February 2023

2022 Annual

Quality Review Technical Report

Florida Healthy Kids Children's Health Insurance Program

Review Period: January 1, 2021 – December 31, 2021

Final

HealthyKids™

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List of Tables and Charts

Acknowledgements, Acronyms, and Initialisms[1]

AAAHC ..... Accreditation Association for Ambulatory Health Care
ABHFL ..... Aetna Behavioral Health of Florida
ACA ..... Annual Compliance Assessment
ADD ..... Follow-Up Care for Children Prescribed ADHD Medication
ADHD ..... Attention-Deficit/Hyperactivity Disorder
ADV ..... Annual Dental Visit
Aetna ..... Aetna Better Health® of Florida
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
Argus ..... Argus Dental Plan
BH ..... Behavioral Health
BI ..... Business Intelligence
BMI ..... Body Mass Index
BR ..... Biased Rate
CAHPS® ..... Consumer Assessment of Healthcare Providers and Systems, a registered trademark of NCQA
CAP ..... Corrective Action Plan
CCC ..... Coordination and Continuity of Care
CCP ..... Community Care 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
CM ..... Care/case management
CMS ..... Centers for Medicare & Medicaid Services
CPC ..... CAHPS Health Plan Survey 5.0H, Child Version
CWP ..... Appropriate Testing for Children with Pharyngitis
DBM ..... Dental Benefit Manager
DD ..... Day
Den. ..... Denominator
DentaQuest ..... DentaQuest of Florida, Inc.
DM ..... Disease management
DSC ..... Dental Services Contract
E ..... Expedited

[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.*

ED ..... Emergency Department
EHR..... Electronic health records
ENT ..... Otolaryngology (ear, nose, and throat)
EPO..... Existing patients only
EQR/EQRO..... External Quality Review/ EQR Organization
ESPDT ..... Early and Periodic Screening, Diagnosis, and Treatment
FAR ..... Final Audit Report
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
HRA..... Health Risk Assessment
IAD ..... Identification of Alcohol and Other Drug Services
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
IPSD ..... Index Prescription Start Date
IRR ..... Inter-rater reliability
IS ..... Information System(s)
ISCAT..... Information Systems Capability Assessment Tool
IVR ..... Interactive voice responses
LOCUS ..... Level of Care Utilization System
MCNA..... Managed Care of North America, Inc.
MCG ..... Milliman Care Guidelines
MCO ..... Managed Care Organization
MCP/Plan ..... Managed Care Plan
MH..... Mental Health
MM ..... Month
MMA ..... Managed Medical Assistance
MPI ..... Master Patient Index
MPT..... Mental Health Utilization
MPTAC..... Medical Policy & Technology Assessment Committee
MSC ..... Medical Services Contract
MSR ..... Member Service Representative
MY ..... Measurement Year
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
PII ..... Personal Identifiable Information
PIP..... Performance Improvement Project
PMV..... Performance Measure Validation
PPC ..... Prenatal and Postpartum Care
PSPS..... Practice Site Performance Summary
Q..... Quarter
QAPI..... Quality Assessment and Performance Improvement
QI..... Quality Improvement
QIC ..... Quality Improvement Committee
QIP ..... Quality Improvement Plan
QM..... Quality Management
QMUM ..... Quality Management/Utilization Management Committee
Qsource®..... a registered trademark
R..... Reportable Rate
Roadmap..... Record of Administrative Data Management and

Processes
Rx ..... Prescription
S ..... Standard
SDOH ..... Social determinants of health
SEA ..... Enrolled Children Receiving Dental Sealants on Permanent Molars
SFTP ..... Secure File Transfer Protocol
Simply ..... Simply Healthcare Plans
SLA ..... Service level agreement
SRD ..... Subcontractual Relationships and Delegation
Td ..... Tetanus and Diphtheria Toxoids Vaccine
Tdap ... Tetanus, Diphtheria Toxoids, and Acellular Pertussis Vaccine
TDENT ..... Dental Treatment Services
TJ ..... The Joint Commission
TIM ..... Text Illness Monitoring
TTY/TTD ..... Text-Based Telecommunications
UM ..... Utilization Management
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
YOY ..... Year-over-year

Overview

In accordance with Title 42 *Code of Federal Regulations* (CFR) § 438.364, Qsource has produced this *2022 Annual External Quality Review Organization (EQRO) Technical Report* to summarize the quality, timeliness, and accessibility of care furnished to enrollees in the Florida Healthy Kids program by the managed care organizations (MCOs) and dental benefit managers (DBMs) contracted by the Florida Healthy Kids Corporation (FHKC) and to identify areas for improvement and recommend interventions to improve the process and outcomes of care. Title 42 of the CFR governs 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. This section provides a brief history of FHKC, the organization's strategy for the Florida Healthy Kids program, EQR activities conducted in 2022, 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. 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 2021, 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 (CCP), 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), 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 June 2022, nearly 236,359 children were enrolled in the Florida Healthy Kids program, according to enrollment data from FHKC's vendor, Maximus. Enrollment numbers for the medical plans were as follows: Aetna totaled 56,864, CCP totaled 12,129, and Simply totaled 79,391. The dental plans total enrollees were as follows: Argus totaled 26,615, DentaQuest totaled 49,132, and MCNA totaled 41,045. In June 2021, nearly 287,538 children were enrolled in the program. Of note, all Plans, with the exception of CCP, service all 67 counties in Florida. CCP provides services for Florida Healthy Kids enrollees in eight counties (Broward, Indian River, Martin, Miami-Dade, Monroe, Okeechobee, Palm Beach, and St. Lucie). Additional information regarding enrollment data has been provided in Chart 1.

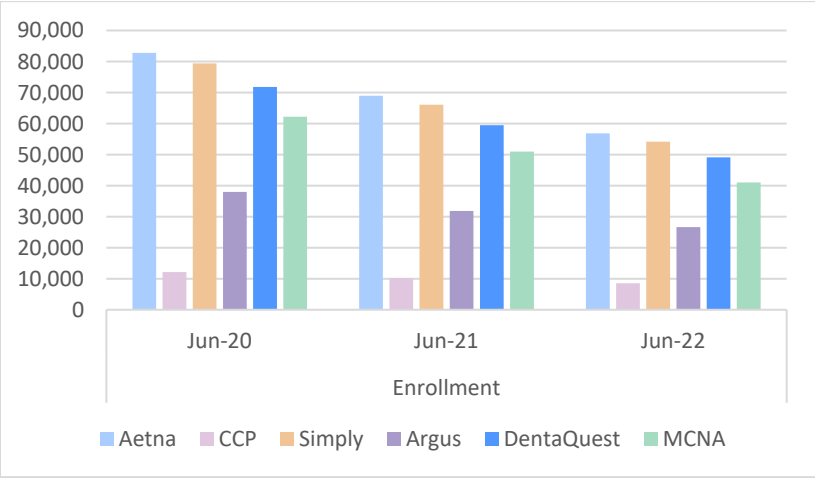

Chart 1. Florida Healthy Kids Enrollment by MCO/DBM

FHKC had a notable reduction in enrollment between 2021 and 2022. The reduction in enrollment between years is attributed to members that were transitioned from FHKC's program to other Medicaid programs within the state to ensure that enrollees maintained coverage during the COVID-19 state of emergency.

FHKC Quality Strategy Plan

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

The Quality Strategy Plan is implemented through the ongoing comprehensive quality assessment and performance improvement programs (QAPIs) that the MCOs and DBMs must have in place. Each MCO/DBM's QAPI includes performance

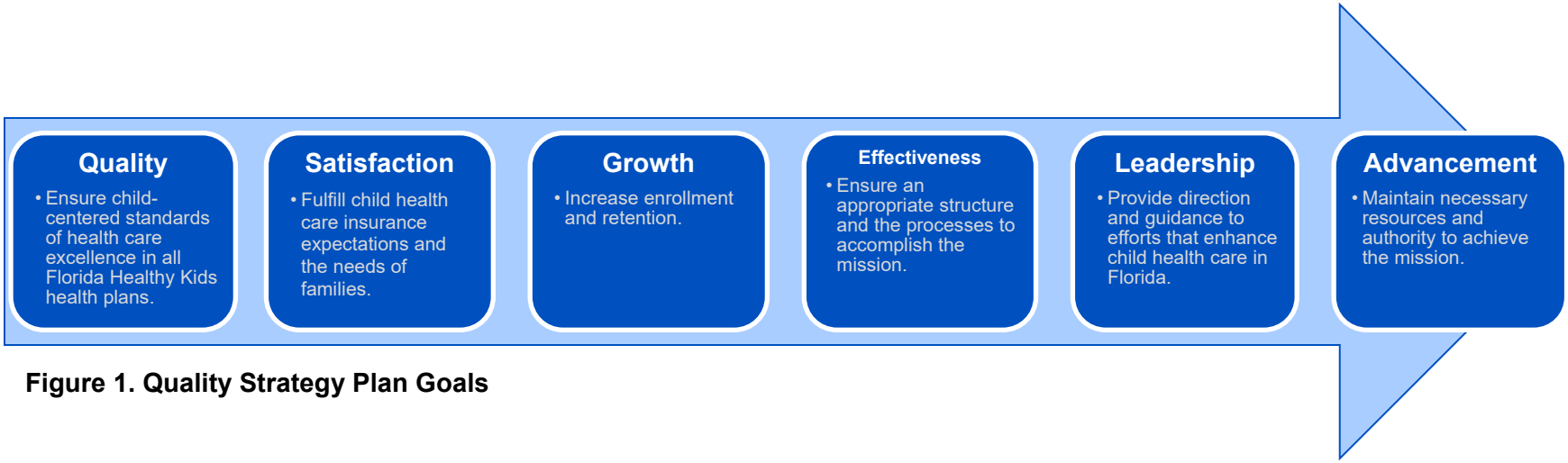

Figure 1. Quality Strategy Plan Goals

improvement projects and performance measures as determined by FHKC and evaluated by Qsource to foster alignment among QAPI requirements, the Quality Strategy Plan, and the annual EQR activities.

FHKC's goals along with their 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 solid 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 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 accept patients with publicly funded insurance coverage, and the insufficient number of pediatric subspecialists currently in the workforce.

To mitigate these challenges, FHKC requires its MCOs and DBMs to meet network adequacy time and distance standards established in the Quality Strategy Plan and supported by the MCO and DBM contracts. FHKC also requires each plan to demonstrate its capacity to service the expected population of Florida Healthy Kids enrollees and to adhere to time standards for providing services. Other areas monitored toward achieving

access to quality care include provider information accuracy, provider quality, care for children with special healthcare needs, transition of care, benefit decisions, and reducing health disparities.

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 regarding the quality, timeliness, 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 2022, according to CMS EQR Protocols published in October 2019. No protocol had yet been published at the time of conducting network adequacy activities for 2022, so Qsource, in cooperation with its subcontractor, Quest Analytics, followed internally developed standards.

Quality of Care

CMS describes Quality of Care 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 is evaluated in part through CAHPS [Consumer Assessment of Healthcare Providers and Systems (CAHPS®)] Health Plan Survey 5.0H, Child Version (CPC). 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.

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)

Timeliness of Care

For quality care to be effective, it must be provided in an appropriate, 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

Access to Care

In addition to quality and timely care, enrollees need to have access to the right type of care to ensure health outcomes. 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 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 may also be monitored through plan-developed PIPs that address the availability and accessibility of services needed by enrollees. In addition, monitoring a Plans' performance on various quality measures allows for monitoring of enrollee access to care.

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

- ANA
- PIPs
- ACA
- PMV

Serving as an EQRO for the CMS EQR Protocol activities, Qsource provided FHKC and its MCOs and DBMs with technical assistance as defined by 42 CFR § 438.358 and incorporated by 42 CFR § 457.1250. In this capacity, Qsource maintained ongoing, collaborative communication with FHKC and supported the MCOs and DBMs in their EQR activities. In January 2022, Qsource provided a PIP refresher training to the plans in which all plans participated. Documents provided for the training included the 2022 PIP Summary Form Instructions and 2022 PIP Summary form. The 2022 PIP Summary Form Instructions contained specific information on how to complete the PIP and also provided a sample of the Plan-Do-Study-Act (PDSA) worksheet to assist the plans as they completed their clinical and

nonclinical PIPs. The 2022 PIP Summary Form document was provided to the plans for use in describing their PIP activities and submitting the information to Qsource for validation. Finally, Qsource conducted three health and dental All-Plan meeting(s) that were attended by FHKC, MCO, and DBM staff. The three All Plan 2022 meeting(s) featured the following topics:

- Value Based Care in the Pediatric Environment
- CATCH My Breath Vaping Prevention Program
- COVID-19 Update and Mental Health During the Pandemic
- Adolescent Substance Use and Mental Health
- Simply Healthy Minds: Ditching the Stigma Around Children's Mental Health
- Special Needs

The meetings were held in March, July, and December 2022.

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 *2022 Annual EQRO Technical Report*, which compiles the results of the EQR activities conducted in 2022 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 2021 EQR.

This *2022 Annual EQRO Technical Report* is based on detailed findings that can be found in the individual EQR activity reports provided to FHKC and its' MCOs and DBMs. Comparative analyses from EQR reviews conducted in 2020, 2021, and 2022 are included in this report where possible.

Finally, 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)

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, timeliness, and access to healthcare services provided for Florida Healthy Kids enrollees.

Performance Improvement Project (PIP) Validation

Assessment Background

PIPs help MCOs and DBMs evaluate performance in relevant areas of clinical care and nonclinical services. They work to improve areas of deficiency, areas benefiting from targeted improvement, and areas identified as a priority according to the Quality Strategy Plan. PIPs intend 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 as appropriate for each PIP. PIPs definitions in 42 CFR § 438.330(d) to include all 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 2022 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 required by contract 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 2022 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 to Qsource in July 2022.

Each PIP validation assessed MCO and DBM performance in 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 are scored as Met, Not Met, or Not Applicable. Qsource's scoring methodology was based on the percentage of elements met out 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. 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 *2022 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 Plan: 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 2022 PIP review, nine PIPs achieved a rating of High Confidence, and one received a rating of Low Confidence. No PIPs received a rating of Moderate or No Confidence. Additional details about each PIP are provided in Appendix A.

Table 3. 2022 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 Plan: Ages 12-17 (CDF-CH)	✓	✓		High Confidence	100%
	Nonclinical	Timely follow-up for patients after they have been hospitalized for mental illness (FUH 7-day)	✓	✓		High Confidence	100%
CCP	Clinical	Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)	✓	✓		High Confidence	90.91%
	Nonclinical	Health Risk Assessment (HRA) Response Rate	✓	✓		Low Confidence	78.72%
DentaQuest	Clinical	Preventative Dental	✓	✓	✓	High Confidence	100%
	Nonclinical	Increasing After-hours Care	✓		✓	High Confidence	100%
MCNA	Clinical	Preventative Dental Visit	✓	✓	✓	High Confidence	97.78%
	Nonclinical	Annual Dental Visit (ADV)	✓	✓	✓	High Confidence	100%
Simply	Clinical	Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)	✓	✓		High Confidence	93.33%
	Nonclinical	Improving Care Coordination to Improve Follow-Up Care for Children Prescribed ADHD Medication (ADD)	✓	✓		High Confidence	93.47%

Strengths, Weaknesses, and Improvements

Strengths for PIP validation indicate that the MCO or DBM excelled on an element and/or step within the activity and this strength can be identified regardless of the PIP 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 written 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. The MCOs and DBMs are not held accountable for addressing suggestions; therefore, suggestions are not monitored or included in this report.

Strengths

Strengths were identified in eight of the nine validation steps for the 2022 PIP validation. More plans received recognition for Step 6 as compared to any other step, with seven PIPs commended for including detailed information regarding data collection procedures for their respective PIPs. Five PIPs were identified to have strengths for Step 7, as the MCOs and DBMS provided comprehensive details related to the data analysis and interpretation of results. For Step 1, additional strengths were identified in four PIPs. Plans demonstrated clear identification of the population for the study and the inclusion of comprehensive analysis of the population's needs. In total, 25 strengths were identified for the 2022 PIP submission by the plans.

