook.		✓	✓
Enrollee Information: Provider Termination Notice	The DBM should update P&P #QM_03 to change the written or verbal communication to written notification and change the 15-business-day requirement to 15 calendar days.	Standard Operating Procedure (SOP) QM_03 updated.		✓	✓
Enrollee Rights and Protections: Enrollee Rights	The DBM should add the enrollee's rights to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; and be furnished healthcare services in accordance with 42 *Code of Federal Regulations* (CFR) 438.206 through 438.210 to P&P #PR_01 and its enrollee handbook.	1. PR_01 updated. 2. Enrollee handbook updated and submitted for FHKC approval.		✓	✓

Table 9. Improvements Since the 2020 ACA by MCO/DBM					
Standard and Element	**2020 AON**	**MCO/DBM Corrective Action**	**Quality**	**Timeliness**	**Access**
Enrollee Rights and Protections: Freedom to Exercise Rights	The DBM should add the enrollee's freedom to exercise rights without adversely affecting the way the enrollee is treated by the DBM, its providers, or the State agency to its enrollee handbook.	1. Updates to Member Handbook. 2. Review of current Member Handbook to accommodate areas for updating verbiage in member rights.		✓	✓
Enrollee Rights and Protections: Compliance with Federal and State Laws	The DBM should revise policy and procedure (P&P) #CP_13 and other relevant P&Ps and documentation to include specific references to all applicable laws cited in 42 CFR 438.100(d).	Updates to P&P CP_13. Language has been updated with P&P in committee approval status.		✓	✓
Enrollee Rights and Protections: Marketing Material Requirements	The DBM should revise Quality – FHK Materials and Marketing Restrictions to include the provision that it will not engage directly or indirectly in marketing activities.	1. Updated Member Materials Notifications Marketing Restrictions Workflow. 2. Submit Cultural Competency Plan.		✓	✓
Credentialing: At-Risk Providers – 1	While criminal background checks and risk level adjustments are AHCA-conducted activities, an appropriate P&P should be developed to address that these are conducted by AHCA and verified by an active, enrolled Medicaid ID.	CR_24 updated.	✓		
Credentialing: Exclusions	P&P #CR_24 should be updated to confirm the status of the provider and disclosed parties in the Social Security Agency's death master file.	CR_24 updated.	✓		

Table 9. Improvements Since the 2020 ACA by MCO/DBM					
Standard and Element	**2020 AON**	**MCO/DBM Corrective Action**	**Quality**	**Timeliness**	**Access**
Credentialing: At-Risk Providers – 2	The provider agreement provision requiring compliance with site visits was not in place for the entire review period; however, it is in place currently. The provider agreement and/or a P&P should be updated to include denying or terminating provider enrollment if site visit access is denied.	1. Update to PR_67.1 2. Florida Provider Agreement	✓		
Credentialing: Appropriate Actions	P&P #PR_67.1 should be updated to include imposing sanctions, suspensions, restrictions, and terminations of providers as a result of an inability to verify the identity of the provider.	CR_24 updated.	✓		
Credentialing: Recredentialing	While the criminal background checks are conducted by AHCA, P&P #CR_24 should reference the requirement for repeat background checks at least every five years.	CR_24 updated.	✓		
Credentialing: Verifications	P&P #CR_24 should be updated to address suspension of prescribing rights by AHCA.	CR_24 updated.	✓		
Credentialing: Disclosures	The appropriate P&P should be updated to address the denial of enrollment based on specific circumstances. The provider agreement provision requiring compliance with disclosure requirements was not in place for the entire review period; however, it is in place currently.	1. Provider Agreement Updated. 2. CR_24 updated.	✓		
Credentialing: Criminal Background Checks	P&P #CR_24 should be updated to include requirements that providers and those with ownership interest in the provider must consent to criminal background checks, including	CR_24 updated.	✓		

Table 9. Improvements Since the 2020 ACA by MCO/DBM					
Standard and Element	**2020 AON**	**MCO/DBM Corrective Action**	**Quality**	**Timeliness**	**Access**
	fingerprinting within 30 days of request. Also, the provider manual or provider agreement should be updated to include this language.				
Credentialing: Education and Training	The credentialing system should be updated to include verification of the Social Security Agency death master file.	1. CR_24 updated. 2. Verification of credentialing system now storing death master file verifications provided by Credentialing.	✓		
DentaQuest					
Enrollee Information: Enrollee Handbook Content – 3	The DBM should update its enrollee handbook to include information about potential required enrollee payment during an enrollee-requested external review if the final decision was adverse to the enrollee.	Updated the Handbook and placed it on the Xchange Folder and also supplied a copy to FHKC as they make final changes to the handbook.		✓	✓
Enrollee Rights and Protections: Freedom to Exercise Rights	The DBM should add the enrollee's freedom to exercise rights without adversely affecting the way the enrollee is treated by the DBM, its providers, or the State agency to its enrollee handbook.	Updated the Handbook and placed it on the Xchange Folder and also supplied a copy to FHKC as they make final changes to the handbook.		✓	✓
Enrollee Rights and Protections: Compliance with Federal and State Laws	The DBM should revise P&P #COM15-ENT and other relevant P&Ps and documentation to include specific references to all applicable laws cited in 42 CFR 438.100(d).	Update made to P&P #COM15-ENT.		✓	✓
Credentialing: At-Risk Providers	The Dental Participating Practice Agreement should be updated to include the requirements to allow unannounced site visits by CMS,	The Dental Participating Practice Agreement and appropriate P&P were updated to include the appropriate requirements.	✓		

Table 9. Improvements Since the 2020 ACA by MCO/DBM					
Standard and Element	**2020 AON**	**MCO/DBM Corrective Action**	**Quality**	**Timeliness**	**Access**
	FHKC, their agents, and designated contractors, and the denial or termination of enrollment if access for site visits is denied. Also, the DBM should update the appropriate P&P to address denying or terminating provider participation if access to unannounced visits by appropriate agencies is not allowed.				
Credentialing: Verifications	The appropriate P&P should be updated to address verification of Medicaid prescribing rights and providers terminated under The Act or the Medicaid or Children's Health Insurance Program (CHIP) program in any other state.	P&P #PECO-1INS was revised to include the corrected required language.	✓		
Credentialing: Disclosures	The Dental Participating Practice Agreement should be updated to include the provision that disclosure information must be provided within 35 days from the date of request from CMS, AHCA, or FHKC.	Updated language to the Dental Provider Agreement.	✓		
Credentialing: Criminal Background Checks	The Dental Participating Practice Agreement should be updated to include the requirement for consenting to criminal background checks, including fingerprinting and the timeframe for submitting requested fingerprints for providers and persons with ownership interest in the practice.	Updated Provider Agreement with this language.	✓		
Credentialing: Education and Training	The credentialing system should be updated to include verification of ongoing service training and copies of provider licenses.	Submission of P&P #PECO1-INS needs to be updated what was submitted did not include the language.	✓		

Table 9. Improvements Since the 2020 ACA by MCO/DBM					
Standard and Element	**2020 AON**	**MCO/DBM Corrective Action**	**Quality**	**Timeliness**	**Access**
MCNA					
Enrollee Information: Enrollee Handbook Content – 3	The DBM should update its enrollee handbook to include information about potential required enrollee payment during an enrollee-requested external review if the final decision was adverse to the enrollee.	MCNA will revise and update the FHKC Member Handbook to include information about the potential payment required from an enrollee if the final decision of the external review requested by that enrollee was not in the enrollee's favor.		✓	✓
Credentialing: Exclusions	P&P #6.301 should be updated to address verification of the identity and exclusion status of appropriate persons with ownership or control interest or who are agents or managing employees of a provider.	Policy 6.301 has been updated to address verification of the identity and exclusion status of appropriate persons with ownership or control interest or who are agents or managing employees of a provider.	✓		
Credentialing: Verifications	P&P #6.301 should be updated to address suspension of prescribing rights by AHCA.	Policy 6.301 has been updated to address suspension of prescribing rights by AHCA.	✓		
Credentialing: Disclosures	P&P #6.203 should be updated to include when providers must be denied enrollment based on ownership and management disclosures.	Policy 6.203 has been updated to include when providers must be denied enrollment based on ownership and management disclosures.	✓		
Credentialing: Education and Training	The credentialing system should be updated to include verification of ongoing service training and copies of provider licenses.	The requirements for this corrective action plan have been reconsidered. Copies of provider licenses requirement is now met, due to primary source verification of license status. Ongoing service training requirements are under review.	✓		
Simply Healthcare					
Enrollee Information:	The MCO should update P&P Provider Quality Incentive Program (PQIP) – FL to address the requirement to make available, upon request,	Update P&P Provider Quality Incentive Program (PQIP) – FL.		✓	✓

Table 9. Improvements Since the 2020 ACA by MCO/DBM					
Standard and Element	**2020 AON**	**MCO/DBM Corrective Action**	**Quality**	**Timeliness**	**Access**
Physician Incentive Plan	any physician incentive plans in place as set forth in 42 CFR 438.3(i).				
Enrollee Information: Enrollee Handbook Content – 3	The MCO should update its enrollee handbook to include information about enrollee continuation of benefits or potential required enrollee payment during an enrollee-requested external review and about how to exercise an advance directive, as required in 42 CFR 438.3(j).	Update Enrollee Handbook.		✓	✓
Enrollee Information: Provider Directory Content	The MCO should update its provider directories for all service areas to include the providers' website uniform resource locators (URLs).	Website URL should be included in the MCO's provider directories.		✓	✓
Enrollee Rights and Protections: Compliance with Federal and State Laws	The MCO should revise Compliance Standards of Work Related to Enrollee Rights and Protections to address the requirement of the MCO's compliance with Section 654 of the *Omnibus Budget Reconciliation Act of 1981* and Title XXI of the federal *Social Security Act*.	Update Compliance Standards of Work.		✓	✓
Credentialing: Mental Healthcare and Substance Abuse Providers	The appropriate policy should be updated to address individuals or entities who meet the minimal licensure and credentialing standards set forth in the statutes and rules referenced in this element's criteria.	Update P&Ps [Policy FL: Additional State Specific Regulatory or Contractual Requirements for Florida].	✓		

Table 9. Improvements Since the 2020 ACA by MCO/DBM					
Standard and Element	**2020 AON**	**MCO/DBM Corrective Action**	**Quality**	**Timeliness**	**Access**
Credentialing: License	Policy #8 should specify that, for participation in the Florida Healthy Kids network, providers must have no current limitations on their license.	Update P&P [Policy FL: Additional State Specific Regulatory or Contractual Requirements for Florida].	✓		
Credentialing: At-Risk Providers – 2	The Florida Healthy Kids Provider Addendum should include the provision to allow unannounced onsite inspections of provider locations. As of 1/1/20, this provision was included. Also, the appropriate policy should be updated to include that providers must be denied enrollment or terminated from the network if the provider fails to provide access for any site visits.	Update Florida Healthy Kids Provider Addendum.	✓		
Credentialing: Exclusions	Policy #6 should be updated to address verification of exclusion status for all providers and disclosed parties and to include verification through the National Plan and Provider Enumeration System (NPPES).	Update P&P [Policy Sanctions and Exclusions: Monthly Ongoing Monitoring].	✓		
Credentialing: Provider Contract Compliance	Appropriate documentation of how accurate directory information is maintained should be developed.	Documentation of how accurate directory information is maintained [(Florida Simply-Healthy Kids Directory 2020) Business & Technical Requirements Document].	✓		
Credentialing: Appropriate Actions	Policy #10 should be updated to specifically reference action to be taken when a provider's identity cannot be verified or when the provider falsifies information on the application.	Update P&P [Policy FL: Additional State Specific Regulatory or Contractual Requirements for Florida].	✓		

Table 9. Improvements Since the 2020 ACA by MCO/DBM					
Standard and Element	**2020 AON**	**MCO/DBM Corrective Action**	**Quality**	**Timeliness**	**Access**
Credentialing: Recredentialing	Policy #9 should be updated to include repeat background checks at least every five years as conducted by AHCA.	Update P&P [Policy FL: Additional State Specific Regulatory or Contractual Requirements for Florida].	✓		
Credentialing: Verifications	Policy #6 should be updated to address verification of suspension of Medicaid prescribing rights by AHCA.	Update P&P [Policy FL: Additional State Specific Regulatory or Contractual Requirements for Florida].	✓		
Credentialing: Disclosures	The provider agreement should be updated to include that the provider must provide disclosures within 35 days of the date of request by CMS, AHCA, or FHKC.	Updated Provider Agreement.	✓		
Credentialing: Verifications and Attestations	Policy #5, Version 5 should be updated to include attestations for misdemeanor convictions.	Update P&P [Policy FL: Additional State Specific Regulatory or Contractual Requirements for Florida].	✓		

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, as incorporated by 42 CFR § 457.1218. The ANA provides valuable information about enrollee access to primary care and specialty care providers as well as the timeliness of that access.

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 dental 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. The 2020 review included an updated list of specialties and specialty roll-up categories for MCOs. Dental reviews remained the same. As in 2019, roll-up category access scores reflect access to any specialty within the category.

Geographical access to MCO services was determined for both urban and rural enrollees by calculating the travel time and distance between MCO enrollees and the provider types specified in the MCO contracts.

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.

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 with FHKC. 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 P&Ps, provider manual, and enrollee handbook to ensure that appointment availability standards were in place during 2020 and consistent

with contract standards. The ANA reviews were conducted in August 2021.

Technical Methods for Data Collection and Analysis

The 2021 ANA evaluation included MCO and DBM provider networks as of June 2021. 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, enrollee handbooks, and provider manuals or provider agreements

The standards used to evaluate the MCOs' and DBMs' provider networks for FHKC enrollees are provided in Appendix B.

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 *2021 Annual Network Adequacy Report*. Analyses were conducted for the provider and specialty types listed in **Table 10** for the MCOs and **Table 11** for the DBMs.

Table 10. ANA Provider/Specialty Categories for MCOs

- Primary Care Provider (PCP) – Family Medicine
- PCP – Pediatrics
- Allergy & Immunology
- Dermatology
- Obstetrics & Gynecology
- Optometry
- Otolaryngology
- Behavioral Health – Pediatric
- Behavioral Health – Other
- Specialist – Pediatric
- Specialist – Other
- Hospital
- Pharmacy

Table 11. ANA Provider/Specialty Categories for DBMs

- Primary Care Dentists
- Orthodontists
- Dental Specialists

Comparative Findings

Comparisons year over year are included where possible. Chart 7 includes the overall weighted network adequacy scores for all the MCOs combined, categorized both by time and distance standards and by the geographical area urban or rural classification. **Chart 8** includes the same data, but for all the DBMs combined. **Chart 9** presents overall trending for each MCO and DBM, respectively, by providing the percentage of

required provider/specialty categories for which the MCO/DBM's compliance percentage increased, decreased, or remained consistent from 2020 to 2021. Plan-specific results for the MCOs and DBMs are presented in Appendix A.

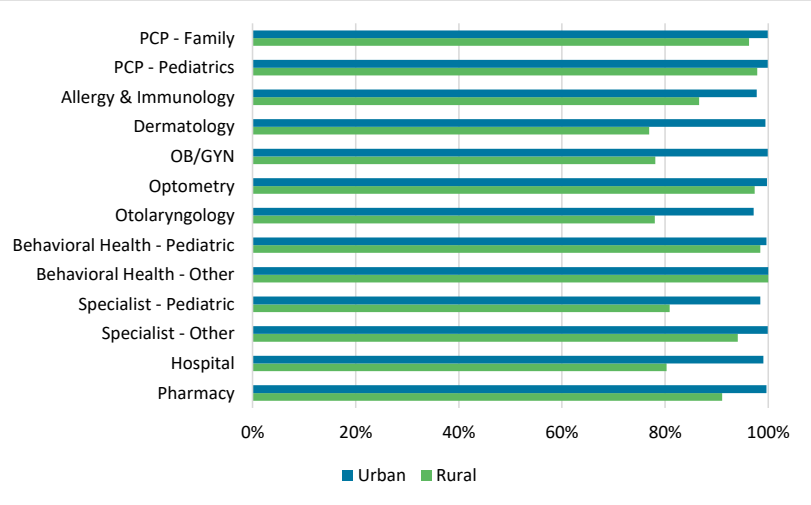

Chart 7. ANA MCO Provider/Specialty Categories Combined Time and Distance Access Overall Weighted Scores by Urban and Rural Areas

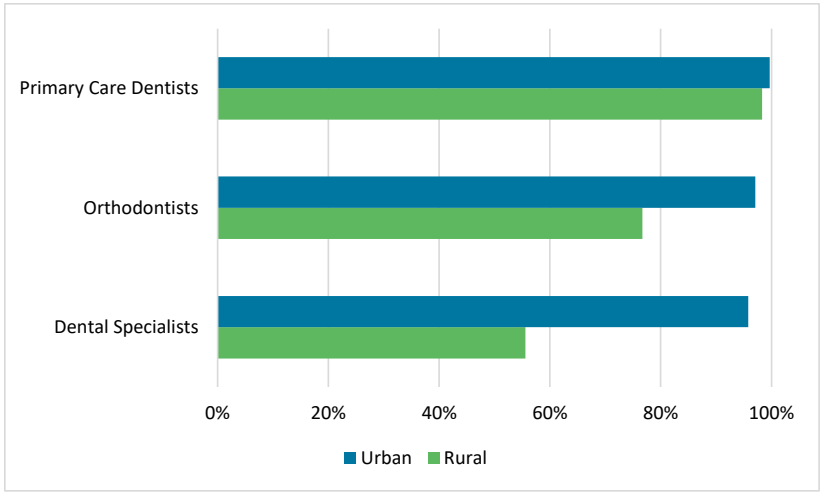

Chart 8. ANA DBM Provider/Specialty Categories Combined Time and Distance Access Overall Weighted Scores by Urban and Rural Areas

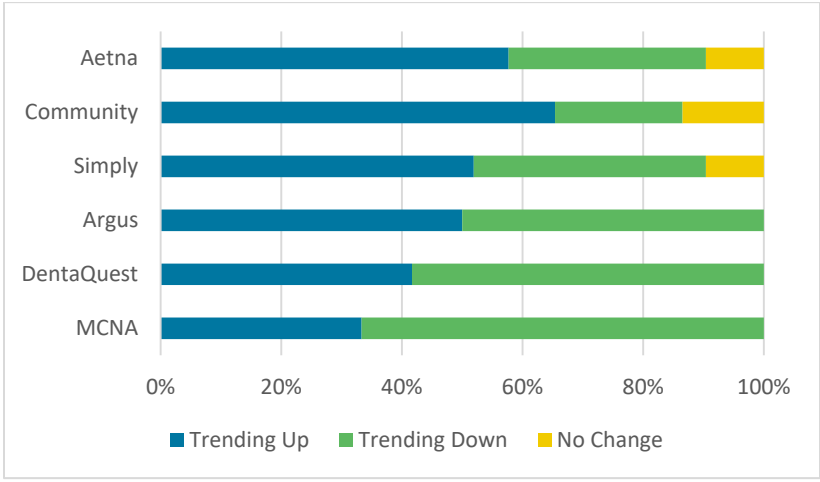

Chart 9. ANA Provider/Specialty Categories Trending from 2020 to 2021 by MCO/DBM

Strengths, Weaknesses, and Improvements

Strengths for the ANA indicate that the MCO or DBM demonstrated particular proficiency in implementing contract revisions and/or significant improvement in enrollee access to network providers. Areas for improvement, or weaknesses, are noted when the MCO and DBM should take action to remedy any network deficiencies or improve network-adequacy-related processes.

Strengths

All three MCOs provided comprehensive access (at least 90%) for time and distance standards to PCPs for both urban and rural enrollees, and comprehensive access to all required specialties/specialty categories for urban enrollees. Similarly, all three DBMs provided comprehensive access to primary care dentists for both urban and rural enrollees, and comprehensive access to orthodontists and any dental specialist for urban enrollees.

Weaknesses

Weaknesses in network adequacy among MCOs primarily involved deficiencies (i.e., less than 100% access) in rural access to several specialty categories, particularly the following provider types for all three MCOs: allergy and immunology, dermatology, obstetrics and gynecology, and hospitals. In addition to these provider types, Community Care did not provide adequate access for rural enrollees to otolaryngology and specialist – pediatric practitioners, while Simply Healthcare did not provide adequate access for rural enrollees to pharmacy providers. Regarding appointment availability and accessibility standards, Aetna and Community Care did not have a P&P that correctly addressed follow-up care requirements (as medically appropriate), and the calendar day designation for the routine appointment standard was not included in the P&P or provider manual.

Among the DBMs, Argus and MCNA provided limited rural access to orthodontists, and all three DBMs provided very limited rural access to any dental specialists.

Improvements

Table 12 includes the MCOs' and DBMs' improvements made based on last year's ANA analysis. Any MCO or DBM not included had no identified areas for improvement in 2020. Improvements are labeled according to their related aspects of care: quality, timeliness, or access.

Table 12. Improvements Since the 2020 ANA by MCO/DBM

MCO/DBM	Area of Network Adequacy/Appointment Availability	2020 Recommendation for Improvement	MCO/DBM's Action	Quality	Timeliness	Access
Aetna	Network Adequacy: Time and Distance Standards	Improve rural access to allergy and immunology, obstetrics and gynecology, and hospital services	The MCO improved rural access to allergy and immunology and obstetrics providers, although rural access to these categories and hospitals remained below 90.0%. Overall weighted practitioner network adequacy based on aggregate claim frequency was 97.2%, slightly higher than the MCO's 2020 ANA score of 95.3%.		✓	✓
	Appointment Availability and Accessibility Standards	Include standards for well-child visits and follow-up care as medically appropriate in provider manual	The provider manual did not specify the well-child visit standard, but included routine appointments, which would include well-child visits.		✓	✓
Community Care	Network Adequacy: Time and Distance Standards	Improve rural access to allergy and immunology, dermatology, obstetrics and gynecology, otolaryngology, specialist – pediatric, specialist – other, and hospital	While the MCO improved rural access to obstetrics and gynecology, specialist – pediatric, specialist – other, and hospitals, there is still room to improve rural access to allergy and immunology, otolaryngology, and dermatology practitioners. Overall weighted practitioner network adequacy demonstrated adequate access based on aggregated claim frequency by specialty.		✓	✓
Simply Healthcare	Network Adequacy: Time and Distance Standards	Improve access to otolaryngology, specialist –	The MCO improved most access scores across time and distance		✓	✓

Table 12. Improvements Since the 2020 ANA by MCO/DBM

MCO/DBM	Area of Network Adequacy/Appointment Availability	2020 Recommendation for Improvement	MCO/DBM's Action	Quality	Timeliness	Access
		pediatric, and pharmacy for rural enrollees	standards for urban and rural enrollees for specialist – pediatric and pharmacy provider types from the previous ANA, although there is still room to improve access to allergy and immunology, obstetrics and gynecology, specialist – pediatric, and pharmacy provider types for rural enrollees. Overall weighted practitioner network adequacy demonstrated adequate access based on aggregated claim frequency by specialty.			
Argus	Network Adequacy: Time and Distance Standards	Improve access to orthodontists and dental specialists for rural enrollees	The DBM had the same opportunities to improve enrollee access identified in the 2021 ANA.		✓	✓
DentaQuest	Network Adequacy: Time and Distance Standards	Improve access to orthodontists and dental specialists for rural enrollees	The DBM had the same opportunities to improve enrollee access identified in the 2021 ANA.		✓	✓
MCNA	Network Adequacy: Time and Distance Standards	Improve access to orthodontists and dental specialists for rural enrollees	The DBM had the same opportunities to improve enrollee access identified in the 2021 ANA.		✓	✓

Validation of Encounter Data (EDV)

Assessment Background

FHKC contracted with Qsource to validate encounter data submitted by the MCOs and DBMs. 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 and access, monitor program integrity, and determine capitation payment rates.

Provisions related to EDV require that providers must submit claims and/or encounters to FHKC, whether a fee-for-service or capitated arrangement; FHKC must review and validate encounter data submitted by its Plans; and FHKC must submit complete, accurate, and timely encounter data to CMS in a standardized format for the Transformed Medicaid Statistical Information System (42 CFR § 438.818(a)(1)-(2), as incorporated in 42 CFR § 457.1233(d)). Accurate and complete encounter data are vital for effective operation and oversight of FHKC's MCOs and DBMs, as noted in the CMS Encounter Data Toolkit (2013): "Encounter data are essential for measuring and monitoring managed care plan quality, service utilization, finances, and compliance with contract requirements. The data are also a critical source of information used to set capitation rates and perform risk adjustment to account for differences in beneficiary health status across plans."

Qsource followed the 2019 CMS protocol for EDV, *Protocol 5: Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan*, which 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

Data submission guidelines provided for the Plans included the data layout, field definitions, lengths, valid values, and data types and relevant instructions. EDV activities prior to 2020 followed the previous EQR Protocol 4 (2012) as well as the previous data submission guidelines. The changes between the 2019 and 2020 EDV hinder trending capabilities. Qsource has included data and results related to the 2021 and 2020 EDV in this report.

Qsource also will conduct a medical record review for capitated physician encounters to fulfill Activity 4 for conducting EDV. MRR will be conducted for encounters with dates of service in 2021Q1. At the time of this report submission, the MRR was not complete; thus, no MRR results are included for this year.

However, results from the MRR conducted for encounters with dates of service in 2020 Q1 are included in this year's report. As the DBMs do not utilize capitation, no encounters are reported for them.

Technical Methods for Data Collection and Analysis

The *2021Q1 Paid Dates Report* submission included new medical claims and encounters, pharmacy claims, and adjustments submitted by each MCO and DBM and in aggregate for all MCOs and DBMs, where applicable, addressing claims and encounters paid between January 1, 2021, and March 31, 2021. The purpose of the EDV Paid Dates Report was to provide aggregate-level claim, encounter (MCOs only), pharmacy (MCOs only), and adjustment data on a time-sensitive basis, allowing for monitoring of the volume of data in each category submitted by each MCO and DBM, identifying any aberrations in terms of expected volume, and timely follow-up on and resolution of any irregularities noted.

Each quarterly EDV Paid Dates Report was supplemented by an MCO/DBM-specific *2021 Quarterly Service Dates Encounter Data Validation Report* (EDV Service Dates Report), which presented claims, encounters (MCOs only), and pharmacy claims (MCOs only) by service date for each quarter of the year. The EDV Service Dates reports included comprehensive data analysis guided by the activities presented in EQR Protocol 5 (2019). The 2021Q1 EDV Service Dates reports addressed claims and encounter data with service dates between January 1 and March 31, 2021, for all claims and encounters adjudicated between January 1 and June 30, 2021 (to address claim payment lag).

Claims and encounter data were analyzed at the institutional and professional levels. Institutional data included any records submitted by a healthcare institution via a CMS-1450 form (UB-04 [Uniform Bill]), a standard billing claim form for institutional medical claims. Professional data included any records submitted by a provider via a CMS-1500 form (Health Insurance Claim Form), a standard claim form for non-institutional medical provider claims. As part of this analysis is dependent on the distinction between institutional and professional claims/encounters, it was necessary to develop appropriate logic to assign claims/encounters to the appropriate category.

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 2021, which included an assessment of encounter and claims processing for measurement year 2020. 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 SQL [Structured Query Language] Server Management Studio for both data maintenance and querying and to 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.

For the MRR conducted for 2021Q1 service dates, Qsource selected a statistically valid stratified random sample of statewide encounters for service dates between January 1 and March 31, 2021, from Aetna and Simply Healthcare. Community Care reported no capitated physician encounters for this time period and thus was not included in the MRR. A sample of 139 encounter records was selected with a 10% oversample of 14 records, for a total of 153 distinct encounters. Qsource requested that the MCOs secure medical records associated with these encounters. The records were reviewed to confirm that key electronic encounter data were supported by the appropriate medical record. Qsource first identified if the appropriate medical record was available, then validated the following data in each medical record as compared to the electronic encounter data:

- Performing provider name match to National Provider Identifier (NPI) number
- Date of service
- All Current Procedural Terminology (CPT) procedure codes
- The first three International Classification of Diseases (ICD-10) diagnosis codes for each encounter

For this validation, Qsource addressed the following:

- Does the performing provider NPI number in the electronic record exactly match that documented in the medical record?
- Does the date of service in the electronic record exactly match that documented in the medical record?
- Are all the procedure/diagnosis codes in the electronic record documented in the medical record and all procedures/diagnoses documented in the medical record coded in the electronic record (Correctly Coded)?
- Are there procedure/diagnosis codes in the electronic record that are not documented in the medical record (Undocumented Codes)?
- Are there procedures/diagnoses documented in the medical record that are not coded in the electronic record (Missing Codes)?

Description of Data Obtained

CMS protocol for EDV defines encounter data as "the information related to the receipt of any item or service by an enrollee in an MCP. It is often thought of as the managed care equivalent of fee-for-service (FFS) claims. Encounter data reflect that a provider rendered a specific service under a managed care delivery system, regardless of if or how the MCP ultimately reimbursed the provider" (EQR Protocol 5). 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 include most of the same information that appears on claim forms; however, encounter data may be less complete or accurate than claim data due to some provider payments via capitation or episodes of care versus a claim for individual services provided. Encounter data are used to assess and improve quality, monitor program integrity, determine capitation payment rates, inform policy and operational decision-making, conduct risk adjustments, and incorporate alternative payment methods (EQR Protocol 5).

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.

For the 2021 EDV Reports, 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 Appendix B.

Comparative Findings

For EDV Activity 2, review of data production capacity, all three MCOs and all three DBMs received an acceptable rating for the ability to produce accurate and complete claims and encounter data for the period covered in the 2021 EDV reports. These ratings were based on an evaluation of:

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

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, frequencies of claim and encounter lines; percentages of enrollees with at least one claim/encounter; and the percentage of enrollment versus claims and encounter data. Qsource also analyzed medical and dental claim data percentages by service type and by provider type, average days from last service date to distinct claim paid date and average days from billing date to distinct claim paid date as well as frequencies of new medical claims and encounters, pharmacy claims, and adjustments. Table 13 includes total claims and encounters submitted by all MCOs and DBMs for 2020 Q1 and 2020 Q2 dates of service. Other more detailed results are included in Appendix A. The total number of claims may differ from the totals in tables A-26 and A-27 due to some claims having more than one provider type.

Table 13. Total Claims and Encounters Submitted by MCOs and DBMs						
2021Q1 Dates of Service	**Claims** N (% of MCO Total)		**Encounters** N (% of MCO Total)		**Total***	**Pharmacy Claims**
	Institutional	**Professional**	**Institutional**	**Professional**		
Total MCOs	17,871 (8.1%)	203,841 (91.9%)	362 (1.0%)	35,524 (99.0%)	257,343	273,896
Total DBMs					57,164	
2021Q2 Dates of Service	**Claims** N (% of MCO Total)		**Encounters** N (% of MCO Total)		**Total***	**Pharmacy Claims**
	Institutional	**Professional**	**Institutional**	**Professional**		
Total MCOs	1,844 (0.9%)	192,717 (99.1%)	419 (1.1%)	36,746 (98.9%)	248,034	287,829
Total DBMs					50,211	

** This column includes total claims and encounters for the MCOs and total claims only for the DBMs.*

A total of 221,712 distinct claims were submitted by the MCOs for 2021Q1 dates of service, with 91.9% professional claims and 8.1% institutional claims. Of the total 35,886 distinct encounters for the same dates of service, 99.0% were professional encounters and 1.0% (all for Community Care) were institutional encounters. The DBMs submitted a total of 57,164 distinct claims for 2021Q1 dates of service. For dates of service in 2021Q2, the MCOs submitted 194,561 distinct claims, with 99.1% professional claims and 0.9% institutional. Of the total 37,165 distinct encounters for the same dates of service, 98.9% were professional and 1.1% (again all for Community Care) were institutional. The DBMs submitted a total of 50,211 distinct claims for 2021Q2 dates of service.

Completeness and Validity

Qsource determined completeness and validity rates for critical data fields for the MCOs and DBMs agreed upon by FHKC, included in Appendix B. The accuracy rates were calculated as the number of valid data points as a percentage of those with data present (completeness). **Chart 7** includes the percentage of fields for which each MCO scored between 95.0% and 100% completeness across claim, encounter, and pharmacy lines submitted, and for which each DBM scored between 95.0% and 100% for claim lines submitted. The percentage of fields with 95.0% to 100% validity across the same categories is included in Chart 8.

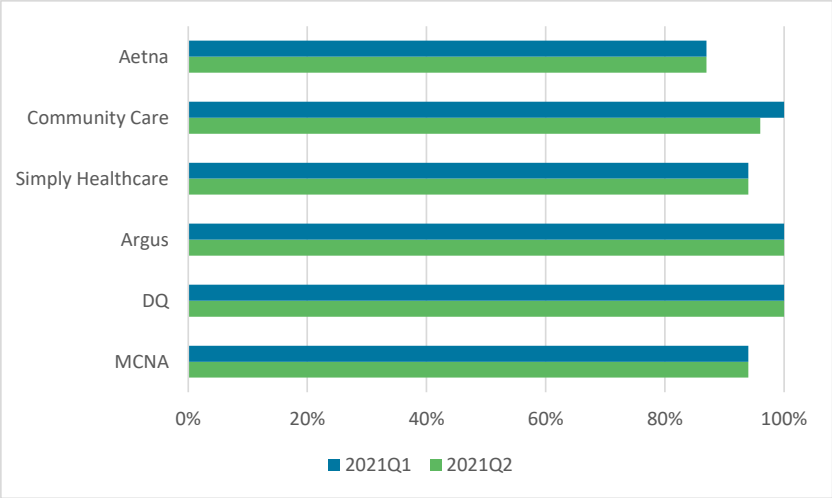

Chart 10. Percentage of Fields with 95.0-100% Completeness Rating

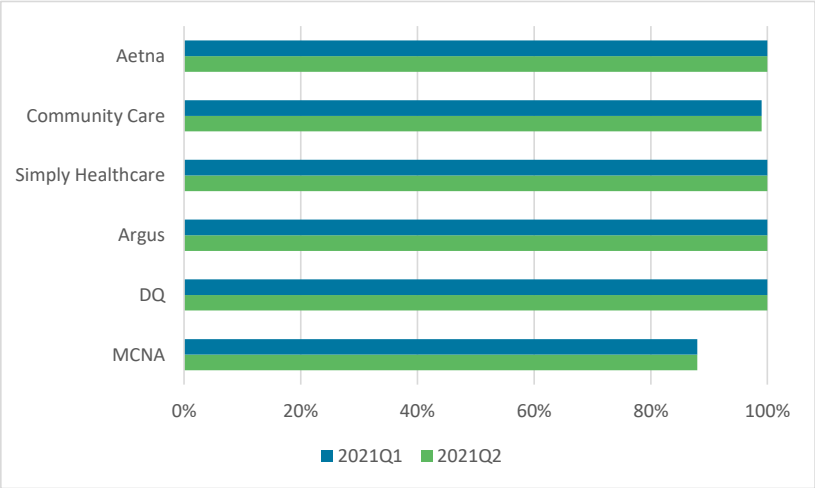

Chart 11. Percentage of Fields with 95.0-100% Validity Rating

As shown in **Charts 10** and **11**, completeness and validity ratings for 2021Q2 closely matched results for Q1. Validity ratings matched for each MCO/DBM, while only Community Care saw a change in completeness ratings (from 100% in Q1 to 96% in Q2).

Specific results by MCO and DBM are provided in Appendix A.

Paid Date Reporting

In addition to service date reporting, Qsource conducted quarterly aggregate analysis of claim/encounter data based on claims/encounters adjudicated in that quarter to provide timely information on the volume of claims/encounters and adjustments occurring in each quarter. Analysis for 2021Q1, Q2, and Q3 for the MCOs and DBMs is included in this report. Chart 12 includes claim, encounter, and pharmacy data by MCO. Chart 13 includes adjustment data by MCO. Chart 14 includes claim data by DBM, and Chart 15 includes adjustment data by DBM.

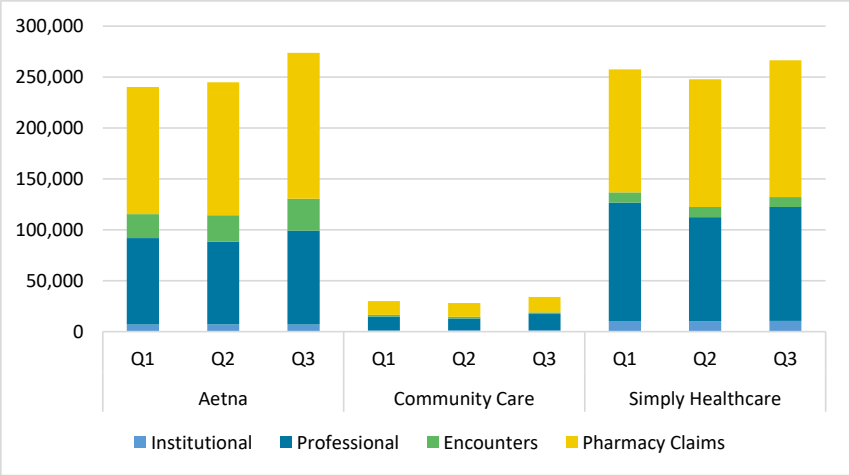

Chart 12. 2021 Q1, Q2, and Q3 Claim, Encounter, and Pharmacy Data by MCO

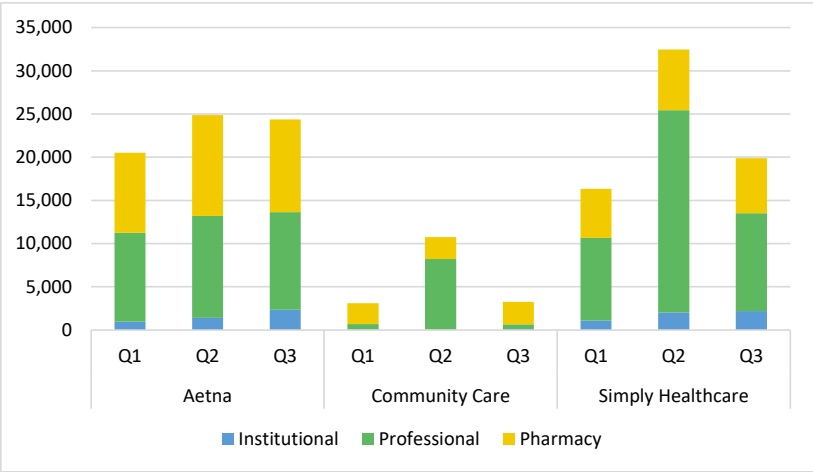

Chart 13. 2021 Q1, Q2, and Q3 Adjustments by MCO

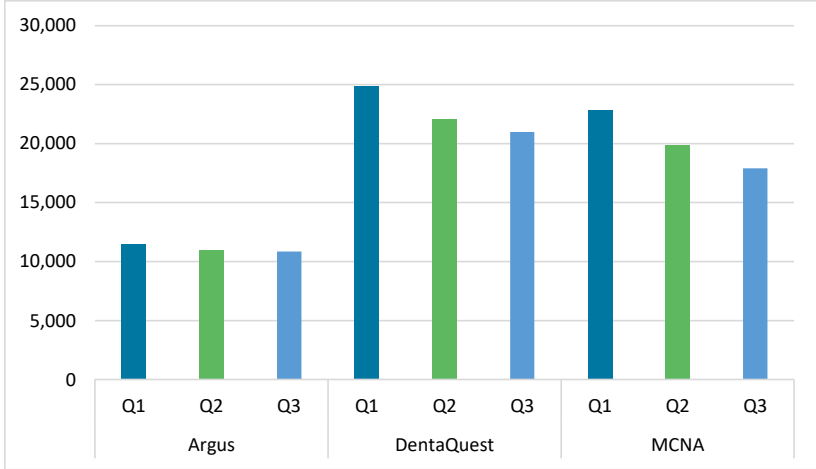

Chart 14. 2021 Q1, Q2, and Q3 Claim Data by DBM

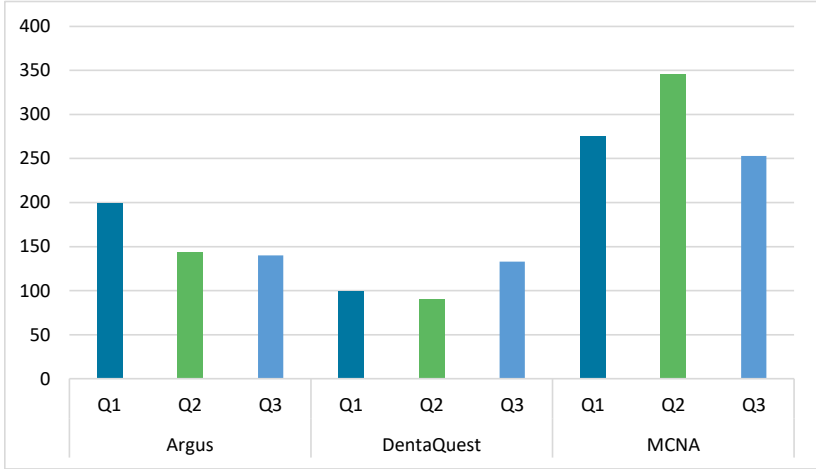

Chart 15. 2021 Q1, Q2, and Q3 Adjustments by DBM

Conclusions and Recommendations

Qsource conducted mandatory and optional EQR activities for the Florida Healthy Kids program for calendar year 2020. From the aggregation and analyses of data across activities for all MCOs and DBMs providing health and dental services for Florida Healthy Kids enrollees, Qsource provides the following conclusions and recommendations for improving the quality and timeliness of care as well as enrollee access to care.

PIP Validation

FHKC's Quality Improvement and Data Analytics Committee approves PIP topics annually. The FHKC-selected PIP topics required the MCOs to focus on improving quality health outcomes by increasing the number of enrollees screened for depression and, if screened positive, received follow-up care. Interventions implemented for this PIP should support improved quality health outcomes as well as improve CDF-CH measure performance. For the DBMs, the clinical topic aims to assist enrollees in accessing preventive dental services and thereby increase DBM PDENT measure performance. All MCO and DBM clinical PIPs received a validation rating of High or Moderate Confidence during the 2021 PIP validation, with overall scores ranging from 88.1% to 100% of elements met.

Performance was more varied for the nonclinical PIPs, with validation ratings ranging from Low to High Confidence and overall scores ranging from 70.0% to 100%. Aetna and MCNA earned ratings of High Confidence for their nonclinical PIPs; all other nonclinical PIPs earned a Moderate Confidence rating with the exception of Argus's *Access – Enrollee Satisfaction and Treatment Dental Services* PIP, which earned a rating of Low Confidence.

Analysis of each PIP's strengths revealed that the Plans exhibited a strong understanding of specific enrollee needs, care, and services; data collection design and plans; and designing improvement strategies to address barriers and thereby effect sustained improvement. At the same time, weaknesses were noted in several PIPs regarding the specificity of the PIP aim statement, performance measure and variable definitions, and addressing quantitative and statistical evidence of improvement. Qsource recommends that the MCOs and DBMs continue to consult CMS and Qsource training materials on the 2019 CMS PIP Protocol 1, and continue implementing rapid-cycle PDSA improvement techniques as these PIPs progress in support of Quality Strategy Plan goals 1 and 4, quality and effectiveness.

PMV

To assess MCO and DBM performance over time, in comparison to each FHKC MCO and DBM, and in relation to national Medicaid averages, FHKC requires Plans to report HEDIS and CMS Child Core Set performance measure results across six

categories of care in support of FHKC's goal to meet or exceed the 75th percentile for the national benchmark, if available.

Overall trending for these measures indicates that the MCOs' measure rates primarily increased from 2020 to 2021, while the DBMs' rates primarily decreased. A recommended course of action is coordination among the MCOs and DBMs, FHKC, and Qsource to identify high-priority areas most in need of a focus on quality health outcome improvement efforts in support of Quality Strategy Plan goals 1 and 5, quality and leadership. In addition, FHKC could consider the inclusion of national Medicaid benchmark data in PMV analyses to help monitor progress toward achieving Quality Strategy Plan goals. No deficiencies were noted in the MCOs' or DBMs' processes for data collection and performance measure reporting.

ACA

FHKC's compliance assessment is stratified based on risk and importance, with the higher risk compliance standards assessed in the first year and the lowest risk compliance standards assessed in the last year. 2021 marks the first year of a new three-year review cycle, with standards reviewed for the MCOs including Availability of Services, Assurances of Adequate Capacity and Services, Grievance and Appeals System, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement (QAPI). This year's ACA also included grievance and appeal file reviews.

While trending comparisons cannot be made due to different standards being reviewed each year of the three-year compliance assessment cycle, summative data for 2019, 2020, and 2021 indicate the MCOs and DBMs are demonstrating acceptable performance across key metrics, and scores for all three categories of quality, timeliness, and access were higher in 2021 than the prior year. An analysis of Plan strengths and weaknesses during the 2021 ACA revealed that the MCOs and DBMs demonstrated compliance with federal and contractual regulations in operational practice but did not consistently address the requirements in all P&Ps and other Plan documentation.

Qsource recommends the MCOs and DBMs conduct internal quality checks to ensure program processes align with the most recent federal regulations as well as all contract and contract amendment requirements toward FHKC's Quality Strategy goals 1 and 4, quality and effectiveness. They should also ensure those processes are in place for all rather than partial time periods under review. Plans must also fulfill the requirement to include performance results specific to the Florida Healthy Kids program in their Quality Improvement Plans. This year, the Plans all successfully resolved deficiencies identified in the 2020 ACA.

ANA

As noted in FHKC's Quality Strategy Plan, ensuring enrollees have adequate and timely access is key to quality care but can also be challenging given the rural nature of the state, provider hesitancy to contract with publicly funded insurance programs,

and a nationwide shortage of pediatric subspecialists. FHKC mitigates these challenges by requiring its MCOs and DBMs to meet certain network adequacy standards.

As in the previous ANA, all Plans provided adequate networks and access for urban enrollees and for primary care providers in both urban and rural areas, but rural access to specialty providers remains deficient. Toward achievement of Quality Strategy Plan goals 1, 2, 3, and 6—quality, satisfaction, growth, and advancement—Qsource recommends that the MCOs and DBMs take action where possible to ensure a robust provider and specialist network to provide services for Florida Healthy Kids enrollees. Specifically, the focus for the MCOs should again be on increasing rural access to the following healthcare provider types: allergy and immunology; obstetrics and gynecology; pediatric specialists; otolaryngology; hospitals; and pharmacies. Although minimum access thresholds are not defined as a percentage of FHKC enrollees in the DBMs' contracts with FHKC, rural access to orthodontists and dental specialists remains an area of weakness for all Plans.

EDV

The one optional EQR activity conducted for FHKC's MCOs and DBMs, EDV, has been evolutionary since first implemented in 2018. Throughout the process, Qsource provided technical assistance for the MCOs and DBMs as they worked to adjust data collection and reporting systems to adhere to data submission guidelines from FHKC.

All MCOs and DBMs assessed for EDV in 2021Q1 and 2021Q2 achieved completeness ratings above 90% except for Aetna, which achieved 87% completeness for both quarters; the other completeness ratings ranged from 94% to 100%. Validity ratings were similar, with only one DBM, MCNA, achieving less than 90% validity at 88% for both quarters; the other validity ratings ranged from 99% to 100%. Likewise, most volume and consistency distribution rates were within expectations. In support of Quality Strategy Plan goals 1 and 4, quality and effectiveness, Qsource recommends that FHKC and Qsource continue to collaborate closely with the Plans to ensure complete and accurate claim and encounter data submission.

APPENDIX A | EQR Activity Findings

In accordance with CMS guidelines for EQRO technical reporting provided in the October 2019 CMS EQR Protocols to provide comparative information in tables presenting performance measure scores and PIP ratings and scores for all Plans, this appendix presents MCO- and DBM-specific results for the 2021 **PIP**, PMV, ACA, ANA, and EDV activities.

PIP Validation

Table A-1 includes each MCO/DBM's full PIP title, aim statement, performance measure(s), interventions (if applicable), measurement results, and any strengths and weaknesses. Interventions do not apply to PIPs in the baseline year and are not included in such cases. The type, topic, overall validation rating, and overall score of each MCO's and DBM's PIPs in addition to the primary area of care impacted by the PIP—quality, access, or timeliness—are provided in the PIP section of the report for each MCO and DBM. More detailed individual MCO and DBM scores are provided for the clinical PIPs in Table A-2 and for the nonclinical PIPs in Table A-3.

Table A-1. 2021 PIP Details for MCOs and DBMs		
MCOs		
Aetna: *Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)*		
Aim Statement	*Will targeted provider interventions increase the rate of [Florida Healthy Kids] members ages 12-17 (on date of encounter) who are screened for depression using a standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen by 5 percentage points over baseline during the first measurement period?*	
Performance Measure(s)	*Screening for Depression and Follow-Up: Ages 12-17 (CDF-CH)*	
Measurement Results	B*: 3.74%	
Strengths	**Step 6. Review the Data Collection Procedures**	1) The MCO described the data collection design and plan in comprehensive detail. 2) The MCO described a comprehensive, externally audited process for estimating data completeness.
Aetna: *Follow-Up After Hospitalization for Mental Illness – 7-Day (FUH – 7-Day)*		
Aim Statement	*Will targeted provider and member interventions increase the rate of follow-up visit with a mental health practitioner within 7 days after a hospital stay for [Florida Healthy Kids] members (6 years of age or older as of the date of discharge) hospitalized with a principal diagnosis of mental illness or intentional self-harm to meet or exceed the 2020 NCQA Quality Compass 50th percentile during the second re-measurement period (MY 2020)?*	
Performance Measure(s)	*Follow-Up After Hospitalization for Mental Illness (FUH 7-day)*	

Table A-1. 2021 PIP Details for MCOs and DBMs		
Interventions	1) BH Liaisons Provider Intervention 2) BH Liaison Member Outreach	
Measurement Results	B: 33.77% R1: 35.58% R2: 51.08%	
Strengths	**Step 6. Review the Data Collection Procedures**	1) The MCO described the data collection design and plan in comprehensive detail. 2) The MCO described a comprehensive, externally audited process for estimating data completeness.
	Step 7. Review the Data Analysis and Interpretation of PIP Results	The MCO presented a comprehensive data analysis plan.
	Step 8. Assess the Improvement Strategies	1) The MCO included a very detailed driver diagram to address causes of/barriers to follow-up care after hospitalization. 2) The MCO included a detailed and comprehensive description and in-depth analysis of PDSA cycles throughout the measurement year for both improvement strategies.
Weaknesses	**Step 1. Review the Selected PIP Topic**	1) The MCO should include an analysis of enrollee needs, care, and services relative to the PIP topic. 2) The MCO should indicate if enrollee or provider input was considered in developing the PIP topic.
Community Care: *Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)*		
Aim Statement	*Does reminder outreach to schedule a well visit appointment by texting or telephone result in an improvement in screening for clinical depression and appropriate follow up in 12 – 17 year old FHKC enrollees during the measurement period? Does education to providers about screening using a standardized tool and submitting the appropriate codes on the encounter submission result in an improvement in screening for clinical and appropriate follow up in 12 – 17 year old FHKC enrollees during the measurement period?*	
Performance Measure(s)	*CDF-CH Screening for Depression and Follow-Up Plan*	
Measurement Results	B: 2.72%	
Strengths	**Step 1. Review the Selected PIP Topic**	The MCO included an analysis of enrollee needs, care, and services relative to the PIP topic.

Table A-1. 2021 PIP Details for MCOs and DBMs		
Weaknesses	**Step 5. Review the Selected PIP Variables and Performance Measures**	The MCO should address how the follow-up visit rates over time will be compared to benchmark and how this comparison will inform quality improvement strategies.
	Step 6. Review the Data Collection Procedures	The MCO should include additional documentation on the process by which data completeness is estimated (incurred but not reported analysis).
Community Care: *Health Risk Assessment (HRA) Response Rate*		
Aim Statement	*Does incentivizing FHKC enrollees to complete the HRA within 90 days of enrollment result in higher return rates?*	
Performance Measure(s)	*The percentage of CCP FHKC new enrollees that complete the HRA within 90 days of enrollment*	
Measurement Results	B: 11.46%	
Weaknesses	**Step 1. Review the Selected PIP Topic**	The MCO should indicate if enrollee or provider input was considered in developing the PIP topic.
	Step 2. Review the PIP Aim Statement	The MCO should indicate the PIP time period.
	Step 5. Review the Selected PIP Variables and Performance Measures	1) The MCO should address how the HRA completion rate over time will be compared to benchmark and how this comparison will inform quality improvement strategies. 2) The MCO should address if any existing measures were available or considered.
Simply Healthcare: *Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)*		
Aim Statement	*Do targeted interventions improve the percentage of beneficiaries ages 12 to 17 who are screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen?*	
Performance Measure(s)	*Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)*	
Interventions	Provider Education	
Measurement Results	B: 3.02% R1: 3.26%	
Strengths	**Step 1. Review the Selected PIP Topic**	The MCO included a comprehensive analysis of enrollee demographics, needs, care, and services relative to the PIP topic.
	Step 6. Review the Data Collection Procedures	The MCO described a comprehensive, externally audited process for estimating data completeness.

Table A-1. 2021 PIP Details for MCOs and DBMs		
	Step 8. Assess the Improvement Strategies	The MCO provided a comprehensive description of the PDSA process and implemented a small test of change to assess the effectiveness of the improvement strategy.
Weaknesses	**Step 2. Review the PIP Aim Statement**	1) The MCO should specifically note the PIP time period (the measurement period) in the aim statement. 2) The MCO should ensure the aim statement is answerable by including a clear and unambiguous goal.
	Step 5. Review the Selected PIP Variables and Performance Measures	The MCO should address the second component variable of the measure, follow-up plan documented after positive screen.
	Step 6. Review the Data Collection Procedures	The MCO should include the integration of enrollment and pharmacy data in its description of the system for collecting valid and reliable data that represent the PIP population.
	Step 9. Assess the Likelihood that Significant and Sustained Improvement Occurred	The MCO should address how the provider-specific improvements are likely the result of the education provided (e.g., provider feedback that education resulted in screening and follow-up being conducted).
Simply Healthcare: *Improving Care Coordination to Improve Follow-Up Care for Children Prescribed ADHD Medication (ADD)*		
Aim Statement	*Do targeted interventions of care coordination will improve Follow-Up Care for Children Prescribed ADHD Medication (ADD) rates in both initiation as well as continuation/maintenance phase?*	
Performance Measure(s)	**Performance Measure 1:** *Follow-Up Care for Children Prescribed ADHD Medication (ADD) Initiation Phase*	
	Performance Measure 2: *Follow-Up Care for Children Prescribed ADHD Medication (ADD) Continuation and Maintenance (C&M) Phase*	
Interventions	Care Gaps identification system	
Measurement Results	**Performance Measure 1:** B: 42.28% R1: 45.73% R2: 50.47%	**Performance Measure 2:** B: 58.54% R1: 66.25% R2: 60.24%
Strengths	**Step 1. Review the Selected PIP Topic**	The MCO included a detailed analysis of enrollee needs, care, and service relative to the PIP topic.
	Step 6. Review the Data Collection Procedures	The MCO described a comprehensive, externally audited process for estimating data completeness.

Table A-1. 2021 PIP Details for MCOs and DBMs		
	Step 8. Assess the Improvement Strategies	1) The MCO included a detailed driver diagram to address causes of/barriers to follow-up care after ADHD medication prescriptions. 2) The MCO included a detailed description of PDSA cycles throughout the measurement year for the improvement strategy.
Weaknesses	**Step 1. Review the Selected PIP Topic**	The MCO should indicate if enrollee or provider input was considered in developing the PIP topic.
	Step 5. Review the Selected PIP Variables and Performance Measures	1) The MCO should define the PIP variables as the qualifying outpatient visits, at 30 days for the Initiation Phase and 210 days for the Continuation and Maintenance Phase. 2) The MCO should address how the outpatient visits are available to measure performance and track improvement over time.
	Step 9. Assess the Likelihood that Significant and Sustained Improvement Occurred	1) The MCO should address the quantitative evidence of improvement in the Initiation Phase rates. 2) The MCO should address the statistical evidence of improvement in the Initiation Phase rates.
DBMs		
Argus: *Children Receiving Preventive Services*		
Aim Statement	*Do targeted interventions to families and enrollees of Florida Healthy Kids, aged 6-18 years as of September 30th of the measurement year increase the percentage of enrollees who receive Preventive Dental Services (per CMS Form-416 specifications)?*	
Performance Measure(s)	**Performance Measure 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*	
	Performance Measure 2: *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)*	
Interventions	1) Welcome to Argus and Healthy Kids educational materials 2) Special COVID-19 Enrollee Education 3) GAP Closures for Those in Need of Preventive Services	
Measurement Results	Performance Measure 1: B: 32.08% R1: 36.68%	Performance Measure 2: B: 46.85% R1: 49.45%

Table A-1. 2021 PIP Details for MCOs and DBMs		
	R2: 37.71% R3:32.08%	R2: 47.44% R3: 40.14%
Strengths	**Step 1. Review the Selected PIP Topic**	The DBM included an exceptionally detailed and relevant analysis of enrollee needs, care, and services.
Weaknesses	**Step 2. Review the PIP Aim Statement**	1) The DBM should specify the PIP time period. 2) The DBM should ensure the aim statement is answerable by including a realistic and unambiguous goal.
	Step 7. Review the Data Analysis and Interpretation of PIP Results	1) The DBM should include a statistical analysis for the first two remeasurement periods. 2) The DBM should address lessons learned about less-than-optimal performance.
	Step 8. Assess the Improvement Strategies	1) The DBM should include the basis for each improvement strategy selected. 2) The DBM should update its driver diagram to address causes/barriers to preventive care as the primary and secondary drivers leading to the formulation of improvement strategies. 3) The DBM should include a description of the PDSA cycles conducted for each intervention.
Argus: *Access and Availability of Services – Enrollee Satisfaction (Children)*		
Aim Statement	*Do targeted intervention to improve enrollee satisfaction with access improve the dental treatment services (TDENT) rates during the measurement period?*	
Performance Measure(s)	*Analysis of TDENT rates for the ages indicated in the study population of 6-18 years*	
Interventions	1) Care Coordination for Enrollee Grievances 2) Care Coordination for Enrollee Access to Services	
Measurement Results	B: 22.80% R1: 24.19% R2: 22.80% R3: 19.84%	
Weaknesses	**Step 2. Review the PIP Aim Statement**	The DBM should ensure the aim statement is answerable by including a realistic and unambiguous goal.
	Step 5. Review the Selected PIP Variables	The DBM should specifically note the TDENT variable.

Table A-1. 2021 PIP Details for MCOs and DBMs		
	and Performance Measures	
	Step 7. Review the Data Analysis and Interpretation of PIP Results	1) The DBM should include a discussion of all remeasurement period performance measure results. 2) The DBM should include a discussion of the statistical significance of changes in rates over all remeasurement periods. 3) The DBM should address whether there were any factors that might influence the comparability of measurements (e.g., changes in measure specifications). 4) The DBM should provide information in a more easily understood manner.
	Step 8. Assess the Improvement Strategies	1) The DBM should update its driver diagram to address causes/barriers to access to care as the primary and secondary drivers leading to the formulation of improvement strategies. 2) The DBM should include a description of all PDSA cycle components conducted for each intervention. 3) The DBM should address cultural and linguistic appropriateness relative to the improvement strategy. 4) The DBM should address follow-up activities planned for each intervention.
	Step 9. Assess the Likelihood that Significant and Sustained Improvement Occurred	1) The DBM should address any quantitative improvement in the performance measure. 2) The DBM should address the likelihood that any improvement is the result of the improvement strategy. 3) The DBM should address statistical evidence that any observed improvement is the result of the improvement strategy. 4) The DBM should address any sustained improvement over time.
DentaQuest: *Preventative Dental*		
Aim Statement	*Will the use of targeted member and provider interventions increase the number of members aged 5-18, with 90 days continuous enrollment, who receive a preventative visit (CDT codes D1000-D1999) from 50.9% to 52.9% between 10/1/2019 and 9/30/2020?*	
Performance Measure(s)	*Increasing preventive dental visits in children*	

Table A-1. 2021 PIP Details for MCOs and DBMs		
Interventions	1) Patient Education 2) Appointment Scheduling Assistance 3) Provider Outreach for Enrollees Ages 15-18 Years 4) Provider Outreach Roster for Enrollees Ages 5-18 Years	
Measurement Results	B: 50.4% R1: 50.9% R2: 44.0%	
Strengths	**Step 5. Review the Selected PIP Variables and Performance Measures**	The DBM provided a detailed and comprehensive description of PIP variables and performance measures.
	Step 6. Review the Data Collection Procedures	1) The DBM described the data collection design and plan in comprehensive detail. 2) The DBM provided a thorough discussion of the data analysis plan and the process by which appropriate data are available.
	Step 7. Review the Data Analysis and Interpretation of PIP Results	The DBM provided an exceptionally comprehensive and relevant discussion of interpretation and analysis of results.
	Step 8. Assess the Improvement Strategies	The DBM addressed all elements in this step in comprehensive detail.
DentaQuest: *Increase Afterhours Care*		
Aim Statement	*Will the use of provider targeted interventions increase the rate of providers (must be actively credentialed for entire measurement period) in the FHKC network who offer afterhours care by 2% (42.4% to 44.4%) between 10/1/2019 and 9/30/2020? Will the use of targeted interventions increase the rate of CMS 416 eligible (90-day continuous enrollment) FHKC members aged 5-18 receiving any dental care by 2% (52.1% to 54.1%) between 10/1/2019 and 9/30/2020?*	
Performance Measure(s)	**Performance Measure 1:** *Increasing percentage of active providers who offer after hours care*	
	Performance Measure 2: *Increase Any Dental Visit*	
Interventions	1) Enrollee Letter Outreach 2) Dental Home Provider 3) Provider Webinar	

Table A-1. 2021 PIP Details for MCOs and DBMs		
Measurement Results	**Performance Measure 1:** B: 42.2% R1: 42.4% R2: 44.1%	**Performance Measure 2:** B: 51.5% R1: 52.1% R2: 45.7%
Strengths	**Step 1. Review the Selected PIP Topic**	The DBM included a detailed and relevant analysis of enrollee needs, care, and services.
	Step 5. Review the Selected PIP Variables and Performance Measures	The DBM provided a detailed and comprehensive description of PIP variables and performance measures.
	Step 6. Review the Data Collection Procedures	1) The DBM described the data collection design and plan in comprehensive detail. 2) The DBM provided a thorough discussion of the data analysis plan and the process by which appropriate data are available.
	Step 7. Review the Data Analysis and Interpretation of PIP Results	The DBM provided an exceptionally comprehensive and relevant discussion of interpretation and analysis of results.
Weaknesses	**Step 8. Assess the Improvement Strategies**	1) The DBM should address an improvement strategy specifically related to the provider after-hours performance measure. 2) The DBM should address causes/barriers identified through data analysis and quality improvement processes for any improvement strategies related to the after-hours performance measure. 3) The DBM should include a description of PDSA cycle components conducted for any improvement strategies related to the after-hours performance measure. 4) The DBM should address cultural and linguistic appropriateness for any improvement strategies related to the after-hours performance measure. 5) The DBM should describe how any improvement strategies related to the provider after-hours performance measure are reflective of major confounding factors that could have an obvious impact on PIP outcomes. 6) The DBM should address follow-up activities planned for any interventions related to the after-hours performance measure.

Table A-1. 2021 PIP Details for MCOs and DBMs

	Step 9. Assess the Likelihood that Significant and Sustained Improvement Occurred	The DBM should address the quantitative evidence of improvement in the after-hours measure rate.
MCNA: *Preventive Dental Visit*		
Aim Statement	*Will targeted interventions improve the percentage of members ages 5-18 accessing at least one preventive dental visit and/or service over a 12 month period?*	
Performance Measure(s)	**Performance Measure 1:** *Preventive Dental Services*	
	Performance Measure 2: *Dental Sealants, ages 6-9 with exclusions*	
	Performance Measure 3: *Dental Sealants, ages 10-14 with exclusions*	
Interventions	1) Care Gap Alerts 2) Text Messages 3) Member Outreach Forms 4) Practice Site Performance Summary (PSPS) Report	
Measurement Results	**Performance Measure 1:** B: 46.91% R1: 48.95% R2: 39.42%	**Performance Measure 2:** B: 16.34% R1: 16.83% R2: 13.11%
		Performance Measure 3: B: 12.33% R1: 13.84% R2: 10.21%
Strengths	**Step 1. Review the Selected PIP Topic**	The DBM included a comprehensive analysis of enrollee needs, care, and services.
	Step 8. Assess the Improvement Strategies	The DBM addressed all elements in this step in comprehensive detail.
	Step 9. Assess the Likelihood that Significant and Sustained Improvement Occurred	The DBM included an analysis of detailed results of its interventions to support the likelihood that they contributed to improvements seen.

Table A-1. 2021 PIP Details for MCOs and DBMs		
Weaknesses	**Step 2. Review the PIP Aim Statement**	The DBM should ensure the aim statement is answerable by including a realistic and unambiguous goal.
MCNA: *Annual Dental Visit (ADV)*		
Aim Statement	*Will targeted member interventions improve the percentage of members ages 5-18 receiving at least one dental visit over a 12-month period?*	
Performance Measure(s)	*Annual dental visit (ADV)*	
Interventions	1) Care Gap Alerts 2) Text Messages 3) Member Outreach Forms 4) ADV Outbound Call Campaign 5) ADV Postcard Mailing	
Measurement Results	B: 59.31% R1: 60.62% R2: 51.76%	
Strengths	**Step 1. Review the Selected PIP Topic**	The DBM included a comprehensive analysis of enrollee needs, care, and services.
	Step 8. Assess the Improvement Strategies	The DBM addressed all elements in this step in comprehensive detail.
	Step 9. Assess the Likelihood that Significant and Sustained Improvement Occurred	The DBM included an analysis of detailed results of its interventions to support the likelihood that they contributed to improvements seen.
Weaknesses	**Step 2. Review the PIP Aim Statement**	The DBM should ensure the aim statement is answerable by including a realistic and unambiguous goal.

** B = Baseline; R1 = Remeasurement Year 1; R2 = Remeasurement Year 2; R3 = Remeasurement Year 3*

Tables A-2 and A-3 summarize overall PIP validation scores, including the total number of evaluation elements assessed and met, the percentage of elements that were met, and the overall validation status. The actual number of steps validated for each MCO and DBM depended on various factors,

including the progress of the PIP study and sampling methods. Table A-2 includes scores for the MCOs' and DBMs' clinical PIPs, and Table A-3 includes scores for the MCOs' and DBMs' nonclinical PIPs.