The 2022 PIP validation demonstrated that the MCOs and DBMs are committed to achieving Quality Strategy Plan goals 1, 3, 4, 5, and 6—quality, growth, effectiveness, leadership, 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

For the 2022 PIP validation activities, eight of the nine PIP steps were identified as having a weakness by one or more plans. Three plans had a total of seven weaknesses identified during the 2022 validation activities. Weakness impacted both clinical and nonclinical PIPs. Step 5 received the most feedback with three plans noted to have received an AON for this step. Weaknesses regarding Step 5 involved tracking performance over time, selection of variables, and consideration of existing evidence (published or unpublished). Additional weaknesses were noted in Steps 2, 7, and 8 with two plans receiving weakness on each of these steps. Some of the plans failed to provide references to existing evidence-based literature or provide information regarding the extent to which interventions were successful in terms of follow-up activities. Additionally, some plans failed to make specific references to the PDSA cycle used for the PIP.

The MCOs and DBMs demonstrated an understanding of the components of a valid PIP. Although the plans demonstrated an understanding, they did not apply the components consistently in their PIP submissions to Qsource. Qsource will continue to work closely with the plans on the PIP validation activities and will provide technical assistance as requested. The plans will also be provided with an updated process overview document and Qsource will conduct another PIP refresher training to assist

the plans as they strive to achieve a rating of high confidence rating for their PIPs.

Detailed weaknesses by Plan are provided in Appendix A.

Improvements

Table A-4 includes the improvements, labeled by the aspect of care affected, made by each MCO/DBM on the AON identified in 2021.

Aetna received one AON for the 2021 clinical PIP validation. For 2022, Aetna provided additional documentation in their clinical PIP submission regarding the analysis of enrollee needs and provider input related to the PIP which fulfills the deficiency noted in the 2021 PIP review.

CCP was identified to have two AONs in their 2021 clinical PIP and three AONs in their 2021 non-clinical PIP. For the 2022 clinical PIP, CCP provided specific information regarding the estimated degree of completion for the data collection process. CCP also provided specific information regarding selected PIP variables and performance measures which addressed the AONs identified in the 2021 clinical PIP. For the 2021 non-clinical PIP, Steps 1, 2, and 5 were identified as having AONs for CCP. CCP addressed Step 2 in the 2022 review of the non-clinical PIP; however, no updates were provided in the 2022 non-clinical PIP to resolve AONs for Steps 1 and 5.

Simply received four AONs for Steps 2, 5, 6, and 9 on the 2021 clinical PIP and three AONs for the 2021 non-clinical PIP on Steps 1, 5, and 9. For the 2022 clinical PIP, Simply provided updated information which included an unambiguous goal, and reported the timeframe for remeasurement period 2. For Step 5, Simply provided information regarding the components under review, but did not fully address the second component variable of measure regarding the follow-up plan documented after a positive screening is received. Additional information is needed to resolve this AON. For Step 6, Simply identified that all eligible enrollees are included in the PIP. Simply addressed Step 9 of the 2022 clinical PIP and provided an assessment of sustained improvement which included statistical information. For the 2022 non-clinical PIP, Simply addressed AONs in Step 1 as identified in the 2021 PIP submission. The plan provided a comprehensive analysis of the enrollee needs for Step 1. For Step 5, Simply provided a detailed description of the PIP variables and performance measures under review which included information regarding outpatient visits. In the 2022 clinical PIP, Simply addressed Step 9 and linked the improvement to provider education efforts.

For 2021, DentaQuest received two AONs for Steps 8 and 9, related to their non-clinical PIP. For 2022, DentaQuest addressed Step 8 by providing information regarding four improvement strategies attempted to improve performance in the measurement year. DentaQuest also addressed Step 9 in the 2022 clinical report by providing a detailed analysis of the likelihood that significant and sustained improvement occurred during the measurement year, as well as information pertaining to BL, R1, and R2.

For 2021, MCNA received one AON for both its clinical and non-clinical PIP submissions for Step 2. MCNA addressed the AONs identified in the 2021 PIP submission by ensuring the PIP Aim statement was answerable and measurable.

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 2022 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 2021. 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. Of the 23 total measures included in the 2022 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 non-HEDIS measures required to be reported by FHKC in 2022 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 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 2022 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 using 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 2022 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:

- **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.
- **Reviews:** The virtual review lasted one day and included the following:
  - An 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
  - A closing session summarizing preliminary findings and recommendations

Description of Data Obtained

Table 4 lists the audited measures for MCOs, and Table 5 lists the audited measures for DBMs. Age stratifications that do not apply to the Florida Healthy Kids population (ages 5–18 years) have been omitted. In the case that a measure 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. 2022 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)

Table 4. 2022 PMV: MCO Performance Measures			
Quality	Timeliness	Access	Measure
✓	✓		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)
✓			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)
			(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)
✓		✓	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 2022 PMV. Each measure is labeled according to the quality, timeliness and/or access of care assessed.

Table 5. 2022 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

Trending analysis is included where possible from the 2021 PMV to the 2022 PMV, provided in Appendix A. To better identify trending for these measures, the use of green and red arrows are used to indicate this year's result for each measure as compared to results from 2021. Table A-5 and Table A-8 indicate an increase (⬆) or decrease (⬇) from the previous year's rate. Trending is not included for two MCO measures (in Table A-6 and Table A-7), because the measure results are generally small (less than one percent).

Chart 2 and Chart 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 2021 PMV to the 2022 PMV, categorized by quality, timeliness, and access.

As compared to 2021, all MCOs and DBMs saw an increase in the total measures being reported. For the MCOs, Community Care Plan (CCP) was noted to have the most improvements with 48 measures trending up in 2022. CCP was also noted to have the most significant improvements between 2021 and 2022, with 33 of the 48 measures improving at a rate of 10% or greater since 2021. CCP had less measures trending down as compared to Aetna and Simply during the same time. Aetna reported 46 measures as trending up and Simply reported 44 measures trending up. Aetna also reported 35 measures trending down and Simply reported 29 measures trending down for 2022. The DBMs showed the most improvement between 2021 and 2022, with more measures trending up in 2022. The DBMs had fewer measures trending down as compared to the MCOs for the same measurement period. For the DBMs, DentaQuest was noted as having the most improvements in 2022 with a total of 125 measures improving from the 2021 measurement year. Of the 125 measures trending up for DentaQuest, 17 measures improved at a rate of 10% or greater from the previous year.

DentaQuest also had less measures trending down as compared to Argus and MCNA.

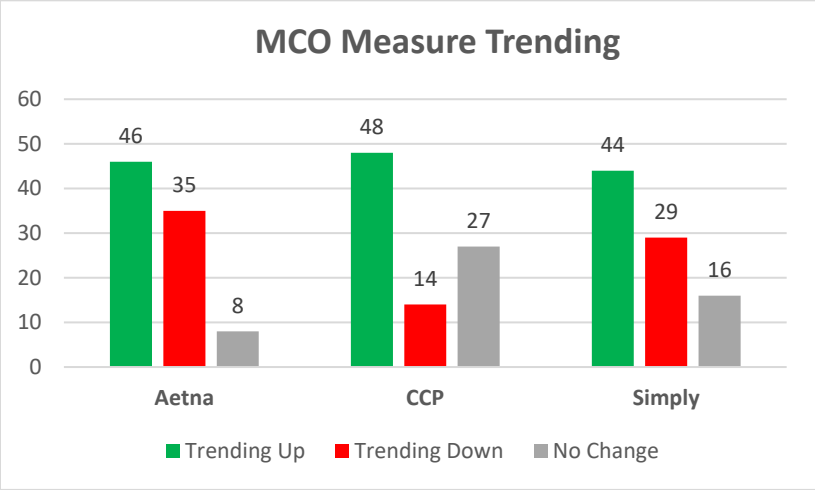

Chart 2. MCO Measure Trending from 2021 to 2022

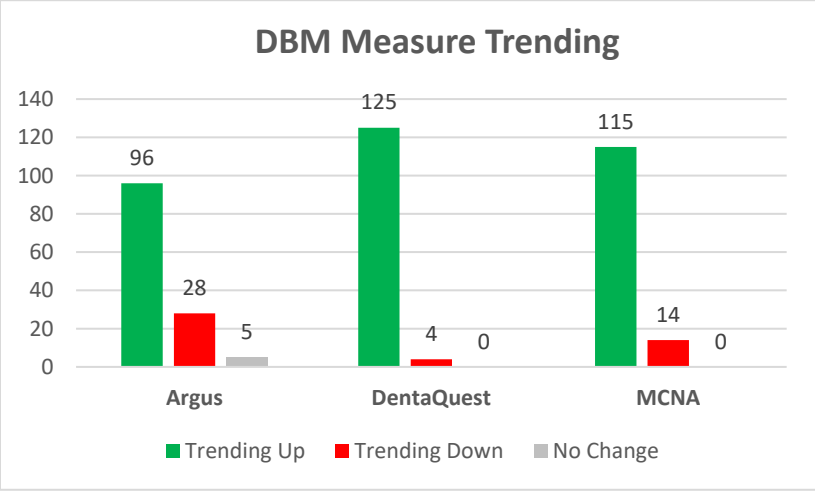

Chart 3. DBM Measure Trending from 2021 to 2022

Strengths, Weaknesses, and Improvements

Strengths for the PMV indicate that the MCO or DBM demonstrated proficiency in processes for calculating performance measures identified by FHKC. Areas for improvement, or weaknesses, are noted when the 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 or DBMs, 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 Agency for Healthcare Administration (AHCA) Managed Medical Assistance (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 2022 PMV, as with the 2021 and 2020 PMV activities.

Improvements

Table A-9 includes the MCOs' and DBMs' significant improvements (more than 10%) made based on last year's PMV

analysis. Any MCO or DBM not included had no identified areas for improvement in 2021.

CCP had the most improvements since 2021, with 48 measures trending up. Of the 48 measures reported by CCP, a total of 33 measures improved at a rate of 10% or greater since 2021. Regarding the aspects of treatment addressed in the performance measure, CCP excelled on performance measures related to both quality and timeliness. Aetna showed the greatest improvement in performance measures related to access when compared to all other plans, with improvements noted in 16 performance measures associated with access.

For the DBMs, DentaQuest had the most improvements in 2022 with a total of 125 measures trending up. Of the 125 measures for DentaQuest, 17 measures improved at a rate of 10% or greater from the previous year. DentaQuest was noted to have less measures trending down as compared to Argus and MCNA. Measures are labeled according to the aspect of care they assess quality, timeliness, or access. Measures trending up at a rate of 10% or higher are broken down by the aspect of care (quality, timeliness, and access) addressed for each plan in Charts 4, 5, and 6.

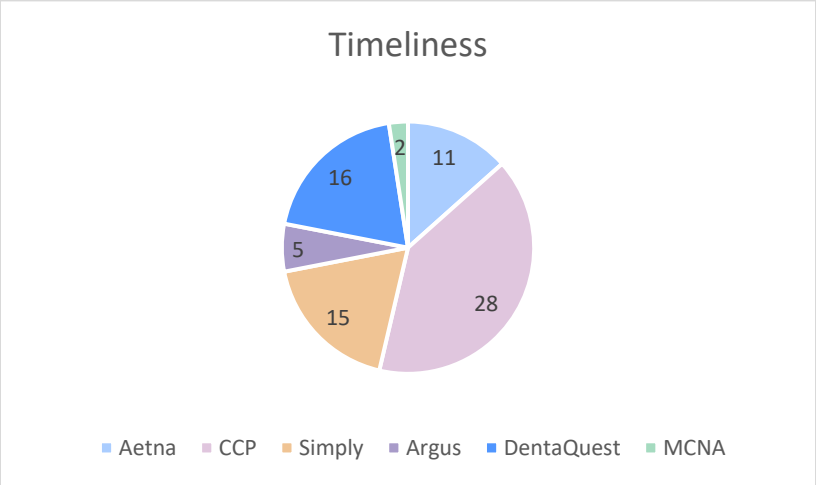

Chart 4. Total Quality Measures Trending at 10% or Greater

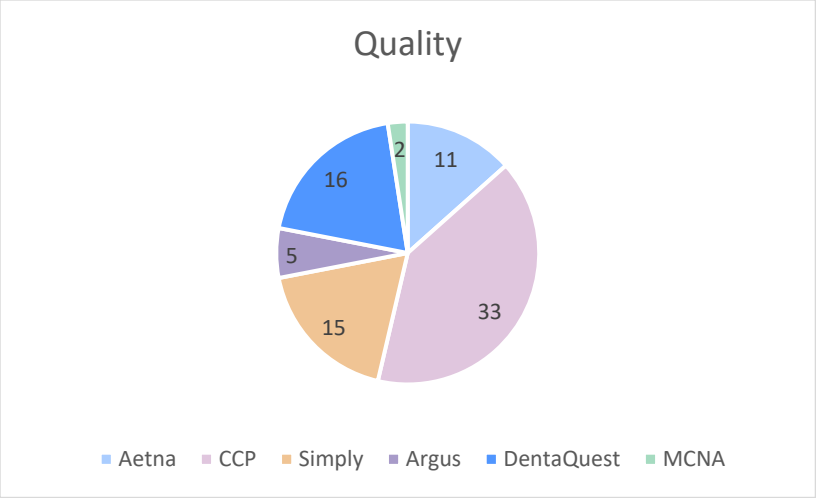

Chart 5. Total Timeliness Measures Trending at 10% or Greater

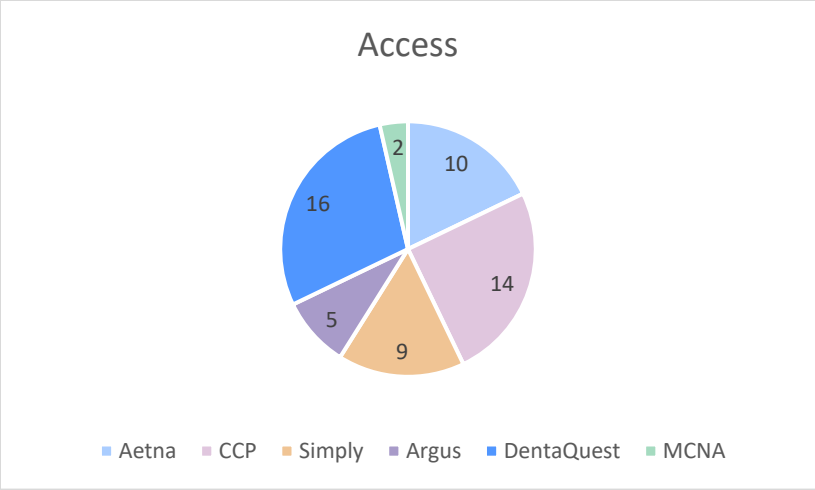

Chart 6. Total Access Measures Trending at 10% or Greater

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

Each year, FHKC reviews nearly one-third of the compliance standards as shown in Table 6. Coordination and Continuity of Care, Coverage and Authorization of Services, and Subcontractual Relationships and Delegation were the standards reviewed and included in this report. Denial file reviews were also completed as part of the assessment.

Table 6. Compliance Assessment Standards

Standard	Quality	Timeliness	Access	Review Year
Availability of Services		✓	✓	2021
Assurances of Adequate Capacity and Services	✓	✓	✓	2021

Table 6. Compliance Assessment Standards

Standard	Quality	Timeliness	Access	Review Year
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

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

The overall results for the 2022 compliance assessments are included for each MCO and DBM in the Comparative Findings section. The discussion of results along with compliance scoring, strengths, weaknesses, and improvements since 2021 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. However, due to the COVID-19 pandemic, all regularly scheduled onsite reviews were migrated to virtual reviews using 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 during the pre-onsite review phase, 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 reviewers completed desktop reviews of all documentation provided by the MCOs and DBMs. During the onsite review, MCO and DBM staff answered questions and provided information to help reviewers 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 reviewers 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 provided additional P&Ps and other relevant documents for reviewers during the virtual review that occurred in April 2022.

To reduce duplication of assessment activities, FHKC allowed certain standard elements to be deemed compliant when an MCO/DBM currently accredited by a nationally recognized accreditation organization such as NCQA, the Accreditation Association for Ambulatory Health Care (AAAHC), or URAC®, had achieved a full score on an element with similar requirements to the regulatory or contractual element. All plans elected to provide full documentation for all elements for the 2022 ACA.

In addition to compliance standards, the ACA included reviews of a random sample of enrollee denied 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 all 2021 denial files, from which a random sample and an oversample was abstracted. A total of 15 denial files (10 sample and 5 oversample) were used.