Table A-2. 2021 Clinical PIP Validation Results

PIP Activity 1: Assess the PIP Methodology	Elements Met/Applicable					
	Aetna	Argus	Community Care	DentaQuest	MCNA	Simply Healthcare
1. State the Selected PIP Topic	3/3	3/3	3/3	3/3	5/5	3/3
2. State the PIP Aim Statement	6/6	4/6	6/6	6/6	5/6	4/6
3. Identify the PIP Population	3/3	3/3	3/3	3/3	3/3	3/3
4. Describe the Sampling Method	0/0	0/0	0/0	0/0	0/0	0/0
5. Describe Selected PIP Variables and Performance Measures	7/7	7/7	6/7	7/7	7/7	6/7
6. Describe Data Collection Procedures	7/7	7/7	6/7	7/7	7/7	6/7
7. Analyze Data and Interpret PIP Results	0/0	5/7	0/0	7/7	7/7	7/7
8. Describe Improvement Strategies	0/0	3/6	0/0	6/6	6/6	5/5
9. Assess for Significant and Sustained Improvement	0/0	2/2	0/0	5/5	5/5	3/4
Total	**26/26**	**34/41**	**24/26**	**44/44**	**45/46**	**37/42**
Validation Score	**100%**	**82.93%**	**92.31%**	**100%**	**97.83%**	**88.10%**
PIP Activity 2: Overall Validation Rating	**High Confidence**	**Moderate Confidence**	**High Confidence**	**High Confidence**	**High Confidence**	**Moderate Confidence**

Table A-3. 2021 Nonclinical PIP Validation Results						
PIP Activity 1: Assess the PIP Methodology	**Elements Met/Applicable**					
	Aetna	**Argus**	**Community Care**	**DentaQuest**	**MCNA**	**Simply Healthcare**
1. State the Selected PIP Topic	3/5	4/4	4/5	4/4	5/5	4/5
2. State the PIP Aim Statement	6/6	5/6	5/6	6/6	5/6	6/6
3. Identify the PIP Population	3/3	3/3	3/3	3/3	3/3	3/3
4. Describe the Sampling Method	0/0	0/0	0/0	0/0	0/0	0/0
5. Describe Selected PIP Variables and Performance Measures	7/7	7/8	6/8	8/8	7/7	5/7
6. Describe Data Collection Procedures	7/7	7/7	7/7	7/7	7/7	7/7
7. Analyze Data and Interpret PIP Results	6/6	3/7	0/0	7/7	7/7	6/6
8. Describe Improvement Strategies	6/6	2/6	0/0	0/6	6/6	6/6
9. Assess for Significant and Sustained Improvement	5/5	1/5	0/0	4/5	5/5	3/5
Total	**43/45**	**32/46**	**25/29**	**39/46**	**45/46**	**40/45**
Validation Score	**95.55%**	**69.57%**	**86.21%**	**84.78%**	**97.83%**	**88.89%**
PIP Activity 2: Overall Validation Rating	**High Confidence**	**Low Confidence**	**Moderate Confidence**	**Moderate Confidence**	**High Confidence**	**Moderate Confidence**

PMV

MCO-specific results appear in tables **A-4**, A-5, and A-6. The green and red arrows in **Table A-4** indicate an increase (⬆) or decrease (⬇) from the previous year's rate. Trending from the 2019 PMV is not possible, as measures reported for the 2019 PMV are not all the same as those reported for the 2020 and 2021 PMV. 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 A-4. 2020 and 2021 PMV Measure Results: MCOs

Measure	Aetna		Community Care		Simply Healthcare	
	2020	2021	2020	2021	2020	2021
Primary Care Access and Preventive Care						
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
Body Mass Index (BMI) Percentile: 3–11 Years	85.48%	89.36%⬆		87.56%	95.96%	91.00%⬇
BMI Percentile: 12–17 Years	89.33%	86.55%⬇		92.08%	94.84%	93.84%⬇
BMI Percentile Total	87.59%	87.83%⬆		89.78%	95.38%	92.46%⬇
Chlamydia Screening in Women (CHL)						
16–20 Years	57.72%	52.54%⬇		52.22%	52.93%	54.90%⬆
Immunizations for Adolescents (IMA)						
Meningococcal	75.43%	77.86%⬆		88.57%	85.40%	86.13% ⬆
Tdap	91.24%	91.24%		95.71%	93.43%	95.62%⬆
HPV	31.87%	40.63%⬆		40.00%	44.04%	44.04%
Combination #1 (Meningococcal and Tdap/Td)	74.21%	76.40%⬆		88.57%	83.70%	85.40%⬆
Combination #2 (Meningococcal, Tdap/Td,and HPV)	29.68%	36.98%⬆		38.57%	41.85%	42.34%⬆
Child and Adolescent Well-Care Visits (WCV)						
3–11 Years		65.00%		63.36%		66.55%

Table A-4. 2020 and 2021 PMV Measure Results: MCOs						
Measure	**Aetna**		**Community Care**		**Simply Healthcare**	
	2020	**2021**	**2020**	**2021**	**2020**	**2021**
12–17 Years		67.31%		60.88%		65.45%
18–21 Years		54.01%		53.47%		53.49%
Total		65.30%		61.51%		65.07%
Screening for Depression and Follow-Up Plan: Ages 12−17 (CDF)		4%		2.72%		3.26%
Maternal and Perinatal Health						
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	NA	NA		NA	80.00%	NA
Cesarean Birth (PC-02)		NA		*		*
Contraceptive Care – Postpartum Women Ages 15−20 (CCP)						
Most or moderately effective contraception –3 days		NA		NA		NA
Most or moderately effective contraception –60 days		NA		NA		NA
Long-acting reversible method of contraception (LARC) – 3 days		NA		NA		NA
LARC – 60 days		NA		NA		NA
Contraceptive Care – All Women Ages 15−20 (CCW)						
Most effective or moderately effective method of contraception		17.00%		10.00%		16.27%
LARC		1.00%		0%		1.67%
Care of Acute and Chronic Conditions						
Asthma Medication Ratio (AMR)						
5–11 Years	85.21%	91.61%⬆		NA	89.91%	83.75%⬇

Table A-4. 2020 and 2021 PMV Measure Results: MCOs						
Measure	**Aetna**		**Community Care**		**Simply Healthcare**	
	2020	**2021**	**2020**	**2021**	**2020**	**2021**
12–18 Years	78.05%	80.45%↑		*	78.95%	78.70%↓
Total	81.89%	85.86%↑		NA	85.07%	81.36%↓
Appropriate Testing for Pharyngitis (CWP)						
3–17 Years	84.52%	83.85%↓		74.19%	84.12%	84.66%↑
18–64 Years	74.64%	73.02%↓		NA	70.90%	79.66%↑
Total	84.17%	83.37%↓		73.47%	83.64%	84.43%↑
Appropriate Treatment for Children with Upper Respiratory Infection (URI)						
3 Months – 17 Years	87.78%	90.79%↑		96.77%	91.10%	91.68%↑
18–64 Years	78.88%	83.40%↑		92.86%	79.90%	85.66%↑
Total	87.54%	90.54%↑		96.69%	90.79%	91.49%↑
Ambulatory Care: Emergency Department Visits (AMB-ED) – Visits / 1,000 Enrollee Months						
1–9 Years	30.56	16.47↓		12.42	32.92	16.68↓
10–19 Years	24.94	16.27↓		12.24	25.72	16.48↓
Behavioral Healthcare						
Follow-Up Care for Children Prescribed ADHD Medication (ADD)						
Initiation Phase	47.30%	44.55%↓		*	45.73%	50.47%↑
Continuation and Maintenance Phase	60.53%	69.74%↑		*	66.25%	60.24%↓
Follow-Up After Hospitalization for Mental Illness (FUH)						
7-Day Follow-Up: 6–17 Years	36.73%	52.09%↑		39.53%	8.76%	41.49%↑
30-Day Follow-Up: 6–17 Years	55.10%	74.42%↑		58.14%	18.98%	67.66%↑
7-Day Follow-Up: 18–64 Years		38.24%		NA		38.78%
30-Day Follow-Up: 18–64 Years		58.82%		NA		48.98%
7-Day Follow-Up Total		51.08%		39.58%		41.23%

Table A-4. 2020 and 2021 PMV Measure Results: MCOs						
Measure	**Aetna**		**Community Care**		**Simply Healthcare**	
	2020	**2021**	**2020**	**2021**	**2020**	**2021**
30-Day Follow-Up Total		73.28%		60.42%		65.90%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)						
7-Day Follow-Up: 6–17 Years	26.67%	39.68%↑		NA	26.0%	33.82%↑
30-Day Follow-Up: 6–17 Years	45.0%	58.73%↑		NA	44.0%	51.47%↑
7-Day Follow-Up: 18–64 Years	NA	NA		*	NA	NA
30-Day Follow-Up: 18–64 Years	NA	NA		*	NA	NA
7-Day Follow-Up Total	49.28%	41.54%↓		NA	29.82%	33.33%↑
30-Day Follow-Up Total	26.09%	60.00%↑		NA	49.12%	52.78%↑
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)						
7-Day Follow-Up: 13–17 Years	NA	NA		NA	NA	NA
30-Day Follow-Up: 13–17 Years	NA	NA		NA	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	10.00%		NA	NA	NA
30-Day Follow-Up Total	NA	13.33%		NA	NA	NA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)						
1–11 Years	NA	NA		NA	NA	NA
12–17 Years	54.69%	58.59%↑		NA	78.95%	54.17%↓
Total	54.05%	58.50%↑		NA	79.25%	56.99%↓
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)						
Blood Glucose Testing: 1–11 Years	NA	34.69%		NA	NA	38.64%
Cholesterol Testing: 1–11 Years	NA	22.45%		NA	NA	29.55%
Blood Glucose and Cholesterol Testing: 1–11 Years	NA	18.37%		NA	NA	27.27%

Table A-4. 2020 and 2021 PMV Measure Results: MCOs						
Measure	**Aetna**		**Community Care**		**Simply Healthcare**	
	2020	**2021**	**2020**	**2021**	**2020**	**2021**
Blood Glucose Testing: 12–17 Years	70.00%	56.60%↓		NA	58.89%	53.65%↓
Cholesterol Testing: 12–17 Years	43.75%	40.38%↓		NA	45.56%	38.02%↓
Blood Glucose and Cholesterol Testing: 12–17 Years	42.50%	38.11%↓		NA	42.22%	34.38%↓
Blood Glucose Testing Total	67.62%	53.18%↓		NA	59.46%	50.85%↓
Cholesterol Testing Total	40.95%	37.58%↓		NA	45.95%	36.44%↓
Blood Glucose and Cholesterol Testing Total	40.0%	35.03%↓		NA	43.24%	33.05%↓
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)						
Alcohol Abuse or Dependence: Initiation ofAOD Treatment: 13–17 Years	NA	NA		*	NA	NA
Alcohol Abuse or Dependence: Engagementof AOD Treatment: 13–17 Years	NA	NA		*	NA	NA
Opioid Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	NA	NA		*	NA	NA
Opioid Abuse or Dependence: Engagementof AOD Treatment: 13–17 Years	NA	NA		*	NA	NA
Other Drug Abuse or Dependence: Initiationof AOD Treatment: 13–17 Years	25.93%	39.02%↑		NA	33.33%	56.38%↑
Other Drug Abuse or Dependence: Engagement of AOD Treatment: 13–17 Years	5.56%	7.32%↑		NA	12.96%	17.02%↑
Initiation of AOD Treatment: 13–17 Years Total	26.56%	36.56%↑		NA	36.67%	56.36%↑

Table A-4. 2020 and 2021 PMV Measure Results: MCOs

Measure	Aetna		Community Care		Simply Healthcare	
	2020	2021	2020	2021	2020	2021
Engagement of AOD Treatment: 13–17 Years Total	4.69%	7.53%↑		NA	15.0%	17.27%↑
Alcohol Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	NA	NA		*	NA	NA
Alcohol Abuse or Dependence: Engagementof AOD Treatment: 18+ Years	NA	NA		*	NA	NA
Opioid Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	NA	NA		*	NA	NA
Opioid Abuse or Dependence: Engagementof AOD Treatment: 18+ Years	NA	NA		*	NA	NA
Other Drug Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	30.56%	57.58%↑		*	34.21%	48.78%↑
Other Drug Abuse or Dependence: Engagement of AOD Treatment: 18+ Years	11.11%	12.12%↑		*	10.53%	9.76%↓
Initiation of AOD Treatment: 18+ Years Total	32.61%	51.06%↑		*	34.09%	48.84%↑
Engagement of AOD Treatment: 18+ Years Total	10.87%	10.64%↓		*	9.09%	9.30%↑
Alcohol Abuse or Dependence: Initiation of AOD Treatment Total	NA	44.12%		*	NA	NA

Table A-4. 2020 and 2021 PMV Measure Results: MCOs						
Measure	**Aetna**		**Community Care**		**Simply Healthcare**	
	2020	**2021**	**2020**	**2021**	**2020**	**2021**
Alcohol Abuse or Dependence: Engagement of AOD Treatment Total	NA	5.88%		*	NA	NA
Opioid Abuse or Dependence: Initiation of AOD Treatment Total	NA	NA		*	NA	NA
Opioid Abuse or Dependence: Engagement of AOD Treatment Total	NA	NA		*	NA	NA
Other Drug Abuse or Dependence: Initiation of AOD Treatment Total	27.78%	44.35%⬆		NA	33.70%	54.07%⬆
Other Drug Abuse or Dependence: Engagement of AOD Treatment Total	7.78%	8.70%⬆		NA	11.96%	14.81%⬆
Initiation of AOD Treatment Total	29.09%	41.43%⬆		NA	35.58%	54.25%⬆
Engagement of AOD Treatment Total	7.27%	8.57%⬆		NA	12.50%	15.03%⬆

** Table cells with a blue background indicate rates that did not change from 2020 to 2021 for that measure.*
† 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 A-5 provides the MCOs' 2021 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 A-5. 2021 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure						
Measure	**Aetna**		**Community Care**		**Simply Healthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**
Alcohol						
Any Services: Male						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	13	0.08%	0	0%	14	0.08%
18–24 Years	11	0.38%	1	0.24%	1	0.04%
Any Services: Female						
0–12 Years	1	0%	0	0%	0	0%
13–17 Years	31	0.18%	0	0%	33	0.21%
18–24 Years	6	0.21%	0	0%	3	0.11%
Any Services: Total						
0–12 Years	1	0%	0	0%	0	0%
13–17 Years	44	0.13%	0	0%	47	0.14%
18–24 Years	17	0.30%	1	0.12%	4	0.07%
Inpatient: Male						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	3	0.02%	0	0%	5	0.03%
18–24 Years	2	0.07%	0	0%	0	0%
Inpatient: Female						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	13	0.08%	0	0%	12	0.08%
18–24 Years	2	0.07%	0	0%	0	0%
Inpatient: Total						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	16	0.05%	0	0%	17	0.05%
18–24 Years	4	0.07%	0	0%	0	0%

Table A-5. 2021 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure						
Measure	**Aetna**		**Community Care**		**Simply Healthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**
Intensive Outpatient/Partial Hospitalization: Male						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	0	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%
Intensive Outpatient/Partial Hospitalization: Female						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	1	0.01%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%
Intensive Outpatient/Partial Hospitalization: Total						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	1	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%
Outpatient or Medication Treatment: Male						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	5	0.03%	0	0%	3	0.02%
18–24 Years	3	0.10%	0	0%	0	0%
Outpatient or Medication Treatment: Female						
0–12 Years	1	0%	0	0%	0	0%
13–17 Years	5	0.03%	0	0%	9	0.06%
18–24 Years	3	0.11%	0	0%	2	2%
Outpatient or Medication Treatment: Total						
0–12 Years	1	0%	0	0%	0	0%
13–17 Years	10	0.03%	0	0%	12	0.04%
18–24 Years	6	0.11%	0	0%	2	2%
Emergency Department: Male						

Table A-5. 2021 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure						
Measure	**Aetna**		**Community Care**		**Simply Healthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	6	0.03%	0	0%	5	0.03%
18–24 Years	6	0.21%	1	0.24%	0	0%
Emergency Department: Female						
0–12 Years	1	0%	0	0%	0	0%
13–17 Years	14	0.08%	0	0%	13	0.08%
18–24 Years	2	0.07%	0	0%	1	0.04%
Emergency Department: Total						
0–12 Years	1	0%	0	0%	0	0%
13–17 Years	20	0.06%	0	0%	18	0.06%
18–24 Years	8	0.14%	1	0.12%	1	0.02%
Telehealth: Male						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	1	0.01%	0	0%	4	0.02%
18–24 Years	0	0%	0	0%	1	0.04%
Telehealth: Female						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	0	0%	0	0%	3	0.02%
18–24 Years	0	0%	0	0%	0	0%
Telehealth: Total						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	1	0%	0	0%	7	0.02%
18–24 Years	0	0%	0	0%	1	0.02%
Opioid						
Any Services: Male						

Table A-5. 2021 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure						
Measure	**Aetna**		**Community Care**		**Simply Healthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**
0–12 Years	1	0%	0	0%	0	0%
13–17 Years	4	0.02%	0	0%	2	0.01%
18–24 Years	0	0%	0	0%	1	0.04%
Any Services: Female						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	6	0.04%	0	0%	5	0.03%
18–24 Years	3	0.11%	0	0%	5	0.18%
Any Services: Total						
0–12 Years	1	0%	0	0%	0	0%
13–17 Years	10	0.03%	0	0%	7	0.02%
18–24 Years	3	0.05%	0	0%	6	0.11%
Inpatient: Male						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	3	0.02%	0	0%	1	0.01%
18–24 Years	0	0%	0	0%	0	0%
Inpatient: Female						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	3	0.02%	0	0%	1	0.01%
18–24 Years	1	0.04%	0	0%	2	0.07%
Inpatient: Total						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	6	0.02%	0	0%	2	0.01%
18–24 Years	1	0.02%	0	0%	2	0.04%
Intensive Outpatient/Partial Hospitalization: Male						
0–12 Years	0	0%	0	0%	0	0%

Table A-5. 2021 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure						
Measure	**Aetna**		**Community Care**		**Simply Healthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**
13–17 Years	0	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%
Intensive Outpatient/Partial Hospitalization: Female						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	0	0%	0	0%	0	0%
18–24 Years	1	0.04%	0	0%	0	0%
Intensive Outpatient/Partial Hospitalization: Total						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	0	0%	0	0%	0	0%
18–24 Years	1	0.02%	0	0%	0	0%
Outpatient or Medication Treatment: Male						
0–12 Years	1	0%	0	0%	0	0%
13–17 Years	1	0.01%	0	0%	1	0.01%
18–24 Years	0	0%	0	0%	1	0.04%
Outpatient or Medication Treatment: Female						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	4	0.02%	0	0%	3	0.02%
18–24 Years	2	0.07%	0	0%	2	0.07%
Outpatient or Medication Treatment: Total						
0–12 Years	1	0%	0	0%	0	0%
13–17 Years	5	0.01%	0	0%	4	0.01%
18–24 Years	2	0.04%	0	0%	3	0.06%
Emergency Department: Male						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	0	0%	0	0%	0	0%

Table A-5. 2021 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure						
Measure	**Aetna**		**Community Care**		**Simply Healthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**
18–24 Years	0	0%	0	0%	0	0%
Emergency Department: Female						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	0	0%	0	0%	1	0.01%
18–24 Years	1	0.04%	0	0%	0	0%
Emergency Department: Total						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	0	0%	0	0%	1	0%
18–24 Years	1	0.02%	0	0%	0	0%
Telehealth: Male						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	0	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%
Telehealth: Female						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	0	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	1	0.04%
Telehealth: Total						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	0	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	1	0.02%
Other						
Any Services: Male						
0–12 Years	10	0.04%	0	0%	9	0.04%
13–17 Years	130	0.75%	0	0%	121	0.73%

Table A-5. 2021 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure						
Measure	**Aetna**		**Community Care**		**Simply Healthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**
18–24 Years	41	1.42%	0	0%	37	1.36%
Any Services: Female						
0–12 Years	3	0.01%	0	0%	2	0.01%
13–17 Years	109	0.65%	0	0%	111	0.70%
18–24 Years	28	0.99%	0	0%	25	0.92%
Any Services: Total						
0–12 Years	13	0.03%	0	0%	11	0.02%
13–17 Years	239	0.70%	0	0%	232	0.71%
18–24 Years	69	1.21%	0	0%	62	1.14%
Inpatient: Male						
0–12 Years	1	0%	0	0%	0	0%
13–17 Years	31	0.18%	0	0%	29	0.18%
18–24 Years	8	0.28%	0	0%	8	0.29%
Inpatient: Female						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	38	0.23%	0	0%	40	0.25%
18–24 Years	5	0.18%	0	0%	6	0.22%
Inpatient: Total						
0–12 Years	1	0%	0	0%	0	0%
13–17 Years	69	0.20%	0	0%	69	0.21%
18–24 Years	13	0.23%	0	0%	14	0.26%
Intensive Outpatient/Partial Hospitalization: Male						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	4	0.02%	0	0%	1	0.01%
18–24 Years	0	0%	0	0%	0	0%

Table A-5. 2021 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure						
Measure	**Aetna**		**Community Care**		**Simply Healthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**
Intensive Outpatient/Partial Hospitalization: Female						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	1	0.01%	0	0%	4	0.03%
18–24 Years	1	0.04%	0	0%	0	0%
Intensive Outpatient/Partial Hospitalization: Total						
0–12 Years	0	0%	0	0%	0	0%
13–17 Years	5	0.01%	0	0%	5	0.02%
18–24 Years	1	0.02%	0	0%	0	0%
Outpatient or Medication Treatment: Male						
0–12 Years	7	0.03%	0	0%	5	0.02%
13–17 Years	59	0.34%	0	0%	71	0.43%
18–24 Years	22	0.76%	0	0%	19	0.70%
Outpatient or Medication Treatment: Female						
0–12 Years	1	0%	0	0%	1	0%
13–17 Years	37	0.22%	0	0%	47	0.29%
18–24 Years	11	0.39%	0	0%	10	0.37%
Outpatient or Medication Treatment: Total						
0–12 Years	8	0.02%	0	0%	6	0.01%
13–17 Years	96	0.28%	0	0%	118	0.36%
18–24 Years	33	0.58%	0	0%	29	0.53%
Emergency Department: Male						
0–12 Years	1	0%	0	0%	3	0.01%
13–17 Years	39	0.23%	0	0%	30	0.18%
18–24 Years	11	0.38%	0	0%	9	0.33%
Emergency Department: Female						

Table A-5. 2021 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure						
Measure	**Aetna**		**Community Care**		**Simply Healthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**
0–12 Years	2	0.01%	0	0%	1	0%
13–17 Years	29	0.17%	0	0%	25	0.16%
18–24 Years	9	0.32%	0	0%	11	0.41%
Emergency Department: Total						
0–12 Years	3	0.01%	0	0%	4	0.01%
13–17 Years	68	0.20%	0	0%	55	0.17%
18–24 Years	20	0.35%	0	0%	20	0.37%
Telehealth: Male						
0–12 Years	1	0%	0	0%	1	0%
13–17 Years	33	0.19%	0	0%	25	0.15%
18–24 Years	7	0.24%	0	0%	3	0.11%
Telehealth: Female						
0–12 Years	1	0%	0	0%	0	0%
13–17 Years	22	0.13%	0	0%	25	0.16%
18–24 Years	4	0.14%	0	0%	4	0.15%
Telehealth: Total						
0–12 Years	2	0%	0	0%	1	0%
13–17 Years	55	0.16%	0	0%	50	0.15%
18–24 Years	11	0.19%	0	0%	7	0.13%

Table A-6 provides the MCOs' 2021 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 A-6. 2021 PMV Results: MCOs – Audited Mental Health Utilization (MPT) Performance Measure						
Measure	**Aetna**		**Community Care**		**Simply Healthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**
Any Services: Male						
0–12 Years	1623	6.24%	169	4.14%	1,641	6.63%
13–17 Years	1219	7.07%	116	4.71%	1,205	7.30%
18–64 Years	134	4.65%	16	3.77%	150	5.51%
Any Services: Female						
0–12 Years	1265	5.00%	122	3.06%	1,309	5.45%
13–17 Years	1833	10.91%	170	7.06%	1,902	11.92%
18–64 Years	222	7.85%	26	6.55%	244	9.00%
Any Services: Total						
0–12 Years	2888	5.63%	291	3.60%	2,950	6.05%
13–17 Years	3052	8.96%	286	5.87%	3,107	9.57%
18–64 Years	356	6.24%	42	5.11%	394	7.25%
Inpatient: Male						
0–12 Years	47	0.18%	3	0.07%	40	0.16%
13–17 Years	100	0.58%	12	0.49%	120	0.73%
18–64 Years	18	0.62%	2	0.47%	25	0.92%
Inpatient: Female						
0–12 Years	60	0.24%	3	0.08%	55	0.23%
13–17 Years	216	1.29%	25	1.04%	252	1.58%
18–64 Years	20	0.71%	3	0.76%	26	0.96%
Inpatient: Total						
0–12 Years	107	0.21%	6	0.07%	95	0.19%
13–17 Years	316	0.93%	37	0.76%	372	1.15%
18–64 Years	38	0.67%	5	0.61%	51	0.94%
Intensive Outpatient/Partial Hospitalization: Male						
0–12 Years	1	0%	0	0%	0	0%
13–17 Years	7	0.04%	1	0.04%	3	0.02%
18–64 Years	0	0%	0	0%	1	0.04%
Intensive Outpatient/Partial Hospitalization: Female						
0–12 Years	3	0.01%	0	0%	1	0%
13–17 Years	22	0.13%	2	0.08%	17	0.11%

Table A-6. 2021 PMV Results: MCOs – Audited Mental Health Utilization (MPT) Performance Measure						
Measure	**Aetna**		**Community Care**		**Simply Healthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**
18–64 Years	3	0.11%	0	0%	4	0.15%
Intensive Outpatient/Partial Hospitalization: Total						
0–12 Years	4	0.01%	0	0%	1	0%
13–17 Years	29	0.09%	3	0.06%	20	0.06%
18–64 Years	3	0.05%	0	0%	5	0.09%
Outpatient: Male						
0–12 Years	1239	4.77%	154	3.77%	1,300	5.25%
13–17 Years	899	5.21%	99	4.02%	913	5.53%
18–64 Years	91	3.16%	15	3.54%	106	3.89%
Outpatient: Female						
0–12 Years	949	3.75%	105	2.63%	997	4.15%
13–17 Years	1310	7.80%	134	5.56%	1,376	8.62%
18–64 Years	155	5.48%	24	6.04%	164	6.05%
Outpatient: Total						
0–12 Years	2188	4.27%	259	3.21%	2,297	4.71%
13–17 Years	2209	6.49%	233	4.78%	2,289	7.05%
18–64 Years	246	4.31%	39	4.75%	270	4.97%
Emergency Department: Male						
0–12 Years	9	0.03%	0	0%	1	0%
13–17 Years	7	0.04%	0	0%	4	0.02%
18–64 Years	2	0.07%	0	0%	1	0.04%
Emergency Department: Female						
0–12 Years	11	0.04%	0	0%	0	0%
13–17 Years	11	0.07%	0	0%	3	0.02%
18–64 Years	2	0.07%	0	0%	1	0.04%
Emergency Department: Total						
0–12 Years	20	0.04%	0	0%	1	0%
13–17 Years	18	0.05%	0	0%	7	0.02%
18–64 Years	4	0.07%	0	0%	2	0.04%
Telehealth: Male						
0–12 Years	888	3.42%	27	0.66%	893	3.61%

Table A-6. 2021 PMV Results: MCOs – Audited Mental Health Utilization (MPT) Performance Measure						
Measure	**Aetna**		**Community Care**		**Simply Healthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**
13–17 Years	688	3.99%	32	1.30%	657	3.98%
18–64 Years	72	2.50%	2	0.47%	75	2.76%
Telehealth: Female						
0–12 Years	715	2.83%	28	0.70%	757	3.15%
13–17 Years	1125	6.70%	48	1.99%	1,196	7.49%
18–64 Years	131	4.63%	7	1.76%	170	6.27%
Telehealth: Total						
0–12 Years	1603	3.13%	55	0.68%	1,650	3.38%
13–17 Years	1813	5.33%	80	1.64%	1,853	5.71%
18–64 Years	203	3.56%	9	1.10%	245	4.51%

DBM-specific PMV results appear in Table A-7. The green and red arrows indicate an increase (⬆) or decrease (⬇) from the previous year's rate.

Table A-7. 2021 PMV Results: DBMs									
Measure	**Argus**			**DentaQuest**			**MCNA**		
	Rate (%)	**Den.***	**Num.***	**Rate (%)**	**Den.**	**Num.**	**Rate (%)**	**Den.**	**Num.**
Annual Dental Visit									
All Enrollees	46.99%⬇	27581	12961	57.93%⬇	40,735	23,598	51.34%⬇	47,628	24,454
Enrollees Age 5 to 6†	45.56%⬇	2,287	1042	58.92% ⬇	1,950	1,149	51.09*%⬇	2,879	1,471
Enrollees Age 7 to 10	52.88%⬇	9578	5065	63.85% ⬇	11,721	7,484	57.34%⬇	12,528	7,183
Enrollees Age 11 to 14	46.81% ⬇	8902	4167	59.08% ⬇	13,852	8,184	52.57%⬇	16,063	8,444
Enrollees Age 15 to 18	39.43%⬇	6814	2687	51.32%⬇	13,212	6,781	45.54%⬇	16,161	7,359
Any Dental Service									
Enrolled at Least 1 Month: All Enrollees	35.11%⬇	60,147	21,118	42.88%⬇	113,050	48,472	39.69%⬇	100,351	39,826
Enrolled at Least 1 Month: Age 5**	13.45%⬇	1,316	177	21.95%⬇	3,485	765	22.78%⬇	4,644	1,058

Table A-7. 2021 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 1 Month: Age 6–9	36.81%↓	20,157	7,420	46.50%↓	31,219	14,516	43.37%↓	26,267	11,392
Enrolled at Least 1 Month: Age 10–14	37.54%↓	23,958	8,994	45.03%↓	44,697	20,125	41.68%↓	38,869	16,201
Enrolled at Least 1 Month: Age 15–18	30.76%↓	14,716	4,527	38.83%↓	33,649	13,066	36.55%↓	30,571	11,175
Enrolled at Least 3 Months Continuously: All Enrollees	39.46%↓	51,089	20,160	47.44%↓	98,616	46,786	44.08%↓	87,768	38,689
Enrolled at Least 3 Months Continuously: Age 5	20.62%↓	548	113	28.45%↓	2,176	619	29.28%↓	3,258	954
Enrolled at Least 3 Months Continuously: Age 6–9	41.40%↓	17,180	7,113	51.69%↓	27,077	13,995	48.44%↓	22,764	11,028
Enrolled at Least 3 Months Continuously: Age 10–14	41.53%↓	20,715	8,603	49.46%↓	39,416	19,497	45.85%↓	34,437	15,790
Enrolled at Least 3 Months Continuously: Age 15–18	34.25%↓	12,646	4,331	42.32%↓	29,947	12,675	39.98%↓	27,309	10,917
Enrolled at Least 6 Months Continuously: All Enrollees	43.55%↓	41,408	18,035	51.49%↓	80,630	41,517	47.94%↓	72,642	34,822
Enrolled at Least 6 Months Continuously: Age 5	0%↓	-	-	35.92%↓	813	292	34.96%↓	1,839	643
Enrolled at Least 6 Months Continuously: Age 6–9	45.64%↓	13,756	6,278	56.09%↓	21,988	12,334	52.59%↓	18,679	9,823
Enrolled at Least 6 Months Continuously: Age 10–14	45.53%↓	17,152	7,809	53.21%↓	32,795	17,451	49.57%↓	28,997	14,373
Enrolled at Least 6 Months Continuously: Age 15–18	37.60%↓	10,500	3,948	45.70%↓	25,034	11,440	43.17%↓	23,127	9,983

Table A-7. 2021 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 11 Months Continuously: All Enrollees	35.11%⬇	23,766	11,698	57.12%⬇	45,044	25,729	53.38%⬇	45,489	24,281
Enrolled at Least 11 Months Continuously: Age 5	0%⬇	-	-	0%	-	-	40.09%⬇	212	85
Enrolled at Least 11 Months Continuously: Age 6–9	52.88%⬇	7,343	3,883	62.68%⬇	11,725	7,349	58.49%⬇	11,261	6,587
Enrolled at Least 11 Months Continuously: Age 10–14	50.96%⬇	10,192	5,194	58.74%⬇	18,716	10,994	55.17%⬇	18,576	10,248
Enrolled at Least 11 Months Continuously: Age 15–18	42.06%⬇	6,231	2,621	50.58%⬇	14,603	7,386	47.67%⬇	15,440	7,361
Preventive Dental Services									
Enrolled at Least 1 Month: All Enrollees	32.08%⬇	60,147	19,293	39.43%⬇	113,050	44,573	36.47%⬇	100,351	36,602
Enrolled at Least 1 Month: Age 5**	12.23%⬇	1,316	161	19.91%⬇	3,485	694	21.47%⬇	4,644	997
Enrolled at Least 1 Month: Age 6–9	34.08%⬇	20,157	6,870	43.77%⬇	31,219	13,666	40.75%⬇	26,267	10,705
Enrolled at Least 1 Month: Age 10–14	34.69%⬇	23,958	8,310	41.90%⬇	44,697	18,727	38.80%⬇	38,869	15,083
Enrolled at Least 1 Month: Age 15–18	29.86%⬇	14,716	3,952	34.13%⬇	33,649	11,486	32.11%⬇	30,571	9,817
Enrolled at Least 3 Months Continuously: All Enrollees	36.19%⬇	51,089	18,489	43.81%⬇	98,616	43,202	40.66%⬇	87,768	35,684
Enrolled at Least 3 Months Continuously: Age 5	18.80%⬇	548	103	26.24%⬇	2,176	571	27.78%⬇	3,258	905
Enrolled at Least 3 Months Continuously: Age 6–9	38.51%⬇	17,180	6,616	48.86%⬇	27,077	13,229	45.71%⬇	22,764	10,406

Table A-7. 2021 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 3 Months Continuously: Age 10–14	38.46%⬇	20,715	7,968	46.18%⬇	39,416	18,201	42.81%⬇	34,437	14,741
Enrolled at Least 3 Months Continuously: Age 15–18	30.06%⬇	12,646	3,802	37.40%⬇	29,947	11,201	35.27%⬇	27,309	9,632
Enrolled at Least 6 Months Continuously: All Enrollees	40.14%⬇	41,408	16,620	47.85%⬇	80,630	38,583	44.48%⬇	72,642	32,309
Enrolled at Least 6 Months Continuously: Age 5	0%⬇	-	-	33.33%⬇	813	271	33.17%⬇	1,839	610
Enrolled at Least 6 Months Continuously: Age 6–9	42.69%⬇	13,756	5,873	53.39%⬇	21,988	11,740	49.95%⬇	18,679	9,331
Enrolled at Least 6 Months Continuously: Age 10–14	42.33%⬇	17,152	7,261	49.96%⬇	32,795	16,386	46.52%⬇	28,997	13,488
Enrolled at Least 6 Months Continuously: Age 15–18	33.20%⬇	10,500	3,486	40.69%⬇	25,034	10,186	38.40%⬇	23,127	8,880
Enrolled at Least 11 Months Continuously: All Enrollees	45.72%⬇	23,766	10,865	53.62%⬇	45,044	24,151	49.90%⬇	45,489	22,699
Enrolled at Least 11 Months Continuously: Age 5	0%⬇	-	-	0%	-	-	37.74%⬇	212	80
Enrolled at Least 11 Months Continuously: Age 6–9	49.76%⬇	7,343	3,654	60.22%⬇	11,725	7,061	56.10%⬇	11,261	6,317
Enrolled at Least 11 Months Continuously: Age 10–14	47.76%⬇	10,192	4,868	55.70%⬇	18,716	10,425	52.16%⬇	18,576	9,690
Enrolled at Least 11 Months Continuously: Age 15–18	37.60%⬇	6,231	2,343	45.64%⬇	14,603	6,665	42.82%⬇	15,440	6,612
Dental Treatment Services									
Enrolled at Least 1 Month: All Enrollees	13.75%⬇	60,147	8,270	16.26%⬇	113,050	18,387	14.14%⬇	100,351	14,191

Table A-7. 2021 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 1 Month: Age 5**	4.48%⬇	1,316	59	6.40%⬇	3,485	223	7.08%⬇	4,644	329
Enrolled at Least 1 Month: Age 6–9	15.53%⬇	20,157	3,131	19.38%⬇	31,219	6,051	17.21%⬇	26,267	4,521
Enrolled at Least 1 Month: Age 10–14	13.38%⬇	23,958	3,205	15.81%⬇	44,697	7,065	13.28%⬇	38,869	5,163
Enrolled at Least 1 Month: Age 15–18	12.74%⬇	14,716	1,875	15.00%⬇	33,649	5,048	13.67%⬇	30,571	4,178
Enrolled at Least 3 Months Continuously: All Enrollees	15.55%⬇	51,089	7,943	18.07%⬇	98,616	17,823	15.75%⬇	87,768	13,827
Enrolled at Least 3 Months Continuously: Age 5	7.48%⬇	548	41	8.27%⬇	2,176	180	9.24%⬇	3,258	301
Enrolled at Least 3 Months Continuously: Age 6–9	17.52%⬇	17,180	3,010	21.66%⬇	27,077	5,865	19.27%⬇	22,764	4,387
Enrolled at Least 3 Months Continuously: Age 10–14	14.96%⬇	20,715	3,098	17.42%⬇	39,416	6,866	14.65%⬇	34,437	5,044
Enrolled at Least 3 Months Continuously: Age 15–18	14.19%⬇	12,646	1,794	16.40%⬇	29,947	4,912	15.00%⬇	27,309	4,095
Enrolled at Least 6 Months Continuously: All Enrollees	17.32%⬇	41,408	7,171	19.64%⬇	80,630	15,835	17.23%⬇	72,642	12,517
Enrolled at Least 6 Months Continuously: Age 5	0%¥	-	-	10.95%⬇	813	89	11.15%⬇	1,839	205
Enrolled at Least 6 Months Continuously: Age 6–9	19.69%⬇	13,756	2,709	23.53%⬇	21,988	5,174	21.02%⬇	18,679	3,926
Enrolled at Least 6 Months Continuously: Age 10–14	15.51%⬇	17,152	2,832	18.69%⬇	32,795	6,128	15.90%⬇	28,997	4,610

Table A-7. 2021 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	15.52%↓	10,500	1,630	17.75%↓	25,034	4,444	16.33%↓	23,127	3,776
Enrolled at Least 11 Months Continuously: All Enrollees	19.84%↓	23,766	4,716	21.74%↓	45,044	9,793	19.44%↓	45,489	8,841
Enrolled at Least 11 Months Continuously: Age 5	0%	-	-	0%	-	-	14.15%↓	212	30
Enrolled at Least 11 Months Continuously: Age 6–9	23.12%↓	7,343	1,698	26.55%↓	11,725	3,113	23.29%↓	11,261	2,623
Enrolled at Least 11 Months Continuously: Age 10–14	18.89%↓	10,192	1,925	20.63%↓	18,716	3,862	18.09%↓	18,576	3,361
Enrolled at Least 11 Months Continuously: Age 15–18	14.54%↓	6,231	1,093	19.30%↓	14,603	2,818	18.31%↓	15,440	2,827
Dental Sealants (The age 5 and age 15–18 stratifications do not apply to this measure.)									
Enrolled at Least 1 Month: All Enrollees	7.82%↓	60,147	4,703	11.13%↑	75,916	8,447	9.81%↓	65,136	6,392
Enrolled at Least 1 Month: Age 6–9	9.30%↓	20,157	1,875	11.88%↓	31,219	3,709	10.77%↓	26,267	2,828
Enrolled at Least 1 Month: Age 10–14	8.77%↓	23,958	2,100	10.60%↓	44,697	4,738	9.17%↓	38,869	3,564
Enrolled at Least 3 Months Continuously: All Enrollees	8.86%↓	51,089	4,524	12.33%↓	66,493	8,198	10.91%↓	57,201	6,240
Enrolled at Least 3 Months Continuously: Age 6–9	10.51%↓	17,180	1,805	13.26%↓	27,077	3,591	12.12%↓	22,764	2,759
Enrolled at Least 3 Months Continuously: Age 10–14	9.77%↓	20,715	2,024	11.69%↓	39,416	4,607	10.11%↓	34,437	3,481
Enrolled at Least 6 Months Continuously: All Enrollees	9.97%↓	41,408	4,129	13.38%↓	54,783	7,331	11.94%↓	47,676	5,694

Table A-7. 2021 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 6 Months Continuously: Age 6–9	11.82%↓	13,756	1626	14.62%↓	21,988	3,215	13.31%↓	18,679	2,486
Enrolled at Least 6 Months Continuously: Age 10–14	10.88%↓	17,152	1866	12.56%↓	32,765	4,116	11.06%↓	28,997	3,208
Enrolled at Least 11 Months Continuously: All Enrollees	11.42%↓	23,766	2,714	15.00%↑	30,441	4,567	13.49%↓	29,837	4,025
Enrolled at Least 11 Months Continuously: Age 6–9	14.49%↓	7,343	1,064	17.02%↓	11,725	1,996	15.02%↓	11,261	1,691
Enrolled at Least 11 Months Continuously: Age 10–14	12.08%↓	10,192	1,231	13.74%↓	18,716	2,571	12.56%↓	18,576	2,334
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	3.31%↓	60,147	1,990	12.61%↓	66,963	8,447	10.32%↓	60,578	6,249
Enrolled at Least 1 Month: Age 6–9	7.60%↓	20,157	1,532	14.68%↓	25,263	3,709	11.82%↓	23,329	2,758
Enrolled at Least 1 Month: Age 10–14	1.91%↓	23,958	458	11.36%↓	41,700	4,738	9.37%↓	37,249	3,491
Enrolled at Least 3 Months Continuously: All Enrollees	3.59%↓	51,089	1,834	14.15%↓	57,922	8,198	10.32%↓	60,578	6,249
Enrolled at Least 3 Months Continuously: Age 6–9	8.20%↓	17,180	1,409	16.79%↓	21,390	3,591	11.82%↓	23,329	2,758
Enrolled at Least 3 Months Continuously: Age 10–14	2.05%↓	20,715	425	12.61%↓	36,532	4,607	9.37%↓	37,249	3,491
Enrolled at Least 6 Months Continuously: All Enrollees	3.91%↓	41,408	1,618	15.56%↓	47,100	7,331	12.66%↓	43,893	5,558
Enrolled at Least 6 Months Continuously: Age 6–9	9.01%↓	13,756	1,239	19.00%↓	16,922	3,215	14.87%↓	16,277	2,421

Table A-7. 2021 PMV Results: DBMs									
Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 6 Months Continuously: Age 10–14	2.21%⬇	17,152	379	13.64%⬇	30,178	4,116	11.36%⬇	27,616	3,137
Enrolled at Least 11 Months Continuously: All Enrollees	5.06%⬇	23,766	1,202	17.95%⬇	25,440	4,567	14.46%⬇	27,017	3,907
Enrolled at Least 11 Months Continuously: Age 6–9	12.41%⬇	7,343	911	23.62%⬇	8,451	1,996	17.19%⬇	9,513	1,635
Enrolled at Least 11 Months Continuously: Age 10–14	2.86%⬇	10,192	291	15.13%⬇	16,989	2,571	12.98%⬇	17,504	2,272
Diagnostic Dental Services									
Enrolled at Least 1 Month: All Enrollees	33.07%⬇	60,147	19,890	41.50%⬇	113,050	46,919	36.80%⬇	100,351	36,932
Enrolled at Least 1 Month: Age 5**	12.77%⬇	1,316	168	21.26%⬇	3,485	741	22.20%⬇	4,644	1,031
Enrolled at Least 1 Month: Age 6–9	35.25%⬇	20,157	7,106	45.62%⬇	31,219	14,242	41.41%⬇	26,267	10,877
Enrolled at Least 1 Month: Age 10–14	35.52%⬇	23,958	8,510	43.63%⬇	44,697	19,501	38.75%⬇	38,869	15,060
Enrolled at Least 1 Month: Age 15–18	27.90%⬇	14,716	4,106	36.96%⬇	33,649	12,435	32.59%⬇	30,571	9,964
Enrolled at Least 3 Months Continuously: All Enrollees	37.22%⬇	51,089	19,016	46.02%⬇	98,616	45,383	40.95%⬇	87,768	35,943
Enrolled at Least 3 Months Continuously: Age 5	20.07%⬇	548	110	27.90%⬇	2,176	607	28.61%⬇	3,258	932
Enrolled at Least 3 Months Continuously: Age 6–9	39.70%⬇	17,180	6,820	50.79%⬇	27,077	13,752	46.42%⬇	22,764	10,567
Enrolled at Least 3 Months Continuously: Age 10–14	39.34%⬇	20,715	8,149	48.03%⬇	39,416	18,933	42.66%⬇	34,437	14,691

Table A-7. 2021 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 3 Months Continuously: Age 15–18	31.13%	12,646	3,937	40.37%	29,947	12,091	35.71%	27,309	9,753
Enrolled at Least 6 Months Continuously: All Enrollees	41.18%	41,408	17,051	50.05%	80,630	40,358	44.70%	72,642	32,472
Enrolled at Least 6 Months Continuously: Age 5	0%	-	-	35.18%	813	286	34.26%	1,839	630
Enrolled at Least 6 Months Continuously: Age 6–9	43.90%	13,756	6,039	55.28%	21,988	12,154	50.65%	18,679	9,460
Enrolled at Least 6 Months Continuously: Age 10–14	43.24%	17,152	7,416	51.79%	32,795	16,984	46.30%	28,997	13,427
Enrolled at Least 6 Months Continuously: Age 15–18	34.25%	10,500	3,596	43.68%	25,034	10,934	38.72%	23,127	8,955
Enrolled at Least 11 Months Continuously: All Enrollees	46.57%	23,766	11,067	55.74%	45,044	25,109	49.76%	45,489	22,634
Enrolled at Least 11 Months Continuously: Age 5	0%	-	-	0%	-	-	39.62%	212	84
Enrolled at Least 11 Months Continuously: Age 6–9	50.82%	7,343	3,732	61.88%	11,725	7,255	56.53%	11,261	6,366
Enrolled at Least 11 Months Continuously: Age 10–14	48.46%	10,192	4,939	57.42%	18,716	10,746	51.56%	18,576	9,578
Enrolled at Least 11 Months Continuously: Age 15–18	38.45%	6,231	2,396	48.67%	14,603	7,108	42.78%	15,440	6,606
Any Dental or Oral Health Service									
Enrolled at Least 1 Month: All Enrollees	35.03%	60,147	21,070	42.88%	113,050	48,472	39.69%	100,351	39,826
Enrolled at Least 1 Month: Age 5**	13.45%	1,316	177	21.95%	3,485	765	22.78%	4,644	1,058

Table A-7. 2021 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 1 Month: Age 6–9	36.69%↓	20,157	7,395	46.50%↓	31,219	14,516	43.37%↓	26,267	11,392
Enrolled at Least 1 Month: Age 10–14	37.47%↓	23,958	8,976	45.03%↓	44,697	20,125	41.68%↓	38,869	16,201
Enrolled at Least 1 Month: Age 15–18	30.73%↓	14,716	4,522	38.65%↓	33,649	13,006	36.55%↓	30,571	11,175
Enrolled at Least 3 Months Continuously: All Enrollees	39.38%↓	51,089	20,119	47.44%↓	98,616	46,786	44.08%↓	87,768	38,689
Enrolled at Least 3 Months Continuously: Age 5	20.62%↓	548	113	28.45%↓	2,176	619	29.28%↓	3,258	954
Enrolled at Least 3 Months Continuously: Age 6–9	41.27%↓	17,180	7,091	51.69%↓	27,077	13,995	48.44%↓	22,764	11,028
Enrolled at Least 3 Months Continuously: Age 10–14	41.45%↓	20,715	8,587	5.07%↓	39,416	1,997	45.85%↓	34,437	15,790
Enrolled at Least 3 Months Continuously: Age 15–18	34.22%↓	12,646	4,328	42.32%↓	29,947	12,675	39.98%↓	27,309	10,917
Enrolled at Least 6 Months Continuously: All Enrollees	43.47%↓	41,408	18,000	51.49%↓	80,630	41,517	47.94%↓	72,642	34,822
Enrolled at Least 6 Months Continuously: Age 5	0%↓	-	-	35.92%↓	813	292	34.96%↓	1,839	643
Enrolled at Least 6 Months Continuously: Age 6–9	45.51%↓	13,756	6,261	56.09%↓	21,988	12,334	52.59%↓	18,679	9,823
Enrolled at Least 6 Months Continuously: Age 10–14	45.44%↓	17,152	7,794	53.21%↓	32,795	17,451	49.57%↓	28,997	14,373
Enrolled at Least 6 Months Continuously: Age 15–18	37.57%↓	10,500	3,945	45.70%↓	25,034	11,440	43.17%↓	23,127	9,983

Table A-7. 2021 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 11 Months Continuously: All Enrollees	49.10%⬇	23,766	11,670	57.12%⬇	45,044	25,729	53.38%⬇	45,489	24,281
Enrolled at Least 11 Months Continuously: Age 5	0%⬇	-	-	0%	-	-	40.09%⬇	212	85
Enrolled at Least 11 Months Continuously: Age 6–9	52.69%⬇	7,343	3,869	62.68%⬇	11,725	7,349	58.49%⬇	11,261	6,587
Enrolled at Least 11 Months Continuously: Age 10–14	50.85%⬇	10,192	5,183	58.74%⬇	18,716	10,994	55.17%⬇	18,576	10,248
Enrolled at Least 11 Months Continuously: Age 15–18	42.02%⬇	6,231	2,618	50.58%⬇	14,603	7,386	47.67%⬇	15,440	7,361

** 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.*
¥ Table cells with a blue background indicate rates that did not change from 2020 to 2021 for that measure.

ACA

ACA Standards

Table A-8 displays each MCO's and DBM's compliance with federal statutes, its relative contract, and additional compliance standards established by FHKC. Individual results are presented for each ACA standard reviewed in the 2021 ACA.

Table A-8. ACA Standard Results 2021: MCOs and DBMs

Standard	MCOs			DBMs		
	Aetna	Community Care	Simply Healthcare	Argus	DentaQuest	MCNA
Availability of Services	75.4%	68.1%	92.3%	88.9%	74.1%	77.8%
Assurances of Adequate Capacity and Services	100%	75.0%	100%	100%	66.7%	100%
Grievances and Appeals	97.4%	100%	85.5%	71.4%	71.3%	88.9%
Practice Guidelines	100%	83.3%	100%	100%	66.7%	100%
Health Information Systems	100%	100%	100%	58.3%	100%	100%
Quality Assessment and Performance Improvement (QAPI)	100%	100%	100%	80.0%	80.0%	100%
2021 Overall Compliance Standard Score	**93.7%**	**91.3%**	**90.3%**	**76.8%**	**74.0%**	**90.2%**

File Review

The results in Table A-9 present each MCO's and DBM's compliance with each file review for the 2021 ACA.

Table A-9. ACA File Review Results 2021: MCOs and DBMs

File Review	MCOs			DBMs		
	Aetna	Community Care	Simply Healthcare	Argus	DentaQuest	MCNA
Grievances	94.0%	100%	100%	96.0%	94.0%	100%

Table A-9. ACA File Review Results 2021: MCOs and DBMs						
File Review	MCOs			DBMs		
	Aetna	Community Care	Simply Healthcare	Argus	DentaQuest	MCNA
Appeals	100%	95.0%	100%	97.8%	100%	98.0%

Table A-10 includes strengths for each MCO/DBM from the 2021 ACA, labeled by the aspect of care to which they relate: quality, timeliness, and access. Any MCO or DBM not listed in the table had no identified strengths for the 2021 ACA.

Table A-10. 2021 ACA Individual MCO/DBM Strengths				
Standard and Element	Strength	Quality	Timeliness	Access
Aetna				
Availability of Services: Delivery Network	1. Policy #6400.06 and Policy #6400.41 (the March 2020 version) included sections specifically for the Florida Healthy Kids program, with references to the managed care organization's (MCO's) Medical Services Contract (MSC) with Florida Healthy Kids Corporation (FHKC). 2. Policy #6400.06 included the FHKC provider network standards.		✓	✓
Availability of Services: Women's Health Specialist	Policy #8300.20 included a section specifically for the Florida Healthy Kids program, with references to the MSC with FHKC.		✓	✓
Availability of Services: Second Opinion	The MCO's enrollee handbook included specific reference to Florida Statute 641.51 regarding the requirement for the MCO to provide enrollees with access to a second medical opinion.		✓	✓
Availability of Services: Timely Treatment Standards	Policy #6400.45 included specific references to the Florida Healthy Kids program and cited the MSC with FHKC.		✓	✓
Availability of Services: Cultural Competency Plan	The MCO's Cultural Competency Plan included *Code of Federal Regulations* (CFR) and MSC citations in reference to regulations governing the Cultural Competency Plan, and the		✓	✓

Table A-10. 2021 ACA Individual MCO/DBM Strengths				
Standard and Element	**Strength**	**Quality**	**Timeliness**	**Access**
	MCO reported having no complaints or grievances related to enrollee culture or language in 2020.			
Assurances of Adequate Capacity and Services: Supporting Documentation	Policy #6400.41 included a section specifically for the Florida Healthy Kids program, with references to the MCO's MSC with FHKC.	✓	✓	✓
Grievances and Appeals: Grievance and Appeal System – General Requirements	Policy #3100.90 and Policy #3100.70 specifically referenced the MCO's MSC with FHKC.			✓
Grievances and Appeals: Enrollee Communication Requirements	Policy #4500.20 specifically referenced the MSC with FHKC.			✓
Practice Guidelines: Practice Guideline Adoption	Policy #8000.90 applied specifically to the Florida Healthy Kids program, with references to the MCO's MSC with FHKC and the CFR.	✓		
Health Information Systems: Provider Data	Policy #6200.10 referenced the MCO's MSC with FHKC and included timely processing standards defined by FHKC.	✓	✓	✓
Quality Assessment and Performance Improvement: Basic Required Elements	1. The 2020 Quality Improvement Program Description (QIPD) included comprehensive description of all aspects of the QI program and operations. 2. The 2019 Program Evaluation provided detailed and clearly presented data on the utilization trends and case management results for enrollees with special healthcare needs.	✓	✓	✓
Quality Assessment and Performance Improvement: Measurement and Submission of Data	Policies #8200.05 and #8400.05 thoroughly outlined performance measure collection and reporting to FHKC.	✓	✓	✓

Table A-10. 2021 ACA Individual MCO/DBM Strengths				
Standard and Element	**Strength**	**Quality**	**Timeliness**	**Access**
Quality Assessment and Performance Improvement: PIP Required Elements	Policy #8400.05 specifically addressed each of the required performance improvement project (PIP) elements.	✓	✓	✓
Quality Assessment and Performance Improvement: Overall QAPI Program Assessment	The 2019 QI Program Evaluation was comprehensive and included key findings and opportunities/actions for improvement for all aspects of the QI program.	✓	✓	✓
Community Care				
Availability of Services: Second Opinion	Policy #FHK UM 001 was specific to Florida Healthy Kids requirements.		✓	✓
Availability of Services: Out-of-Network Services	Policy #PO-1817 was specific to Florida Healthy Kids requirements.		✓	✓
Availability of Services: Furnishing Services – Timely Access	The Master Services Agreement specifically applied to Florida Healthy Kids requirements and referenced applicable CFR sections.		✓	✓
Availability of Services: Furnishing Services – Accessibility Considerations	Master Services Agreement Exhibit E referenced the applicable CFR section.		✓	✓
Assurances of Adequate Capacity and Services: Supporting Documentation	Policy #PO-1817 was specific to Florida Healthy Kids requirements.	✓	✓	✓
Assurances of Adequate Capacity and Services: Submission of Documentation	The Community Care Plan – Florida Healthy Kids Corporation 2020-02 Medical Services and Coverage Report Guide clearly demonstrated a link between each required report and the MSC, and it included thorough information for each report.	✓	✓	✓

Table A-10. 2021 ACA Individual MCO/DBM Strengths				
Standard and Element	**Strength**	**Quality**	**Timeliness**	**Access**
Assurances of Adequate Capacity and Services: Submission of Documentation – Significant Change	1. The MCO's internal seven-day turnaround time for reporting significant changes to the Agency was not a requirement. 2. Policy #PO-1804 was specific to Florida Healthy Kids requirements.	✓	✓	✓
Assurances of Adequate Capacity and Services: Submission of Documentation – Anticipated Provider Termination	Policy #PO-0203 was specific to Florida Healthy Kids requirements.	✓	✓	✓
Grievances and Appeals: Grievance and Appeal System – General Requirements	Policy #QM521 included a thorough representation of the grievance and appeal processes specific to the Florida Healthy Kids program.			✓
Practice Guidelines: Practice Guideline Adoption	The 2020 Florida Healthy Kids Quality Improvement Program was specific to Florida Healthy Kids requirements.	✓		
Health Information Systems: Data Collection	Policy #IT061 thoroughly addressed the MCO's health information system requirements and included provisions beyond those for this element.	✓	✓	✓
Quality Assessment and Performance Improvement: Basic Required Elements	Documentation provided addressed the QAPI program, and Policy #UM025 and Quality Improvement Committee (QIC) meeting minutes addressed over and under utilization in comprehensive detail.	✓	✓	✓
Quality Assessment and Performance Improvement: Quality Improvement Committee	The QIC met monthly throughout the review period.	✓	✓	✓
Simply Healthcare				
Availability of Services: Furnishing Services – Timely Access	Policy and Procedure (P&P) Network Standards; Availability of Providers – FL included the requirements for this element in a "Florida Healthy Kids Specifics" section.		✓	✓

Table A-10. 2021 ACA Individual MCO/DBM Strengths				
Standard and Element	**Strength**	**Quality**	**Timeliness**	**Access**
Availability of Services: Furnishing Services – Access and Cultural Considerations	P&P #QM023 referenced the applicable CFR section for this requirement.		✓	✓
Availability of Services: Furnishing Services – Accessibility Considerations	P&P Network Standards; Availability of Providers – FL referenced the applicable CFR section.		✓	✓
Assurances of Adequate Capacity and Services: Supporting Documentation	P&P Network Standards; Availability of Providers – FL included requirements specific to Florida Healthy Kids.	✓	✓	✓
Practice Guidelines: Practice Guideline Adoption	P&P Clinical Criteria for Utilization Management Decisions – Core Process included a section specifically to address Florida Healthy Kids requirements and referenced applicable sections of the CFR.	✓		
Quality Assessment and Performance Improvement: Basic Elements Required	The Quality Management Program Description included a comprehensive and detailed description of the MCO's QAPI program.	✓	✓	✓
Argus				
Availability of Services: Second Opinion	P&P #UM_72 was thorough and well organized.	✓	✓	✓
Assurances of Adequate Capacity and Services: Supporting Documentation	P&P #PR_64 included Florida Healthy Kids network adequacy standards.	✓	✓	✓
Grievances and Appeals: Grievance and Appeal System – General Requirements	P&P #GA_9.2 included a detailed description of grievance and appeal processes specific to Florida Healthy Kids.			✓

Table A-10. 2021 ACA Individual MCO/DBM Strengths				
Standard and Element	**Strength**	**Quality**	**Timeliness**	**Access**
Grievances and Appeals: Evidence and Testimony	P&P #GA_9.2 included a reference to ensuring that the enrollee understands any time limits that apply.			✓
Practice Guidelines: Guideline Dissemination	P&P #UM_62's annotated standards upon which the dental benefit manager's (DBM's) clinical guidelines were based were informative and well organized.	✓		
Health Information Systems: Health Information Systems – Required Information	The DBM's Aldera system was updated to capture the enrollee's primary dental provider assignment.	✓	✓	✓
Quality Assessment and Performance Improvement: Basic Elements Required	P&P #UM_61 included a comprehensive presentation of monitoring for over and under utilization and follow-up activities.	✓	✓	✓
DentaQuest				
Grievances and Appeals: Grievance and Appeal System – General Requirements	P&P #CGA09-INS-MCDCHIP included provisions specific to Florida Healthy Kids.			✓
Grievances and Appeals: Grievance and Appeal System – Applicability	P&P #CGA09-INS-MCDCHIP included applicable CFR references.			✓
Grievances and Appeals: Timeframe for Standard Grievance Resolution	The DBM's 30-day complaint resolution timeframe is more stringent than the 90-calendar-day requirement.			✓
Practice Guidelines: Practice Guideline Adoption	P&P #UM01-INS included the DBM's clinical guidelines as exhibits organized by service area criteria.	✓		
MCNA				
Availability of Services: Delivery Network	P&P #5.106 included Florida Healthy Kids network adequacy standards and a detailed review/revision history.		✓	✓

Table A-10. 2021 ACA Individual MCO/DBM Strengths

Standard and Element	Strength	Quality	Timeliness	Access
Availability of Services: Second Opinion	P&P #3.206 included a detailed review/revision history.		✓	✓
Availability of Services: Out-of-Network Services	P&P #5.509 included a detailed review/revision history.		✓	✓
Availability of Services: Furnishing Services – Timely Access	P&P #5.106 included CFR references for requirements in this element.		✓	✓
Availability of Services: Furnishing Services – Accessibility Considerations	P&P #10.300 included a detailed review/revision history.		✓	✓
Assurances of Adequate Capacity and Services: Supporting Documentation	P&P #10.104 included Florida Healthy Kids network adequacy standards and a detailed review/revision history.	✓	✓	✓
Assurances of Adequate Capacity and Services: Submission of Documentation	P&P #10.301 included a detailed review/revision history.	✓	✓	✓
Practice Guidelines: Practice Guideline Adoption	P&P #2.100 included CFR references for requirements in this element and a detailed review/revision history.	✓		
Health Information Systems: Health Information Systems – Required Information	1. P&P #12.300 included CFR references for requirements in this element and a detailed review/revision history. 2. The DBM's DentalTrac™ system was updated to capture the enrollee's primary dental provider assignment.	✓	✓	✓
Health Information Systems: Data Collection	The DBM's DentalTrac system is an integrated system that collects and stores information for enrollees, providers, and services furnished to enrollees in a well-organized and easy-to-access format.	✓	✓	✓

Table A-10. 2021 ACA Individual MCO/DBM Strengths				
Standard and Element	**Strength**	**Quality**	**Timeliness**	**Access**
Quality Assessment and Performance Improvement: Measurement and Submission of Data	The QIPD specifically addressed reporting of performance measures to FHKC.	✓	✓	✓
Quality Assessment and Performance Improvement: PIP Required Elements	P&P #2.102 included a comprehensive description of the PIP process and components.	✓	✓	✓

Table A-11 includes areas of noncompliance (AONs), or weaknesses, for each MCO/DBM from the 2021 ACA, labeled by the aspect of care to which they relate: quality, timeliness, and access. Any MCO or DBM not listed in the table had no identified weaknesses for the 2021 ACA.

Table A-11. 2021 ACA Individual MCO/DBM Weaknesses				
Standard and Element	**Weakness**	**Quality**	**Timeliness**	**Access**
Aetna				
Availability of Services: Second Opinion	The managed care organization (MCO) should have a policy in place for the requirement that it must provide for a second opinion from a network provider, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee.		✓	✓
Availability of Services: Out-of-Network Services	While Policy #6400.41 did not include the out-of-network service requirements for the entire review year, the MCO's revision to this policy in March 2020 included the addition of these requirements.		✓	✓

Table A-11. 2021 ACA Individual MCO/DBM Weaknesses				
Standard and Element	**Weakness**	**Quality**	**Timeliness**	**Access**
Availability of Services: Out-of-Network Provider Payment – 2	While Policy #6400.41 did not include the out-of-network provider payment requirements for the entire review year, the MCO's revision to this policy in March 2020 included the addition of these requirements.		✓	✓
Availability of Services: Indian Healthcare Providers (IHCPs)	While Policy #6400.41 did not include the sufficient number of IHCPs requirement for the entire review year, the MCO's revision to this policy in March 2020 included the addition of this requirement.		✓	✓
Grievances and Appeals: Independent External Review Timeframe	While Policy #3100.70 did not include the provision that the enrollee must request an independent external review within 120 calendar days from the date of the MCO's notice that an appealed adverse benefit determination has been upheld for the entire review year, updates to the policy included the addition of this provision.			✓
Community Care				
Availability of Services: Out-of-Network Provider Payment – 2	The MCO should update Policy #PO-1817 to address the requirement that if it materially failed to provide adequate access for an enrollee's ongoing healthcare needs, including access to an out-of-network provider, Florida Healthy Kids Corporation (FHKC) may direct enrollees to seek related covered services from an out-of-network provider and that should FHKC direct such action, the MCO shall be financially responsible for such services to the extent the MCO would be responsible if the services had been provided by a network provider.		✓	✓
Availability of Services: Family Planning Providers	The MCO should have a policy to address the requirement that it must demonstrate that its network includes sufficient family planning providers to ensure timely access to covered services.		✓	✓
Availability of Services: Furnishing Services – Timely Access	The MCO should update its Master Services Agreement to address the requirement to take into account the urgency of the need for services. While Policy #PO-1820 did not include specific reference to Florida Healthy Kids contract requirements for appointment timeliness for the entire review year, this provision was added on 6/11/20.		✓	✓

Table A-11. 2021 ACA Individual MCO/DBM Weaknesses

Standard and Element	Weakness	Quality	Timeliness	Access
Availability of Services: Furnishing Services – Access and Cultural Considerations	The MCO should update its Cultural Competency Plan to include the provision that it promotes the delivery of services to enrollees with disabilities and that it does so regardless of gender, sexual orientation, or gender identity.		✓	✓
Availability of Services: Indian Healthcare Providers	1. The MCO should have a policy in place to address the requirement that it must maintain sufficient numbers of IHCPs in its provider network to ensure timely access to services from such providers to enrollees eligible to receive such services. 2. The MCO should have a policy in place to address the requirement that it must allow any enrollee who is eligible to receive services from a network IHCP to choose the IHCP as their primary care provider so long as the IHCP has the capacity to provide the services. 3. The MCO should have a policy in place to address the requirement that it must allow any enrollee who is eligible to receive services from an IHCP to obtain services covered under the MCO's contract with FHKC from an out-of-network IHCP. 4. The MCO should have a policy in place to address the requirement that it must allow out-of-network IHCPs to refer enrollees to a network provider. 5. The MCO should have a policy in place to address the requirement that it must permit enrollees eligible to receive covered services from out-of-state IHCPs if there are too few IHCPs in the state to ensure timely access to those services.		✓	✓
Assurances of Adequate Capacity and Services: Submission of Documentation – Anticipated Provider Termination	While Policy #PO-0203 did not include the provider termination notification requirements for the entire review year, the MCO's revision to this policy on 6/11/20 included the requirements.	✓	✓	✓
Practice Guidelines: Guideline Dissemination	The MCO should update Policy #PM700 to include the provision that the MCO must disseminate practice guidelines to enrollees and potential enrollees, upon request.	✓		

Table A-11. 2021 ACA Individual MCO/DBM Weaknesses				
Standard and Element	**Weakness**	**Quality**	**Timeliness**	**Access**
Simply Healthcare				
Availability of Services: Second Opinion	The MCO should update its enrollee handbook to communicate that the second opinion is provided at no cost to the enrollee.		✓	✓
Grievances and Appeals: Authority to File – Provider or Authorized Representative	The MCO should update Policy and Procedure (P&P) Member Complaints and Grievances to address the authorized representative's ability to file expedited appeals and independent external reviews on behalf of the enrollee.			✓
Grievances and Appeals: Timeframe for Standard Appeal Resolution	The MCO should update P&P Member Appeals – FL to include that standard resolution of appeals occurs as expeditiously as the enrollee's health condition requires.			✓
Grievances and Appeals: Independent External Review Timeframe	The MCO should update P&P Member Appeals – FL to specifically reference independent external reviews for Florida Healthy Kids enrollees.			✓
Grievances and Appeals: Denial of Request for Expedited Resolution	The MCO should update P&P Member Appeals – FL to address resolution of denied expedited appeals as expeditiously as the enrollee's health condition requires. The MCO should update the denial of expedited resolution notice letter template to include the 30-calendar-day decision timeframe and that the enrollee can file a grievance if they disagree with the decision to deny an expedited appeal.			✓
Grievances and Appeals: Reversed Appeal Resolutions for Services Not Furnished	The MCO should update P&P Member Appeals – FL to specifically include reference to independent external review reversals.			✓
Grievances and Appeals: Reversed Appeal Resolutions for Services Furnished	The MCO should update P&P Member Appeals – FL to include specific reference to independent external review reversals of decisions to deny authorization of services.			✓

Table A-11. 2021 ACA Individual MCO/DBM Weaknesses

Standard and Element	Weakness	Quality	Timeliness	Access
Argus				
Availability of Services: Indian Healthcare Providers	1. The dental benefit manager (DBM) should have a P&P to address the DBM's requirement to maintain sufficient numbers of IHCPs in its provider network to ensure timely access to services from such providers to enrollees eligible to receive such services. 2. The DBM should have a P&P to address the DBM's requirement to allow any enrollee who is eligible to receive services from a network IHCP to choose the IHCP as their primary dental care provider so long as the IHCP has the capacity to provide the services. 3. The DBM should have a P&P to address the DBM's requirement to allow any enrollee who is eligible to receive services from an IHCP to obtain services covered under the DBM's contract with FHKC from an out-of-network IHCP. 4. The DBM should have a P&P to address the DBM's requirement to allow out-of-network IHCPs to refer enrollees to a network provider. 5. The DBM should have a P&P to address the DBM's requirement to permit enrollees eligible to receive covered services from out-of-state IHCPs if there are too few IHCPs in the state to ensure timely access to those services.		✓	✓
Grievances and Appeals: Authority to File – Provider or Authorized Representative	The DBM should update P&P #GA_9.2 to address the requirement for written consent to appoint a provider/authorized representative and also to include the ability of the authorized representative to file a grievance, request an expedited appeal, or request an independent external review on behalf of the enrollee.			✓
Grievances and Appeals: Procedures to File a Grievance or Appeal	While P&P #GA_9.2 did not include the provision that appeals made by enrollees verbally, except for expedited appeals, must be followed by a written request from the enrollee as required for the review year, the provision does not need to be added to the P&P. This *Code of Federal Regulations* (CFR) regulation changed in 2021 to the provision that the enrollee may request an appeal either orally or in writing, with no written requirement.			✓

Table A-11. 2021 ACA Individual MCO/DBM Weaknesses

Standard and Element	Weakness	Quality	Timeliness	Access
Grievances and Appeals: Enrollee Communication Requirements	The DBM should update Florida Healthy Kids Enrollee Materials/Notices/Marketing Restrictions/Florida KidCare Materials to include the requirement to include taglines in a conspicuously visible font size in all written enrollee materials critical to obtaining services.			✓
Grievances and Appeals: Grievance and Appeal Decisions	The DBM should update P&P #GA_9.2 to address the requirement that individuals making decisions on grievances and appeals are not subordinates of the initial reviewer and include reference to grievances involving clinical issues.			✓
Grievances and Appeals: Oral Appeals Confirmation	While P&P #GA_9.2 did not include the provision that oral inquiries seeking to appeal an adverse benefit determination must be confirmed in writing as required for the review year, the provision does not need to be added to the P&P. This CFR regulation changed in 2021 to the provision that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals, with no written requirement.			✓
Grievances and Appeals: Timeframe for Standard Grievance Resolution	The DBM should update P&P #GA_9.2 to include that grievances are reviewed and written notice of results is sent to the enrollee as expeditiously as the enrollee's health condition requires.			✓
Grievances and Appeals: Timeframe for Standard Appeal Resolution	The DBM should update P&P #GA_9.2 to include that appeals are reviewed and written notice of results are sent to the enrollee as expeditiously as the enrollee's health condition requires.			✓
Grievances and Appeals: Denial of Request for Expedited Resolution	1. The DBM should update P&P #GA_9.2 to address its requirement to make reasonable efforts to provide oral notice of a denial of expedited resolution. 2. The DBM should update P&P #GA_9.2 to address its requirement to give written notice of denial of expedited resolution within two calendar days, including the right to file a grievance for denials of requests for expedited appeal resolution.			✓
Grievances and Appeals: Record-Keeping Requirements	The DBM should update P&P #GA_9.2 to include documents relevant to the grievance and appeal as a record-keeping requirement.			✓

Table A-11. 2021 ACA Individual MCO/DBM Weaknesses

Standard and Element	Weakness	Quality	Timeliness	Access
Grievances and Appeals: Record Accessibility	The DBM should update P&P #GA_9.2 to include that records are accurately maintained in a manner accessible to FHKC and available upon request to the Centers for Medicare & Medicaid Services (CMS).			✓
Grievances and Appeals: Reversed Appeal Resolutions for Services Not Furnished	The DBM should update P&P #GA_9.2 to include the requirement that, when an independent external review reverses the appeal decision, the DBM will authorize or provide disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.			✓
Grievances and Appeals: Reversed Appeal Resolutions for Services Furnished	The DBM should update P&P #GA_9.2 to address the payment of disputed services while an appeal was pending when the DBM or independent external review reverses a decision to deny authorization of services.			✓
Health Information Systems: Provider Data	1. The DBM should have a P&P or other documentation to address the provision that it must ensure data received from providers are accurate and complete by verifying the accuracy and timeliness of reported data, including data from network providers the DBM is compensating on the basis of capitation payments. 2. The DBM should have a P&P or other documentation to address the provision that it must ensure data received from providers are accurate and complete by screening the data for completeness, logic, and consistency.	✓	✓	✓
Health Information Systems: Data Availability	The DBM should have a P&P to address the provision that it must make all collected data available to FHKC, the Agency for Health Care Administration, and the Centers for Medicare & Medicaid Services, upon request.	✓	✓	✓
Quality Assessment and Performance Improvement: Basic Elements Required	The DBM should update the Quality Improvement Plan to address collection and submission of required performance measure data to FHKC.	✓	✓	✓
Quality Assessment and Performance Improvement:	The DBM should ensure that FHKC-program-specific results are included in the Quality Management Program Evaluation.	✓	✓	✓