Description of Data Obtained

Throughout the documentation review and virtual assessment processes, Qsource reviewers used the survey tools to collect information and document findings. Each MCO's and DBM's compliance with regulatory and contractual standards were validated 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 7 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 7. 2022 ACA Overall Compliance Scores

Standard	Overall Compliance	
	MCOs	DBMs
Coordination and Continuity of Care	67.5/68 (99.26%)	33.9/40 (84.75%)
Coverage and Authorization of Services	18/18 (100%)	8/8 (100%)
Subcontractual Relationships and Delegation	18/18 (100%)	8/8 (100%)
Denial File Review	10/10 (100%)	8/10 (80.00%)
Total Overall Score	113.5/114 (99.56%)	57.90/66 (87.72%)

Comparative Findings

Chart 7 includes overall compliance scores for all standards evaluated over the past three-year period (2020–2022), organized according to each element's relative care category: quality, timeliness, and access. Detailed discussion of the 2022 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. For 2022, Coordination and Continuity of Care, Coverage and Authorization of Services, and Sub-contractual Relationships and Delegation were the specific areas of review for the compliance assessment. Each MCO and DBM under contract with FHKC during the measurement year were evaluated on these areas of practice. The MCOs performed higher than the DBMs regarding Coordination and Continuity of Care, as the MCOs received a combined score of 99.26% as compared to the DBM's combined score of 84.75%. The lower scores for the DBMs were attributed to missing documentation in the DBMs submission. The MCOs and DBMs performed at the same rate (100%) for both Coverage and Authorization of Services and Sub-contractual Relationships and Delegation. The DBMs were also noted to have achieved a score of 80.00% for the denial file review while the MCOs scored at 100% for denial file review.

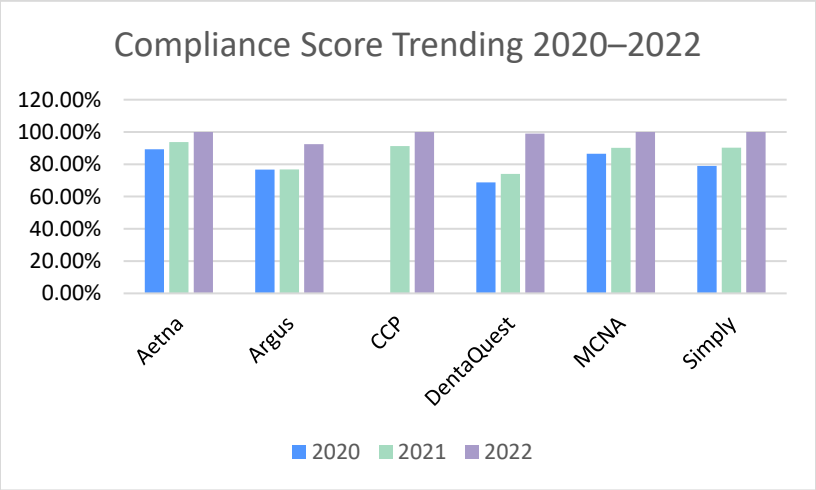

Chart 7. MCO/DBM Overall Compliance Score Trending 2020–2022

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 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 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.

Strengths

For the 2022 ACA, strengths were identified across all three standards assessed. More strengths were identified for the plans regarding Coverage and Authorization of Services as compared to Coordination and Continuity of Care and Subcontractual Relationships and Delegation. Both the MCOs and DBMs had strengths identified regarding process documents and workflows submitted, which provided a clear indication that the plans are working within the guidelines specified by CMS, NCQA, and FHKC. The use of evidence-based practice was observed in the documentation presented for review. Additional strengths were noted with early engagement of new enrollees through clear and timely communication. The plans also provided information regarding frequent training opportunities and evaluation of staff through inter-rater reliability testing. Some plans provided documentation connecting their compliance practices to their performance improvement projects further indicating a commitment to providing access and services as indicated in the quality strategy plan set out by FHKC. Chart 8 provides a visual diagram of each plan's strengths and how those strengths are aligned to the quality strategy plan of improving access, timeliness, and quality of services for enrollees. Some standards apply to more than one category and may be counted for multiple categories.

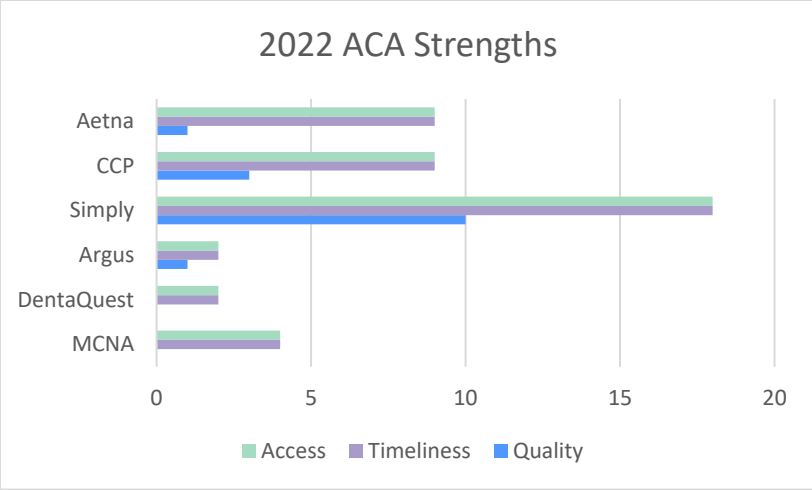

Chart 8. 2022 ACA Strengths

Detailed strengths by Plan are included in Appendix A.

Weaknesses

Weaknesses were identified in Coverage and Authorization Services for plans receiving an AON in 2022. No weaknesses were identified for Coordination and Continuity of Care or Subcontractual Relationships and Delegation. Weaknesses were attributed primarily to elements in which no documentation was received for review throughout the assessment period. Additional areas with AONs were related to family planning referrals, tracking out-of-pocket copays, and expedited requests. Some documentation presented failed to clearly identify CFR requirements for the element under review. Chart 9 shows the combined strengths and weaknesses as it relates to quality, timeliness, and access for the 2022 ACA. Some standards apply

to more than one category and may be counted for multiple categories.

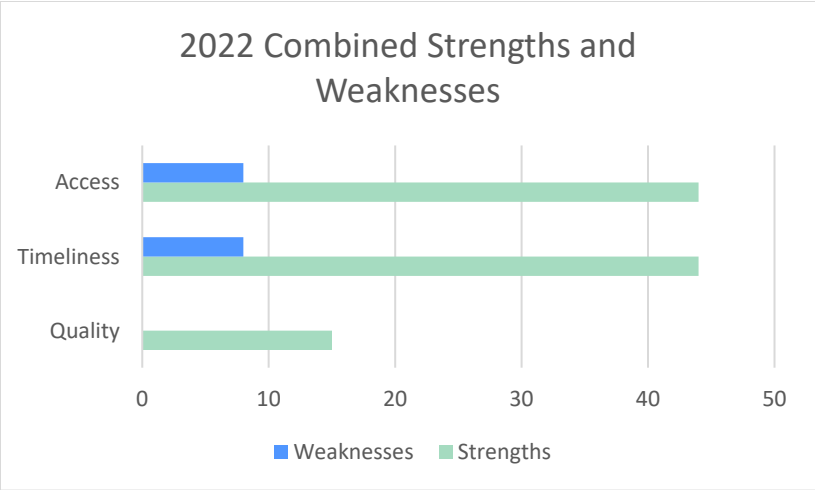

Chart 9. 2022 ACA Combined Strengths and Weaknesses

Detailed weaknesses by Plan are included in Appendix A.

Improvements

Table A-14 includes the MCOs' and DBMs' improvements made based on last year's ACA analysis of AONs. Any MCO or DBM not included had no identified areas for improvement in 2021. The six standards assessed as part of the 2021 ACA were Availability of Services, Assurances of Adequate Capacity and Services, Grievances and Appeals, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement (QAPI). Improvements are labeled according to their related aspects of care: quality, timeliness, or access.

In 2021, CCP received two AONs related to Availability of Services which are also related to timeliness and access. CCP provided additional documentation for their policy and handbook, which resolved their AONs. Simply received six AONs during the 2021 ACA, mostly related to Grievance and Appeals; however, Simply received one AON related to Availability of Services. Simply provided an update to the enrollee handbook which addressed the AON related to Availability of Services. Additionally, Simply made updates to their Grievance and Appeals policy which satisfied the AONs noted during the 2021 review. Argus had 14 AONs in 2021. These AONs consisted of the following standards: Availability of Services, Grievance and Appeals, Health Information Systems, and Quality Assessment and Performance Improvement. Argus presented an updated policy which satisfied the AON for the Availability of Services standard. For Grievance and Appeals, Argus provided updated policy information to address the AONs found during the 2021 ACA. In addition to providing policies, Argus noted a change in the CFR requirements which changed the requirement of written follow-up to a verbal request. Regarding Health Information Systems, Argus had partial improvement since 2021, as only part of the information provided addressed the deficiency noted for the plan. For Quality Assessment and Performance Improvement, Argus provided an updated policy which addressed one of the AONs received for this standard. DentaQuest received an AON in 2021 pertaining to the Practice Standards guideline. DentaQuest provided an updated policy

which addressed the deficiency noted in the 2021 ACA report. MCNA received AONs for the Availability of Services and Grievance and Appeals standards for 2021. MCNA provided updated policy information addressing the AONs noted in the Availability of Services standard. MCNA also provided an updated handbook and policies to address three of the four AONs related to Grievance and Appeals. See Table A-14 for more detailed information regarding improvements made since 2021.

Annual Network Adequacy (ANA)

Assessment Background

The ANA provides valuable information about enrollee access to primary and specialty care providers as well as the timeliness of that access. 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.

Network adequacy reviews were conducted for primary care providers only for the health plans prior to 2018. Beginning in 2018, the network validation process was expanded to include specialty providers as well as hospitals. For the dental plans, beginning in 2018 the network adequacy reviews expanded the scope from primary dental providers to include dental specialty provider types. Additional changes occurred in the network adequacy review for 2019 as contracts between FHKC and the MCOs and DBMs were amended effective July 1, 2018. The 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. Additional changes occurred in 2020 with the network adequacy review including an updated list of specialty provider types and specialty roll-up categories for MCOs. Network adequacy for the dental plans remained the same for 2020 with no additional changes in requirements for network adequacy.

Geographical access was determined for both urban and rural enrollees by calculating the travel time and distance between enrollees and the provider types specified in the contracts between FHKC and the MCOs and DBMs.

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 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 to each 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 2021 and consistent with contract standards. The ANA reviews were conducted in August 2022.

Technical Methods for Data Collection and Analysis

The 2022 ANA evaluation included MCO and DBM provider networks as of June 2022. MCO and DBM relevant P&Ps and provider and enrollee communication materials were assessed. The reviewers focused on the following areas:

- Analyses of the geographic distribution and availability of providers to Florida Healthy Kids enrollees
- 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

Data provided from MCOs' and DBMs' provider files and enrollment data supplied by FHKC were used in the quantitative analysis. 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. After Provider and enrollee address information had been validated, it was cleaned and standardized to United States Postal Service (USPS) specifications. The addresses generated from this process were analyzed to assess network adequacy for all MCOs and DBMs. Analyses were conducted for the provider and specialty types listed in Table 8 for the MCOs and Table 9 for the DBMs. Additional information about this process is in each MCO's and DBM's *2022 Annual Network Adequacy Report*.

Table 8. ANA Provider/Specialty Categories for MCOs

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

Table 9. ANA Provider/Specialty Categories for DBMs

- Primary Care Dentists
- Orthodontists
- Dental Specialists

Comparative Findings

Comparisons year over year are included where possible.

Travel time refers to the length of time it takes for the enrollee to reach the provider's location. Chart 10 shows 2021-2022 trending information for both urban and rural travel time. The chart indicates the total number of measures that trended up, trended down, or remained unchanged since 2021. Distance analysis refers to the total distance from the enrollee's address to the provider's location. Chart 11 shows the total number of urban and rural measures of distance for each MCO and DBM which trended up, trended down, or remained unchanged in 2022.

Chart 10 and Chart 11 are representative of the total number of required provider/specialty categories. The percentage of compliance for each plan is provided for the 2022 measurement year. Additional information pertaining to plan-specific results for the MCOs and DBMs are presented in Appendix A.

For travel time trending, CCP had the most improvements among the MCOs since 2021; 8 measures remained unchanged, and 11 measures trended up. Simply had the most measures trending down during the same time. For the DBMs, DentaQuest had the most improvements, with two measures trending up, whereas Argus had the most measures trending down for the same measurement period.

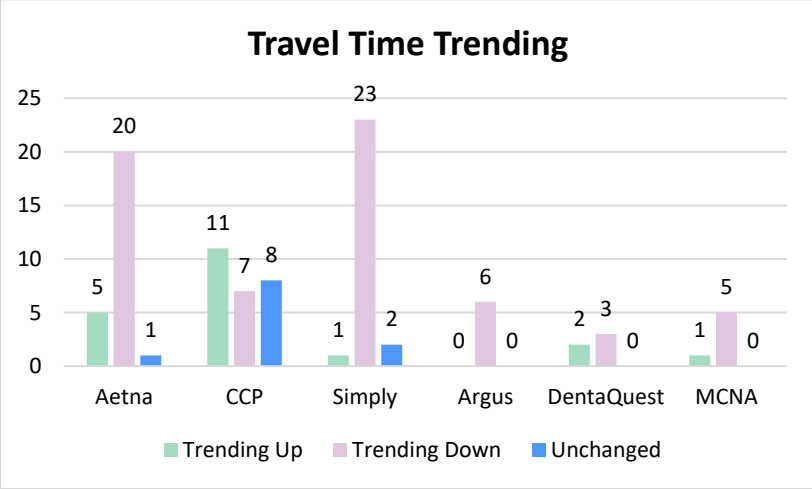

Chart 10. ANA Provider/Specialty Categories Travel Trending from 2021 to 2022

For distance analysis for the MCOs, Aetna and CCP both had four measures trending up, and CCP had six measures unchanged. Simply had 22 measures trending down for the same time period. Distance analysis trends for the DBMs indicated that MCNA had the most improvements since 2021 with three measures trending up. DentaQuest and Argus both had no measures improved and six measures trending down.

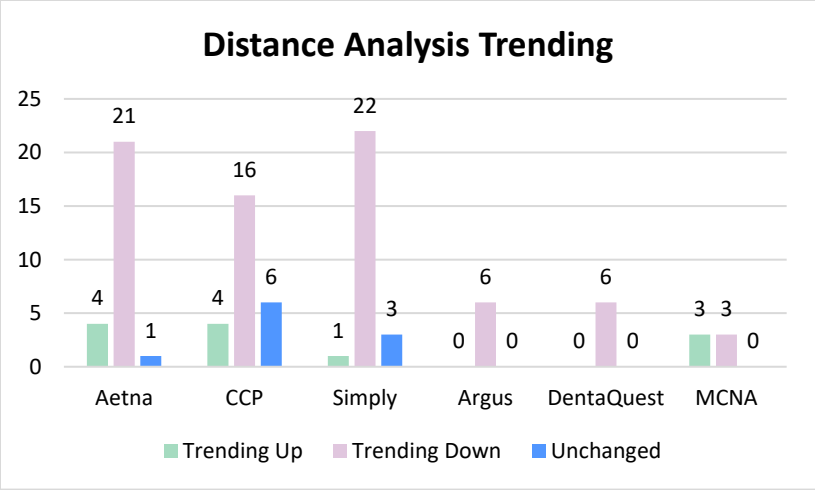

Chart 11. ANA Distance Analysis Trending from 2021 to 2022

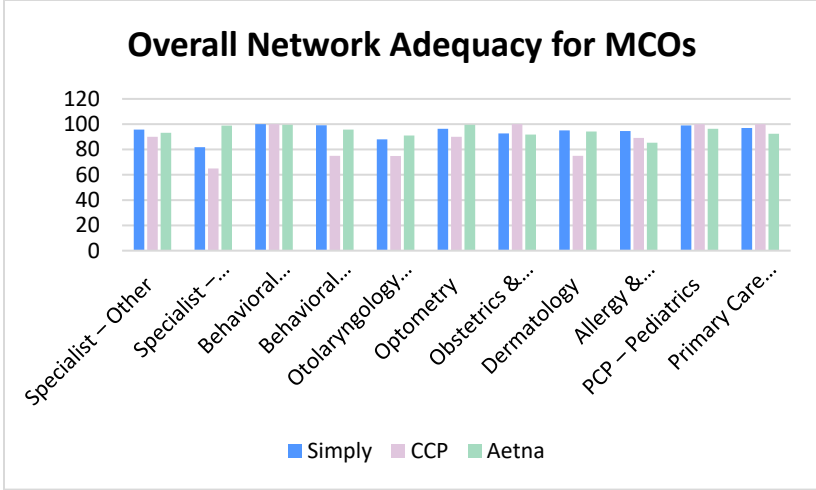

Chart 12. ANA Provider/Specialty Categories Overall Network Adequacy for MCOs

All specialty provider types for the MCOs along with the corresponding percentages of compliance with network standards are listed in Chart 12. Chart 13 provides the same information for the DBMs.