Table A-11. 2021 ACA Individual MCO/DBM Weaknesses				
Standard and Element	**Weakness**	**Quality**	**Timeliness**	**Access**
Overall QAPI Program Assessment				
DentaQuest				
Availability of Services: Out-of-Network Provider Payment	The DBM should update P&P #NET07-INS to include the provision that the DBM ensures the enrollee cost for out-of-network providers is no greater than it would be if the services were furnished within the network.		✓	✓
Availability of Services: Furnishing Services – Timely Access	1. The DBM should add language about taking into account the urgency of the need for services to P&P #NET05-INS and its Dental Participating Practice Agreement. 2. The DBM should add the provision that participating providers make services available 24 hours a day, seven days a week, when medically necessary to P&P #NET05-INS and its Dental Participating Practice Agreement.		✓	✓
Availability of Services: Furnishing Services – Access and Cultural Considerations	The DBM should update P&P #NET07-INS to include the provision that it promotes delivery of services in a culturally competent manner regardless of gender, sexual orientation, or gender identity.		✓	✓
Assurances of Adequate Capacity and Services: Submission of Documentation – Significant Change	1. The DBM should have a P&P to include the provision that it must submit documentation as specified by FHKC, at any time there has been a significant change (as defined by FHKC) in DBM operations that would affect the adequacy of capacity and services, including changes in DBM services, benefits, geographic service area, or composition of or payments to its provider network. 2. The DBM should have a P&P to include the provision that it must submit documentation as specified by FHKC, at any time there has been a significant change (as defined by FHKC) in DBM operations that would affect the adequacy of capacity and services, including enrollment of a new population in the DBM.	✓	✓	✓
Grievances and Appeals: Procedures to File Grievance or Appeal	While P&P #CGA09-INS did not include the provision that appeals made by enrollees verbally that are expedited do not need to be followed by a written request from the enrollee			✓

Table A-11. 2021 ACA Individual MCO/DBM Weaknesses

Standard and Element	Weakness	Quality	Timeliness	Access
	for the entire review year, updates to the P&P in May 2020 included the addition of this provision.			
Grievances and Appeals: Enrollee Communication Requirements	The DBM should update appropriate documentation to reflect that it provides information to enrollees in a manner and format that may be easily understood and is readily accessible, and any method(s) established by FHKC when notifying enrollees about any aspect of the grievance and appeal process, including using FHKC-developed definitions regarding grievances and appeals.			✓
Grievances and Appeals: Grievance and Appeal Decisions	The DBM should update P&P #CGA06-INS to address the requirement that individuals making decisions on grievances are not subordinates of an individual involved in a previous level of review.			✓
Grievances and Appeals: Oral Appeals Confirmation	While P&P #CGA09-INS did not include the provision that appeals made by enrollees verbally that are expedited do not need to be followed by a written request from the enrollee for the entire review year, updates to the P&P in May 2020 included the addition of this provision.			✓
Grievances and Appeals: Evidence and Testimony	The DBM should add language to address the enrollee's opportunity to present evidence and testimony and make legal and factual arguments for grievances and appeals to P&P #CGA06-INS and P&P #CGA09-INS, respectively.			✓
Grievances and Appeals: Enrollee Opportunity to Examine Case File	The DBM should update P&P #CGA09-INS to include the provision that appeal-related information must be provided free of charge.			✓
Grievances and Appeals: Parties to the Appeal	While P&P #CGA09-INS did not include the provision that parties to the appeal or independent review must include the legal representative of a deceased enrollee's estate for the entire review year, updates to the P&P in May 2020 included the addition of this provision.			✓
Grievances and Appeals: Timeframe for Expedited Appeals	The DBM should update P&P #CGA09-INS to include the provision that expedited appeals are resolved as expeditiously as the enrollee's health condition requires.			✓

Table A-11. 2021 ACA Individual MCO/DBM Weaknesses

Standard and Element	Weakness	Quality	Timeliness	Access
Grievances and Appeals: Requirements Following Extension	The DBM should update P&P #CGA09-INS to include the provision that grievances and appeals with an extended timeframe are resolved as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.			✓
Grievances and Appeals: Punitive Action	While P&P #CGA09-INS did not include the provision that the DBM must ensure that punitive action is not taken against a provider who files an appeal, requests an expedited resolution, or supports an enrollee's appeal or request for an expedited appeal for the entire review year, updates to the P&P in May 2020 included the addition of this provision.			✓
Grievances and Appeals: Record Accessibility	While P&P #CGA09-INS did not include the provision that records must be accurately maintained in a manner accessible to FHKC and available upon request to CMS for the entire review year, updates to the P&P in May 2020 included the addition of this provision.			✓
Grievances and Appeals: Reversed Appeal Resolutions for Services Furnished	The DBM should update P&P #CGA09-INS to include the provision that if the DBM or independent external review reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the DBM must pay for those services, in accordance with FHKC policy and regulations.			✓
Practice Guidelines: Guideline Dissemination	The DBM should update its Utilization Management Program Description 2020 to include the provision that it will disseminate practice guidelines to potential enrollees upon request.	✓		
Practice Guidelines: Guideline Application	1. The DBM should update P&P #UM01-INS to include the provision that its practice guidelines are consistent with enrollee education. 2. The DBM should update P&P #UM01-INS to include the provision that its practice guidelines are consistent with other areas to which the guidelines apply.	✓		
Quality Assessment and Performance Improvement: Basic Elements Required	The DBM should address performance measure collection and submission requirements specific to Florida Healthy Kids in its Quality Improvement Program Description.	✓	✓	✓
Quality Assessment and Performance Improvement:	The DBM should address results of all required aspects of the QI program specific to Florida Healthy Kids in its QI Program Evaluation.	✓	✓	✓

Table A-11. 2021 ACA Individual MCO/DBM Weaknesses				
Standard and Element	**Weakness**	**Quality**	**Timeliness**	**Access**
Overall QAPI Program Assessment				
MCNA				
Availability of Services: Furnishing Services – Access and Cultural Considerations	The DBM should update P&P #5.106 to include the provision that it promotes delivery of services in a culturally competent manner, regardless of gender, sexual orientation, or gender identity.		✓	✓
Availability of Services: Indian Healthcare Providers	1. The DBM should have a P&P to address the DBM's requirement to maintain sufficient numbers of IHCPs in its provider network to ensure timely access to services from such providers to enrollees eligible to receive such services. 2. The DBM should have a P&P to address the DBM's requirement to allow any enrollee who is eligible to receive services from a network IHCP to choose the IHCP as their primary dental care provider so long as the IHCP has the capacity to provide the services. 3. The DBM should have a P&P to address the DBM's requirement to allow any enrollee who is eligible to receive services from an IHCP to obtain services covered under the DBM's contract with FHKC from an out-of-network IHCP. 4. The DBM should have a P&P to address the DBM's requirement to allow out-of-network IHCPs to refer enrollees to a network provider. 5. The DBM should have a P&P to address the DBM's requirement to permit enrollees eligible to receive covered services from out-of-state IHCPs if there are too few IHCPs in the state to ensure timely access to those services.		✓	✓
Grievances and Appeals: Processes for Grievances and Appeals	The DBM should update the enrollee handbook to indicate that appeals will be acknowledged upon receipt.			✓
Grievances and Appeals: Timeframe for Standard Appeal Resolution	The DBM should update P&P #13.200 to address that appeals will be resolved and notice provided within 30 calendar days of receipt.			✓

Table A-11. 2021 ACA Individual MCO/DBM Weaknesses

Standard and Element	Weakness	Quality	Timeliness	Access
Grievances and Appeals: Extension of Timeframes	The DBM should update the enrollee handbook to indicate the 14-calendar-day extension process.			✓
Grievances and Appeals: Independent External Review Timeframe	The DBM should update P&P #13.200 to reflect a 120-calendar-day timeframe to request an independent external review, and to replace State fair hearing language with independent external review. The DBM also should update the appeal resolution letter template to include the 120-calendar-day requirement for filing an independent external review.			✓

ANA

The following evaluation activities were performed for all three 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

The network adequacy information in **Tables A-12** through **A-15** was obtained from analyses performed on provider and enrollee data. The standards used to assess provider networks for the MCOs and DBMs appear in Appendix B. The contract minimum standard for the MCOs is to provide 90% of their Florida Healthy Kids enrollees with access to one provider for each of the required provider types within required timeframes. Results for areas not meeting this minimum standard are emphasized with **bold red** text. **Table A-12** includes the time analysis results by MCO, and Table A-13 includes the distance analysis results by MCO. Tables A-16 and A-17 include results from the appointment availability and accessibility review.

Table A-12. 2021 Network Adequacy Results: Time Analysis by MCO and Provider/Specialty Type

Provider/Specialty Type	Aetna		Community Care		Simply Healthcare	
	Urban	Rural	Urban	Rural	Urban	Rural
Primary Care Provider (PCP) – Family Medicine	99.82%	91.98%	100%	97.19%	99.91%	97.75%
PCP – Pediatrics	99.68%	93.63%	100%	100%	99.85%	98.90%
Allergy & Immunology	95.15%	**83.07%**	97.12%	98.21%	98.86%	91.77%
Dermatology	98.44%	91.21%	100%	**44.76%**	99.49%	97.75%
Obstetrics & Gynecology	99.96%	**89.81%**	99.79%	**52.69%**	99.96%	**87.14%**
Optometry	99.50%	99.91%	100%	96.16%	99.83%	99.69%
Otolaryngology	93.19%	96.40%	97.86%	**44.76%**	98.36%	96.61%
Behavioral Health – Pediatric	99.87%	100%	99.26%	99.74%	99.85%	100%
Behavioral Health – Other	99.93%	100%	99.99%	100%	99.99%	100%
Specialist – Pediatric	99.55%	98.77%	97.57%	**69.57%**	97.10%	**84.02%**
Specialist – Other	99.85%	92.80%	100%	90.28%	99.91%	96.48%

Table A-12. 2021 Network Adequacy Results: Time Analysis by MCO and Provider/Specialty Type						
Provider/Specialty Type	**Aetna**		**Community Care**		**Simply Healthcare**	
	Urban	Rural	Urban	Rural	Urban	Rural
Hospital	98.49%	**87.52%**	100%	**59.08%**	99.86%	90.75%
Pharmacy	99.82%	91.98%	99.78%	95.65%	99.88%	94.23%

Table A-13. 2021 Network Adequacy Results: Distance Analysis by MCO and Provider/Specialty Type						
Provider/Specialty Type	**Aetna**		**Community Care**		**Simply Healthcare**	
	Urban	Rural	Urban	Rural	Urban	Rural
Primary Care Provider (PCP) – Family Medicine	99.89%	94.29%	100%	97.95%	99.94%	98.63%
PCP – Pediatrics	99.77%	95.26%	100%	100%	99.93%	99.56%
Allergy & Immunology	97.37%	**71.16%**	98.52%	89.51%	99.65%	85.95%
Dermatology	99.31%	**88.35%**	100%	43.73%	99.80%	95.46%
Obstetrics & Gynecology	99.98%	92.69%	99.91%	55.24%	99.99%	90.93%
Optometry	99.81%	99.14%	100%	90.28%	99.94%	99.03%
Otolaryngology (ENT)	95.30%	93.92%	99.25%	42.46%	99.24%	93.79%
Behavioral Health – Pediatric	99.93%	100%	99.26%	91.05%	99.90%	100%
Behavioral Health – Other	99.97%	100%	100%	100%	100%	100%
Specialist – Pediatric	99.70%	97.57%	99.15%	63.68%	97.84%	71.77%
Specialist – Other	99.91%	94.63%	100%	92.84%	99.95%	97.75%
Hospital	96.54%	91.26%	99.97%	59.08%	99.61%	93.97%
Pharmacy	99.89%	94.29%	99.76%	93.09%	99.63%	87.10%

Table A-14 includes results from the time analysis by DBM, and **Table A-15** includes results from the distance analysis by DBM. The minimum access threshold is not defined in the DBMs' contracts as a percentage of FHKC enrollees with access; thus, no areas are identified as not meeting a standard in these two tables.

Table A-14. 2021 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	99.56%	99.47%	99.59%	95.52%	99.69%	98.66%
Orthodontists	94.35%	80.10%	98.90%	71.44%	99.04%	77.92%
Dental Specialists	94.05%	55.26%	95.04%	54.17%	93.93%	45.19%

Table A-15. 2021 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	99.82%	99.70%	99.71%	96.95%	99.82%	99.61%
Orthodontists	92.16%	72.43%	97.78%	63.23%	97.69%	73.25%
Dental Specialists	94.77%	40.40%	96.40%	43.35%	95.53%	31.04%

Table A-16 includes results from the review of appointment availability standards by MCO/DBM. Table A-17 includes results of the appointment availability standards provider and enrollee communication review.

Table A-16. 2021 Appointment Availability Standards Review Results

Standard	Standard Met or Not Met					
	Aetna	Community Care	Simply Healthcare	Argus	DentaQuest	MCNA
Emergency care shall be provided immediately.	Yes	Yes	Yes	Yes	Yes	Yes

Table A-16. 2021 Appointment Availability Standards Review Results						
Standard	**Standard Met or Not Met**					
	Aetna	**Community Care**	**Simply Healthcare**	**Argus**	**DentaQuest**	**MCNA**
Urgently needed care shall be provided within 24 hours.	Yes	Yes	Yes	Yes	Yes	Yes
Routine care shall be provided within seven calendar days of the enrollee's request for services.	No	No	Yes	Yes	Yes	No
Well-child visits, as recommended by the American Academy of Pediatrics, shall be provided within four weeks of the enrollee's request.	Yes	Yes	Yes	Yes	Yes	Yes
Follow-up care shall be provided as medically appropriate.	No	No	Yes	Yes	Yes	Yes

Table A-17. 2021 Appointment Availability Standards Provider and Enrollee Communication Review Results						
Standard	**Standard Met or Not Met**					
	Aetna	**Community Care**	**Simply Healthcare**	**Argus**	**DentaQuest**	**MCNA**
Provider Manual						
Emergency care shall be provided immediately.	Yes	Yes	Yes	Yes	Yes	Yes
Urgently needed care shall be provided within 24 hours.	Yes	Yes	Yes	Yes	Yes	Yes
Routine care shall be provided within seven calendar days of the enrollee's request for services.	No	Yes	Yes	Yes	Yes	Yes

Table A-17. 2021 Appointment Availability Standards Provider and Enrollee Communication Review Results						
Standard	**Standard Met or Not Met**					
	Aetna	**Community Care**	**Simply Healthcare**	**Argus**	**DentaQuest**	**MCNA**
Well-child visits, as recommended by the American Academy of Pediatrics, shall be provided within four weeks of the enrollee's request.	Yes	No	Yes	Yes	Yes	Yes
Follow-up care shall be provided as medically appropriate.	Yes	No	Yes	Yes	Yes	No
Enrollee Handbook						
Emergency care shall be provided immediately.	Yes	Yes	Yes	Yes	Yes	Yes
Urgently needed care shall be provided within 24 hours.	Yes	Yes	Yes	Yes	Yes	Yes
Routine care shall be provided within seven calendar days of the enrollee's request for services.	Yes	Yes	Yes	Yes	Yes	Yes
Well-child visits, as recommended by the American Academy of Pediatrics, shall be provided within four weeks of the enrollee's request.	Yes	Yes	Yes	Yes	Yes	Yes
Follow-up care shall be provided as medically appropriate.	Yes	Yes	Yes	Yes	Yes	Yes

EDV

The results in **tables A-18** through **A-40** were obtained through analysis of MCO claim and encounter data and DBM claim data for service dates in 2020Q4, 2021Q1, and 2021Q2. Discussion of these results is included in the EDV section of the report.

Table A-18. Total Claim Lines and Encounter Lines Submitted by MCOs

MCO	2020Q4 Dates of Service		2021Q1 Dates of Service		2021Q2 Dates of Service	
	Claim Lines	Encounter Lines	Claim Lines	Encounter Lines	Claim Lines	Encounter Lines
Aetna	353,026	21,237	355,979	28,694	294,867	40,045
Community Care	55,578	3,406	77,003	2,946	56,417	3,129
Simply Healthcare	378,596	15,305	379,030	16,189	311,799	16,760

Table A-19. Total Claim Lines Submitted by DBMs

DBM	2020Q4 Dates of Service	2021Q1 Dates of Service	2021Q2 Dates of Service
Argus	57,900	60,657	52,087
DentaQuest	109,013	122,030	102,413
MCNA	102,628	102,420	89,369

Table A-20. Percentage of MCO Enrollees with at Least One Claim/Encounter

MCO	2020Q4 Dates of Service			2021Q1 Dates of Service			2021Q2 Dates of Service		
	Percentage with Distinct Claim	Percentage with Distinct Encounter	Percentage with Distinct Claim and/or Encounter	Percentage with Distinct Claim	Percentage with Distinct Encounter	Percentage with Distinct Claim and/or Encounter	Percentage with Distinct Claim	Percentage with Distinct Encounter	Percentage with Distinct Claim and/or Encounter
Aetna	47.84%	6.77%	50.25%	47.81%	8.42%	50.72%	47.72%	47.72%	51.72%
Community Care	44.77%	3.33%	46.07%	45.97%	4.29%	47.91%	48.48%	4.28%	51.58%

Table A-20. Percentage of MCO Enrollees with at Least One Claim/Encounter									
MCO	2020Q4 Dates of Service			2021Q1 Dates of Service			2021Q2 Dates of Service		
	Percentage with Distinct Claim	Percentage with Distinct Encounter	Percentage with Distinct Claim and/or Encounter	Percentage with Distinct Claim	Percentage with Distinct Encounter	Percentage with Distinct Claim and/or Encounter	Percentage with Distinct Claim	Percentage with Distinct Encounter	Percentage with Distinct Claim and/or Encounter
Simply Healthcare	52.59%	2.49%	53.23%*	50.88%	2.72%	51.66%	52.17%	2.96%	53.02%

** While some enrollees had both claims and encounters, only one claim/encounter was counted for each enrollee; thus, the count of enrollees with a distinct claim and/or encounter total does not equal the total of the percentage with a distinct claim and the percentage with a distinct encounter.*

Table A-21. Percentage of DBM Enrollees with at Least One Claim			
DBM	2020Q4 Dates of Service	2021Q1 Dates of Service	2021Q2 Dates of Service
Argus	20.24%	23.86%	23.32%
DentaQuest	22.17%	27.72%	25.18%
MCNA	21.22%	24.28%	22.29%

Table A-22. Percentage of Enrollment Versus Claims and Encounter Data by MCO/DBM						
MCO/DBM	2020Q4 Dates of Service		2021Q1 Dates of Service		2021Q2 Dates of Service	
	% Enrollment	% Claims & Encounters	% Enrollment	% Claims & Encounters	% Enrollment	% Claims & Encounters
Aetna	47.64%	43.86%	47.37%	45.87%	47.49%	45.10%
Community Care	6.99%	6.29%	7.0%	6.37%	7.00%	6.91%
Simply Healthcare	45.37%	49.85%	45.63%	47.76%	45.51%	47.98%
Argus	22.04%	20.60%	22.32%	20.63%	22.38%	21.30%
DentaQuest	41.75%	41.43%	41.77%	43.79%	41.81%	42.29%

Table A-22. Percentage of Enrollment Versus Claims and Encounter Data by MCO/DBM						
MCO/DBM	2020Q4 Dates of Service		2021Q1 Dates of Service		2021Q2 Dates of Service	
	% Enrollment	% Claims & Encounters	% Enrollment	% Claims & Encounters	% Enrollment	% Claims & Encounters
MCNA	36.20%	37.97%	35.90%	35.58%	35.81%	36.42%

Table A-23. Distribution by Medical Service Type for MCOs—Claim Lines							
MCO	Medical Service Type						
	Anesthesia	Evaluation and Management	Medicine	Other	Pathology and Laboratory	Radiology	Surgery
2020Q4 Dates of Service							
Aetna	1,385 (0.39%)	77,382 (21.92%)	93,317 (26.43%)	36,931 (10.46%)	79,413 (22.49%)	13,557 (3.84%)	51,041 (14.46%)
Community Care	136 (0.24%)	11,901 (21.41%)	14,485 (26.06%)	6,213 (11.18%)	10,615 (19.10%)	1,775 (3.19%)	10,453 (18.81%)
Simply Healthcare	1,723 (0.46%)	77,349 (20.43%)	114,827 (30.33%)	42,647 (11.26%)	82,681 (21.84%)	14,095 (3.72%)	45,274 (11.96%)
2021Q1 Dates of Service							
Aetna	1,263 (0.35%)	75,352 (21.17%)	89,762 (25.22%)	42,531 (11.95%)	77,999 (21.91%)	13,898 (3.90%)	55,174 (15.50%)
Community Care	116 (0.15%)	20,810 (27.02%)	15,978 (20.75%)	7,659 (9.95%)	12,543 (16.29%)	1,961 (2.55%)	17,936 (23.29%)
Simply Healthcare	1,850 (0.49%)	80,761 (21.31%)	115,906 (30.58%)	38,863 (10.25%)	72,497 (19.13%)	14,066 (3.71%)	55,087 (14.53%)
2021Q2 Dates of Service							
Aetna	1,122 (0.38%)	63,034 (21.38%)	67,576 (22.92%)	33,534 (11.37%)	73,114 (24.80%)	12,790 (4.34%)	43,697 (14.82%)

Table A-23. Distribution by Medical Service Type for MCOs—Claim Lines

MCO	Medical Service Type						
	Anesthesia	Evaluation and Management	Medicine	Other	Pathology and Laboratory	Radiology	Surgery
Community Care	130 (0.23%)	12,106 (21.46%)	10,742 (19.04%)	6,883 (12.20%)	11,733 (20.80%)	1,780 (3.16%)	13,043 (23.12%)
Simply Healthcare	1,846 (0.59%)	71,131 (22.81%)	74,490 (23.89%)	32,211 (10.33%)	74,089 (23.76%)	14,981 (4.80%)	43,051 (13.81%)

Table A-24. Distribution by Medical Service Type for MCOs—Encounter Lines

MCO	Medical Service Type						
	Anesthesia	Evaluation and Management	Medicine	Other	Pathology and Laboratory	Radiology	Surgery
2020Q4 Dates of Service							
Aetna	0 (0%)	4,800 (22.60%)	14,892 (70.12%)	826 (3.89%)	7 (0.03%)	5 (0.02%)	707 (3.33%)
Community Care	0 (0%)	0 (0%)	2,599 (76.31%)	618 (18.14%)	0 (0%)	0 (0%)	189 (5.55%)
Simply Healthcare	0 (0%)	1,149 (7.51%)	10,232 (66.85%)	3,524 (23.03%)	18 (0.12%)	24 (0.16%)	358 (2.34%)
2021Q1 Dates of Service							
Aetna	0 (0%)	5,033 (17.54%)	22,240 (77.51%)	689 (2.40%)	9 (0.03%)	13 (0.05%)	710 (2.47%)
Community Care	0 (0%)	6 (0.20%)	2,710 (91.99%)	228 (7.74%)	0 (0%)	0 (0%)	2 (0.07%)
Simply Healthcare	0 (0%)	1,086 (6.71%)	11,171 (69.0%)	3,606 (22.27%)	40 (0.25%)	0 (0%)	286 (1.77%)

Table A-24. Distribution by Medical Service Type for MCOs—Encounter Lines

MCO	Medical Service Type						
	Anesthesia	Evaluation and Management	Medicine	Other	Pathology and Laboratory	Radiology	Surgery
2021Q2 Dates of Service							
Aetna	0 (0.00%)	5,948 (14.85%)	31,410 (78.44%)	1,995 (4.98%)	15 (0.04%)	53 (0.13%)	624 (1.56%)
Community Care	0 (0.00%)	12 (0.38%)	2,871 (91.75%)	242 (7.73%)	0 (0.00%)	2 (0.06%)	2 (0.06%)
Simply Healthcare	0 (0.00%)	1,077 (6.43%)	11,172 (66.66%)	4,141 (24.71%)	33 (0.20%)	0 (0.00%)	337 (2.01%)

Table A-25. Distribution by Dental Service Type for DBMs—Claim Lines

Dental Service Type	Argus			DentaQuest			MCNA		
	2020Q4	2021Q1	2021Q2	2020Q4	2021Q1	2021Q2	2020Q4	2021Q1	2021Q2
Dental Preventative Services	42.22% (24,444)	42.95% (26,052)	41.23% 21,473	42.34% (46,157)	42.81% (52,236)	42.40% (43,425)	41.79% (42,885)	41.84% (42,855)	41.51% (37,095)
Dental Radiographs/Diagnostic Imaging	28.06% (16,249)	29.51% (17,899)	29.02% (15,114)	28.50% (31,070)	29.17% (35,593)	28.50% (29,186)	29.90% (30,684)	30.45% (31,184)	29.43% (26,299)
Dental Clinical Oral Evaluations	11.31% (6,549)	11.94% (7,240)	12.24% (6,376)	12.57% (13,699)	13.03% (15,895)	12.75% (13,056)	12.20% (12,518)	12.48% (12,786)	12.35% (11,036)
Dental Restorative	8.05% (4,662)	7.06% (4,284)	7.18% (3,740)	7.60% (8,289)	6.60% (8,059)	7.05% (7,218)	7.44% (7,639)	6.64% (6,796)	7.32% (6,542)
Dental Adjunctive General Service	3.80% (2,200)	3.06% (1,857)	3.74% (1,946)	3.13% (3,417)	2.92% (3,566)	3.24% (3,314)	3.20% (3,280)	3.16% (3,237)	3.53% (3,152)
Dental Oral & Maxillofacial Surgery	3.02% (1,750)	2.14% (1,299)	2.65% (1,379)	2.55% (2,783)	2.33% (2,848)	2.41% (2,464)	2.93% (3,011)	2.88% (2,946)	3.14% (2,802)

Table A-25. Distribution by Dental Service Type for DBMs—Claim Lines

Dental Service Type	Argus			DentaQuest			MCNA		
	2020Q4	2021Q1	2021Q2	2020Q4	2021Q1	2021Q2	2020Q4	2021Q1	2021Q2
Dental Orthodontics	1.64% (952)	1.60% (972)	1.87% (976)	1.51% (1,644)	1.30% (1,588)	1.19% (1,214)	0.93% (954)	0.90% (919)	0.88% (786)
Dental Endodontics	1.18% (683)	1.00% (608)	0.94% (490)	0.99% (1,080)	0.91% (1,114)	0.92% (945)	0.81% (836)	0.76% (782)	0.82% (735)
Dental Oral Pathology Laboratory	0.31% (179)	0.40% (243)	0.72% (373)	0.53% (581)	0.62% (759)	1.17% (1,194)	0.45% (464)	0.50% (511)	0.63% (564)
Dental Periodontics	0.22% (128)	0.20% (122)	0.24% (124)	0.14% (152)	0.15% (179)	0.25% (254)	0.20% (208)	0.24% (241)	0.27% (238)
Dental Pre-Diagnostic Services	0.10% (58)	0.07% (42)	0.08% (41)	0.06% (70)	0.09% (108)	0.06% (66)	0.07% (67)	0.07% (73)	0.07% (63)
Dental Tests And Examinations	0.07% (42)	0.06% (39)	0.10% (53)	0.05% (53)	0.06% (70)	0.06% (61)	0.07% (72)	0.08% (86)	0.06% (51)
Dental Fixed Prosthodontics	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)
Dental Removable Prosthodontics	0%* (1)	0% (0)	0%* (2)	0%* (2)	0%* (2)	0% (0)	0%* (2)	0% (0)	0% (0)
Dental Image Capture Only	0.01% (3)	0% (0)	0% (0)	0%* (2)	0%* (3)	0%* (2)	0%* (4)	0%* (4)	0%* (4)
Undefined	0% (0)	0% (0)	0% (0)	0.01% (14)	0.01% (10)	0% (0)	0%* (3)	0% (0)	0%* (2)
Total	**57,900**	**60,657**	**52,087**	**109,013**	**122,030**	**102,413**	**102,628**	**102,420**	**89,369**

** Claims records were present for this service for the DBM; however, they were too small to yield a positive percentage given the ratio of these records to the total number of records for all service types.*

Table A-26. Distinct Claims by Provider Type for MCOs

Provider Type	Aetna # Distinct Claims			Community Care # Distinct Claims			Simply Healthcare # Distinct Claims		
	2020Q4	2021Q1	2021Q2	2020Q4	2021Q1	2021Q2	2020Q4	2021Q1	2021Q2
Physician	70,170 (70.50%)	65,274 (69.14%)	61,128 (70.27%)	10,024 (65.90%)	9,188 (62.70%)	9,311 (60.43%)	77,234 (62.53%)	73,073 (64.87%)	67,868 (62.40%)
Independent Laboratory	12,807 (12.87%)	11,915 (12.62%)	10,907 (12.54%)	1,550 (10.19%)	1,633 (11.14%)	1,677 (10.88%)	11,773 (9.53%)	9,179 (8.15%)	10,432 (9.59%)
General Hospital	7,259 (7.29%)	6,659 (7.05%)	6,534 (7.51%)	1,090 (7.17%)	1,090 (7.44%)	1,131 (7.34%)	9,456 (7.66%)	9,597 (8.52%)	10,029 (9.22%)
Nurse Practitioner (ARNP)	3,108 (3.12%)	3,215 (3.41%)	3,211 (3.69%)	477 (3.14%)	526 (3.59%)	700 (4.54%)	5,140 (4.16%)	5,477 (4.86%)	5,563 (5.11%)
Durable Medical Equipment/Medical Supplies	1,509 (1.52%)	1,477 (1.56%)	1,444 (1.66%)	79 (0.52%)	77 (0.53%)	248 (1.61%)	1,277 (1.03%)	1,207 (1.07%)	1,205 (1.11%)
Therapist (PT, OT, ST, RT)	0 (0%)	0 (0%)	61 (0.07%)	0 (0%)	24 (0.16%)	46 (0.30%)	0 (0%)	124 (0.11%)	147 (0.14%)
Physician Assistant	914 (0.92%)	864 (0.92%)	834 (0.96%)	311 (2.04%)	329 (2.25%)	45 (0.29%)	991 (0.80%)	892 (0.79%)	940 (0.86%)
Specialized Therapeutic Services	0 (0%)	0 (0%)	0 (0%)	8,985 (7.27%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	
Comprehensive Behavioral Health Assessment	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1,396 (1.13%)	0 (0%)	
Prescribed Drug Services	539 (0.54%)	502 (0.53%)	497 (0.57%)	0 (0%)	0 (0%)	24 (0.16%)	0 (0%)	30 (0.03%)	25 (0.02%)
Optometrist	0 (0%)	884 (0.94%)	293 (0.34%)	5,137 (4.16%)	1 (0.01%)	4 (0.03%)	0 (0%)	209 (0.19%)	24 (0.02%)

Table A-26. Distinct Claims by Provider Type for MCOs

Provider Type	Aetna # Distinct Claims			Community Care # Distinct Claims			Simply Healthcare # Distinct Claims		
	2020Q4	2021Q1	2021Q2	2020Q4	2021Q1	2021Q2	2020Q4	2021Q1	2021Q2
Podiatrist	225 (0.23%)	237 (0.25%)	241 (0.28%)	74 (0.49%)	55 (0.38%)	41 (0.27%)	0 (0%)	521 (0.46%)	483 (0.44%)
Chiropractor	0 (0%)	0 (0%)	74 (0.09%)	40 (0.26%)	14 (0.10%)	15 (0.10%)	0 (0%)	186 (0.17%)	81 (0.07%)
Home Health Services	178 (0.18%)	0 (0%)	130 (0.15%)	32 (0.21%)	46 (0.31%)	0 (0%)	0 (0%)	7 (0.01%)	0 (0%)
Ambulance	0 (0%)	0 (0%)	171 (0.20%)	0 (0%)	17 (0.12%)	18 (0.12%)	0 (0%)	157 (0.14%)	160 (0.15%)
Audiologist/Hearing Aid Specialist	0 (0%)	0 (0%)	65 (0.07%)	0 (0%)	0 (0%)	11 (0.07%)	0 (0%)	0 (0%)	38 (0.03%)
Federally Qualified Health Center	0 (0%)	0 (0%)	184 (0.21%)	0 (0%)	0 (0%)	7 (0.05%)	0 (0%)	0 (0%)	39 (0.04%)
Non-Emergency Transportation	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (0.01%)	0 (0%)	0 (0%)	0 (0%)
Dentist	0 (0%)	0 (0%)	14 (0.02%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	99 (0.09%)
Home and Community-Based Services Waiver	0 (0%)	0 (0%)	13 (0.01%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	23 (0.02%)
Residential And Freestanding Psych	0 (0%)	0 (0%)	2 (0.00%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Other	2,823 (2.84%)	475 (0.50%)	1,184 (1.36%)	1,534 (10.08%)	1,651 (11.24%)	2,038 (13.23%)	2,005 (1.62%)	11,791 (10.47%)	11,613 (10.68%)

Table A-26. Distinct Claims by Provider Type for MCOs

Provider Type	Aetna # Distinct Claims			Community Care # Distinct Claims			Simply Healthcare # Distinct Claims		
	2020Q4	2021Q1	2021Q2	2020Q4	2021Q1	2021Q2	2020Q4	2021Q1	2021Q2
Blank	0 (0%)	2,204 (2.33%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	131 (0.11%)	206 (0.19%)	0 (0%)
Total	**99,532**	**94,472**	**86,987**	**15,211**	**14,664**	**15,412***	**123,525**	**112,656**	**108,769***

** Total number of claims may be greater than the total in Table 16 due to some claims having more than one provider type.*

Table A-27. Distinct Encounters by Provider Type for MCOs

Provider Type	Aetna # Distinct Claims			Community Care # Distinct Claims			Simply Healthcare # Distinct Claims		
	2020Q4	2021Q1	2021Q2	2020Q4	2021Q1	2021Q2	2020Q4	2021Q1	2021Q2
Physician	4,522 (25.46%)	4,577 (19.14%)	4,908 (19.50%)	0 (0%)	0 (0%)	0 (0%)	1,251 (12.95%)	1,202 (11.73%)	1,200 (11.70%)
Physician Assistant	657 (3.70%)	654 (2.73%)	683 (2.71%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Nurse Practitioner (ARNP)	297 (1.67%)	0 (0%)	314 (1.25%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Comprehensive Behavioral Health Assessment	804 (4.52%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Mental Health Targeted Case Management	587 (3.30%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Therapist (PT, OT, ST, RT)	595 (3.35%)	4,306 (18.01%)	4,737 (18.82%)	0 (0%)	1,397 (80.33%)	1,402 (80.71%)	7,191 (74.43%)	7,826 (76.37%)	7,672 (74.82%)

Table A-27. Distinct Encounters by Provider Type for MCOs

Provider Type	Aetna # Distinct Claims			Community Care # Distinct Claims			Simply Healthcare # Distinct Claims		
	2020Q4	2021Q1	2021Q2	2020Q4	2021Q1	2021Q2	2020Q4	2021Q1	2021Q2
Home Health Services	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1,156 (11.96%)	1,218 (11.89%)	1,382 (13.48%)
Specialized Therapeutic Services	8,290 (46.66%)	9,807 (41.10%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Social Worker/Case Manager	0 (0%)	874 (3.65%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Optometrist	0 (0%)	0 (0%)	1,342 (5.33%)	331 (20.86%)	342 (19.67%)	333 (19.17%)	0 (0%)	0 (0%)	0 (0%)
Podiatrist	0 (0%)	0 (0%)	89 (0.35%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Chiropractor	0 (0%)	0 (0%)	26 (0.10%)	0 (0%)	0 (0%)	0 (0%)	46 (0.48%)	0 (0%)	0 (0%)
Non-Emergency Transportation	0 (0%)	0 (0%)	1 (0.00%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Durable Med Equipt/Medical Supplies	0 (0%)	0 (0%)	0 (0%)	3 (0.19%)	0 (0%)	2 (0.12%)	0 (0%)	0 (0%)	0 (0%)
Audiologist/Hearing Aid Specialist	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	18 (0.19%)	1 (0.01%)	0 (0%)
Other	699 (3.93%	1,410 (5.9%)	13,298 (52.82%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Blank	1,281 (7.21%)	2,286 (9.56%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	**17,768**	**23,914**	**25,398***	**1,587**	**1,739**	**1,737**	**9,662**	**10,247**	**10,254**

** Total number of claims may be greater than the total in Table 16 due to some claims having more than one provider type.*

Table A-28. Average Number of Days from Last Service Date to Distinct Claim Paid Date for MCOs						
MCO	Professional			Institutional		
	Avg. Days from Last Service Date to Distinct Claim Paid Date			Avg. Days from Last Service Date to Distinct Claim Paid Date		
	2020Q4	2021Q1	2021Q2	2020Q4	2021Q1	2021Q2
Aetna	24.14	24.00	26.66	24.69	21.88	20.87
Community Care	23.83	45.17	24.29	22.59	24.50	24.82
Simply Healthcare	26.33	23.29	22.19	23.58	22.16	24.06

Table A-29. Average Number of Days from Billing Date to Distinct Claim Paid Date for MCOs						
MCO	Professional			Institutional		
	Avg. Days from Billing Date to Distinct Claim Paid Date			Avg. Days from Billing Date to Distinct Claim Paid Date		
	2020Q4	2021Q1	2021Q2	2020Q4	2021Q1	2021Q2
Aetna	6.96	6.31	6.51	10.52	8.46	7.57
Community Care	3.77	3.64	4.1	4.53	4.67	4.89
Simply Healthcare	8.23	9.3	8.45	9.44	8.99	11.05

Table A-30. Average Number of Days from Last Service Date and from Billing Date to Distinct Claim Paid Date for DBMs						
DBM	Avg. Days from Last Service Date to Distinct Claim Paid Date			Avg. Days from Billing Date to Distinct Claim Paid Date		
	2020Q4	2021Q1	2021Q2	2020Q4	2021Q1	2021Q2
Argus	21.9	20.16	19.81	12.78	12.87	12.85
DentaQuest	13.23	11.64	11.72	6.45	5.32	5.39
MCNA	22.45	19.15	17.77	8.8	9.63	9.28

Table A-31 includes completeness and validity rates of claim data for the MCOs. Scores below 95.0% are identified in **red**.

Table A-31. Completeness and Validity Rates—Claim Lines Submitted by MCOs						
Field	**2020Q4 Dates of Service**		**2021Q1 Dates of Service**		**2021Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
	Aetna (N=353,026)		**Aetna (N=355,979)**		**Aetna (N=294,867)**	
Member Identification (ID)	100%	100%	100%	100%	100%	100%
Plan ID	100%	100%	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%	100%	100%
Billing Date	100%	100%	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%	100%	100%
Admit Date	100%	100%	100%	100%	100%	97.71%
Diagnosis Code	100%	99.17%	100%	98.0%	97.71%	98.09%
Procedure Code	97.50%	96.88%	97.64%	98.78%	100%	100%
First Date of Service	100%	100%	100%	100%	100%	100%†
Last Date of Service	100%	100%	100%	100%	100%	100%
Units of Service	100%	100%	100%	100%	100%	100%
Total Days	100%	100%	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%	99.46%	100%
Treating Provider Type	98.90%	100%	98.37%	100%	100%	100%
Treating Provider National Provider Identifier (NPI)	100%†	100%	100%	100%	99.46%	100%
Treating Provider Medicaid ID	98.90%	100%	98.37%	100%	99.46%	100%
Treating Provider Specialty Code	98.90%	100%	98.37%	100%†	98.69%	100%
Billing Provider Type	95.05%	100%	98.41%	100%	100%	100%

Table A-31. Completeness and Validity Rates—Claim Lines Submitted by MCOs						
Field	**2020Q4 Dates of Service**		**2021Q1 Dates of Service**		**2021Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
Billing Provider NPI	100%†	100%	100%	100%	100%	100%
Billing Provider Medicaid ID	95.05%	100%	98.41%	100%	98.69%	100%
Billing Provider Specialty Code	95.05%	100%	98.41%	100%	98.69%	100%
Facility Provider Type	99.73%	100%	99.83%	100%	99.68%	100%
Facility Provider NPI	100%	100%	100%	100%	100%	100%
Facility Provider Medicaid ID	99.73%	100%	99.83%	100%	99.68%	100%
Place of Service	99.90%	100%	99.98%	100%	99.98%	100%
	Community Care (N=55,578)		**Community Care (N=77,003)**		**Community Care (N=56,417)**	
Member ID	100%	100%	100%	100%	100%	100%
Plan ID	100%	100%	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%	100%	100%
Billing Date	100%	100%	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%	100%	100%
Admit Date	100%	100%	100%	100%	100%	100%
Diagnosis Code	100%	98.98%	100%†	98.29%	100%	98.43%
Procedure Code	98.04%	98.45%	98.38%	99.18%	97.21%	99.15%
First Date of Service	100%	100%	100%	100%	100%	100%
Last Date of Service	100%	100%	100%	100%	100%	100%
Units of Service	100%	100%	100%	100%	100%	100%
Total Days	100%	100%	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%	100%	100%
Treating Provider Type	99.95%	100%	99.95%	100%	99.96%	100%

Table A-31. Completeness and Validity Rates—Claim Lines Submitted by MCOs						
Field	**2020Q4 Dates of Service**		**2021Q1 Dates of Service**		**2021Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
Treating Provider NPI	99.92%	100%	99.95%	100%	99.96%	100%
Treating Provider Medicaid ID	99.14%	100%	99.36%	99.97%	99.29%	100%
Treating Provider Specialty Code	100%	99.81%	100%	99.76%	100%	99.91%
Billing Provider Type	100%	100%	100%	100%	100%	100%
Billing Provider NPI	100%	100%	100%	100%	100%	100%
Billing Provider Medicaid ID	99.84%	100%	99.63%	100%	99.46%	100%
Billing Provider Specialty Code	100%	99.98%	100%	99.94%	100%	99.99%
Facility Provider Type	100%	100%	99.96%	100%	99.56%	100%
Facility Provider NPI	100%	100%	100%	100%	100%	100%
Facility Provider Medicaid ID	99.53%	100%	99.02%	100%	99.56%	100%
Place of Service	100%	96.78%	100%	**94.34%**	100%	**94.90%**
	Simply Healthcare (N=378,596)		**Simply Healthcare (N=379,030)**		**Simply Healthcare (N=311,799)**	
Member ID	100%†	99.94%	100%	99.96%	100%	99.93%
Plan ID	100%	100%	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%	100%	100%
Billing Date	100%	100%	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%	100%	100%
Admit Date	100%	100%	100%	100%	100%	100%
Diagnosis Code	**88.00%**	99.09%	100%	98.67%	100%	98.35%
Procedure Code	98.20%	96.51%	98.14%	97.99%	97.94%	98.05%
First Date of Service	100%	100%	100%	100%	100%	100%
Last Date of Service	100%	100%	100%	100%	100%	100%

Table A-31. Completeness and Validity Rates—Claim Lines Submitted by MCOs						
Field	2020Q4 Dates of Service		2021Q1 Dates of Service		2021Q2 Dates of Service	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
Units of Service	100%	100%	100%	100%	100%	100%
Total Days	100%	100%	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%	100%	100%
Treating Provider Type	99.95%	99.99%	99.93%	100%	99.96%	100%
Treating Provider NPI	100%†	100%	100%†	100%	100%*	100%
Treating Provider Medicaid ID	99.78%	99.99%	99.90%	100%	99.91%	100%
Treating Provider Specialty Code	99.93%	99.99%	99.90%	100%†	99.91%	100%
Billing Provider Type	99.90%	99.99%	99.79%	100%	99.81%	100%
Billing Provider NPI	99.90%	100%	99.95%	100%	99.92%	100%
Billing Provider Medicaid ID	96.00%	99.99%	99.64%	100%	99.68%	100%
Billing Provider Specialty Code	99.86%	99.97%	99.74%	99.97%	99.69%	99.99%
Facility Provider Type	99.94%	100%	99.89%	100%	99.98%	100%
Facility Provider NPI	99.94%	100%	99.89%	100%	99.98%	100%
Facility Provider Medicaid ID	99.94%	100%	99.88%	100%	99.91%	100%
Place of Service	100%	100%	100%	100%	100%	100%

** Valid rates are those deemed accurate of records determined complete.*
† This rate was rounded up to 100%.

Table A-32 includes completeness and validity rates of encounter data for the MCOs. Scores below 95.0% are identified in **red**.

Table A-32. Completeness and Validity Rates—Encounter Lines Submitted by MCOs

Field	2020Q4 Dates of Service		2021Q1 Dates of Service		2021Q2 Dates of Service	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
	Aetna (N=21,237)		**Aetna (N=28,694)**		**Aetna (N=40,045)**	
Member Identification (ID)	100%	100%	100%	100%	100%	100%
Plan ID	100%	100%	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%	100%	100%
Billing Date	100%	100%†	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%	100%	100%
Admit Date	100%	99.94%	100%	99.98%	100%	100%*
Diagnosis Code	97.64%	100%†	98.08%	100%	98.60%	100%
Procedure Code	100%	100%	100%	100%	100%	100%
First Date of Service	100%	100%	100%	100%	100%	100%
Last Date of Service	100%	100%	100%	100%	100%	100%
Units of Service	100%	100%	100%	100%	100%	100%
Total Days	100%	100%	100%	100%	100%	100%
Financial Report Service Category	**91.74%**	100%	**90.52%**	100%	**79.52%**	100%
Treating Provider Type	100%	100%	100%	100%	100%	100%
Treating Provider National Provider Identifier (NPI)	**91.74%**	100%	**90.52%**	100%	**79.52%**	100%
Treating Provider Medicaid ID	**91.74%**	100%	**90.52%**	100%	**79.52%**	100%
Treating Provider Specialty Code	**93.84%**	100%	**91.98%**	100%	**82.62%**	100%
Billing Provider Type	100%	100%	100%	100%	100%	100%

Table A-32. Completeness and Validity Rates—Encounter Lines Submitted by MCOs						
Field	**2020Q4 Dates of Service**		**2021Q1 Dates of Service**		**2021Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
Billing Provider NPI	**93.84%**	100%	**91.98%**	100%	**82.62%**	100%
Billing Provider Medicaid ID	**93.84%**	100%	**91.98%**	99.95%	**82.62%**	99.89%
Billing Provider Specialty Code	99.22%	100%	98.65%	100%	99.60%	100%
Facility Provider Type	100%	100%	100%	100%	100%	100%
Facility Provider NPI	100%	100%	100%	100%	100%	100%
Facility Provider Medicaid ID	100%	100%	100%	100%	100%	100%
Place of Service	100%	100%†	100%	100%	100%	100%
	Community Care (N=3,406)		**Community Care (N=2,946)**		**Community Care (N=3,129)**	
Member ID	100%	100%	100%	100%	100%	100%
Plan ID	100%	100%	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%	100%	100%
Billing Date	100%	100%	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%	100%	100%
Admit Date	100%	100%	100%	100%	100%	100%
Diagnosis Code	100%†	100%†	99.97%	99.97%	99.81%	100%
Procedure Code	100%	100%	100%	100%	100%	100%
First Date of Service	100%	100%	100%	100%	100%	100%
Last Date of Service	100%	100%	100%	100%	100%	100%
Units of Service	100%	100%	100%	100%	100%	100%
Total Days	100%	100%	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%	100%	100%
Treating Provider Type	99.79%	100%	100%	100%	100%	100%

Table A-32. Completeness and Validity Rates—Encounter Lines Submitted by MCOs						
Field	2020Q4 Dates of Service		2021Q1 Dates of Service		2021Q2 Dates of Service	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
Treating Provider NPI	99.79%	100%	99.59%	100%	99.04%	100%
Treating Provider Medicaid ID	100%	100%	100%	100%	100%	100%
Treating Provider Specialty Code	100%	100%	100%	100%	100%	100%
Billing Provider Type	100%	100%	100%	100%	100%	100%
Billing Provider NPI	100%	100%	100%	100%	100%	100%
Billing Provider Medicaid ID	100%	100%	100%	100%	100%	100%
Billing Provider Specialty Code	100%	100%	100%	100%	100%	100%
Facility Provider Type	100%	100%	100%	100%	100%	100%
Facility Provider NPI	100%	100%	100%	100%	100%	100%
Facility Provider Medicaid ID	100%	100%	100%	100%	100%	100%
Place of Service	100%	100%	100%	100%	100%	100%
	Simply Healthcare (N=15,305)		**Simply Healthcare (N=16,189)**		**Simply Healthcare (N=16,760)**	
Member ID	100%	100%	100%	100%	100%	100%
Plan ID	100%	100%	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%	100%	100%
Billing Date	100%	100%	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%	100%	100%
Admit Date	100%	99.54%	100%	100%	100%	100%
Diagnosis Code	100%	99.77%	100%	99.81%	100%	99.80%
Procedure Code	100%	100%	100%	100%	100%	100%
First Date of Service	100%	100%	100%	100%	100%	100%
Last Date of Service	100%	100%	100%	100%	100%	100%

Table A-32. Completeness and Validity Rates—Encounter Lines Submitted by MCOs						
Field	2020Q4 Dates of Service		2021Q1 Dates of Service		2021Q2 Dates of Service	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
Units of Service	100%	100%	100%	100%	100%	100%
Total Days	100%	100%	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%	100%	100%
Treating Provider Type	100%	100%	100%	100%	100%	100%
Treating Provider NPI	100%	100%	100%	100%	100%	100%
Treating Provider Medicaid ID	100%	100%	100%	100%	100%	100%
Treating Provider Specialty Code	100%	100%	100%	100%	100%	100%
Billing Provider Type	100%	100%	100%	100%	100%	100%
Billing Provider NPI	100%	100%	100%	100%	100%	100%
Billing Provider Medicaid ID	100%	100%	100%	100%	100%	100%
Billing Provider Specialty Code	100%	100%	100%	100%	100%	100%
Facility Provider Type	100%	100%	100%	100%	100%	100%
Facility Provider NPI	100%	100%	100%	100%	100%	100%
Facility Provider Medicaid ID	100%	100%	100%	100%	100%	100%
Place of Service	100%	100%	100%	100%	100%	100%

** Valid rates are those deemed accurate of records determined complete.*
† This rate was rounded up to 100%.

Table A-33 includes completeness and validity rates of pharmacy data for the MCOs. Scores below 95.0% are identified in **red**.

Table A-33. Completeness and Validity Rates—Pharmacy Lines Submitted by MCOs						
Field	**2020Q4 Dates of Service**		**2021Q1 Dates of Service**		**2021Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
	Aetna (N=144,688)		**Aetna (N=141,932)**		**Aetna (N=152,593)**	
Member Identification (ID)	100%	100%	100%	100%	100%	100%
Plan ID	100%	100%	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%	100%	100%
Billing Date	100%	100%	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%	100%	100%
First Date of Service	100%	100%	100%	100%	100%	100%
Units of Service	100%	100%	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%	100%	100%
Treating Provider Type	**91.82%**	100%	**90.91%**	100%	**91.01%**	100%
Treating Provider National Provider Identifier (NPI)	99.97%	100%	99.97%	100%	99.97%	100%
Treating Provider Medicaid ID	**91.82%**	100%	**90.91%**	100%	**91.01%**	100%
Treating Provider Specialty Code	**91.82%**	100%	**90.91%**	100%	**91.01%**	100%
Billing Provider Type	99.30%	100%	99.37%	100%	99.61%	100%
Billing Provider NPI	100%†	99.99%	100%	100%†	100%	100%
Billing Provider Medicaid ID	99.30%	100%	99.37%	100%	99.61%	100%
Billing Provider Specialty Code	99.30%	100%	99.37%	100%	99.61%	100%
National Drug Code (NDC)	100%	100%	100%	99.99%	100%	100%
Class	99.77%	100%	99.65%	100%	99.80%	100%
Primary Pharmacy ID	100%	99.98%	100%	100%†	100%	100%

Table A-33. Completeness and Validity Rates—Pharmacy Lines Submitted by MCOs						
Field	**2020Q4 Dates of Service**		**2021Q1 Dates of Service**		**2021Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
Days' Supply	100%	100%	100%	100%	100%	100%
	Community Care (N=18,463)		**Community Care (N=17,843)**		**Community Care (N=18,522)**	
Member ID	100%	100%	100%	100%	100%	100%
Plan ID	100%	100%	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%	100%	100%
Billing Date	100%	100%	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%	100%	100%
First Date of Service	100%	100%	100%	100%	100%	100%
Units of Service	100%	100%	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%	100%	100%
Treating Provider Type	**78.07%**	100%	96.40%	100%	**93.56%**	100%
Treating Provider National Provider Identifier (NPI)	100%	100%	100%	100%	100%	100%
Treating Provider Medicaid ID	**78.07%**	100%	96.40%	100%	**93.56%**	100%
Treating Provider Specialty Code	**78.07%**	100%	96.40%	100%	**93.56%**	100%
Billing Provider Type	99.29%	100%	100%	100%	99.99%	99.83%
Billing Provider NPI	100%	100%	100%	100%	100%	100%
Billing Provider Medicaid ID	99.35%	100%	100%	100%	99.99%	100%
Billing Provider Specialty Code	99.29%	100%	100%	100%	99.99%	100%
National Drug Code (NDC)	99.73%	100%	99.85%	100%	99.92%	100%
Class	100%	99.68%	100%	99.78%	100%	100%

Table A-33. Completeness and Validity Rates—Pharmacy Lines Submitted by MCOs						
Field	**2020Q4 Dates of Service**		**2021Q1 Dates of Service**		**2021Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
Primary Pharmacy ID	100%	100%	100%	100%	100%	100%
Days' Supply	100%	100%	100%	100%	100%	100%
	Simply Healthcare (N=156,872)		**Simply Healthcare (N=141,382)**		**Simply Healthcare (N=147,763)**	
Member ID	100%	99.99%	100%	100%†	100%	99.99%
Plan ID	100%	100%	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%	100%	100%
Billing Date	100%	100%	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%	100%	100%
First Date of Service	100%	100%	100%	100%	100%	100%
Units of Service	100%	100%	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%	100%	100%
Treating Provider Type	99.87%	100%	99.90%	100%	99.75%	100%
Treating Provider National Provider Identifier (NPI)	100%	100%	100%	100%	100%	100%
Treating Provider Medicaid ID	99.87%	100%†	99.90%	100%	99.75%	99.99%
Treating Provider Specialty Code	99.87%	100%†	99.90%	100%†	99.75%	100%
Billing Provider Type	100%	100%	100%	100%	100%	100%
Billing Provider NPI	100%	100%	100%†	100%	99.81%	100%
Billing Provider Medicaid ID	99.70%	100%	99.78%	100%	99.44%	100%
Billing Provider Specialty Code	100%	100%	100%	100%	100%	100%
National Drug Code (NDC)	**84.69%**	100%	**90.12%**	100%	**90.49%**	100%

Table A-33. Completeness and Validity Rates—Pharmacy Lines Submitted by MCOs						
Field	2020Q4 Dates of Service		2021Q1 Dates of Service		2021Q2 Dates of Service	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
Class	**84.69%**	100%	**90.11%**	100%	**90.44%**	100%
Primary Pharmacy ID	**84.87%**	100%	**90.36%**	100%	**90.47%**	100%
Days' Supply	**84.87%**	100%	**90.36%**	100%	**90.66%**	100%

** Valid rates are those deemed accurate of records determined complete.*
† This rate was rounded up to 100%.

Table A-34 includes completeness and validity rates of claim data for the DBMs. Scores below 95.0% are identified in **red**.

Table A-34. Completeness and Validity Rates—Claim Lines Submitted by DBMs						
Field	2020Q4 Dates of Service		2021Q1 Dates of Service		2021Q2 Dates of Service	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
	Argus (N=57,900)		**Argus (N=60,657)**		**Argus (N=52,087)**	
Member Identification (ID)	100%	99.99%	100%	99.97%	100%	99.87%
Plan ID	100%	100%	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%	100%	100%
Billing Date	100%	99.86%	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%	100%	100%
Primary Procedure Code	100%	99.90%	100%	99.87%	100%	99.83%
First Date of Service	100%	100%	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%	100%	100%
Treating Provider Type	100%	100%	100%	100%	100%	100%
Treating Provider National Provider Identifier (NPI)	100%	100%	100%	100%	100%	100%*

Table A-34. Completeness and Validity Rates—Claim Lines Submitted by DBMs						
Field	**2020Q4 Dates of Service**		**2021Q1 Dates of Service**		**2021Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
Treating Provider Medicaid ID	100%	100%	100%	100%	100%	100%
Treating Provider Specialty Code	100%	100%	100%	100%	100%	100%
Billing Provider Type	100%	100%	100%	100%	100%	100%
Billing Provider NPI	99.81%	100%	99.95%	100%	99.82%	100%
Billing Provider Medicaid ID	99.81%	100%	99.95%	100%	99.82%	100%
Billing Provider Specialty Code	100%	100%	100%	100%	100%	100%
Place of Service	99.19%	100%	99.48%	100%	99.57%	100%
	DentaQuest (N=109,013)		**DentaQuest (N=122,030)**		**DentaQuest (N=102,413)**	
Member ID	100%	99.99%	100%	100%	100%	99.87%
Plan ID	100%	100%	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%	100%	100%
Billing Date	100%	100%	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%	100%	100%
Primary Procedure Code	100%	99.87%	100%	99.90%	100%	99.83%
First Date of Service	100%	100%	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%	100%	100%
Treating Provider Type	100%	100%	100%	100%	100%	100%
Treating Provider National Provider Identifier (NPI)	99.41%	100%	99.66%	100%	100%	100%*
Treating Provider Medicaid ID	96.21%	100%	96.36%	100%	100%	100%

Table A-34. Completeness and Validity Rates—Claim Lines Submitted by DBMs						
Field	**2020Q4 Dates of Service**		**2021Q1 Dates of Service**		**2021Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
Treating Provider Specialty Code	100%	100%	100%	100%	100%	100%
Billing Provider Type	100%	100%	100%	100%	100%	100%
Billing Provider NPI	99.49%	100%	99.90%	100%	99.82%	100%
Billing Provider Medicaid ID	96.21%	100%	96.36%	100%	99.82%	100%
Billing Provider Specialty Code	100%	100%	100%	100%	100%	100%
Place of Service	100%	99.99%	100%	100%	99.57%	100%
	MCNA (N=102,628)		**MCNA (N=102,420)**		**MCNA (N=89,369)**	
Member ID	97.40%	100%	**94.59%**	100%	**86.57%**	100%
Plan ID	100%	100%	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%	100%	100%
Billing Date	100%	100%	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%	100%	100%
Primary Procedure Code	100%	99.90%	100%	99.90%	100%	99.90%
First Date of Service	100%	100%	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%	100%	100%
Treating Provider Type	100%	100%	100%	100%	100%	100%
Treating Provider NPI	100%	99.71%	100%	99.68%	100%	99.34%
Treating Provider Medicaid ID	99.71%	**87.76%**	99.52%	**93.50%**	99.31%	94.27%
Treating Provider Specialty Code	100%	100%	100%	100%	100%	100%
Billing Provider Type	100%	100%	100%	100%	100%	100%

Table A-34. Completeness and Validity Rates—Claim Lines Submitted by DBMs						
Field	**2020Q4 Dates of Service**		**2021Q1 Dates of Service**		**2021Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
Billing Provider National Provider Identifier (NPI)	100%	99.71%	100%	99.68%	100%	99.34%
Billing Provider Medicaid ID	99.71%	**87.76%**	99.52%	**93.50%**	99.31%	94.27%
Billing Provider Specialty Code	100%	100%	100%	100%	100%	100%
Place of Service	100%	99.99%	100%	100%†	100%	100%†

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

† This rate was rounded up to 100%.

Tables A-35 through A-40 include claim, encounter, and pharmacy claim data adjudicated/paid in 2020Q4, 2021Q1, and 2021Q2.

Table A-35. 2020Q4 Claims and Encounters Adjudicated/Paid by MCOs and DBMs					
MCO	**Claims** N (% of MCO Total)		**Encounters**	**Total Claims and Encounters**	**Pharmacy Claims**
	Institutional	**Professional**	**Professional**		
Aetna	7,962 (7.60%)	96,741 (92.40%)	18,827 (100%)	123,530	126,078
Service Date Range	11/3/18 – 12/21/20	4/24/19 – 12/24/20	5/17/17 – 12/28/20	5/17/17 – 12/28/20	6/16/19 – 1/1/21
Community Care Plan	1,186 (8.39%)	12,950 (91.61%)	1,283 (78.47%)	15,771	13,231
Service Date Range	1/13/20 – 12/24/20	1/2/20 –12/29/20	1/16/20 – 12/28/20	1/2/20 – 12/29/20	3/12/20 – 12/31/20
Simply Healthcare	9,301 (5.93%)	147,582 (94.07%)	9,924 (100%)	166,807	129,872
Service Date Range	12/28/14 – 12/13/20	2/3/16 – 12/29/20	2/1/19 – 12/29/20	12/28/14 – 12/29/20	7/26/19 – 12/16/20
Total MCOs	**18,449 (6.69%)**	**257,273 (93.31%)**	**30,386**	**306,108**	**269,181**
DBM	**Claims**			**Total**	
Argus	11,771 (100%)		*	11,771	†
Service Date Range	6/12/19 – 12/29/20			6/12/19 – 12/29/20	

Table A-35. 2020Q4 Claims and Encounters Adjudicated/Paid by MCOs and DBMs				
DentaQuest	24,184 (100%)	*	24,184	†
Service Date Range	6/29/15 – 12/28/20		6/29/15 – 12/28/20	
MCNA	20,367 (100%)	*	20,367	†
Service Date Range	6/29/17 – 12/24/20		6/29/17 – 12/24/20	
Total DBMs			**56,322**	†

** The DBMs are fee-for-service only and do not utilize capitation; therefore, no encounters are reported.*
† The DBMs do not process pharmacy claims; thus, no pharmacy data are included.

Table A-36. 2021Q1 Claims and Encounters Adjudicated/Paid by MCOs and DBMs					
MCO	**Claims** N (% of MCO Total)		**Encounters**	**Total Claims and Encounters**	**Pharmacy Claims**
	Institutional	**Professional**	**Professional**		
Aetna	7,131 (7.76%)	84,790 (92.24%)	23,382	115,303	124,891
Service Date Range	8/26/19 – 3/22/21	3/26/18 – 3/24/21	4/26/17 – 3/29/21	4/26/17 – 3/29/21	11/6/19 – 4/1/21
Community Care Plan	1,137 (7.64%)	13,740 (92.36%)	1,302	16,501	13,387
Service Date Range	1/3/20 – 3/22/21	1/2/20 – 3/26/21	2/2/20 – 3/30/21	12/20 – 3/30/21	9/16/20 – 3/31/21
Simply Healthcare	10,003 (7.89%)	116,743 (92.11%)	9,948	136,694	120,902
Service Date Range	10/28/16 – 3/16/21	10/20/15 – 3/18/21	1/5/20 – 3/29/21	10/20/15 – 3/29/21	7/29/19 – 3/18/21
Total MCOs	**18,271 (7.82%)**	**215,273 (92.18%)**	**34,954**	**268,498**	**259,180**
DBM	**Claims**			**Total**	
Argus	11,485		*	11,485	†
Service Date Range	9/6/18 – 3/23/21			9/6/18 – 3/23/21	
DentaQuest	24,854		*	24,854	†
Service Date Range	12/7/17 – 3/29/21			12/7/17 – 3/29/21	

Table A-36. 2021Q1 Claims and Encounters Adjudicated/Paid by MCOs and DBMs				
MCNA	22,850	*	22,850	†
Service Date Range	1/24/18 – 3/26/21		1/24/18 – 3/26/21	
Total DBMs			**59,189**	†

** The DBMs are fee-for-service only and do not utilize capitation; therefore, no encounters are reported.*
† The DBMs do not process pharmacy claims; thus, no pharmacy data are included.

Table A-37. 2021Q2 Claims and Encounters Adjudicated/Paid by MCOs and DBMs					
MCO	**Claims** N (% of MCO Total)		**Encounters**	**Total Claims and Encounters**	**Pharmacy Claims**
	Institutional	**Professional**	**Professional**		
Aetna	7,253 (8.20%)	81,218 (91.80%)	25,727	114,198	130,572
Service Date Range	12/1/19 – 6/20/21	9/9/19 – 6/23/21	12/12/17 – 6/26/21	12/12/17 – 6/26/21	10/21/19 – 7/1/21
Community Care Plan	1,295 (9.96%)	11,708 (90.04%)	1,260	14,687	13,434
Service Date Range	1/10/20 – 6/22/21	1/2/20 – 6/25/21	2/2/20 – 6/24/21	1/2/20 – 6/25/21	12/9/20 – 6/30/21
Simply Healthcare	10,176 (9.06%)	102,158 (90.94%)	10,164	122,498	125,312
Service Date Range	2/22/15 – 6/15/21	1/29/13 – 6/17/21	4/2/19 – 6/26/21	1/29/13 – 6/26/21	12/17/19 – 6/17/21
Total MCOs	**18,724 (8.76%)**	**195,084 (91.24%)**	**37,151**	**251,383**	**269,318**
DBM	**Claims**			**Total**	
Argus	10,992 (100%)		*	10,992	†
Service Date Range	3/12/20 – 6/23/21			3/12/20 – 6/23/21	
DentaQuest	22,106 (100%)		*	22,106	†
Service Date Range	12/28/18 – 6/28/21			12/28/18 –6/28/21	

Table A-37. 2021Q2 Claims and Encounters Adjudicated/Paid by MCOs and DBMs				
MCNA	19,909 (100%)	*	19,909	†
Service Date Range	6/5/18 – 6/25/21		6/5/18 – 6/25/21	
Total DBMs			**53,007**	†

** The DBMs are fee-for-service only and do not utilize capitation; therefore, no encounters are reported.*
† The DBMs do not process pharmacy claims; thus, no pharmacy data are included.

Table A-38. 2020Q4 Claim Adjustments Submitted by MCOs and DBMs				
MCO	**Claim Adjustments**		**Total Claim Adjustments**	**Pharmacy Claim Adjustments**
	Institutional	Professional		
Aetna	1,003 (7.51%)	12,351 (92.49%)	13,351	10,519
Service Date Range	3/6/17 – 11/23/20	2/27/17 – 12/5/20	2/27/17 – 12/5/20	9/6/19 – 12/31/20
Community Care Plan	35 (0.31%)	11,244 (99.69%)	11,279	2,605
Service Date Range	1/2/20 – 11/25/20	1/2/20 – 12/17/20	1/2/20 – 12/17/20	5/18/20 – 12/31/20
Simply Healthcare	1,238 (8.55%)	13,241 (91.45%)	14,479	6,722
Service Date Range	10/15/14 – 12/3/20	11/12/13 – 12/5/20	11/12/13 – 12/5/20	8/17/20 – 12/5/20
Total MCOs	**2,276 (5.82%)**	**36,836 (94.18%)**	**39,109**	**19,846**
DBM	**Claim Adjustments**		**Total**	
Argus	462 (100%)		462	*
Service Date Range	6/18/19 – 12/15/20		6/18/19 – 12/15/20	
DentaQuest	565 (100%)		565	*
Service Date Range	4/24/17 – 12/14/20		4/24/17 – 12/14/20	
MCNA	247 (100%)		247	*
Service Date Range	2/8/17 – 12/7/20		2/8/17 – 12/7/20	
Total DBMs			**1,274**	*

** The DBMs do not process pharmacy claims; thus, no pharmacy data are included.*

Table A-39. 2021Q1 Claim Adjustments Submitted by MCOs and DBMs				
MCO	**Claim Adjustments**		**Total Claim Adjustments**	**Pharmacy Claim Adjustments**
	Institutional	Professional		
Aetna	945 (8.40%)	10,306 (91.60%)	11,251	9,273
Service Date Range	4/14/17 – 3/6/21	3/8/17 – 3/11/21	3/8/17 – 3/11/21	11/6/19 – 3/31/21
Community Care Plan	34 (5.11%)	631 (94.89%)	665	2,420
Service Date Range	3/7/20 – 2/20/21	1/5/20 – 3/3/21	1/5/20 – 3/3/21	12/17/20 – 3/31/21
Simply Healthcare	1,083 (10.18%)	9,558 (89.82%)	10,641	5,680
Service Date Range	1/12/18 – 3/7/21	4/22/14 – 3/10/21	4/22/14 –3/10/21	11/15/20 – 3/6/21
Total MCOs	**2,062 (9.14%)**	**20,495 (90.86)**	**22,557**	**17,373**
DBM	**Claim Adjustments**		**Total**	
Argus	199		199	*
Service Date Range	12/14/19 – 3/8/21		12/14/19 – 3/8/21	
DentaQuest	99		99	*
Service Date Range	6/25/19 – 3/12/21		6/25/19 –3/12/21	
MCNA	275		275	*
Service Date Range	1/12/16 – 3/3/21		1/12/16 – 3/3/21	
Total DBMs			**573**	*

** The DBMs do not process pharmacy claims; thus, no pharmacy data are included.*

Table A-40. 2021Q2 Claim Adjustments Submitted by MCOs and DBMs				
MCO	**Claim Adjustments**		**Total Claim Adjustments**	**Pharmacy Claim Adjustments**
	Institutional	Professional		
Aetna	1,409 (10.67%)	11,794 (89.33%)	13,203	11,667
Service Date Range	2/12/17 – 5/26/21	4/3/17 – 6/11/21	2/12/17 – 6/11/21	10/21/19 – 6/30/21

Table A-40. 2021Q2 Claim Adjustments Submitted by MCOs and DBMs				
Community Care Plan	42 (0.51%)	8,153 (99.49%)	8,195	2,546
Service Date Range	1/26/20 – 5/25/21	1/3/20 – 6/4/21	1/3/20 – 6/4/21	2/20/21 – 6/30/21
Simply Healthcare	2,040 (8.02%)	23,395 (91.98%)	25,435	7,030
Service Date Range	1/28/18 – 6/3/21	8/7/17 – 6/7/21	8/7/17 – 6/7/21	2/22/21 – 6/5/21
Total MCOs	**3,491 (7.45%)**	**43,342 (92.55%)**	**46,833**	**21,243**
DBM	**Claim Adjustments**		**Total**	
Argus	143 (100%)		143	*
Service Date Range	5/28/20 – 4/27/21		5/28/20 – 4/27/21	
DentaQuest	90 (100%)		90	*
Service Date Range	1/4/20 – 6/17/21		1/4/20 – 6/17/21	
MCNA	346 (100%)		346	*
Service Date Range	1/4/16 – 5/27/21		1/4/16 – 5/27/21	
Total DBMs			**579**	*

** The DBMs do not process pharmacy claims; thus, no pharmacy data are included.*

APPENDIX B | 2021 Sample Assessment Tools

The assessment tools presented in this appendix represent a comprehensive sample of the tools used to evaluate performance for the **PIP** and ACA EQR activities. The ANA and EDV activities do not use tools in their evaluation; however, the standards used to evaluate MCO and DBM provider networks are included in the ANA section of this appendix, and the encounter data fields validated are included in the EDV section of this appendix. 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.