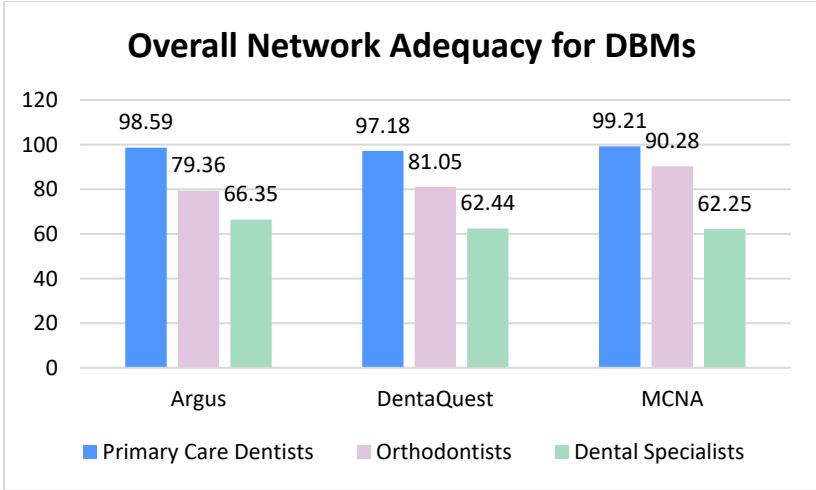

Chart 13. ANA Provider/Specialty Categories Overall Network Adequacy for DBMs

Strengths, Weaknesses, and Improvements

Strengths indicate that the MCO or DBM demonstrated 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

The MCOs provided comprehensive access (90% or greater) for time and distance standards for both urban and rural enrollees to the following specialty provider types: Primary Care Provider (PCP), PCP Pediatrics, Obstetrics & Gynecology, Optometry, and Behavioral Health: Other. All three MCOs were at 100% access for Behavioral Health-Other. In addition, CCP provided 100% access for PCP and PCP Pediatrics. Similarly, all DBMs provided comprehensive access for time and distance to Primary Care Dentist above 95% for urban and rural enrollees. MCNA also met time and distance standards for Orthodontics. Detailed strengths by Plan are included in Appendix A.

Weaknesses

Weaknesses within network adequacy among the MCOs primarily consisted of the following specialty provider types: Allergy & Immunology, Dermatology, Otolaryngology, Behavioral Health: Pediatric, Specialist: Pediatric, and Specialist: Other. CCP did not provide adequate access for the following provider types during 2022: Allergy and Immunology, Dermatology, Otolaryngology, Behavioral Health-Pediatric, and Specialist: Pediatric. Aetna did not meet access standards for time and distance for Allergy and Immunology. Simply did not meet access standards for time and distance for Specialist: Pediatric and Otolaryngology. As with the MCOs, the DBMs showed a decline in access to care for time and distance with Orthodontist and Dental Specialist. Neither Argus nor DentaQuest met the access standards for time and distance for both Orthodontics and Dental Specialist.

Detailed weaknesses by Plan are included in Appendix A.

Improvements

Table A-21 includes the MCOs' and DBMs' improvements made based on last year's ANA analysis. If a MCO or DBM had no identified areas for improvement in 2021, they are excluded from this report.

Conclusions and Recommendations

Qsource conducted mandatory and optional EQR activities for all MCOs and DBMs providing health and dental services for the Florida Healthy Kids program for calendar year 2022. Based on these activities, Qsource has created the following conclusions and recommendations to improve enrollees access to, quality of and timeliness to care.

PIP Validation

All plans continue to show a commitment to improving the quality of services provided to the enrollees of FHKC as evidenced by information reported during 2022. The plans have shown improvement since 2021 in terms of their performance improvement projects. Furthermore, the plans provided documentation to resolve AONs that were identified in the 2021 PIP validation activities. Most PIPs submitted by the plans had a high confidence rating that interventions implemented would help to improve the quality of services provided to enrollees. Recommendations for future PIP tasks are as follows:

- Provide evidence-based literature regarding interventions used for the PIP.
- Clearly identify data collection methods.
- Ensure the PDSA process is clearly addressed for each intervention.
- Provide specific data ranges when describing the PIP interventions.
- Address lessons learned following the implementation of the intervention.
- Continuously assess interventions for significant and sustained improvement and clearly identify how information is monitored throughout the year.

PMV

The 2022 PMV activities focused on performance metrics in relation to HEDIS and Child Core set measures. All plans were deemed fully compliant with all NCQA-defined Information System Standards for HEDIS-applied data and processes. Each MCO 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. Recommendations for future PMV activities are as follows:

- Ensure all relevant policies, procedures, and reports are provided for PMV submissions.

ACA

Coverage and Authorization of Services (CAS), Coordination and Continuity of Care (CCC) and Subcontractual Relationships and Delegation (SRD) are the areas addressed in the 2022 ACA activities. For the 2022 ACA, most plans scored above 95% for both CAS and CCC, with only one plan scoring below 90%. For SRD, all applicable plans scored 100% during the 2022 review. In addition, denial file reviews were completed for each plan; Qsource found that all plans were complying at a rate of 95% or greater. Recommendations for future ACA activities include the following:

- Ensure that all policies are written to provide specific information regarding expedited authorization requests and that the policy is no more stringent than what is allowed per contract with FHKC.

- Ensure all documentation submitted for review is clearly labeled and identified for each element within the ACA tools.
- All documentation submitted for ACA review should be relevant for the lookback period under review.
- Ensure that information regarding family planning referrals is updated in the member handbook to indicate that a referral is not required.

ANA

The 2022 ANA activities assessed time and distance standards for all plans. Although the plans trended down in 2022 regarding time and distance standards to specialty providers, the plans were mostly compliant with time and distance standards as outlined by FHKC contracts. Allergy & Immunology, Dermatology, Otolaryngology, Behavioral Health-Pediatric, Specialist: Pediatric, and Specialist: Other were areas of improvement identified for the MCOs. The DBMs showed a decline in access to care for time and distance with Orthodontists and Dental Specialists. Recommendations for future ANA activities include the following:

- Ensure that all information regarding FHKC approved waivers is provided for ANA reviews.
- Continue engaging with providers to grow the network.
- Focus on growing the network in areas in which the plan did not meet time and distance standards at 90% or above.

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 2022 PIP, PMV, ACA, and ANA activities.

PIP Validation

Table A-1 includes each MCO/DBM's full PIP title, aim statement, performance measure(s), improvement strategy, measurement results, strengths and weaknesses. For PIPs in their baseline year, the improvement strategy does not apply and therefore are not included. 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. Detailed MCO and DBM scores for the clinical PIPs are in Table A-2 and for the nonclinical PIPs, in Table A-3.

Table A-1. 2022 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 FHKC 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 year (MY 2021)?
Performance Measure	Performance Measure 1. Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)
Improvement Strategy	Improvement Strategy #1. Provider Notification: Aetna sent out fax blasts quarterly to all FHKC providers in 2021 notifying them of the reimbursement rates for the depression screening codes. The intent of these interventions is to: promote depression screening among this age group; educate practitioners on the depression screening requirements, especially those associated with the CDF-CH measure, and inform and educate practitioners about the correct, appropriate coding/billing for effective reimbursement of these services.
Measurement Results	BL: 8.56%, R1: 6.52% with Goal rate of 8.56%.
Strengths	Step 2. Review the PIP Aim Statement: The MCO organized all information in a clear method and addressed each element as stated.

Table A-1. 2022 PIP Details for MCOs and DBMs	
	Step 3. Review the Identified PIP Population: The MCO clearly identified the PIP population and addressed information related to anchor dates and continuous enrollment. This helps to remove any ambiguity on who is included in the PIP population for the MCO.
Aetna: Timely follow-up for patients after they have been hospitalized for mental illness (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 FHKC 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 2021 National Committee for Quality Assurance (NCQA) Quality Compass 50th percentile during the third re-measurement period (MY 2021)?
Performance Measure	Follow-Up After Hospitalization for Mental Illness (FUH 7-day)
Improvement Strategies	Improvement Strategy #1. Behavioral Health (BH) Liaisons Provider Intervention: Aetna's BH Liaisons identifies hospitals/facilities that discharged members without the recommended 7-day follow-up appointment and conducts in-service meetings with the discharge planning teams and leadership at each of these facilities. During these meetings, the BH Liaison: educates the discharge planning staff at selected facilities on the HEDIS measures for FUH, and the recommended follow-up visits at 7 and 30-days post discharge, identifies barriers to scheduling follow-up appointments with member prior to discharge, and discusses options and best practices to promote scheduling the recommended follow-up appointments and circumvent or address barriers to care. Improvement Strategy #2. Behavioral Health (BH) Liaisons Member Outreach: Member Outreach calls placed by Aetna Behavioral Health of Florida (ABHFL) BH Liaisons to members (or their parents/guardians) during or after the child's acute BH hospitalization or BH residential treatment to obtain and if need be, verify aftercare appointment information (date/time/provider) OR to coordinate aftercare appointments with a licensed mental health (MH) professional within 7 or 30 days of discharge if appointment has not been made by facility within the specified time frame.
Measurement Results	BL: 33.77%, R1: 35.58%, R2: 51.08%, R3: 49.82% with Goal rate of 38.99%.
Strengths	Step 1. Review the Selected PIP Topic: The information provided for each element was specific and detailed. The MCO selected a topic which is considered a high priority health need for a special population. This topic aligns with priorities identified by CMS in addition to addressing utilization of services at the enrollee level. Step 6. Review the Data Collection Procedures: The MCO described the data collection design in comprehensive detail. Step 7. Review the Data Analysis and Interpretation of PIP Results: The MCO provided comprehensive detail for

Table A-1. 2022 PIP Details for MCOs and DBMs	
	each element under Analysis and Interpretation of PIP results. Step 9. Assess the Likelihood that Significant and Sustained Improvement Occurred: The MCO provided comprehensive detailed information regarding the PDSA cycle utilized by the MCO. The MCO's information regarding each step of the PDSA was robust. Both cycle 1 and cycle 2 were addressed specifically to provide a supporting documentation regarding the performance of this non-clinical PIP.
Community Care Plan: Screening for Depression and Follow-Up Plan Ages 12 to 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 in each measurement year? Does education to providers about screening using a standardized tool and submitting the appropriate codes on the encounter submission result in an increase in screening for depression and appropriate follow up in 12–17-year-old FHKC enrollees in each measurement year?
Performance Measure	Screening for Depression and Follow-Up Plan Ages 12 to 17 (CDF-CH)
Improvement Strategies	Improvement Strategy #1. Provider Education: Education of provider offices on coding the depression screening completion on encounter submissions or submitting a separate data file pulled from their electronic health records (EHR). Improvement Strategy #2. Data Collection: Collect medical records as non-standard supplemental data.
Measurement Results	BL: 2.72%, R1: 4.63% with Goal rate of 12.72%.
Strengths	Step 1. Review the Selected PIP Topic: CCP identified the need for early provider engagement to combat depression in adolescents. CCP clearly identified other health-related issues that could impact the enrollees which may become life-threatening if depression is left untreated. Information regarding those to be included in the study was clear and measurable. Information regarding exclusions from the study were noted to be enrollees that have an active diagnosis of bipolar disorder or depression. Step 3. Review the Identified PIP Population: CCP provided additional information regarding the population and verified that there are no enrollment length criteria for this population for the PIP study which helps to clarify there are no limitations to being included in the study from an enrollment perspective and all enrollees are captured for the study during the measurement year. Step 5. Review the Selected PIP Variables and Performance Measures: Frequent monitoring of CMS Core Set measures for the population within the study population. The MCO also clearly outlined their process as it pertains to PIP variables and performance measures for their clinical PIP. Research conducted for the PIP study clearly

Table A-1. 2022 PIP Details for MCOs and DBMs	
	indicates that this measure is meaningful for the enrollees under the management of CCP. Step 6. Review the Data Collection Procedures: CCP provided a diagram showing the flow of data withing their internal systems as it pertains to claims and encounters. Information comes into the MCO and is transferred to the Data Warehouse and then to the Inovalon Secure File Transfer Protocol (SFTP) site. HEDIS and Child Core Set rates are produced, and information is then loaded back to CCP's Data Warehouse for review. The process appears clean and easy to navigate. Step 7. Review the Data Analysis and Interpretation of PIP Results: Interventions in 2021 confirm an increase in the number of enrollees ages 12 to 17 that have received a depression screening during the measurement year.
Weaknesses	Step 8. Describe Improvement Strategies. Element 01: CCP should provide references to reviewed studies to show that evidence-based literature was reviewed for the purposes of this study. Step 8. Describe Improvement Strategies. Element 03: Although the MCO noted steps taken which indicate a PDSA process was in place, the MCO did not describe each part of the PDSA for each strategy. The MCO should describe each step in the PDSA process for each improvement strategy. Step 8. Describe Improvement Strategies. Element 04: CCP should address whether the study was culturally and linguistically appropriate. Step 8. Describe Improvement Strategies. Element 06: CCP should disclose the extent to which their interventions are successful in terms of improvement with follow-up activities as indicated in their intervention strategies.
Community Care Plan: Health Risk Assessment (HRA) Response Rate	
Aim Statement	Does incentivizing newly enrolled FHKC enrollees to complete the HRA within 90 days of enrollment result in higher return rates in each measurement year?
Performance Measure	The percentage of CCP FHKC new enrollees that complete the HRA within 90 days of enrollment.
Improvement Strategy	Improvement Strategy #1. Onboarding Member Calls: Onboarding calls at least three attempts on different days and at various times of the day.
Measurement Results	BL: 11.46%, R1 13.27% with Goal rate of 12.61%.
Strengths	Step 6. Review the Data Collection Procedures. Element 07: While not noted specifically, the HRA form (paper form and electronic form in the JIVA system) allows for consistent and accurate data collection.