PIP Validation

The FHKC 2021 PIP Validation Tool was used to assess applicable MCO and DBM PIPs in accordance with CMS protocol.

2021 PIP Validation Tool—<MCO/DBM Name> <PIP Title>				
Step 1: Review the Selected PIP Topic				
PIP topics should target improvement in relevant areas of clinical or nonclinical services.				
Element #	**The PIP topic:**	**Met**	**Not Met**	**NA***
1	Reflects comprehensive analysis of enrollee needs, care, and services	☐	☐	☐
2	Considers performance on CMS Child or Adult Core Set measures	☐	☐	☐
3	Considers input from enrollees or providers who are users of, or concerned with, specific service areas	☐	☐	☐
4	Addresses care of special populations or high-priority services, as appropriate	☐	☐	☐
5	Aligns with priority areas identified by the Department of Health and Human Services (HHS) and/or CMS	☐	☐	☐
Step 1 Results:	**Total**	**Met**	**Not Met**	**NA**
Elements	5			
Comment:	<Type comment here>.			

* *Not Applicable*

2021 PIP Validation Tool—<MCO/DBM Name> <PIP Title>	
Strength:	<Type strength here>.
AON[2]:	<Type AON here>.
Suggestion:	<Type suggestion here>.

[2] *Area of Noncompliance*

2021 PIP Validation Tool—<MCO/DBM Name> <PIP Title>					
Step 2: Review the PIP Aim Statement					
The PIP aim statement identifies the focus of the PIP and establishes the framework for data collection and analysis.					
Element #	**The aim statement:**		**Met**	**Not Met**	**NA**
1	Clearly specifies the PIP improvement strategy		☐	☐	☐
2	Clearly specifies the PIP population		☐	☐	☐
3	Clearly specifies the PIP time period		☐	☐	☐
4	Is concise		☐	☐	☐
5	Is answerable (includes a realistic and unambiguous goal)		☐	☐	☐
6	Is measurable		☐	☐	☐
Step 2 Results:		**Total**	**Met**	**Not Met**	**NA**
Elements		6			
Comment:	<Type comment here>.				
Strength:	<Type strength here>.				
AON:	<Type AON here>.				
Suggestion:	<Type suggestion here>.				

2021 PIP Validation Tool—<MCO/DBM Name> <PIP Title>				
Step 3: Review the Identified PIP Population				
The population should be clearly defined in relation to the PIP aim statement.				
Element #	**The PIP population:**	**Met**	**Not Met**	**NA**
1	Is clearly defined in terms of the PIP aim statement	☐	☐	☐
2	Includes the entire eligible population or a representative and generalizable sample	☐	☐	☐
3	Captures all enrollees to whom the PIP aim statement applies, if the entire population is included	☐	☐	☐
Step 3 Results:	**Total**	**Met**	**Not Met**	**NA**
Elements	3			
Comment:	<Type comment here>.			
Strength:	<Type strength here>.			
AON:	<Type AON here>.			
Suggestion:	<Type suggestion here>.			

2021 PIP Validation Tool—<MCO/DBM Name> <PIP Title>				
Step 4: Review the Sampling Method				
Appropriate sampling methods are necessary to ensure that the collection of information produces valid and reliable results.				
Element #	**The sample:**	**Met**	**Not Met**	**NA**
1	Frame contains a complete, recent, and accurate list of the target PIP population	☐	☐	☐
2	Method considers and specifies the true or estimated frequency of the event, the confidence interval to be used, and the acceptable margin of error	☐	☐	☐
3	Contains a sufficient number of enrollees to account for non-response (if applicable)	☐	☐	☐
4	Method assesses the representativeness of the sample according to subgroups	☐	☐	☐
5	Techniques are valid and protect against bias	☐	☐	☐
Step 4 Results:	**Total**	**Met**	**Not Met**	**NA**
Elements	5			
Comment:	<Type comment here>.			
Strength:	<Type strength here>.			
AON:	<Type AON here>.			
Suggestion:	<Type suggestion here>.			

2021 PIP Validation Tool—<MCO/DBM Name> <PIP Title>				
Step 5: Review the Selected PIP Variables and Performance Measures				
Selected variables should identify performance relative to the PIP aim statement, and performance measures should be reliable and clearly defined indicators of performance.				
Element #	**Variables are:**	**Met**	**Not Met**	**NA**
1(a)	Objective, clearly defined, and time specific	☐	☐	☐
1(b)	Available to measure performance and track improvement over time	☐	☐	☐
	Performance measures:			
2	Assess an important aspect of care that will make a difference to enrollees' health or functional status	☐	☐	☐
3	Are appropriate based on the availability of data and resources to collect the data	☐	☐	☐
4	Are based on current clinical knowledge or health services research	☐	☐	☐
5	Address performance at a point in time; track performance over time; compare performance measures to benchmarks over time; and inform the selection and evaluation of quality improvement strategies	☐	☐	☐
6	Consider existing measures	☐	☐	☐
7	If internally developed: ▪ Address accepted clinical guidelines relevant to the PIP aim statement ▪ Address an important aspect of care or operations meaningful to enrollees ▪ Have data sources available to allow reliable and accurate measure calculation ▪ Have clearly defined criteria	☐	☐	☐
8	Capture changes in enrollee satisfaction or experience of care (if applicable)	☐	☐	☐
9	Include a strategy for inter-rater reliability (for manual data collection, if applicable)	☐	☐	☐
10	Are based on strong evidence that the process being measured is meaningfully associated with outcomes, if process measures are used	☐	☐	☐

2021 PIP Validation Tool—<MCO/DBM Name> <PIP Title>					
Step 5 Results:		**Total**	**Met**	**Not Met**	**NA**
Elements		11			
Comment:	<Type comment here>.				
Strength:	<Type strength here>.				
AON:	<Type AON here>.				
Suggestion:	<Type suggestion here>.				

2021 PIP Validation Tool—<MCO/DBM Name> <PIP Title>				
Step 6: Review the Data Collection Procedures				
Data collection procedures must ensure production of valid and reliable performance measures. Validity means that the data are measuring what is intended to be measured. Reliability means that the data are producing consistent results.				
Element #	**The PIP design/data collection plan:**	**Met**	**Not Met**	**NA**
1	Includes a systematic method for collecting valid and reliable data that represent the PIP population	☐	☐	☐
2	Specifies the frequency of data collection	☐	☐	☐
3	Clearly specifies the data sources	☐	☐	☐
4	Clearly identifies the data elements to be collected	☐	☐	☐
5	Connects to the data analysis plan to ensure appropriate data are available	☐	☐	☐
6	Includes data collection instruments that allow for consistent and accurate data collection over PIP time periods	☐	☐	☐
7	Specifies well-defined methods to collect meaningful and useful information, if qualitative data collection methods were used	☐	☐	☐
8	Includes an estimated degree of data completeness for administrative data collection	☐	☐	☐
9	Describes qualifications of staff responsible for abstracting data	☐	☐	☐
10	Describes the intra- and inter-rater reliability processes in place	☐	☐	☐
11	Includes guidelines developed for abstraction staff	☐	☐	☐
Step 6 Results:	**Total**	**Met**	**Not Met**	**NA**
Elements	11			
Comment:	<Type comment here>.			
Strength:	<Type strength here>.			
AON:	<Type AON here>.			
Suggestion:	<Type suggestion here>.			

2021 PIP Validation Tool—<MCO/DBM Name> <PIP Title>				
Step 7: Review the Data Analysis and Interpretation of PIP Results				
Data analysis and interpretation should be based on appropriate techniques and a continuous quality improvement philosophy and reflect an understanding of lessons learned and opportunities for improvement.				
Element #	**Analysis and interpretation:**	**Met**	**Not Met**	**NA**
1	Are conducted in accordance with the data analysis plan	☐	☐	☐
2	Include discussion of the baseline measurement and remeasurement(s) of performance measures	☐	☐	☐
3	Include a discussion of the statistical significance of any differences between baseline and repeat measurement(s)	☐	☐	☐
4	Identify any factors that may influence comparability of initial and repeat measurements	☐	☐	☐
5	Identify factors that threaten internal or external validity of findings	☐	☐	☐
6	Compare results across multiple entities, if applicable	☐	☐	☐
7	Are presented in a concise and easily understood manner	☐	☐	☐
8	Include lessons learned about less-than-optimal performance	☐	☐	☐
Step 7 Results:		**Total**	**Met**	**Not Met**	**NA**
Elements		8			
Comment:	<Type comment here>.				
Strength:	<Type strength here>.				
AON:	<Type AON here>.				
Suggestion:	<Type suggestion here>.				

2021 PIP Validation Tool—<MCO/DBM Name> <PIP Title>				
Step 8: Assess the Improvement Strategies				
Improvement results from developing and implementing effective improvement strategies.				
Element #	**Improvement strategies are:**	**Met**	**Not Met**	**NA**
1	Evidence based	☐	☐	☐
2	Related to causes/barriers identified through data analysis and quality improvement processes	☐	☐	☐
3	Implemented on a rapid-cycle, Plan-Do-Study-Act (PDSA) basis	☐	☐	☐
4	Culturally and linguistically appropriate	☐	☐	☐
5	Reflective of major confounding factors that could have an obvious impact on PIP outcomes	☐	☐	☐
6	Successful in terms of improvement with follow-up activities identified	☐	☐	☐
Step 8 Results:	**Total**	**Met**	**Not Met**	**NA**
Elements	6			
Comment:	<Type comment here>.			
Strength:	<Type strength here>.			
AON:	<Type AON here>.			
Suggestion:	<Type suggestion here>.			

2021 PIP Validation Tool—<MCO/DBM Name> <PIP Title>				
Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred				
PIP methods and findings should reflect statistically significant improvement that may be associated with the PIP improvement strategy. Sustained improvement is demonstrated by improvement over repeat measurements.				
Element #	**Assessments for real improvement indicate:**	**Met**	**Not Met**	**NA**
1	Whether the remeasurement methodology is the same as the baseline methodology	☐	☐	☐
2	Whether there is quantitative evidence of improvement in processes or outcomes of care	☐	☐	☐
3	How the reported improvement in performance, if any, is likely to be the result of the selected improvement strategy	☐	☐	☐
4	The statistical evidence that any observed improvement, if any, is the result of the improvement strategy	☐	☐	☐
5	Whether sustained improvement is demonstrated through repeated measurements over time	☐	☐	☐
Step 9 Results:		**Total**	**Met**	**Not Met**	**NA**
Elements		5			
Comment:	<Type comment here>.				
Strength:	<Type strength here>.				
AON:	<Type AON here>.				
Suggestion:	<Type suggestion here>.				

ACA

The following assessment tools were used for the ACA evaluation:

- 2021 Compliance Assessment Standards Survey Tools (MCO and DBM)
- Grievance File Review Tool (MCO and DBM)
- Appeal File Review Tool (MCO and DBM)

MCO Compliance Assessment Standard Tools

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
1. Delivery Network 42 *Code of Federal Regulations* (CFR) 438.206(b)(1) Medical Services Contract (MSC) 24-4	The managed care organization (MCO) must maintain and monitor a provider network that is: a. supported by written agreements; and b. sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency, physical and mental disabilities, or other barriers to care and the MCO's ability to meet such needs through the provider network when determining network adequacy.	☐ a. Supported by written agreements ☐ b. Sufficient to provide adequate access to all services covered under the contract for all enrollees ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Women's Health Specialist 42 CFR 438.206(b)(2) MSC 24-4-1	The MCO must provide female enrollees with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive healthcare services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
3. Second Opinion 42 CFR 438.206(b)(3) MSC Attachment A	The MCO must provide for a second opinion from a network provider, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
4. Out-of-Network Services 42 CFR 438.206(b)(4)	If the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO must adequately and timely cover these services out of network for the enrollee, for as long as the MCO provider network is unable to provide them.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
5. Out-of-Network Provider Payment – 1 42 CFR 438.206(b)(5)	The MCO must require out-of-network providers to coordinate with the MCO for payment and ensure the cost to the enrollee is no greater than it would be if the services were furnished within the network.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
AON					
Suggestion					
6. Out-of-Network Provider Payment – 2 MSC 24-4-4	In the event the MCO materially failed to provide adequate access for an enrollee's ongoing healthcare needs, including access to an out-of-network provider, Florida Healthy Kids Corporation (FHKC) may direct enrollees to seek related covered services from an out-of-network provider. Should FHKC direct such action, the MCO shall be financially responsible for such services to the extent the MCO would be responsible if the services had been provided by a network provider.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
7. Family Planning Providers 42 CFR 438.206(b)(7) MSC 24-4-1	The MCO must demonstrate that its network includes sufficient family planning providers to ensure timely access to covered services.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
8. Furnishing Services – Timely Access 42CFR 438.206(c)(1)(i)-(vi) MSC 24-1, 24-4-3	The MCO must: a. meet and require its network providers to meet FHKC standards for timely access to care and services, taking into account the urgency of the need for services; b. ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee for service (FFS), if the provider serves only Medicaid enrollees; c. make services included in its contract with FHKC available 24 hours a day, seven days a week, when medically necessary; d. establish mechanisms to ensure compliance by network providers; e. monitor network providers regularly to determine compliance; f. take corrective action if there is a failure to comply by a network provider; and g. handle provider complaints.	☐ a. Met FHKC standards for timely access to care and services and took into account the urgency for the service ☐ b. Provider hours offered no less than commercial enrollees or comparable to Medicaid FFS ☐ c. Services available 24/7 when medically necessary ☐ d. Mechanisms established to ensure compliance ☐ e. Network providers monitored regularly ☐ f. Corrective action taken for failure to comply ☐ g. Handled provider complaints ☐ Not Applicable	**0.142** **0.142** **0.142** **0.142** **0.142** **0.142** **0.142** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
9. Timely Treatment Standards MSC 24-4-3	The MCO must provide timely treatment for enrollees in accordance with the following standards: a. emergency care shall be provided immediately; b. urgently needed care shall be provided within 24 hours; c. routine care shall be provided within seven calendar days of the enrollee's request for services d. well-child visits, as recommended by the American Academy of Pediatrics, shall be provided within four weeks of the enrollee's request; and e. follow-up care shall be provided as medically appropriate.	☐ a. Emergency care provided immediately ☐ b. Urgent care provided within 24 hours ☐ c. Routine care provided within seven calendar days of request ☐ d. Well-child visits provided within four weeks of request ☐ e. Follow-up care provided as medically appropriate ☐ Not Applicable	**0.200** **0.200** **0.200** **0.200** **0.200** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
10. Furnishing Services – Access and Cultural Considerations 42 CFR 438.206(c)(2) MSC 20	The MCO must promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
Strength					
AON					
Suggestion					
11. Cultural Competency Plan MSC 20	The MCO must maintain a comprehensive written cultural competency plan describing how the MCO, its providers, employees, and systems will effectively provide services to enrollees of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes, affirms, and respects the worth of the enrollee and protects and preserves the dignity of each.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
12. Indian Healthcare Providers (IHCPs) MSC 24-3-10	The MCO must: a. maintain sufficient numbers of IHCPs in its provider network to ensure timely access to services from such providers to enrollees eligible to receive such services; b. allow any enrollee who is eligible to receive services from a network IHCP to choose the IHCP as their primary care provider so long as the IHCP has the capacity to provide the services; c. allow any enrollee who is eligible to receive services from an IHCP to obtain services covered under the MCO's contract with FHKC from an out-of-network IHCP;	☐ a. Sufficient numbers of IHCPs maintained ☐ b. Enrollee allowed to choose IHCP as primary care provider ☐ c. Enrollee allowed to obtain services from out-of-network IHCP ☐ d. Out-of-network IHCPs allowed to refer enrollees to network provider ☐ e. Enrollees permitted to receive covered services out of state if too few IHCPs to ensure timely access to services	**0.200** **0.200** **0.200** **0.200** **0.200**	**1.000**	**X.XXX**

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
	d. allow out-of-network IHCPs to refer enrollees to a network provider; and e. permit enrollees eligible to receive covered services from out-of-state IHCPs if there are too few IHCPs in the state to ensure timely access to those services.	☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
13. Furnishing Services – Accessibility Considerations 42 CFR 438.206(c)(3)	The MCO must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
Availability of Services			**XX.X%**	**13.000**	**X.XXX**

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Assurances of Adequate Capacity and Services					
1. Supporting Documentation 42 *Code of Federal Regulations* (CFR) 438.207(b)(1)-(2) Medical Services Contract (MSC) 24-4	The managed care organization (MCO) must submit documentation to Florida Healthy Kids Corporation (FHKC), in a format specified by FHKC, to demonstrate that it: a. offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area; and b. maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.	☐ a. Offered appropriate range of services adequate for number of enrollees ☐ b. Maintained sufficient number, mix, and geographic distribution of network providers to meet enrollees' needs ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Submission of Documentation 42 CFR 438.207(c)(1)-(2) MSC 24-4	The MCO must submit the documentation as specified by FHKC, but no less frequently than: a. at the time it enters into a contract with FHKC; and b. on an annual basis.	☐ a. Documentation submitted when contract was entered ☐ b. Documentation submitted annually ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Assurances of Adequate Capacity and Services					
3. Submission of Documentation – Significant Change 42 CFR 438.207(c)(3)(i)-(ii) MSC 24-4	The MCO must submit the documentation, as specified by FHKC, at any time there has been a significant change (as defined by FHKC) in MCO operations that would affect the adequacy of capacity and services, including: a. changes in MCO services, benefits, geographic service area, or composition of or payments to its provider network; or b. enrollment of a new population in the MCO.	☐ a. Documentation submitted for changes in services, benefits, service area, or payments ☐ b. Documentation submitted for enrollment of new population ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
4. Submission of Documentation – Anticipated Provider Termination MSC 24-1	The MCO shall provide FHKC with 60 calendar days' advance written notice of any anticipated termination of large provider groups, hospitals, or any independently practicing provider if the independently practicing provider has at least 50 enrollees on its patient panel.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
Assurances of Adequate Capacity and Services			**XX.X%**	**4.000**	**X.XXX**

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
1. Grievance and Appeal System – General Requirements *42 Code of Federal Regulations* (CFR) 438.402(a) Medical Services Contract (MSC) 23	The managed care organization (MCO) must have a system in place for enrollees that includes: a. a grievance process; and b. an appeals process.	☐ a. Grievance process included ☐ b. Appeal process included ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Grievance and Appeal System – Applicability MSC 23	The grievance and appeal system must be the same for Title XXI enrollees and full-pay enrollees.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
3. Grievance and Appeal System – Policies and Procedures MSC 23	The MCO must establish and maintain policies and procedures for the grievance and appeal system, including procedures for expedited appeals.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
4. Grievance and Appeal System – Policies and Procedures for Providers and Subcontractors 42 CFR 438.414 MSC 23	The MCO must provide its grievance and appeal policies and procedures to providers and subcontractors when the MCO enters into a written agreement with such entities or individuals or after any approved changes.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
5. Level of Appeal 42 CFR 438.402(b) MSC 23-2	The MCO must have only one level of appeal for enrollees.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
6. Enrollee Authority to File 42 CFR 438.402(c)(1)(i)	An enrollee may: a. file a grievance and request an appeal with the MCO; and b. request an independent external review after receiving notice under 42 CFR 438.408 that the adverse benefit determination is upheld.	☐ a. Enrollees able to file a grievance and request an appeal ☐ b. Enrollees able to request independent external reviews ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
7. Deemed Exhaustion of Appeals 42 CFR 438.402 (c)(1)(i)(A), 438.408(c)(3) MSC 23-2	If the MCO fails to adhere to the notice and timing requirements in 42 CFR 438.408, the enrollee is deemed to have exhausted the MCO's appeals process and may request an independent external review.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
8. Authority to File – Provider or Authorized Representative 42 CFR 438.402(c)(1)(ii) MSC 23	With the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, request an expedited appeal, or request an independent external review, on behalf of an enrollee. When the term "enrollee" is used throughout subpart F of 42 CFR, it includes providers and authorized representatives consistent with this paragraph.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
9. Grievance Timing to File – Enrollee 438.402(c)(2)(i) MSC 23-1	An enrollee may file a grievance at any time.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
10. Appeal Timing to File 438.402(c)(2)(ii) MSC 23-2	Following receipt of a notification of an adverse benefit determination by the MCO, an enrollee has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the MCO.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
11. Procedures to File a Grievance or Appeal 438.402(c)(3)(i)-(ii) MSC 23-1, 23-2	The enrollee may: a. file a grievance either orally or in writing and, as determined by Florida Healthy Kids Corporation (FHKC), either with FHKC or with the MCO; and b. request an appeal either orally or in writing; however, except for expedited appeals, oral appeals must be followed by a written, signed appeal.	☐ a. Enrollees able to file a grievance orally or in writing ☐ b. Enrollees able to request an appeal either orally or in writing ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
12. Grievance or Appeal Enrollee Assistance 42 CFR 438.406(a) MSC 23	In handling grievances and appeals, the MCO must give enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate text-based telecommunications (TTY/TTD) and interpreter capabilities.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
13. Enrollee Communication Requirements MSC 23	The MCO must follow requirements of 42 CFR 438.10, including providing information to enrollees in a manner and format that may be easily understood and is readily accessible, and any method(s) established by FHKC when notifying enrollees about any aspect of the grievance and appeal process, including using FHKC-developed definitions regarding grievances and appeals.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
14. Processes for Grievances and Appeals 42 CFR 438.406 (b)(1) MSC 23-1, 23-2	The MCO's process for handling enrollee grievances and appeals of adverse benefit determinations must acknowledge receipt of each grievance and appeal within five business days of receipt.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
15. Grievance and Appeal Decisions 42 CFR 438.406 (b)(2)(i) MSC 23	The MCO must ensure that the individuals who make decisions on grievances and appeals are not involved in any previous level of review or decision-making and not a subordinate of any such individual.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
16. Grievance and Appeal Decisions – Clinical Expertise 42 CFR 438.406 (b)(2)(ii)(A)-(C) MSC 23	The MCO must ensure that the individuals who make decisions on grievances and appeals, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by FHKC, in treating the enrollee's condition or disease: a. An appeal of a denial that is based on lack of medical necessity b. A grievance regarding denial of expedited resolution of an appeal c. A grievance or appeal that involves clinical issues	☐ a. Appropriate clinical expertise used when deciding an appeal of a denial based on lack of medical necessity ☐ b. Appropriate clinical expertise used when deciding a grievance regarding denial of expedited resolution of an appeal ☐ c. Appropriate clinical expertise used when deciding a clinical grievance or appeal ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
Suggestion					
17. Grievance and Appeal Decisions – Submitted Information Consideration 42 CFR 438.406 (b)(2)(iii) MSC 23	The MCO must ensure that the individuals who make decisions on grievances and appeals are individuals who take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
18. Oral Appeals Confirmation 42 CFR 438.406 (b)(3) MSC 23-2	The MCO must provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
19. Evidence and Testimony 42 CFR 438.406(b)(4) MSC 23-1, 23-2	The MCO must provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments for grievances and appeals. The MCO must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR 438.408(b) and (c) in the case of expedited resolution.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
20. Enrollee Opportunity to Examine Case File 42 CFR 438.406 (b)(5) MSC 23-2	The MCO must provide the enrollee and their representative the enrollee's case file, including medical records; other documents and records; and any new or additional evidence considered, relied upon, or generated by the MCO in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR 438.408(b) and (c).	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
21. Parties to the Appeal 42 CFR 438.406 (b)(6)(i)-(ii), 42 CFR 438.408(f)(3) MSC 23-3	The MCO must include, as parties to the appeal or independent external review: a. the enrollee and their representative; or b. the legal representative of a deceased enrollee's estate.	☐ a. Enrollee or representative included ☐ b. Deceased enrollee's legal representative included ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
22. Timeframe for Standard Grievance Resolution 42 CFR 438.408 (b)(1) MSC 23-1	For standard resolution of a grievance and notice to the affected parties, the timeframe may not exceed 90 calendar days from the date the MCO receives the grievance, unless extended appropriately.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
23. Timeframe for Standard Appeal Resolution 42 CFR 438.408 (b)(2) MSC 23-2	For standard resolution of an appeal and notice to the affected parties, the timeframe must be as expeditiously as the enrollee's health condition requires, but no longer than 30 calendar days from the date the MCO receives the appeal, unless extended appropriately.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
24. Timeframe for Expedited Appeals 42 CFR 438.408(b)(3) MSC 23-3	For expedited resolution of an appeal and notice to affected parties, the timeframe must be no longer than 72 hours after the MCO receives the appeal, unless extended appropriately.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
25. Extension of Timeframes 42 CFR 438.408 (c)(1)(i)-(ii) MSC 23-1, 23-2	The MCO may extend the timeframes from paragraph (b) of 42 CFR 438.408 by up to 14 calendar days if: a. the enrollee requests the extension; or b. the MCO shows (to the satisfaction of FHKC, upon its request) that there is need for additional information and how the delay is in the enrollee's best interest.	☐ a. Enrollee requested extension ☐ b. Extension due to need for additional information and in enrollee's best interest ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
26. Requirements Following Extension 42 CFR 438.408 (c)(2)(i)-(iii) MSC 23-1, 23-2	If the MCO extends the timeframes not at the request of the enrollee, it must: a. make reasonable efforts to give the enrollee prompt oral notice of the delay. b. within two calendar days, give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and c. resolve the grievance or appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.	☐ a. Efforts made to give oral notice of delays ☐ b. Written notice given within two calendar days ☐ c. Appeals resolved as soon as possible and no later than when the extension expired ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
27. Expedited Resolution Oral Notice 42 CFR 438.408 (d)(2)(ii) MSC 23-2	For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
28. Content of Notice of Appeal Resolution 42 CFR 438.408(e)(1) MSC 23-2	The written notice of the resolution must include the results of the resolution process and the date it was completed.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
29. Content of Notice for Denied Appeals 42 CFR 438.408 (e)(2)(i) MSC 23-2	For appeals not resolved wholly in favor of the enrollee, the written notice must include the right to request an independent external review and how to do so.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
30. Independent External Review Timeframe 42 CFR 438.408 (f)(2) MSC 23-3	The enrollee must request an independent external review within 120 calendar days from the date of the MCO's notice that an appealed adverse benefit determination has been upheld or when the appeal process has been deemed exhausted by way of the MCO's failure to adhere to notification and timing requirements.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
31. Independent Review Organization (IRO) MSC 23-3	The MCO must maintain a contract with an IRO for the provision of enrollees' option to have a post-appeal independent external review. This contract must specify and meet all state and federal laws, regulations, and guidance applicable to Children's Health Insurance Plan grievance and appeal process requirements and subcontractor requirements, including FHKC's audit rights.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
32. Expedited Resolution of Appeals 42 CFR 438.410(a) MSC 23-2	The MCO must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life; physical or mental health; or ability to attain, maintain, or regain maximum function.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
33. Punitive Action 42 CFR 438.410(b) MSC 23	The MCO must ensure that punitive action is not taken against a provider who files an appeal, requests an expedited resolution, or supports an enrollee's appeal or request for an expedited appeal.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
34. Denial of Request for Expedited Resolution 42 CFR 438.410 (c)(1)-(2)	If the MCO denies a request for expedited resolution of an appeal, it must: a. transfer the appeal to the timeframe for standard resolution in accordance with 42 CFR 438.408(b)(2). b. follow the requirements in 42 CFR 438.408(c)(2).	☐ a. Appeal transferred to timeline for standard resolution ☐ b. Followed requirements ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
35. Record-Keeping Requirements 42 CFR 438.416(b)(1)-(6) MSC 23	The MCO's record of each grievance or appeal must contain at a minimum: a. a general description of the reason for the appeal or grievance; b. the date it was received; c. the date of each review or, if applicable, review meeting; d. the resolution at each level of the appeal or grievance process, if applicable; e. the date of resolution at each level, if applicable; f. the name of the enrollee for whom the appeal or grievance was filed; and g. documents relevant to each grievance and appeal.	☐ a. General description included ☐ b. Date received included ☐ c. Review date(s) included ☐ d. Resolution(s) included ☐ e. Resolution date(s) included ☐ f. Enrollee's name included ☐ g. Documents relevant to the grievance or appeal included ☐ Not Applicable	**0.142** **0.142** **0.142** **0.142** **0.142** **0.142** **0.142** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
36. Record Accessibility 42 CFR 438.416(c) MSC 23	The records must be accurately maintained in a manner accessible to FHKC and available upon request to the Centers for Medicare & Medicaid Services.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
37. Reversed Appeal Resolutions for Services Not Furnished 42 CFR 438.424(a) MSC 23-3	If the MCO or the independent external review reverses a decision to deny, limit, or delay services that were **not** furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
38. Reversed Appeal Resolutions for Services Furnished 42 CFR 438.424(b)	If the MCO or independent external review reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO must pay for those services, in accordance with FHKC policy and regulations.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
Grievance and Appeals			**XX.X%**	**38.000**	**X.XXX**

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Practice Guidelines					
1. Practice Guideline Adoption 42 *Code of Federal Regulations* (CFR) 438.236(b)(1)-(4) Medical Services Contract (MSC) 22-6	The managed care organization (MCO) must adopt practice guidelines that: a. are based on valid and reliable clinical evidence or a consensus of providers in the relevant field; b. consider the needs of the MCO's enrollees; c. are adopted in consultation with contracting healthcare professionals; and d. are reviewed and updated periodically as appropriate.	☐ a. Guidelines based on valid and reliable evidence ☐ b. Guidelines considered the needs of enrollees ☐ c. Guidelines adopted in consultation with healthcare professionals ☐ d. Guidelines reviewed and updated periodically ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Guideline Dissemination 42 CFR 438.236(c) MSC 22-6	The MCO must disseminate the guidelines to: a. all affected providers, and b. upon request, to enrollees and potential enrollees.	☐ a. Guidelines disseminated to all affected providers ☐ b. Guidelines disseminated to enrollees and potential enrollees upon request ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Practice Guidelines					
3. Guideline Application 42 CFR 438.236(d) MSC 22-6	The following must be consistent with the practice guidelines: a. Decisions for utilization management b. Enrollee education c. Coverage of services d. Other areas to which the guidelines apply	☐ a. Decisions for utilization management were consistent with guidelines ☐ b. Enrollee education was consistent with guidelines ☐ c. Coverage of services was consistent with guidelines ☐ d. Other applicable areas were consistent with the guidelines ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
Practice Guidelines			**XX.X%**	**3.000**	**X.XXX**

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Health Information Systems					
1. Health Information Systems – Required Information *42 Code of Federal Regulations* (CFR) 438.242(a) Medical Services Contract (MSC) 6-2	The managed care organization (MCO) must maintain a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to: a. utilization; b. claims; c. grievances and appeals; and d. disenrollments for other than loss of Medicaid eligibility.	☐ a. Information provided on utilization ☐ b. Information provided on claims ☐ c. Information provided on grievances and appeals ☐ d. Information provided on disenrollments ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Data Collection 42 CFR 438.242(b)(1)-(2) MSC 6-2	The MCO's health information system must: a. comply with Section 6504(a) of the *Affordable Care Act* (which requires that claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by Florida Healthy Kids Corporation [FHKC] to meet the requirements of section 1903(r)(1)(F) of the Act); b. collect data on enrollee and provider characteristics; and c. collect data on all services furnished to enrollees through an encounter data system, including data sufficient to identify the provider who delivers any item or service to enrollees.	☐ a. Complied with Section 6504(a) of the *Affordable Care Act* ☐ b. Data collected on enrollee and provider characteristics ☐ c. Data collected on services furnished to enrollees ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Health Information Systems					
Findings					
Strength					
AON					
Suggestion					
3. Provider Data 42 CFR 438.242 (b)(3) MSC 6-2	The MCO must ensure that data received from providers are accurate and complete by: a. verifying the accuracy and timeliness of reported data, including data from network providers the MCO is compensating on the basis of capitation payments; b. screening the data for completeness, logic, and consistency; c. collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for FHKC Medicaid quality improvement and care coordination efforts.	☐ a. Verified the accuracy and timeliness of data ☐ b. Screened the data for completeness, logic, and consistency ☐ c. Collected data in standardized formats ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
Health Information Systems			**XX.X%**	**3.000**	**X.XXX**