Table A-1. 2022 PIP Details for MCOs and DBMs

	Step 6. Review the Data Collection Procedures. Element 09: The MCO addressed information regarding the qualification of staff who review the HRA data coming into the plan. The MCO gathered data administratively and it was not necessary to provide information regarding the staff qualifications. Based on the information presented, the MCO has a clean process outlined for their staff as it pertains to HRA information gathering. Step 7. Review the Data Analysis and Interpretation of PIP Results: Information for each element was submitted in a clear and concise manner.
Weaknesses	Step 1. Review the Selected PIP Topic. Element 02: The MCO should specifically indicate if the PIP topic addresses a CMS Core measure. Step 1. Review the Selected PIP Topic. Element 03: The MCO should include specific statements regarding the participation of enrollees and/or providers in selecting the PIP topic for review. Step 5. Review the Selected PIP Variables and Performance Measures. Element 05: The MCO should include information regarding comparisons of performance over time. In addition, MCO should address how the PIP variable was selected for the study and provide documentation regarding quality improvement activities based on the comparison of performance over time. Step 5. Review the Selected PIP Variables and Performance Measures. Element 06: The MCO should indicate if any consideration was given on existing measures. If there are no existing measures, then the MCO should acknowledge that information within the text of the PIP. Step 8. Assess the Improvement Strategies. Element 01: The MCO should provide reference to existing evidence (published or unpublished) suggesting that the test of change would likely lead to the directed improvement. Step 8. Assess the Improvement Strategies. Element 03: The MCO should make specific reference to PDSA cycle for each intervention when reporting on performance improvement measures. Step 9. Assess the Likelihood that Significant and Sustained Improvement Occurred. Element 01: The MCO should specifically state if the same methodology was used for the remeasurement year as was used in the baseline year. Step 9. Assess the Likelihood that Significant and Sustained Improvement Occurred. Element 02: The MCO should refer to the baseline measure within the summary text to show how much improvement has occurred between

Table A-1. 2022 PIP Details for MCOs and DBMs	
	baseline and remeasurement years. This additional information will help to show the level of improvement between baseline and remeasurement years. Step 9. Assess the Likelihood that Significant and Sustained Improvement Occurred. Element 03: The MCO should indicate baseline measure rate in comparison to the rate in the remeasurement year. Step 9. Assess the Likelihood that Significant and Sustained Improvement Occurred. Element 05: The MCO should indicate how sustained improvement is monitored throughout the measurement year when providing information for significant and sustained improvement. A timeline of when interventions were implemented would provide further evidence of the intervention's success for sustained improvement.
Simply Healthcare: Screening for Depression and Follow-Up Plan Ages 12 to 17 (CDF-CH)	
Aim Statement	Will targeted interventions result in an annual 2% improvement in the percentage of beneficiaries ages 12 to 17 who are screened for depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen during the Remeasurement 2 period?
Performance Measure	Screening for Depression and Follow-Up Plan Ages 12 to 17 (CDF-CH)
Improvement Strategy	Improvement Strategy #1. Provider Education and Medical Record Review: Does medical record review and subsequent provider education improve the percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter using an age-appropriate standardized depression screening tool? And is a follow-up plan is documented on the date of the positive screen?
Measurement Results	BL 3.02%, R1 3.26%, R2 5.12% with Goal rate of 5.26%.
Weaknesses	Step 2: Review the PIP Aim Statement: The MCO should provide specific date ranges or references to the HEDIS audit year (ex. MY 2021) to clearly identify the time period in which the PIP is conducted. Step 5: Review the Selected PIP Variables and Performance Measures: The MCO should clearly identify the dates and/or remeasurement year information when submitting information for the PIP. Step 7: Review the Data Analysis and Interpretation of PIP Results: The MCO should address lessons learned during the remeasurement year. No information was provided regarding interventions that were tried during the remeasurement year to influence the outcome of the PIP. If no lessons were learned during the remeasurement year, the MCO should clearly indicate that information in their PIP submission.

Table A-1. 2022 PIP Details for MCOs and DBMs	
Simply Healthcare: Improving Care Coordination to Improve Follow-Up Care for Children Prescribed ADHD Medication (ADD)	
Aim Statement	Will interventions targeting care coordination among providers improve Follow-Up Care for Children Prescribed ADHD Medication (ADD) rates in both initiation as well as continuation/maintenance phase for all FHKC Plan enrollees 6-18 years of age who were dispensed an ADHD medication (during the 12-month Intake Period) to the NCQA Quality Compass® 75th percentile during Remeasurement 3?
Performance Measure	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 Performance measure.
Improvement Strategy	Improvement Strategy #1. Care Gaps: Developed a system where gaps in care among members recently prescribed ADHD medications (last 90 days) without a follow-up are identified and shared with Behavioral Health (BH) Providers. This was designed to address gaps in communication among primary care physicians (PCPs) and behavioral health prescribers.
Measurement Results	Performance Measure 1. BL: 42.28%, R1: 45.73%, R2: 50.47%, R3: 44.28% with Goal rate of 49.12%. Performance Measure 2. BL: 58.54%, R1: 66.25%, R2: 60.24%, R3: 68.42% with Goal rate of 62.44%.
Strengths	Step 1. Review the Selected PIP Topic: The MCO provided a detailed analysis of enrollee needs and the positive impacts of care coordination on follow-up care for enrollees ages 6 to 12 who have been prescribed ADHD medications. Step 8. Assess the Improvement Strategies: The MCO provided specific details for each step within the PDSA process.
Weaknesses	Step 2. Review the PIP Aim Statement. Element 02: The MCO should be consistent when describing the PIP population for review. Step 3. Review the Identified PIP Population. Element 01: The MCO should be consistent in the description of the PIP population throughout the PIP summary form. The MCO should ensure that all information is in alignment throughout the submission. Step 5. Review the Selected PIP Variables and Performance Measures. Element 01(a): The MCO should include information regarding the maintenance phase of treatment to ensure that all information related to the PIP is captured clearly.

Table A-1. 2022 PIP Details for MCOs and DBMs	
DBMs	
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 10/1/2020 and 9/30/2021?
Performance Measure	Increasing preventative dental visits in children.
Improvement Strategies	Improvement Strategy #1. Member education: Orthodontist educates the MCO's patients (members) who have not received preventative dental visit on the importance of scheduling an appointment and provide member with educational resource to reinforce teaching. Orthodontic providers in Broward, Hillsborough, Miami-Dade, Orange, and Palm Beach Counties who had serviced members aged 13-18 who had not had a preventative visit but had had an orthodontic visit in the previous 6 months, were informed of this improvement strategy and received an Rx tear pad containing educational information to provide to their patients who needed preventative visit. The MCO sought to increase PDENT visits among the members. Improvement Strategy #2. Member Outreach: Live calls with appointment scheduling assistance to members aged 17-18 who reside in all counties in Florida with no preventative services in the previous year. The MCO sought to increase the PDENT rate among these members. Improvement Strategy #3. Provider Letter: FHKC Providers will receive a letter containing a roster of members aged 15-18 (10% withheld as control group) who reside in all counties in Florida and who did not have a preventative visit in the prior year. FHKC providers are expected to outreach to members to assist in scheduling appointments. The MCO sought to increase the PDENT score among these members. Improvement Strategy #4. Provider Letter: FHKC Providers will receive a letter containing a roster of members aged 5-18 who reside in all counties in Florida and who did not have a preventative visit in the prior year. FHKC providers are expected to outreach to members to assist in scheduling appointments. The MCO sought to increase the PDENT score among these members. Improvement Strategy #5. Member Outreach: Live calls with scheduling assistance to members aged 6-14 in Broward County.

Table A-1. 2022 PIP Details for MCOs and DBMs	
	Improvement Strategy #6. Member Outreach: Interactive voice response (IVR) calls and provider recall letters to members overdue for preventative dental visit. Non-compliant membership was divided equally, with half of group receiving the provider recall letter intervention and half receiving an IVR call with education and reminder to schedule a dental visit. All counties were included.
Measurement Results	BL: 50.4%, R1: 50.9%, R2: 50.4%, R3: 50.4% with Goal rate of 52.4%.
Strengths	Step 6. Review the Data Collection Procedures. Element 01: The DBM provided a detailed description of the data collection methods utilized for the PIP. The DBM included an illustrated chart which clearly indicates all data sources and the flow of data through the DBM's systems to capture the administrative data related to this PIP. Step 7. The DBM's information was well organized and easy to follow from baseline through each remeasurement year. Step 8. The DBM clearly identified each step with descriptive detail within the PDSA cycle for each intervention attempted during remeasurement period 2.
DentaQuest: Increasing After-hours Care	
Aim Statement(s)	Will the use of provider targeted interventions increase the percentage of providers (must be actively credentialed for entire measurement period) in the FHKC network who offer after-hours care by 2% between 10/1/2020 and 9/30/2021? 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% between 10/1/2020 and 9/30/2021?
Performance Measure(s)	Increasing percentage of active providers who offer after-hours care. Increase Any Dental Visit.
Improvement Strategies	Improvement Strategy #1. Member Letter: A letter with contact information for nearby providers offices was sent to members with no visit in the previous 6 months and lived in a county with less than 10 providers. Improvement Strategy #2. Assignment of dental home provider: Members with no dental visit in the previous six months will be assigned to a dental home provider. The provider will be provided the member's contact information and is expected to outreach to member. Improvement Strategy #3. Provider education: Providers were contacted by members of the MCO's provider

Table A-1. 2022 PIP Details for MCOs and DBMs	
	engagement team and invited to join us for an educational webinar on how to use and reap the benefits of the dental home roster. The webinar was a virtual training to assist providers in utilizing their assigned panel roster of members. Improvement Strategy #4. Expanded office hours: Providers that offered care to FHKC members during regular business hours were contacted by the MCO provider engagement team and inquired if they have expanded their hours beyond normal business hours and if not, requested that the provider expand their business hours.
Measurement Results	Performance Measure 1. BL: 32.3%, R1: 42.4%, R2: 44.1%, R3: 50.8% with Goal rate of 44.4%. Performance Measure 2. BL: 51.5%, R1: 52.1%, R2: 45.7%, R3: 48.13% with Goal rate of 54.1%.
Strengths	Step 5. Review the Selected PIP Variables and Performance Measures. Element 07: The DBM clearly identified and addressed important aspects of care and data sources for collection for the internally developed performance measure. Step 6. Review the Data Collection Procedures. Element 04: The DBM provided a comprehensive detail of the data elements collected for Performance Measure 1 which included all information from the file layout that is to be captured for data collection needs. Step 7. Review the Data Analysis and Interpretation of PIP Results: The DBM provided detailed information regarding each performance measure and performance over each remeasurement period. The information was well organized for the PIP validation review.
MCNA: Preventative Dental Visit	
Aim Statement	Will targeted member and provider interventions increase the percentage of members ages 5-18 accessing at least one preventative dental visit and/or service two percentage points over baseline (48.91% for preventative services, 18.34% for dental sealants ages 6-9, and 14.33% for dental sealants ages 10-14) during measurement year (MY) 2021 (01/01/21 – 12/31/21)?
Performance Measure	Performance Measure 1: Preventative Dental Services. Performance Measure 2: Dental Sealants, ages 6-9 with exclusions. Performance Measure 3: Dental Sealants, ages 10-14 with exclusions.
Improvement Strategy	Improvement Strategy #1. Care Gap Alerts: MCNA Member Service Representatives (MSRs) help with scheduling

Table A-1. 2022 PIP Details for MCOs and DBMs

	an appointment when an alert is triggered in the DentalTrac™ system during inbound calls that indicates the member is overdue for a preventative dental visit. The MSR offers to locate a provider if the member does not already have one, and performs a three-way call, if necessary, with the provider's office to schedule an appointment. When the member's preferred language is something other than English, the MSRs are trained to assist them in locating a dentist who speaks the language of their choice. In the event MCNA's network does not have a provider that can accommodate the member's preferred language choice, our MSRs are trained to offer and coordinate translation services. Improvement Strategy #2. Text Messages: Text messages are sent once a month to members who have no claims history on file. Members continue to receive text messages until an encounter is received. Improvement Strategy #3. Member Outreach Forms: MCNA created a Member Outreach Form which allows providers to communicate with MCNA when a member is non-compliant with their treatment plan, failing appointments, behind on their dental checkup, etc. and upon receipt of the form via mail, email, or fax, an MCNA representative contacts the member and provides the assistance needed. Improvement Strategy #4. Practice Site Performance Summary (PSPS) Report: Quarterly profiling report that educates offices on their performance and assists clinicians and their staff to eliminate administrative inefficiencies and highlight their utilization rates in comparison with their peers.
Measurement Results	Performance Measure 1. BL: 46.91%, R1: 48.95%, R2: 39.42%, R3: 45.90% with Goal rate of 48.91%. Performance Measure 2. BL: 16.34%, R1: 16.83%, R2: 13.11%, R3: 16.92% with Goal rate of 18.34%. Performance Measure 3. BL: 12.33%, R1: 13.84%, R2: 10.21%, R3: 12.89% with Goal rate of 14.33%.
Strengths	Step 1. Review the Selected PIP Topic. Element 01: Although the PIP topic was selected by FHKC, the DBM provided a comprehensive analysis of FHKC enrollee needs and provided statistics relevant to Florida and the dental health of children in the state. Step 3. Review the Identified PIP Population: The DBM clearly identified the codes associated with the services under review for the PIP population. Step 6. Review the Data Collection Procedures: The DBM included an extensive list of all codes that would impact the performance measures. This helps clearly identify which codes impacted the PIP population and the services received by said population.

Table A-1. 2022 PIP Details for MCOs and DBMs	
Weaknesses	Step 7. Review the Data Analysis and Interpretation of PIP Results. Element 08: The DBM should address lessons learned following the implementation of the performance measures. Identifying lessons learned could assist the DBM in adjusting their PIP approach to produce better outcomes based on the performance measure being evaluated.
MCNA: Annual Dental Visit (ADV)	
Aim Statement	Will targeted member interventions increase the percentage of members ages 5-18 receiving at least one dental visit to meet or exceed the 2019 National Committee for Quality Assurance Quality (NCQA) Compass® 50th percentile (58.03%) during measurement year (MY) 2021 (01/01/21 – 12/31/21)?
Performance Measure	Performance Measure 1: Annual dental visit (ADV).
Improvement Strategies	Improvement Strategy #1. Care Gap Alerts: MCNA Member Service Representatives (MSRs) offer assistance with scheduling an appointment when an alert is triggered in the DentalTrac™ system during inbound calls that indicates the member is overdue for a preventative dental visit. The MSR offers to locate a provider if the member does not already have one and performs a three-way call, if necessary, with the provider office to schedule an appointment. When the member's preferred language is something other than English, the MSRs are trained to assist them in locating a dentist who speaks the language of their choice. In the event MCNA's network does not have a provider that can accommodate the member's preferred language choice, our MSRs are trained to offer and coordinate translation services. Improvement Strategy #2. Text Messages: Text messages will be sent once a month to members who have no claims history on file. Members will continue to receive a text message until an encounter is received. Improvement Strategy #3. Member Outreach Forms: MCNA has created a Member Outreach Form that allows providers to communicate with MCNA when a member is non-compliant with their treatment plan, failing appointments, behind on their dental checkup, etc. and upon receipt of the form via mail, email, or fax, an MCNA representative contacts the member and provides the assistance needed. Improvement Strategy #4. ADV Outbound Call Campaign: Conduct outbound calls to members who have not had a dental visit within the last six months to encourage them to schedule an appointment. Improvement Strategy #5. ADV Postcard Mailing: Postcard mailing to members who have not a dental visit to encourage members to schedule an appointment.
Measurement Results	Performance measure 1. BL: 59.31%, R1: 60.62%, R2: 51.76%, R3: 56.68% with Goal rate of 58.03%.
Strengths	Step 6. Review the Data Collection Procedures: The DBM provided an extensive list of programming logic codes to

Table A-1. 2022 PIP Details for MCOs and DBMs	
	be captured in the administrative data collection. This provides clear indication of the codes being reviewed for this PIP.

Table A-2 and Table 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 several 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. 2022 Clinical PIP Validation Results

PIP Activity 1: Assess the PIP Methodology	Elements Met/Assessed				
	Aetna	Community Care	DentaQuest	MCNA	Simply Healthcare
1. State the Selected PIP Topic	3/3	3/3	3/3	4/4	4/4
2. State the PIP Aim Statement	6/6	6/6	6/6	6/6	5/6
3. Identify the PIP Population	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
5. Describe Selected PIP Variables and Performance Measures	7/7	7/7	7/7	7/7	6/7
6. Describe Data Collection Procedures	7/7	7/7	7/7	7/7	7/7
7. Analyze Data and Interpret PIP Results	7/7	7/7	7/7	6/7	6/7
8. Describe Improvement Strategies	6/6	2/6	6/6	6/6	6/6
9. Assess for Significant and Sustained Improvement	5/5	5/5	5/5	5/5	5/5
Total	**44/44**	**40/44**	**44/44**	**44/45**	**42/45**
Validation Score	100%	90.91%	100%	97.78%	93.33%

Table A-2. 2022 Clinical PIP Validation Results					
PIP Activity 1: Assess the PIP Methodology	**Elements Met/Assessed**				
	Aetna	**Community Care**	**DentaQuest**	**MCNA**	**Simply Healthcare**
PIP Activity 2: Overall Validation Rating	**High Confidence**	**High Confidence**	**High Confidence**	**High Confidence**	**High Confidence**

Table A-3. 2022 Nonclinical PIP Validation Results					
PIP Activity 1: Assess the PIP Methodology	**Elements Met/Assessed**				
	Aetna	**Community Care**	**DentaQuest**	**MCNA**	**Simply Healthcare**
1. State the Selected PIP Topic	5/5	3/5	3/3	5/5	5/5
2. State the PIP Aim Statement	6/6	6/6	6/6	6/6	5/6
3. Identify the PIP Population	3/3	3/3	3/3	3/3	2/3
4. Describe the Sampling Method	0/0	0/0	0/0	0/0	0/0
5. Describe Selected PIP Variables and Performance Measures	7/7	6/8	7/7	7/7	6/7
6. Describe Data Collection Procedures	7/7	7/7	7/7	7/7	7/7
7. Analyze Data and Interpret PIP Results	7/7	7/7	7/7	7/7	7/7
8. Describe Improvement Strategies	6/6	4/6	6/6	6/6	6/6
9. Assess for Significant and Sustained Improvement	5/5	1/5	5/5	5/5	5/5
Total	**46/46**	**37/47**	**44/44**	**46/46**	**43/46**
Validation Score	100%	78.72%	100%	100%	93.48%

Table A-3. 2022 Nonclinical PIP Validation Results

PIP Activity 1: Assess the PIP Methodology	Elements Met/Assessed				
	Aetna	Community Care	DentaQuest	MCNA	Simply Healthcare
PIP Activity 2: Overall Validation Rating	High Confidence	Low Confidence	High Confidence	High Confidence	Low Confidence

Table A-4. Improvements Since the 2021 PIP by MCO/DBM

MCO/DBM	PIP Topic	2021 AON	MCO/DBM's Action	Quality	Timeliness	Access
Aetna	**Follow-Up After Hospitalization for Mental Illness (FUH 7-day)**	**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.	1) This topic is relevant and significant to the MCO because it focuses on a high-risk condition for Florida Healthy membership. It is critical to ensure timely access to follow-up for patients after they have been hospitalized for mental illness to ensure the member understands the care they need after discharge, address any transition needs including home environment, and to address any barriers to continuing prescribed care. The focus of this study is the FUH 7-day measure which indicates what percent of members had access to and completed a follow up visit with a mental health practitioner within 7 days after a hospital stay for treatment of selected mental illness or intentional self-harm diagnosis. Timely follow-up care following hospitalization for behavioral health-related diagnoses will improve the outcome of care and will reduce re-admission rates by helping members to better manage their symptoms and maintain their health status. 2) This study topic was reviewed and approved by the Quality Management Oversight Committee, which includes behavioral health providers concerned with improving the outcome of care. The Quality Management Oversight Committee also reviews the results from the Behavioral Health Member Satisfaction survey which includes feedback	✓	✓	

Table A-4. Improvements Since the 2021 PIP by MCO/DBM

MCO/DBM	PIP Topic	2021 AON	MCO/DBM's Action	Quality	Timeliness	Access
			from members on the behavioral health services they receive.			
CCP	Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)	**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.	The MCO used claims/encounter data which allowed the MCO to objectively capture the health status of their enrollees. Monthly monitoring of the CMS Core Set measures and tracking the variable over time using the claims/encounter data allows the plan to measure rates and levels of improvements made since the last measurement period.	✓	✓	
		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).	Estimated degree of data completeness for administrative data collection was reported as 100% for the MCO.			
	Health Risk Assessment (HRA) Response Rate	**Step 1. Review the Selected PIP Topic:** The MCO should indicate if enrollee or provider input was considered in developing the PIP topic.	No reference to input from enrollees or providers who are users of, or concerned with, specific service areas was noted for this PIP submission.	✓	✓	
		Step 2. Review the PIP Aim Statement:	Completion of the HRA within 90 days of enrollment during the measurement year was identified as the PIP time period.			

Table A-4. Improvements Since the 2021 PIP by MCO/DBM

MCO/DBM	PIP Topic	2021 AON	MCO/DBM's Action	Quality	Timeliness	Access
		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.	1) Although the MCO reported on the historical factors of the HRA rate, the MCO did not address comparisons of performance over time. The MCO also failed to identify selection methods for and improvement activities for PIP variables. 2) The MCO made no reference to consideration given on existing measures.			
Simply	**Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)**	**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.	1) The time period for the PIP was reported to be Remeasurement Year 2. The MCO did not provide specific dates for the remeasurement period such as January 1, 2021-December 31, 2021, or measurement year (MY) 2021. 2) The PIP goal is unambiguous and is answerable. Will targeted interventions result in an annual 2% improvement in the percentage of beneficiaries ages 12 to 17 who are screened for depression on the date of the encounter using an age-appropriate standardized depression screening tool.	✓	✓	

Table A-4. Improvements Since the 2021 PIP by MCO/DBM

MCO/DBM	PIP Topic	2021 AON	MCO/DBM's Action	Quality	Timeliness	Access
		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.	Element 01(a): The MCO identified two components to the PIP. 1st Component: Date of depression screening received for enrollees 12-17 years of age, measured quarterly and annually. 2nd Component: Date of documented follow-up for enrollees 12-17 years of age who screen positive, measured quarterly and annually. The numerator for this measure includes the following two groups: ♦ Those beneficiaries with a positive screen for depression during an outpatient visit using a standardized tool with a follow up plan documented. ♦ Those beneficiaries with a negative screen for depression during an outpatient visit using a standardized tool. ♦ Denominator Description: Beneficiaries ages 12 to 17 with an outpatient visit during the measurement year. Baseline rate was established in 2019 at a rate of 3.02%. Benchmark rate for Remeasurement Year 2 was reported to be at 5.26%. Source of Benchmark was reported to be internal with a 2% year-over-year (YOY) improvement. No information was provided by the MCO regarding goal rate and how this rate was determined by the organization for the PIP. Although the MCO reported the frequency in which the data was to be collected, the MCO failed to identify that the data collected for this PIP was collected during Remeasurement Year 2 (MY 2021).			
		Step 6. Review the Data Collection Procedures: The MCO should include the integration of enrollment and pharmacy data in its description of the system	Business Intelligence (BI) staff will use administrative claims data from the data warehouse to collect data on all MCO members who meet the eligibility criteria. The quarterly analysis will focus on two comparisons: (1) compare results to a benchmark established by CMS; and (2) compare results to results for the previous quarter. Each quarter,			

Table A-4. Improvements Since the 2021 PIP by MCO/DBM

MCO/DBM	PIP Topic	2021 AON	MCO/DBM's Action	Quality	Timeliness	Access
		for collecting valid and reliable data that represent the PIP population.	administrative claims data is used to calculate rolling 13-month reports of percentage of eligible members who received a depression screening using a standardized tool, and, if positive, members who have a follow-up plan documented on the date of the positive screen. Line graphs were provided by the DBM to show trends for a period of 13 months. The Quality Improvement Committee review executive summaries of quarterly results. Annual analysis of collected administrative data is conducted by the Quality Management (QM) department based on the Plan's claim database. Results are compared to the most recent CMS benchmark and/or baseline rate for this measure. In all re-measurement years, in addition to the comparison to the CMS benchmark, the score for each re-measurement period is compared against baseline and against the previous year's re-measurement result, if applicable. Fisher's exact test of significance is used to determine if the change is statistically significant. The MCO's Depression screening PIP work group reviews the data and applies the PDSA process to identify root causes and appropriate interventions, which are then evaluated on an ongoing basis. Additional analyses are completed by service region to identify any significant differences that may need to be addressed through interventions. Patterns based on spoken language, race/ethnicity, and gender are explored. Appropriate statistical tests, e.g., chi-square, are used to determine if there are significant differences among the subgroups. An executive summary of annual results is submitted to the Quality Improvement Committee (QIC) for review.			
		Step 9. Assess the Likelihood that Significant and Sustained	The Remeasurement 2 result for MY 2021 was 5.12%. Compared to Remeasurement 1 (3.26%), this was an improvement of 1.86%. Although the MCO did not meet its			

Table A-4. Improvements Since the 2021 PIP by MCO/DBM

MCO/DBM	PIP Topic	2021 AON	MCO/DBM's Action	Quality	Timeliness	Access
		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).	YOY improvement goal of 2%, the actual improvement seen was extremely statistically significant when compared to Remeasurement 1 and to the Baseline Year. Based on these findings, 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). MCO plans to expand on medical record review and develop additional provider educational materials and trainings. The MCO will monitor ongoing actions in order to develop additional process measures to support baseline rate and outcomes.			
	Improving Care Coordination to Improve Follow-Up Care for Children Prescribed ADHD Medication (ADD)	**Step 1. Review the Selected PIP Topic:** The MCO should indicate if enrollee or provider input was considered in developing the PIP topic.	The MCO provided a comprehensive analysis of the enrollee needs. Although the PIP was required by FHKC as a non-clinical PIP, the MCO reported this measure was chosen specifically due to the high volume of the MCO members that are under the age of 18, and because primary care practitioners typically prescribe these medications. These measures look at the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medications that have at least three follow-up care visits within a 9-month period, one of which is within 30 days of when the first ADHD medication was dispensed.	✓	✓	
		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	Performance Measure 1 was reported as the percentage of members 6–12 years of age as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase (HEDIS MY 2020 Specs). The variable is qualifying outpatient visits, at 30 days for the Initiation Phase. Numerator was described as an outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after			

Table A-4. Improvements Since the 2021 PIP by MCO/DBM

MCO/DBM	PIP Topic	2021 AON	MCO/DBM's Action	Quality	Timeliness	Access
		Continuation and Maintenance Phase. 2) The MCO should address how the outpatient visits are available to measure performance and track improvement over time.	the IPSD. Denominator description is the Rate 1 eligible population as per HEDIS MY 2021 specs. Baseline rate was established at 42.28% in 2018. Benchmark Rate was 49.12% for MY 2021. Source of the Benchmark is the MY 2021 NCQA Quality Compass 75th percentile. Goal rate is the MY 2021 Quality Compass. Performance Measure 2 is the percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. The variable was defined as qualifying outpatient visits, at 210 days for the Continuation and Maintenance Phase. Claims and pharmacy data are readily available through a certified HEDIS software to a dedicated HEDIS team to measure adherence rates and improvement rates over time. The numerator was defined as numerator compliant for rate 1-initiation phase and at least two follow-up visits on different dates of service with any practitioner from 31-300 days after the IPSD. The denominator was described to be rate 2 eligible population as per HEDIS MY 2021 specifications. Baseline was established in 2018 at 58.54%. Benchmark rate was reported to be 62.44% for MY 2021. The source of the benchmark is the MY 2021 NCQA Quality Compass 75th percentile. Goal rate is determined by the MY 2021 NCQA Quality Compass.			
		Step 9. Assess the Likelihood that Significant and Sustained Improvement Occurred: 1) The MCO should address the quantitative	For Study Indicator 1: the Remeasurement 3 result for MY 2021 was 44.28% compared to the Remeasurement 2 result of 50.47%, a decline of 6.19%. When comparing Remeasurement 3 to the Baseline period, there was a statistically significant improvement of 2.0%. The MCO did not meet its goal of reaching the NCQA 75th percentile.			

Table A-4. Improvements Since the 2021 PIP by MCO/DBM

MCO/DBM	PIP Topic	2021 AON	MCO/DBM's Action	Quality	Timeliness	Access
		evidence of improvement in the Initiation Phase rates. 2) The MCO should address the statistical evidence of improvement in the Initiation Phase rates.	Using Fisher's exact test, the p-value from baseline to Remeasurement 3 at a 95% confidence level is 0.4873, not achieving statistical significance at p<.05. In addition, the p-value from Remeasurement 2 to Remeasurement 3 at a 95% confidence level is 0.0122, achieving statistical significance at p<.05. For Study Indicator 2: The Remeasurement 3 result for MY 2021 was 68.42% compared to the Remeasurement 2 result of 60.24%, an improvement of 8.18%.			
DentaQuest	**Increase Afterhours Care**	**Step 8. Assess the Improvement Strategies**: 1) The DBM should address an improvement strategy specifically related to the provider afterhours 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	The DBM implemented four improvement strategies for this PIP. Improvement strategy 1: The DBM hypothesized that a notification of providers near a member's home address would encourage utilization. This letter contained all contact information for a member, thus removing this barrier and making it easy for members to contact a provider. Improvement strategy 2: The DBM has successfully implemented dental home assignment in other markets and seen an increase in member utilization. The DBM decided to implement this in FHKC. Improvement strategy 3: Historically, the DBM has seen that markets in which dental home is implemented and widely used, utilization rates are higher. The DBM believes that training and educating providers on the dental home roster will lead to increased utilization. Improvement strategy 4: A high proportion of those on Medicaid/CHIP, or their parents, work jobs that do not allow flexibility to leave for medical or dental appointments. The DBM believes offering dental care outside of standard working hours will allow members to receive the care they need and lead to increased utilization. Due to COVID limitations and challenges, providers may be more amenable to increasing their hours to accommodate their patients. Additionally, the DBM knows based on experience and trends that providers do not always update	✓		✓

Table A-4. Improvements Since the 2021 PIP by MCO/DBM

MCO/DBM	PIP Topic	2021 AON	MCO/DBM's Action	Quality	Timeliness	Access
		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 afterhours performance measure.	their information proactively. Since providers do not update their information proactively, the DBM approached providers to request they participate in providing after-hours care. The DBM also captured information on those providers who are offering after-hours care so that the provider information may be updated in the DBM systems. This intervention will improve the percentage of providers offering after-hours care which in turn will drive the ADENT percentage higher since more providers are offering hours that can accommodate member schedules. 2) Improvement strategy 1: The DBM aimed to address the barrier of access to providers through the geo-coded letter. The hope was that the member would be motivated to reach out to one of the providers and establish care and a lasting relationship with that office. Improvement strategy 2: One barrier identified was access to care. The PIP team hopes to address this through dental home assignment. Improvement strategy 3: Following the Driver Diagram, the DBM sought to increase member access to providers and therefore increase utilization for FHKC members. Improvement strategy 4: The key driver diagram and cause and effect diagram were completed by the quality improvement (QI) team and used to develop improvement strategies to overcome specific barriers and causes that were identified through the process. Key drivers were access to care and importance of care. The secondary drivers that influence the primary driver were listed. Secondary drivers included finding a provider, scheduling an appointment, education on oral health as well as appointment scheduling and availability. The QI team produced potential change ideas to test to influence the secondary driver.			
		Step 9. Assess the Likelihood that	For performance measure 1, there was no quantitative improvement of care between baseline and remeasurement			

Table A-4. Improvements Since the 2021 PIP by MCO/DBM

MCO/DBM	PIP Topic	2021 AON	MCO/DBM's Action	Quality	Timeliness	Access
		Significant and Sustained Improvement Occurred: The DBM should address the quantitative evidence of improvement in the after-hours measure rate.	1. Statistical testing did not demonstrate significance. For baseline to remeasurement 3, there is quantitative evidence of an increase in the number of providers offering. The increase is 8.6 percentage points, and the value is statistically significant with a p-value <0.00001. This is a significant improvement from the baseline. Because this was an improvement from prior year as well as from baseline year, no further analysis was conducted for remeasurement 2 and remeasurement 3. For performance measure 2, there was no quantitative improvement from baseline to remeasurement 1 and baseline to remeasurement 2. There was a statistically significant decrease in ADENT when comparing the baseline to remeasurement 2. The DBM improvement between baseline and remeasurement 1 was not statistically significant. Baseline to measurement 1 had a p-value of 0.000374. While the change between baseline and remeasurement 2 was statistically significant with a p-value of 0.0001, the change was negative and can be attributed to COVID-19. For baseline to remeasurement 3 for performance measure 2, there is quantitative evidence of a decrease in outcomes of care when remeasurement 3 is compared to the baseline. Baseline ADENT rate is 51.5% and remeasurement 3 rate is 48.13%, which is 3.37 percentage points lower between baseline and remeasurement 3. The data was analyzed to determine statistical significance in this decrease. Statistical significance was performed using a two tailed Z score with a 95% confidence interval, resulting in a p-value of <0.00001. This indicates that there was a statistically significant decrease between baseline and remeasurement 3. There is quantitative evidence of an increase in outcomes of care when remeasurement 3 is compared to remeasurement 2. For these reasons, an additional statistical analysis was			

Table A-4. Improvements Since the 2021 PIP by MCO/DBM

MCO/DBM	PIP Topic	2021 AON	MCO/DBM's Action	Quality	Timeliness	Access
			conducted between remeasurement period 2 and remeasurement period 3. The result was a statistically significant improvement from prior year. With the impact of COVID continuing, this result is encouraging and indicative of successful improvement strategies.			
MCNA	**Preventive Dental Visit**	**Step 2. Review the PIP Aim Statement:** The DBM should ensure the aim statement is answerable by including a realistic and unambiguous goal.	The PIP Aim statement established a goal of 2% points over baseline of 48.91% for preventative services, 18.34% for dental sealants ages 6-9, and 14.33% for dental sealants ages 10-14. The PIP Aim statement is measurable.	✓	✓	✓
	Annual Dental Visit (ADV)	**Step 2. Review the PIP Aim Statement:** The DBM should ensure the aim statement is answerable by including a realistic and unambiguous goal.	The PIP Aim statement was answerable. The DBM identified the goal to be the 2019 National Committee for Quality Assurance (NCQA) Quality Compass [5]0th percentile (58.03%).	✓	✓	✓

PMV

MCO-specific results appear in Table A-5, Table A-6, and Table A-7. The green and red arrows in Table A-5 indicate an increase (⬆) or decrease (⬇) from the previous year's rate. Where measure results appear without green or red arrows, trending was not possible. Table cells with a blue background indicate rates that did not change from the 2021 PMV to the 2022 PMV for that measure.