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement (QAPI)					
1. Basic Elements Required 42 *Code of Federal Regulations* (CFR) 438.330(b)(1)-(4) Medical Services Contract (MSC) 26-2	The managed care organization (MCO) must maintain a comprehensive QAPI program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes. At a minimum, the QAPI program must include: a. performance improvement projects (PIPs) focusing on clinical and nonclinical areas; b. collection and submission of performance measurement data; c. mechanisms to detect both underutilization and overutilization of services; d. mechanisms to assess the quality and appropriateness of care furnished to enrollees with special healthcare needs; e. written policies and procedures that address components of effective healthcare management including anticipation, identification, monitoring, measurement, evaluation of enrollee healthcare needs, and effective action to promote quality of care; and f. any performance measures and PIPs that are required by the Centers for Medicare & Medicaid Services (CMS) during the term of the MCO's contract with Florida Healthy Kids Corporation (FHKC).	☐ a. PIPs included ☐ b. Collection and submission of data included ☐ c. Mechanisms to detect over and under utilization of services included ☐ d. Mechanisms to assess care for enrollees with special needs included ☐ e. Written policies and procedures included ☐ f. Performance measures and PIPs required by CMS included ☐ Not Applicable	**0.167** **0.167** **0.167** **0.167** **0.167** **0.167** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement (QAPI)					
2. Measurement and Submission of Data 42 CFR 438.330(c)(2)(i) MSC 26-3	Annually, the MCO must measure and report to FHKC on its performance, using the standard measures required by FHKC, including performance measures specified by CMS in accordance with 42 CFR 438.330(a)(2).	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
3. PIP Required Elements 42 CFR 438.330(d)(2)(i)-(iv) MSC 26-3	Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and must include: a. measurement of performance using objective quality indicators; b. implementation of interventions to achieve improvement in the access to and quality of care; c. evaluation of the effectiveness of the interventions based on the performance measures in 42 CFR 438.330(d)(2)(i); and d. planning and initiation of activities for increasing or sustaining improvement.	☐ a. Measurement of performance using objective quality indicators included ☐ b. Implementation of interventions included ☐ c. Evaluation of intervention effectiveness included ☐ d. Activities included for increasing or sustaining improvement ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement (QAPI)					
4. Annual Quality Improvement Plan (QIP) – Components MSC 26-2	The MCO must incorporate an annual QIP, which must: a. include an executive summary describing the structure of the MCO's QAPI, the MCO's approach to quality improvement, and how the MCO evaluates the QIP and QAPI to determine new or improved quality improvement strategies; b. define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success; c. implement specific interventions to better manage enrollee care and promote improved health outcomes; and d. identify performance goals supporting the QAPI program.	☐ a. Executive summary included ☐ b. Defined and implemented improvements in processes ☐ c. Implemented specific interventions to better manage enrollee care and promote improved health outcomes ☐ d. Identified performance goals supporting the QAPI program ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
5. Overall QAPI Program Assessment MSC 26-2	The MCO must use the results of the QIP to assess and report on the overall QAPI program to FHKC annually.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement (QAPI)					
6. Quality Improvement Committee (QIC) MSC 26-2	The MCO must have a QIC that: a. develops and is responsible for oversight of the QIP; b. is chaired or co-chaired by the MCO's medical director; c. meets at least quarterly; and d. includes provider representation.	☐ a. QIP developed and overseen by QIC ☐ b. Chaired or co-chaired by medical director ☐ c. Met at least quarterly ☐ d. Included provider representation ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
Quality Assessment and Performance Improvement (QAPI)			**XX.X%**	**6.000**	**X.XXX**

DBM Compliance Assessment Standard Tools

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
1. Delivery Network 42 *Code of Federal Regulations* (CFR) 438.206(b)(1) Dental Services Contract (DSC) 3-2, Amendment 3	The dental benefit manager (DBM) must maintain and monitor a network of appropriate providers, under staff or contract, sufficient to provide prompt access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Second Opinion 42 CFR 438.206(b)(3) DSC 3-2, Amendment 3	The DBM must provide for a second opinion from a network provider, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
3. Out-of-Network Services 42 CFR 438.206(b)(4)	If the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, the DBM must adequately and timely cover these services out of network for the enrollee, for as long as the DBM provider network is unable to provide them.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
4. Out-of-Network Provider Payment 42 CFR 438.206(b)(5) DSC 3-31-1, Amendment 3	The DBM must require out-of-network providers to coordinate with the DBM for payment and ensure the cost to the enrollee is no greater than it would be if the services were furnished within the network.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
5. Furnishing Services – Timely Access 42 CFR 438.206(c)(1)(i)-(vi) DSC 3-2-2, 3-2-4, Amendment 3	The DBM must: a. meet and require its network providers to meet FHKC standards for timely access to care and services, taking into account the urgency of the need for services; b. ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee for service (FFS), if the provider serves only Medicaid enrollees; c. make services included in its contract with FHKC available 24 hours a day, seven days a week, when medically necessary; d. establish mechanisms to ensure compliance by network providers; e. monitor network providers regularly to determine compliance; and f. take corrective action if there is a failure to comply by a network provider.	☐ a. Met FHKC standards for timely access to care and services and took into account the urgency for the service ☐ b. Provider hours offered no less that commercial enrollees or comparable to Medicaid FFS ☐ c. Services available 24/7 when medically necessary ☐ d. Mechanisms established to ensure compliance ☐ e. Network providers monitored regularly ☐ f. Corrective action taken for failure to comply ☐ Not Applicable	**0.166** **0.166** **0.166** **0.166** **0.166** **0.166** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
6. Timely Treatment Standards DSC 3-2-4	The DBM must provide timely treatment for enrollees in accordance with the following standards: a. emergency care shall be provided immediately; b. urgently needed care shall be provided within 24 hours; c. 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 d. routine dental examinations shall be provided within four weeks of the enrollee's request; and e. follow-up care shall be provided as medically appropriate.	☐ a. Emergency care provided immediately ☐ b. Urgent care provided within 24 hours ☐ c. Routine care provided within seven calendar days of request ☐ d. Well-child visits provided within four weeks of request ☐ e. Follow-up care provided as medically appropriate ☐ Not Applicable	**0.200** **0.200** **0.200** **0.200** **0.200** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
7. Furnishing Services – Access and Cultural Considerations 42 CFR 438.206(c)(2)	The DBM must promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, and/or disabilities, and regardless of gender, sexual orientation, or gender identity.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
AON					
Suggestion					
8. Indian Healthcare Providers (IHCPs) DSC 3-2-2	The DBM must: a. maintain sufficient numbers of IHCPs in its provider network to ensure timely access to services from such providers to enrollees eligible to receive such services; b. allow any enrollee who is eligible to receive services from a network IHCP to choose the IHCP as their primary dental care provider so long as the IHCP has the capacity to provide the services; c. allow any enrollee who is eligible to receive services from an IHCP to obtain services covered under the DBM's contract with FHKC from an out-of-network IHCP; d. allow out-of-network IHCPs to refer enrollees to a network provider; and e. permit enrollees eligible to receive covered services from out-of-state IHCPs if there are too few IHCPs in the state to ensure timely access to those services.	☐ a. Sufficient numbers of IHCPs maintained ☐ b. Enrollee allowed to choose IHCP as primary dental care provider ☐ c. Enrollee allowed to obtain services from out-of-network IHCP ☐ d. Out-of-network IHCPs allowed to refer enrollees to network provider ☐ e. Enrollees permitted to receive covered services out of state if too few IHCPs to ensure timely access to services ☐ Not Applicable	**0.200** **0.200** **0.200** **0.200** **0.200** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
9. Furnishing Services – Accessibility Considerations 42 CFR 438.206(c)(3)	The DBM must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
Availability of Services			**XX.X%**	**9.000**	**X.XXX**

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Assurances of Adequate Capacity and Services					
1. Supporting Documentation *42 Code of Federal Regulations* (CFR) 438.207(b)(1)-(2) Dental Services Contract (DSC) 3-2, Amendment 3	The dental benefit manager (DBM) must submit documentation to Florida Healthy Kids Corporation (FHKC), in a format specified by FHKC, to demonstrate that it: a. offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area; and b. maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.	☐ a. Offered appropriate range of services adequate for number of enrollees ☐ b. Maintained sufficient number, mix, and geographic distribution of network providers to meet enrollees' needs ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Submission of Documentation 42 CFR 438.207(c)(1)-(2) DSC 3-2, Amendment 3	The DBM must submit the documentation as specified by FHKC, but no less frequently than: a. at the time it enters into a contract with FHKC; and b. on an annual basis.	☐ a. Documentation submitted when contract was entered ☐ b. Documentation submitted annually ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Assurances of Adequate Capacity and Services					
3. Submission of Documentation – Significant Change 42 CFR 438.207(c)(3)(i)-(ii) DSC 3-2, Amendment 3	The DBM must submit the documentation, as specified by FHKC, at any time there has been a significant change (as defined by FHKC) in DBM operations that would affect the adequacy of capacity and services, including: a. changes in DBM services, benefits, geographic service area, or composition of or payments to its provider network; or b. enrollment of a new population in the DBM.	☐ a. Documentation submitted for changes in services, benefits, service area, or payments ☐ b. Documentation submitted for enrollment of new population ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
Assurances of Adequate Capacity and Services			**XX.X%**	**3.000**	**X.XXX**

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
1. Grievance and Appeal System – General Requirements *42 Code of Federal Regulations* (CFR) 438.402(a) Dental Services Contract (DSC) 3-14, Amendment 3	The dental benefit manager (DBM) must have a system in place for enrollees that includes: a. a grievance process; and b. an appeals process.	☐ a. Grievance process included ☐ b. Appeal process included ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Grievance and Appeal System – Applicability DSC 3-14, Amendment 3	The grievance and appeal system must be the same for Title XXI enrollees and full-pay enrollees.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
3. Grievance and Appeal System – Policies and Procedures for Providers and Subcontractors DSC 3-14, Amendment 3	The DBM must provide its grievance and appeal process and policies and procedures to providers and subcontractors when the DBM enters into a contract or agreement with such entities or individuals.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
4. Level of Appeal 42 CFR 438.402(b) DSC 3-14, Amendment 3	The DBM must have only one level of appeal for enrollees.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
5. Enrollee Authority to File 42 CFR 438.402(c)(1)(i)	An enrollee may: a. file a grievance and request an appeal with the DBM; and b. request an independent external review after receiving notice under 42 CFR 438.408 that the adverse benefit determination is upheld.	☐ a. Enrollees able to file a grievance and request an appeal ☐ b. Enrollees able to request independent external reviews ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
6. Deemed Exhaustion of Appeals 42 CFR 438.402 (c)(1)(i)(A), 438.408(c)(3) DSC 3-14, Amendment 3	If the DBM fails to adhere to the notice and timing requirements in 42 CFR 438.408, the enrollee is deemed to have exhausted the DBM's appeals process and may request an independent external review.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
7. Authority to File – Provider or Authorized Representative 42 CFR 438.402(c)(1)(ii) DSC 3-14, Amendment 3	With the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, request an expedited appeal, or request an independent external review, on behalf of an enrollee. When the term "enrollee" is used throughout subpart F of 42 CFR, it includes providers and authorized representatives consistent with this paragraph.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
8. Grievance Timing to File – Enrollee 438.402(c)(2)(i) DSC 3-14, Amendment 3	An enrollee may file a grievance at any time.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
9. Appeal Timing to File 438.402(c)(2)(ii) DSC 3-14, Amendment 3	Following receipt of a notification of an adverse benefit determination by the DBM, an enrollee has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the DBM.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
10. Procedures to File a Grievance or Appeal 438.402(c)(3)(i)-(ii) DSC 3-14, Amendment 3	The enrollee may: a. file a grievance either orally or in writing and, as determined by Florida Healthy Kids Corporation (FHKC), either with FHKC or with the DBM; and b. request an appeal either orally or in writing; however, except for expedited appeals, oral appeals must be followed by a written, signed appeal.	☐ a. Enrollees able to file a grievance orally or in writing ☐ b. Enrollees able to request an appeal either orally or in writing ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
11. Grievance or Appeal Enrollee Assistance 42 CFR 438.406(a) DSC 3-14, Amendment 3	In handling grievances and appeals, the DBM must give enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate text-based telecommunications (TTY/TTD) and interpreter capabilities.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
12. Enrollee Communication Requirements DSC 3-14, Amendment 3	The DBM must follow requirements of 42 CFR 438.10, including providing information to enrollees in a manner and format that may be easily understood and is readily accessible, and any method(s) established by FHKC when notifying enrollees about any aspect of the grievance and appeal process, including using FHKC-developed definitions regarding grievances and appeals.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
13. Processes for Grievances and Appeals 42 CFR 438.406 (b)(1) DSC 3-14, Amendment 3	The DBM's process for handling enrollee grievances and appeals of adverse benefit determinations must acknowledge receipt of each grievance and appeal.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
14. Grievance and Appeal Decisions 42 CFR 438.406 (b)(2)(i) DSC 3-14, Amendment 3	The DBM must ensure that the individuals who make decisions on grievances and appeals are not involved in any previous level of review or decision-making and not a subordinate of any such individual.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
15. Grievance and Appeal Decisions – Clinical Expertise 42 CFR 438.406 (b)(2)(ii)(A)-(C) DSC 3-14, Amendment 3	The DBM must ensure that the individuals who make decisions on grievances and appeals, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by FHKC, in treating the enrollee's condition or disease: a. An appeal of a denial that is based on lack of medical necessity b. A grievance regarding denial of expedited resolution of an appeal c. A grievance or appeal that involves clinical issues	☐ a. Appropriate clinical expertise used when deciding an appeal of a denial based on lack of medical necessity ☐ b. Appropriate clinical expertise used when deciding a grievance regarding denial of expedited resolution of an appeal ☐ c. Appropriate clinical expertise used when deciding a clinical grievance or appeal ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
16. Grievance and Appeal Decisions – Submitted Information Consideration 42 CFR 438.406 (b)(2)(iii) DSC 3-14, Amendment 3	The DBM must ensure that the individuals who make decisions on grievances and appeals are individuals who take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
Findings **Strength** **AON** **Suggestion**					
17. Oral Appeals Confirmation 42 CFR 438.406 (b)(3) DSC 3-14, Amendment 3	The DBM must provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
18. Evidence and Testimony 42 CFR 438.406(b)(4) DSC 3-14, Amendment 3	The DBM must provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments for grievances and appeals. The DBM must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR 438.408(b) and (c) in the case of expedited resolution.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
Suggestion					
19. Enrollee Opportunity to Examine Case File 42 CFR 438.406 (b)(5) DSC 3-14, Amendment 3	The DBM must provide the enrollee and their representative the enrollee's case file, including medical records; other documents and records; and any new or additional evidence considered, relied upon, or generated by the DBM in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR 438.408(b) and (c).	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
20. Parties to the Appeal 42 CFR 438.406 (b)(6)(i)-(ii), 42 CFR 438.408(f)(3) DSC 3-14, Amendment 3	The DBM must include, as parties to the appeal or independent external review: a. the enrollee and their representative; or b. the legal representative of a deceased enrollee's estate.	☐ a. Enrollee or representative included ☐ b. Deceased enrollee's legal representative included ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
21. Timeframe for Standard Grievance Resolution 42 CFR 438.408 (b)(1) DSC 3-14, Amendment 3	The DBM must resolve each grievance and provide notice as expeditiously as the enrollee's health condition requires, but not to exceed 90 calendar days from the date the DBM receives the grievance, unless extended appropriately.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
22. Timeframe for Standard Appeal Resolution 42 CFR 438.408 (b)(2) DSC 3-14, Amendment 3	The DBM must resolve each appeal and provide notice as expeditiously as the enrollee's health condition requires, but not to exceed 30 calendar days from the date the DBM receives the appeal, unless extended appropriately.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
23. Timeframe for Expedited Appeals 42 CFR 438.408(b)(3) DSC 3-14, Amendment 3	The DBM must resolve each expedited appeal and provide notice as expeditiously as the enrollee's health condition requires, but not to exceed 72 hours from the date the DBM receives the appeal, unless extended appropriately.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
24. Extension of Timeframes 42 CFR 438.408 (c)(1)(i)-(ii) DSC 3-5	The DBM may extend the timeframes from paragraph (b) of 42 CFR 438.408 by up to 14 calendar days if: a. the enrollee requests the extension; or b. the DBM shows (to the satisfaction of FHKC, upon its request) that there is need for additional information and how the delay is in the enrollee's best interest.	☐ a. Enrollee requested extension ☐ b. Extension due to need for additional information and in enrollee's best interest ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
25. Requirements Following Extension 42 CFR 438.408 (c)(2)(i)-(iii) DSC 3-14, Amendment 3	If the DBM extends the timeframes not at the request of the enrollee, it must: a. make reasonable efforts to give the enrollee prompt oral notice of the delay. b. within two calendar days, give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and c. resolve the grievance or appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.	☐ a. Efforts made to give oral notice of delays ☐ b. Written notice given within two calendar days ☐ c. Appeals resolved as soon as possible and no later than when the extension expired ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
26. Expedited Resolution Oral Notice 42 CFR 438.408 (d)(2)(ii) DSC 3-14, Amendment 3	For notice of an expedited resolution, the DBM must also make reasonable efforts to provide oral notice.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
27. Content of Notice of Appeal Resolution 42 CFR 438.408 (e)(1) DSC 3-14, Amendment 3	The written notice of the resolution must include the results of the resolution process and the date it was completed.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
28. Content of Notice for Denied Appeals 42 CFR 438.408 (e)(2)(i) DSC 3-14, Amendment 3	For appeals not resolved wholly in favor of the enrollee, the written notice must include the right to request an independent external review and how to do so.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
29. Independent External Review Timeframe 42 CFR 438.408 (f)(2) DSC 3-14, Amendment 3	The enrollee must request an independent external review within 120 calendar days from the date of the DBM's notice that an appealed adverse benefit determination has been upheld or when the appeal process has been deemed exhausted by way of the DBM's failure to adhere to notification and timing requirements.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
30. Independent Review Organization (IRO) DSC 3-14, Amendment 4	The DBM must maintain a contract with an IRO for the provision of enrollees' option to have a post-appeal independent external review. This contract must specify and meet all state and federal laws, regulations, and guidance applicable to Children's Health Insurance Plan grievance and appeal process requirements and subcontractor requirements, including FHKC's audit rights.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
31. IRO – Memorandum of Understanding DSC 3-14, Amendment 4	The DBM and its IRO must enter into a memorandum of understanding with FHKC. The DBM must allow FHKC full access to audit, monitor, and evaluate the IRO's performance of independent external review.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
32. Expedited Resolution of Appeals 42 CFR 438.410(a) DSC 3-14, Amendment 3	The DBM must establish and maintain an expedited review process for appeals, when the DBM determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life; physical or mental health; or ability to attain, maintain, or regain maximum function.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
33. Punitive Action 42 CFR 438.410(b) DSC 3-14, Amendment 3	The DBM must ensure that punitive action is not taken against a provider who files an appeal, requests an expedited resolution, or supports an enrollee's appeal or request for an expedited appeal.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
34. Denial of Request for Expedited Resolution 42 CFR 438.410 (c)(1)-(2) DSC 3-14, Amendment 3	If the DBM denies a request for expedited resolution of an appeal, it must: a. make reasonable efforts to give the enrollee prompt oral notice of the delay; b. give the enrollee written notice of the decision within two calendar days, including informing the enrollee of the right to file a grievance; and c. resolve the appeal as expeditiously as the enrollee's health condition requires, but no later than the timeframe for a standard appeal (30 calendar days).	☐ a. Reasonable efforts to give enrollee prompt oral notice of delay ☐ b. Enrollee given written notice of decision within two calendar days with information of enrollee's right to file a grievance ☐ c. Appeal resolved as expeditiously as enrollee's health condition required, but no later than 30 calendar days ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
35. Record-Keeping Requirements 42 CFR 438.416(b)(1)-(6) DSC 3-14, Amendment 3	The DBM's record of each grievance or appeal must contain at a minimum: a. a general description of the reason for the appeal or grievance; b. the date it was received; c. the date of each review or, if applicable, review meeting; d. the resolution at each level of the appeal or grievance process, if applicable; e. the date of resolution at each level, if applicable; f. the name of the enrollee for whom the appeal or grievance was filed; and g. documents relevant to each grievance and appeal.	☐ a. General description included ☐ b. Date received included ☐ c. Review date(s) included ☐ d. Resolution(s) included ☐ e. Resolution date(s) included ☐ f. Enrollee's name included ☐ g. Documents relevant to the grievance or appeal included ☐ Not Applicable	**0.142** **0.142** **0.142** **0.142** **0.142** **0.142** **0.142** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
36. Record Accessibility 42 CFR 438.416(c) DSC 3-14, Amendment 3	The records must be accurately maintained in a manner accessible to the FHKC and available upon request to the Centers for Medicare & Medicaid Services.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievances and Appeals					
Suggestion					
37. Reversed Appeal Resolutions for Services Not Furnished 42 CFR 438.424(a) DSC 3-14, Amendment 3	If the DBM, or the independent external review reverses a decision to deny, limit, or delay services that were **not** furnished while the appeal was pending, the DBM must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
38. Reversed Appeal Resolutions for Services Furnished 42 CFR 438.424(b) DSC 3-14, Amendment 3	If the DBM or independent external review reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the DBM must pay for those services, in accordance with FHKC policy and regulations.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Grievances and Appeals					
Suggestion					
Grievance and Appeals			XX.X%	38.000	X.XXX

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Practice Guidelines					
1. Practice Guideline Adoption 42 *Code of Federal Regulations* (CFR) 438.236(b)(1)-(4) Dental Services Contract (DSC) 3-5, Amendment 3	The dental benefit manager (DBM) must adopt practice guidelines that: a. are based on valid and reliable clinical evidence or a consensus of providers in the relevant field; b. consider the needs of the DBM's enrollees; c. are adopted in consultation with contracting healthcare professionals; and d. are reviewed and updated periodically as appropriate.	☐ a. Guidelines based on valid and reliable evidence ☐ b. Guidelines considered the needs of enrollees ☐ c. Guidelines adopted in consultation with healthcare professionals ☐ d. Guidelines reviewed and updated periodically ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Guideline Dissemination 42 CFR 438.236(c) DSC 3-5, Amendment 3	The DBM must disseminate the guidelines to: a. all affected providers, and b. upon request, to enrollees and potential enrollees.	☐ a. Guidelines disseminated to all affected providers ☐ b. Guidelines disseminated to enrollees and potential enrollees upon request ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Practice Guidelines					
3. Guideline Application 42 CFR 438.236(d) DSC 3-5, Amendment 3	The following must be consistent with the guidelines: a. Decisions for utilization management b. Enrollee education c. Coverage of services d. Other areas to which the guidelines apply	☐ a. Decisions for utilization management were consistent with guidelines ☐ b. Enrollee education was consistent with guidelines ☐ c. Coverage of services was consistent with guidelines ☐ d. Other applicable areas were consistent with the guidelines ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
Practice Guidelines			**XX.X%**	**3.000**	**X.XXX**

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Health Information Systems					
1. Health Information Systems – Required Information *42 Code of Federal Regulations* (CFR) 438.242(a) Dental Services Contract (DSC) 3-27, Amendment 3	The dental benefit manager (DBM) must maintain a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to: a. utilization; b. claims; c. grievances and appeals; and d. disenrollments for other than loss of Medicaid eligibility.	☐ a. Information provided on utilization ☐ b. Information provided on claims ☐ c. Information provided on grievances and appeals ☐ d. Information provided on disenrollments ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Data Collection 42 CFR 438.242(b)(2) DSC 3-27, Amendment 3	The DBM's health information system must: a. comply with Section 6504(a) of the *Affordable Care Act*; b. collect data on enrollee and provider characteristics; and c. collect data on all services furnished to enrollees through an encounter data system, including data sufficient to identify the provider who delivers any item or service to enrollees.	☐ a. Complied with Section 6504(a) of the *Affordable Care Act* ☐ b. Data collected on enrollee and provider characteristics ☐ c. Data collected on services furnished to enrollees ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**
Findings **Strength**					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Health Information Systems					
AON					
Suggestion					
3. Provider Data 42 CFR 438.242 (b)(3) DSC 3-27, Amendment 3	The DBM must ensure that data received from providers are accurate and complete by: a. verifying the accuracy and timeliness of reported data, including data from network providers the DBM is compensating on the basis of capitation payments; b. screening the data for completeness, logic, and consistency; c. collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for Florida Healthy Kids Corporation (FHKC) Medicaid quality improvement and care coordination efforts.	☐ a. Verified the accuracy and timeliness of data ☐ b. Screened the data for completeness, logic and consistency ☐ c. Collected data in standardized formats ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
4. Data Availability DSC 3-27, Amendment 3	The DBM must make all collected data available to FHKC, the Agency for Health Care Administration, and the Centers for Medicare & Medicaid Services, upon request.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					

2021 Annual Compliance Assessment: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Health Information Systems					
Health Information Systems			**XX.X%**	**4.000**	**X.XXX**

2021 Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement (QAPI)					
1. Basic Elements Required 42 *Code of Federal Regulations* (CFR) 438.330(b)(1)-(4) Dental Services Contract (DSC) 3-24, Amendment 3	The dental benefit manager (DBM) must maintain a comprehensive QAPI program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes. At a minimum, the QAPI program must include: a. performance improvement projects (PIPs) focusing on clinical and nonclinical areas; b. collection and submission of performance measurement data; c. mechanisms to detect both underutilization and overutilization of services; d. mechanisms to assess the quality and appropriateness of care furnished to enrollees with special healthcare needs; and e. any performance measures and PIPs that are required by the Centers for Medicare & Medicaid Services (CMS) during the term of the DBM's contract with Florida Healthy Kids Corporation (FHKC).	☐ a. PIPs included ☐ b. Collection and submission of data included ☐ c. Mechanisms to detect over and under utilization of services included ☐ d. Mechanisms to assess care for enrollees with special needs included ☐ e. Performance measures and PIPs required by CMS included ☐ Not Applicable	**0.200** **0.200** **0.200** **0.200** **0.200** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement (QAPI)					
2. Measurement and Submission of Data CFR 438.330(c)(2)(i) DSC 3-24-3, Amendment 3	Annually, the DBM must measure and report to FHKC on its performance, using the standard measures required by FHKC, including performance measures specified by CMS in accordance with 42 CFR 438.330(a)(2).	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
3. PIP Required Elements CFR 438.330(d)(2)(i)-(iv) DSC 3-24-3, Amendment 3	Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and must include: a. measurement of performance using objective quality indicators; b. implementation of interventions to achieve improvement in the access to and quality of care; c. evaluation of the effectiveness of the interventions based on the performance measures in 42 CFR 438.330(d)(2)(i); and d. planning and initiation of activities for increasing or sustaining improvement.	☐ a. Measurement of performance using objective quality indicators included ☐ b. Implementation of interventions included ☐ c. Evaluation of intervention effectiveness included ☐ d. Activities included for increasing or sustaining improvement ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2021 Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement (QAPI)					
4. Annual Quality Improvement Plan (QIP) – Components DSC 3-24-1	The DBM must have an ongoing QIP that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes in service performance to its enrollees. The DBM must: a. have policies and procedures that address all components of effective healthcare management, including, but not limited to: i. focus on preventive care for enrollees; ii. anticipation, identification, monitoring, measurement, and evaluation of enrollees' healthcare needs; and iii. effective action to promote quality of care; b. define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success; and c. demonstrate in its care management specific interventions to better manage the care and promote healthier enrollee outcomes.	☐ a. Policies and procedures addressed effective healthcare management ☐ b. Improvements in processes that enhanced efficiency, effective utilization, and improved outcome management ☐ c. Specific interventions to better manage care and promote healthier outcomes enrollee demonstrated in care management ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**		
Findings					
Strength					
AON					
Suggestion					

2021 Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement (QAPI)					
5. QIP Committee DSC 3-24-2	The DBM must have a QIP committee that: a. is chaired or co-chaired by the DBM's medical director; b. includes: i. the quality director; ii. the grievance coordinator; iii. the utilization review manager; iv. the credentialing manager; v. the risk manager/infection control professional (if applicable); vi. advocate representation (if applicable); and vii. provider representation, either through providers serving on the committee or through a provider liaison position such as a representative from the network management department; c. meets on a regular basis, no less than quarterly; and d. keeps minutes or other appropriate documentation of such meetings.	☐ a. Chaired or co-chaired by medical director ☐ b. Included required committee members ☐ c. Met no less than quarterly ☐ d. Kept minutes and other appropriate documentation ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					

2021 Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement (QAPI)					
6. Overall QAPI Program Assessment DSC 3-24, Amendment 3	The DBM must assess and report on the overall QAPI program to FHKC annually.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
Quality Assessment and Performance Improvement (QAPI)			**XX.X%**	**6.000**	**X.XXX**

MCO and DBM Grievances File Review Tool

Grievances File Review Tool																
MCO/DBM: <Name>																<DD/MM/YYYY>
			Time Standard Calculation: Business Days								Time Standard Calculation: Calendar Days					
1	2	3	4		5	6	7	8		9		10	11	12	13		14	
File #	Case ID*	Griev-ance Rcvd. Date	Griev-ance Ackn.		Date Ackn.	No. of Days to Ackn.	Time Standard	Time Standard Met		Investiga-tion of Griev. Doc.		Date Resolved	No. of Days to Resolve	Time Standard	Time Standard Met		Notification of Resolution	
			Y	N				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.*
*** Appropriate extension applied*

Total Compliant:	
Total Applicable:	
Percent Compliant:	

MCO and DBM Appeals File Review Tool

Appeals File Review Tool

MCO/DBM: <Name> **<MM/DD/YYYY>**

			Time Standard Calculation: Business Days										Time Standard Calculation†				
1	2	3	4		5		6	7	8	9		10		11	12	13	14	15	
File #	Case ID*	Appeal Rcvd. Date	Appeal Ackn.		Appro-priate Clinical Reviewer		Date Ackn.	No. of Days to Ackn.	Time Stan-dard	Time Stan-dard Met		Investiga-tion of Appeal Doc.		E/S**	Date Written Notification of Decision to Enrollee	Time to Resolve†	Time Standard	Time Standard Met	
			Y	N	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.*

† Calendar days for standard appeals; hours for expedited appeals

*** Expedited or standard*

Total Compliant:	
Total Applicable:	
Percent Compliant:	

ANA

The ANA tool templates for appointment availability were used to assess appointment availability for FHKC's MCOs and DBMs as part of the 2021 ANA.

2021 Appointment Availability Standards Review Tool		
Standard	**Evident in MCO P&Ps**	**Comments**
Emergency care shall be provided immediately.		
Urgently needed care shall be provided within 24 hours.		
Routine care shall be provided within seven calendar days of the enrollee's request for services.		
Well-child visits, as recommended by the American Academy of Pediatrics, shall be provided within four weeks of the enrollee's request.		
Follow-up care shall be provided as medically appropriate.		

2021 Appointment Availability Standards Provider and Enrollee Communication Review Tool		
Standard	**Evident in Provider Manual**	**Evident in Enrollee Handbook**
Emergency care shall be provided immediately.		
Urgently needed care shall be provided within 24 hours.		
Routine care shall be provided within seven calendar days of the enrollee's request for services.		
Well-child visits, as recommended by the American Academy of Pediatrics, shall be provided within four weeks of the enrollee's request.		
Follow-up care shall be provided as medically appropriate.		

Geographic access standards used in ANA analyses were derived from the Medical Services Contract (MSC) between FHKC and Aetna, section 24-4-2, effective January 1, 2020.

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

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

Appointment access standards were derived from the MSC, section 24-4-3, Appointment Access:

- Emergency care shall be provided immediately.
- Urgently needed care shall be provided within twenty-four (24) hours.
- Routine care shall be provided within seven (7) Calendar Days of the Enrollee's request for services.
- Well-child visits, as recommended by the American Academy of Pediatrics, shall be provided within four (4) weeks of the Enrollee's request.
- Follow-up care shall be provided as medically appropriate.

FHKC specified the provider/specialty types included in analyses. Analyses also were based on the provider categories and the specialty code used to identify each provider in the provider files for the MCOs.

MCO Provider/Specialty Types and Provider Categories	
Specialty Type	**Specialty Code**
Allergy/Immunology	007
Dermatology	011
OB/GYN	016
Optometry	200
Otolaryngology (ENT)	013
PCP – Pediatrician	101
PCP – Family Physician	002
Behavioral Health – Pediatric	
Pediatric Psychiatry	P029
Behavioral Health – Other	
Psychiatry	029
Psychology	103
Social Work	102
Substance Abuse Specialist	800
Specialist – Pediatric	
Pediatric Cardiology	P008
Pediatric Endocrinology	P012
Pediatric Gastroenterology	P014

MCO Provider/Specialty Types and Provider Categories	
Specialty Type	**Specialty Code**
Pediatric Oncology	P021
Pediatric Orthopedic Surgery	P025
Pediatric Pulmonology	P030
Pediatric Surgery	P015
Specialist – Other	
Cardiology	008
Chiropractor	010
Endocrinology	012
Gastroenterology	014
General Surgery	015
Infectious Disease	017
Internal Medicine	003
Nephrology	018
Neurology	019
Oncology	021
Ophthalmology	023
Orthopedic Surgery	025
Podiatry	028

MCO Provider/Specialty Types and Provider Categories	
Specialty Type	**Specialty Code**
Pulmonology	030
Urology	033
Physical Therapy	049
Occupational Therapy	050
Speech Therapy	051
Hospital	040
Pharmacy	301
Freestanding Psychiatric Facilities (informational only)	052
Laboratory (informational only)	058

Geographic access standards used in ANA analyses were derived from the Dental Services Contract (DSC) between FHKC and the DBMs, section 3-2-3, amended July 1, 2018.

2020 ANA FHKC Travel Time and Distance Requirements for DBMs				
Provider/Specialty Type	**Time (in minutes)**		**Distance (in miles)**	
	Urban	**Rural**	**Urban**	**Rural**
Primary Care Dentists	20	30	20	30
Dental Specialists	20	40	20	30
Orthodontists	30	70	20	50

FHKC specified the provider/specialty types included in analyses for informational purposes only. Analyses also were based on the provider categories and the specialty code used to identify each provider in the provider files for the DBMs.

DBM Provider Specialty Types and Codes	
Specialty Type	**Specialty Code**
Primary Care Dentists	
Pediatric Dentists	P201
General Dentists	201
Dental Specialists	
Endodontists	204
Oral Surgeons	024
Periodontists	203

DBM Provider Specialty Types and Codes	
Specialty Type	**Specialty Code**
Prosthodontists	206
Orthodontists	202

EDV

Qsource validated data fields for the MCOs and DBMs upon which FHKC agreed.

Validation Techniques for MCO and DBM Claims and Encounter Data for 2020	
Field Name	**Validation**
MCOs	
Member Identification (ID)	Validate field length and format
Plan ID	Validate field value
Claim Reference Number	Validate field length
Billing Date	Validate valid date
Claim Paid Date	Validate valid date
Admit Date	For institutional claims only, validate valid date
Diagnosis Code	Validate field value
Procedure Code	Validate field value
First Date of Service	Validate valid date
Last Date of Service	Validate valid date
Units of Service	Validate field length and format
Total Days	Validate field length and format
Financial Report Service Category	Validate field value
Treating Provider Type	Validate field value
Treating Provider National Provider Identifier (NPI)	Validate field length and format
Treating Provider Medicaid ID	Validate field length and format
Treating Provider Specialty Code	Validate field value
Billing Provider Type	Validate field value

Validation Techniques for MCO and DBM Claims and Encounter Data for 2020	
Field Name	**Validation**
Billing Provider NPI	Validate field length and format
Billing Provider Medicaid ID	Validate field length and format
Billing Provider Specialty Code	Validate field value
Facility Provider Type	Validate field value
Facility Provider NPI	Validate field length and format
Facility Provider Medicaid ID	Validate field value
Place of Service	Validate field value
National Drug Code ID	Validate field length and format
Class	Validate field length and format
Primary Pharmacy ID	Validate field length and format
Days' Supply	Validate field length and format
DBMs	
Member Identification (ID)	Validate field length and format
Plan ID	Validate field value
Billing Date	Validate valid date
Claim Paid Date	Validate valid date
Procedure Code	Validate field value
First Date of Service	Validate valid date
Last Date of Service	Validate valid date
Financial Report Service Category	Validate field value
Treating Provider Type	Validate field value

Validation Techniques for MCO and DBM Claims and Encounter Data for 2020	
Field Name	**Validation**
Treating Provider National Provider Identifier (NPI)	Validate field length and format
Treating Provider Medicaid ID	Validate field length and format
Treating Provider Specialty Code	Validate field value
Billing Provider Type	Validate field value
Billing Provider NPI	Validate field length and format
Billing Provider Medicaid ID	Validate field length and format
Billing Provider Specialty Code	Validate field value
Place of Service	Validate field value