Table A-5. 2021 and 2022 PMV Measure Results: MCOs

Measure	Aetna		Community Care		Simply Healthcare	
	2021	2022	2021	2022	2021	2022
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	89.36%	84.74% ⬇	87.56%	NA ⬇	91.00%	88.06% ⬇
BMI Percentile: 12–17 Years	86.55%	84.16% ⬇	92.08%	NA ⬇	93.84%	84.76% ⬇
BMI Percentile Total	87.83%	84.43% ⬇	89.78%	NA ⬇	92.46%	86.37% ⬇
Chlamydia Screening in Women (CHL)						
16–20 Years	52.54%	48.65% ⬇	52.22%	55.91% ⬆	54.90%	49.66% ⬇
Immunizations for Adolescents (IMA)						
Meningococcal	77.86%	79.32% ⬆	88.57%	NA ⬇	86.13%	82.48% ⬇
Tdap	91.24%	93.67% ⬆	95.71%	NA ⬇	95.62%	95.38% ⬇
Human Papillomavirus (HPV)	40.63%	42.34% ⬆	40.00%	NA ⬇	44.04%	43.31% ⬇
Combination #1 (Meningococcal and Tdap/Td)	76.40%	78.83% ⬆	88.57%	NA ⬇	85.40%	81.75% ⬇
Combination #2 (Meningococcal, Tdap/Td, and HPV)	36.98%	39.90% ⬆	38.57%	NA ⬇	42.34%	40.63% ⬇
Child and Adolescent Well-Care Visits (WCV)						
3–11 Years	65.00%	68.67% ⬆	63.36%	69.32% ⬆	66.55%	70.23% ⬆
12–17 Years	67.31%	66.33% ⬇	60.88%	68.11% ⬆	65.45%	68.08% ⬆
18–21 Years	54.01%	50.94% ⬇	53.47%	57.96% ⬆	53.49%	51.74% ⬇

Total	65.30%	66.14%↑	61.51%	67.99%↑	65.07%	67.78%↑
Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF)	4.00%	7.00%↑	2.72%	4.89%↑	3.26%	5.00%↑
Maternal and Perinatal Health						
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	NA	66.67%↑	NA	NA	NA	66.67% ↑
Cesarean Birth (PC-02)	NA	NR	NA	NA	NA	0.00%
Contraceptive Care – Postpartum Women Ages 15–20 (CCP)						
Most or moderately effective contraception – 3 days	NA	50.00%↑	NA	NA	NA	0.00%
Most or moderately effective contraception – 60 days	NA	50.00%↑	NA	NA	NA	17.00% ↑
Long-acting reversible method of contraception (LARC) – 3 days	NA	50.00%↑	NA	NA	NA	0.00%
LARC – 60 days	NA	50.00%↑	NA	NA	NA	0.00%
Contraceptive Care – All Women Ages 15–20 (CCW)						
Most effective or moderately effective method of contraception	17.00%	17.52%↑	10.00%	5.29%↓	16.27%	16.00% ↓
LARC	1.00%	1.30%↑	0.00%	0.07%↑	1.67%	1.00% ↓
Care of Acute and Chronic Conditions						
Asthma Medication Ratio (AMR)						
5–11 Years	91.61%	88.15%↓	NA	85.00%↑	83.75%	86.33%↑
12–18 Years	80.45%	81.82%↑	NA	77.78%↑	78.70%	78.17% ↓
Total	85.86%	85.02%↓	NA	82.76%↑	81.36%	82.42%↑
Appropriate Testing for Pharyngitis (CWP)						
3–17 Years	83.85%	74.32%↓	74.19%	48.68%↓	84.66%	71.97% ↓
18–64 Years	73.02%	61.94%↓	NA	69.23%↑	79.66%	64.79%↓
Total	83.37%	73.52%↓	73.47%	50.30%↓	84.43%	71.52%↓

Appropriate Treatment for Children with Upper Respiratory Infection (URI)						
3 Months – 17 Years	90.79%	93.81%↑	96.77%	90.37%↓	91.68%	94.72%↑
18–64 Years	83.40%	88.00%↑	92.86%	85.71%↓	85.66%	86.67%↑
Total	90.54%	93.60%↑	96.69%	90.25%↓	91.49%	94.44%↑
Ambulatory Care: Emergency Department Visits (AMB-ED) – Visits / 1,000 Enrollee Months						
1–9 Years	16.47%	21.37%↑	12.42%	16.39%↑	16.68	20.14%↑
10–19 Years	16.27%	20.64%↑	12.24%	13.67%↑	16.48	19.79% ↑
Behavioral Healthcare						
Follow-Up Care for Children Prescribed ADHD Medication (ADD)						
Initiation Phase	44.55%	38.84%↓	NA	31.65%↑	50.47%	44.28%↓
Continuation and Maintenance Phase	69.74%	51.97%↓	NA	45.45%↑	60.24%	68.42%↑
Follow-Up After Hospitalization for Mental Illness (FUH)						
7-Day Follow-Up: 6–17 Years	52.09%	50.00%↓	39.53%	42.55%↑	41.49%	41.88%↑
30-Day Follow-Up: 6–17 Years	74.42%	71.04%↓	58.14%	74.47%↑	67.66%	70.48% ↑
7-Day Follow-Up: 18–64 Years	38.24%	46.88%↑	NA	25.00%↑	38.78%	32.00% ↓
30-Day Follow-Up: 18–64 Years	58.82%	68.75%↑	NA	25.00%↑	48.98%	44.00%↓
7-Day Follow-Up Total	51.08%	49.82%↓	39.58%	41.18%↑	41.23%	41.34% ↑
30-Day Follow-Up Total	73.28%	70.91%↓	60.42%	70.59%↑	65.90%	69.05%↑
Follow-Up After Emergency Department Visit for Mental Illness (FUM)						
7-Day Follow-Up: 6–17 Years	39.68%	34.07%↓	NA	14.29%↑	33.82%	35.58%↑
30-Day Follow-Up: 6–17 Years	58.73%	45.05%↓	NA	28.57%↑	51.47%	53.85%↑
7-Day Follow-Up: 18–64 Years	NA	18.18%↑	NA	NA	NA	14.29%↑
30-Day Follow-Up: 18–64 Years	NA	45.45%↑	NA	NA	NA	28.57%↑
7-Day Follow-Up Total	41.54%	32.35%↓	NA	14.29%↑	33.33%	33.33%
30-Day Follow-Up Total	60.00%	45.10%↓	NA	28.57%↑	52.78%	51.39%↓
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)						

7-Day Follow-Up: 13–17 Years	NA	4.55%↑	NA	NA	NA	0.00%
30-Day Follow-Up: 13–17 Years	NA	4.55%↑	NA	NA	NA	13.33%↑
7-Day Follow-Up: ≥18 Years	NA	0.00%	NA	NA	NA	0.00%
30-Day Follow-Up: ≥18 Years	NA	0.00%	NA	NA	NA	0.00%
7-Day Follow-Up Total	10.00%	3.23%↓	NA	NA	NA	0.00%
30-Day Follow-Up Total	13.33%	3.23%↓	NA	NA	NA	9.52%↑
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)						
1–11 Years	NA	50.00%↑	NA	0.00%	NA	58.82%↑
12–17 Years	58.59%	60.53%↑	NA	60.00%↑	54.17%	54.17%
Total	58.50%	58.82%↑	NA	50.00%↑	56.99%	54.87%↓
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)						
Blood Glucose Testing: 1–11 Years	34.69%	32.61%↓	NA	14.29%↑	38.64%	51.43%↑
Cholesterol Testing: 1–11 Years	22.45%	30.43%↑	NA	0.00%	29.55%	31.43%↑
Blood Glucose and Cholesterol Testing: 1–11 Years	18.37%	23.91%↑	NA	0.00%	27.27%	31.43%↑
Blood Glucose Testing: 12–17 Years	56.60%	66.91%↑	NA	75.00%↑	53.65%	65.26%↑
Cholesterol Testing: 12–17 Years	40.38%	45.72%↑	NA	75.00%↑	38.02%	46.32%↑
Blood Glucose and Cholesterol Testing: 12–17 Years	38.11%	42.75%↑	NA	66.67%↑	34.38%	42.63%↑
Blood Glucose Testing Total	53.18%	61.90%↑	NA	52.63%↑	50.85%	63.11%↑
Cholesterol Testing Total	37.58%	43.49%↑	NA	47.37%↑	36.44%	44.00%↑
Blood Glucose and Cholesterol Testing Total	35.03%	40.00%↑	NA	42.11%↑	33.05%	40.89%↑
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)						
Alcohol Abuse or Dependence: Initiation of AOD Treatment: 13–17	NA	46.67%↑	NA	100%↑	NA	64.71%↑

Years						
Alcohol Abuse or Dependence: Engagement of AOD Treatment: 13–17 Years	NA	0.00%	NA	100%↑	NA	0.00%
Opioid Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	NA	100%↑	NA	NA	NA	100%↑
Opioid Abuse or Dependence: Engagement of AOD Treatment: 13–17 Years	NA	0.00%	NA	NA	NA	0.00%
Other Drug Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	39.02%	53.75%↑	NA	81.82%↑	56.38%	67.37%↑
Other Drug Abuse or Dependence: Engagement of AOD Treatment: 13–17 Years	7.32%	6.25%↓	NA	9.09%↑	17.02%	15.79%↓
Initiation of AOD Treatment: 13–17 Years Total	36.56%	51.72%↓	NA	81.82%↑	56.36%	64.76%↑
Engagement of AOD Treatment: 13–17 Years Total	7.53%	5.75%↓	NA	9.09%↑	17.27%	14.29%↓
Alcohol Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	NA	31.25%↑	NA	0.00%	NA	33.33%↑
Alcohol Abuse or Dependence: Engagement of AOD Treatment: 18+ Years	NA	6.25%↑	NA	0.00%	NA	0.00%
Opioid Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	NA	N/A	NA	0.00%	NA	100%↑
Opioid Abuse or Dependence: Engagement of AOD Treatment: 18+ Years	NA	N/A	NA	0.00%	NA	0.00%
Other Drug Abuse or Dependence:	57.58%	37.25%↓	NA	40.00%↑	48.78%	47.62%↓

Initiation of AOD Treatment: 18+ Years						
Other Drug Abuse or Dependence: Engagement of AOD Treatment: 18+ Years	12.12%	11.76%↓	NA	0.00%	9.76%	14.29%↑
Initiation of AOD Treatment: 18+ Years Total	51.06%	32.79%↓	NA	33.33%↑	48.84%	46.67%↓
Engagement of AOD Treatment: 18+ Years Total	10.64%	9.84%↓	NA	0.00%	9.30%	13.33%↓
Alcohol Abuse or Dependence: Initiation of AOD Treatment Total	44.12%	38.71%↓	NA	50.00%↑	NA	60.00%↑
Alcohol Abuse or Dependence: Engagement of AOD Treatment Total	5.88%	3.23%↓	NA	50.00%↑	NA	0.00%
Opioid Abuse or Dependence: Initiation of AOD Treatment Total	NA	100%↑	NA	0.00%	NA	100%↑
Opioid Abuse or Dependence: Engagement of AOD Treatment Total	NA	0.00%	NA	0.00%	NA	0.00%
Other Drug Abuse or Dependence: Initiation of AOD Treatment Total	44.35%	47.33%↑	NA	68.75%↑	54.07%	61.31%↓
Other Drug Abuse or Dependence: Engagement of AOD Treatment Total	8.70%	8.40%↓	NA	6.25%↑	14.81%	15.33%↑
Initiation of AOD Treatment Total	41.43%	43.92%↑	NA	64.71%↑	54.25%	59.33%↑
Engagement of AOD Treatment Total	8.57%	7.43%↓	NA	5.88%↑	15.03%	14.00%↓

** Table cells with a blue background indicate rates that did not change from 2021 to 2022 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-6 provides the MCOs' 2022 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-6. 2022 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	1	0.01%	0	0.00%	1	0.01%
13–17 Years	14	0.10%	0	0.00%	14	0.10%
18–24 Years	5	0.21%	0	0.00%	6	0.27%
Any Services: Female						
0–12 Years	1	0.01%	0	0.00%	1	0.01%
13–17 Years	28	0.21%	2	0.12%	26	0.20%
18–24 Years	9	0.40%	0	0.00%	2	0.09%
Any Services: Total						
0–12 Years	2	0.01%	0	0.00%	2	0.01%
13–17 Years	42	0.15%	2	0.06%	40	0.15%
18–24 Years	14	0.30%	0	0.00%	8	0.18%
Inpatient: Male						
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	2	0.01%	0	0.00%	3	0.02%
18–24 Years	0	0.00%	0	0.00%	0	0.00%
Inpatient: Female						
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	8	0.06%	0	0.00%	8	0.06%

Measure	Aetna		Community Care		Simply Healthcare	
	No.	%	No.	%	No.	%
18–24 Years	2	0.09%	0	0.00%	0	0.00%
Inpatient: Total						
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	10	0.04%	0	0.00%	11	0.04%
18–24 Years	2	0.04%	0	0.00%	0	0.00%
Intensive Outpatient/Partial Hospitalization: Male						
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	0	0.00%	0	0.00%	0	0.00%
18–24 Years	0	0.00%	0	0.00%	0	0.00%
Intensive Outpatient/Partial Hospitalization: Female						
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	1	0.01%	0	0.00%	1	0.01%
18–24 Years	0	0.00%	0	0.00%	0	0.00%
Intensive Outpatient/Partial Hospitalization: Total						
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	1	0.00%	0	0.00%	0	0.00%
18–24 Years	0	0.00%	0	0.00%	0	0.00%
Outpatient or Medication Treatment: Male						
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	4	0.03%	0	0.00%	7	0.05%
18–24 Years	1	0.40%	0	0.00%	1	0.05%
Outpatient or Medication Treatment: Female						
0–12 Years	1	0.01%	0	0.00%	1	0.01%
13–17 Years	9	0.07%	2	0.12%	7	0.05%

Measure	Aetna		Community Care		Simply Healthcare	
	No.	%	No.	%	No.	%
18–24 Years	2	0.09%	0	0.00%	0	0.00%
Outpatient or Medication Treatment: Total						
0–12 Years	1	0.01%	0	0.00%	1	0.00%
13–17 Years	13	0.05%	2	0.06%	14	0.04%
18–24 Years	3	0.07%	0	0.00%	1	0.02%
Emergency Department: Male						
0–12 Years	0	0.00%	0	0.00%	1	0.01%
13–17 Years	7	0.05%	0	0.00%	4	0.03%
18–24 Years	3	0.13%	0	0.00%	4	0.18%
Emergency Department: Female						
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	7	0.05%	0	0.00%	7	0.05%
18–24 Years	5	0.22%	0	0.00%	2	0.09%
Emergency Department: Total						
0–12 Years	0	0.00%	0	0.00%	1	0.00%
13–17 Years	14	0.05%	0	0.00%	11	0.04%
18–24 Years	8	0.17%	0	0.00%	6	0.14%
Telehealth: Male						
0–12 Years	1	0.01%	0	0.00%	0	0.00%
13–17 Years	2	0.01%	0	0.00%	1	0.01%
18–24 Years	1	0.04%	0	0.00%	1	0.05%
Telehealth: Female						
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	7	0.05%	0	0.00%	6	0.05%

Measure	Aetna		Community Care		Simply Healthcare	
	No.	%	No.	%	No.	%
18–24 Years	0	0.00%	0	0.00%	0	0.00%
Telehealth: Total						
0–12 Years	1	0.00%	0	0.00%	0	0.00%
13–17 Years	0	0.03%	0	0.00%	7	0.03%
18–24 Years	1	0.02%	0	0.00%	1	0.02%
Opioid						
Any Services: Male						
0–12 Years	0	0.00%	0	0.00%	1	0.01%
13–17 Years	0	0.00%	0	0.00%	6	0.04%
18–24 Years	1	0.04%	0	0.00%	2	0.09%
Any Services: Female						
0–12 Years	1	0.01%	0	0.00%	1	0.01%
13–17 Years	10	0.07%	0	0.00%	10	0.08%
18–24 Years	2	0.09%	1	0.38%	1	0.04%
Any Services: Total						
0–12 Years	1	0.00%	0	0.00%	2	0.01%
13–17 Years	10	0.04%	0	0.00%	16	0.06%
18–24 Years	3	0.07%	1	0.19%	3	0.07%
Inpatient: Male						
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	0	0.00%	0	0.00%	1	0.01%
18–24 Years	0	0.00%	0	0.00%	0	0.00%
Inpatient: Female						
0–12 Years	0	0.00%	0	0.00%	0	0.00%

Measure	Aetna		Community Care		Simply Healthcare	
	No.	%	No.	%	No.	%
13–17 Years	3	0.02%	0	0.00%	3	0.02%
18–24 Years	0	0.00%	0	0.00%	1	0.04%
Inpatient: Total						
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	3	0.01%	0	0.00%	4	0.02%
18–24 Years	0	0.00%	0	0.00%	1	0.02%
Intensive Outpatient/Partial Hospitalization: Male						
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	0	0.00%	0	0.00%	0	0.00%
18–24 Years	0	0.00%	0	0.00%	0	0.00%
Intensive Outpatient/Partial Hospitalization: Female						
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	1	0.01%	0	0.00%	0	0.00%
18–24 Years	0	0.00%	0	0.00%	0	0.00%
Intensive Outpatient/Partial Hospitalization: Total						
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	1	0.00%	0	0.00%	0	0.00%
18–24 Years	0	0.00%	0	0.00%	0	0.00%
Outpatient or Medication Treatment: Male						
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	0	0.00%	0	0.00%	3	0.02%
18–24 Years	1	0.04%	0	0.00%	2	0.09%
Outpatient or Medication Treatment: Female						
0–12 Years	1	0.01%	0	0.00%	1	0.01%

Measure	Aetna		Community Care		Simply Healthcare	
	No.	%	No.	%	No.	%
13–17 Years	6	0.04%	0	0.00%	7	0.05%
18–24 Years	2	0.09%	0	0.00%	0	0.00%
Outpatient or Medication Treatment: Total						
0–12 Years	1	0.00%	0	0.00%	1	0.00%
13–17 Years	6	0.02%	0	0.00%	10	0.04%
18–24 Years	3	0.07%	0	0.00%	0	0.05%
Emergency Department: Male						
0–12 Years	0	0.00%	0	0.00%	1	0.01%
13–17 Years	0	0.00%	0	0.00%	2	0.01%
18–24 Years	0	0.00%	0	0.00%	0	0.00%
Emergency Department: Female						
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	0	0.00%	0	0.00%	0	0.00%
18–24 Years	0	0.00%	0	0.00%	0	0.00%
Emergency Department: Total						
0–12 Years	0	0.00%	0	0.00%	1	0.00%
13–17 Years	0	0.00%	0	0.00%	2	0.01%
18–24 Years	0	0.00%	0	0.00%	0	0.00%
Telehealth: Male						
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	0	0.00%	0	0.00%	0	0.00%
18–24 Years	0	0.00%	0	0.00%	0	0.00%
Telehealth: Female						
0–12 Years	0	0.00%	0	0.00%	0	0.00%

Measure	Aetna		Community Care		Simply Healthcare	
	No.	%	No.	%	No.	%
13–17 Years	3	0.02%	0	0.00%	0	0.00%
18–24 Years	0	0.00%	1	0.38%	0	0.00%
Telehealth: Total						
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	3	0.01%	0	0.00%	0	0.00%
18–24 Years	0	0.00%	1	0.19%	0	0.00%
Other						
Any Services: Male						
0–12 Years	2	0.01%	0	0.00%	3	0.02%
13–17 Years	115	0.83%	10	0.61%	110	0.82%
18–24 Years	32	1.35%	1	0.38%	25	1.14%
Any Services: Female						
0–12 Years	3	0.02%	1	0.04%	2	0.01%
13–17 Years	107	0.78%	10	0.62%	122	0.94%
18–24 Years	27	1.20%	4	1.51%	23	1.03%
Any Services: Total						
0–12 Years	5	0.01%	1	0.02%	5	0.01%
13–17 Years	222	0.81%	20	0.62%	232	0.88%
18–24 Years	59	1.28%	5	0.94%	48	1.08%
Inpatient: Male						
0–12 Years	1	0.01%	0	0.00%	0	0.00%
13–17 Years	24	0.17%	4	0.25%	26	0.19%
18–24 Years	4	0.17%	0	0.00%	1	0.05%
Inpatient: Female						

Measure	Aetna		Community Care		Simply Healthcare	
	No.	%	No.	%	No.	%
0–12 Years	1	0.01%	0	0.00%	0	0.00%
13–17 Years	37	0.27%	3	0.19%	52	0.40%
18–24 Years	7	0.31%	1	0.38%	5	0.22%
Inpatient: Total						
0–12 Years	2	0.01%	0	0.00%	0	0.00%
13–17 Years	61	0.22%	7	0.22%	78	0.29%
18–24 Years	11	0.24%	1	0.19%	6	0.14%
Intensive Outpatient/Partial Hospitalization: Male						
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	2	0.01%	0	0.00%	4	0.03%
18–24 Years	2	0.08%	0	0.00%	0	0.00%
Intensive Outpatient/Partial Hospitalization: Female						
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	1	0.01%	0	0.00%	2	0.02%
18–24 Years	0	0.00%	0	0.00%	0	0.00%
Intensive Outpatient/Partial Hospitalization: Total						
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	3	0.01%	0	0.00%	6	0.02%
18–24 Years	2	0.04%	0	0.00%	0	0.00%
Outpatient or Medication Treatment: Male						
0–12 Years	1	0.04%	0	0.00%	2	0.01%
13–17 Years	48	0.35%	6	0.37%	60	0.45%
18–24 Years	18	0.76%	1	0.38%	17	0.78%
Outpatient or Medication Treatment: Female						

Measure	Aetna		Community Care		Simply Healthcare	
	No.	%	No.	%	No.	%
0–12 Years	0	0.00%	0	0.00%	0	0.00%
13–17 Years	39	0.29%	8	0.50%	36	0.28%
18–24 Years	14	0.62%	2	0.75%	10	0.45%
Outpatient or Medication Treatment: Total						
0–12 Years	0	0.00%	0	0.00%	2	0.01%
13–17 Years	87	0.32%	14	0.43%	96	0.36%
18–24 Years	32	0.69%	3	0.56%	27	0.61%
Emergency Department: Male						
0–12 Years	0	0.00%	0	0.00%	1	0.01%
13–17 Years	39	0.28%	1	0.06%	26	0.19%
18–24 Years	16	0.68%	0	0.00%	6	0.27%
Emergency Department: Female						
0–12 Years	2	0.01%	1	0.04%	0	0.00%
13–17 Years	29	0.21%	1	0.06%	29	0.22%
18–24 Years	7	0.31%	1	0.38%	7	0.31%
Emergency Department: Total						
0–12 Years	2	0.01%	1	0.02%	1	0.00%
13–17 Years	68	0.25%	2	0.06%	55	0.21%
18–24 Years	23	0.50%	1	0.19%	13	0.29%
Telehealth: Male						
0–12 Years	1	0.01%	0	0.00%	0	0.00%
13–17 Years	23	0.17%	0	0.00%	23	0.17%
18–24 Years	7	0.30%	0	0.00%	7	0.32%
Telehealth: Female						

Measure	Aetna		Community Care		Simply Healthcare	
	No.	%	No.	%	No.	%
0–12 Years	0	0.00%	0	0.00%	2	0.01%
13–17 Years	19	0.14%	0	0.00%	24	0.18%
18–24 Years	6	0.27%	1	0.38%	4	0.18%
Telehealth: Total						
0–12 Years	1	0.00%	0	0.00%	2	0.01%
13–17 Years	42	0.15%	0	0.00%	47	0.18%
18–24 Years	13	0.28%	1	0.19%	11	0.25%

Table A-7 provides the MCOs' 2022 PMV results for the MPT measure. Because the results for this measure are typically minor compared to the number of enrollees for each MCO, trending is not included.

Table A-7. 2022 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	1,211	6.35%	97	3.76%	1168	6.25%
13–17 Years	1,027	7.44%	90	5.52%	990	7.35%
18–24 Years	105	4.44%	3	1.13%	113	5.16%
Any Services: Female						
0–12 Years	1,125	6.06%	83	3.28%	999	5.58%
13–17 Years	1,916	14.05%	134	8.37%	1887	14.39%
18–24 Years	202	9.00%	14	5.27%	215	9.58%
Any Services: Total						
0–12 Years	2,336	6.21%	180	3.52%	2167	5.52%
13–17 Years	2,943	10.73%	224	6.93%	2867	10.81%
18–24 Years	307	6.66%	17	3.20%	328	7.40%
Inpatient: Male						
0–12 Years	30	0.16%	4	0.15%	30	0.16%
13–17 Years	112	0.81%	16	0.98%	101	0.75%
18–24 Years	11	0.47%	0	0.00%	8	0.37%
Inpatient: Female						
0–12 Years	59	0.32%	6	0.24%	43	0.24%
13–17 Years	246	1.80%	20	1.25%	244	1.87%
18–24 Years	20	0.89%	3	1.13%	16	0.71%

Table A-7. 2022 PMV Results: MCOs – Audited Mental Health Utilization (MPT) Performance Measure						
Measure	Aetna		Community Care		Simply Healthcare	
	No.	%	No.	%	No.	%
Inpatient: Total						
0–12 Years	89	0.24%	10	0.20%	73	0.20%
13–17 Years	358	1.31%	36	1.11%	345	1.30%
18–24 Years	31	0.67%	3	0.56%	24	0.54%
Intensive Outpatient/Partial Hospitalization: Male						
0–12 Years	1	0.01%	0	0.00%	2	0.01%
13–17 Years	13	0.09%	0	0.00%	5	0.04%
18–24 Years	0	0.00%	0	0.00%	0	0.00%
Intensive Outpatient/Partial Hospitalization: Female						
0–12 Years	2	0.01%	0	0.00%	1	0.01%
13–17 Years	22	0.16%	1	0.06%	25	0.19%
18–24 Years	1	0.04%	1	0.38%	3	0.13%
Intensive Outpatient/Partial Hospitalization: Total						
0–12 Years	3	0.01%	0	0.00%	3	0.01%
13–17 Years	35	0.13%	1	0.03%	30	0.11%
18–24 Years	1	0.02%	1	0.19%	3	0.07%
Outpatient or Medication Treatment: Male						
0–12 Years	794	4.16%	91	3.52%	711	3.80%
13–17 Years	572	4.15%	73	4.48%	549	4.08%
18–24 Years	63	2.67%	3	1.13%	67	3.06%
Outpatient or Medication Treatment: Female						
0–12 Years	665	3.58%	74	2.92%	582	3.25%
13–17 Years	1119	8.21%	114	7.12%	1023	7.84%

Table A-7. 2022 PMV Results: MCOs – Audited Mental Health Utilization (MPT) Performance Measure						
Measure	**Aetna**		**Community Care**		**Simply Healthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**
18–24 Years	110	4.90%	12	4.52%	109	4.86%
Outpatient or Medication Treatment: Total						
0–12 Years	1,459	3.88%	165	3.23%	1293	3.53%
13–17 Years	1,691	6.16%	187	5.79%	1572	5.93%
18–24 Years	173	3.76%	15	2.82%	176	3.97%
Emergency Department: Male						
0–12 Years	3	0.02%	0	0.00%	1	0.01%
13–17 Years	3	0.02%	0	0.00%	2	0.01%
18–24 Years	2	0.08%	0	0.00%	0	0.00%
Emergency Department: Female						
0–12 Years	4	0.02%	0	0.00%	1	0.01%
13–17 Years	8	0.06%	0	0.00%	12	0.09%
18–24 Years	1	0.04%	0	0.00%	1	0.04%
Emergency Department: Total						
0–12 Years	7	0.02%	0	0.00%	2	0.01%
13–17 Years	11	0.04%	0	0.00%	14	0.05%
18–24 Years	3	0.07%	0	0.00%	1	0.02%
Telehealth: Male						
0–12 Years	697	3.65%	14	0.54%	733	3.92%
13–17 Years	675	4.89%	31	1.90%	649	4.82%
18–24 Years	59	2.50%	0	0.00%	68	3.11%
Telehealth: Female						
0–12 Years	709	3.82%	20	0.79%	653	3.65%

Table A-7. 2022 PMV Results: MCOs – Audited Mental Health Utilization (MPT) Performance Measure						
Measure	**Aetna**		**Community Care**		**Simply Healthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**
13–17 Years	1,310	9.61%	34	2.12%	1321	10.13%
18–24 Years	144	6.42%	3	1.13%	151	6.73%
Telehealth: Total						
0–12 Years	1,406	3.73%	34	0.66%	1386	3.79%
13–17 Years	1,985	7.24%	65	2.01%	1970	7.43%
18–24 Years	203	4.41%	3	0.56%	219	4.94%

DBM-specific PMV results appear in Table A-8. The green and red arrows indicate an increase (⬆) or decrease (⬇) from the previous year's rate. Table cells with a blue background indicate rates that did not change from the 2021 PMV to the 2022 PMV for that measure.

Table A-8. 2022 PMV Results: DBMs									
Measure	**Argus**			**DentaQuest**			**MCNA**		
	Rate (%)	**Den.***	**Num.***	**Rate (%)**	**Den.**	**Num.**	**Rate (%)**	**Den.**	**Num.**
Annual Dental Visit									
All Enrollees	46.84%⬇	29,315	13,731	62.08%⬆	28,673	17,801	56.63%⬆	37,796	21,406
Enrollees Aged 5 to 6†	45.91%⬆	2,226	1,022	63.06%⬆	1,784	1,125	55.47%⬆	2,201	1,221
Enrollees Aged 7 to 10	52.35%⬇	9,715	5,086	69.30%⬆	8,176	5,666	63.63%⬆	9,656	6,145
Enrollees Aged 11 to 14	47.90%⬆	9,702	4,647	62.60%⬆	9,788	6,127	58.62%⬆	12,436	7,290
Enrollees Aged 15 to 18	38.79%⬇	7,672	2,976	54.71%⬆	8,925	4,883	50.10%⬆	13,473	6,750
Any Dental Service									
Enrolled at Least 1 Month: All Enrollees	48.31%⬆	46,480	18,643	45.95%⬆	82,910	38,098	43.53%⬆	73,308	31,909
Enrolled at Least 1 Month: Age 5**	19.13%⬆	852	163	26.91%⬆	2,315	623	25.15% ⬆	3,090	777
Enrolled at Least 1 Month:	41.66%⬆	14,672	6,113	50.64%⬆	21,746	11,013	47.38%⬆	18,251	8,648

Table A-8. 2022 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Age 6–9									
Enrolled at Least 1 Month: Age 10–14	43.29%↑	18,840	8,156	48.10%↑	32,486	15,627	46.16%↑	27,957	12,905
Enrolled at Least 1 Month: Age 15–18	34.76%↑	12,116	4,211	41.10%↑	26,363	10,835	39.90%↑	24,010	9,579
Enrolled at Least 3 Months Continuously: All Enrollees	43.08%↑	42,254	18,202	51.14%↑	71,225	36,423	47.89%↑	31,042	64,821
Enrolled at Least 3 Months Continuously: Age 5	23.81%↑	567	135	35.91%↑	1,423	511	32.47%↑	2,159	701
Enrolled at Least 3 Months Continuously: Age 6–9	45.03%↑	13,269	5,975	56.18%↑	18,650	10,477	52.32%↑	16,046	8,395
Enrolled at Least 3 Months Continuously: Age 10–14	46.12%↑	17,287	7,973	53.29%↑	28,123	14,987	50.34%↑	25,031	12,601
Enrolled at Least 3 Months Continuously: Age 15–18	37.00%↑	11,131	4,119	45.37%↑	23,029	10,448	43.29%↑	21,585	9,345
Enrolled at Least 6 Months Continuously: All Enrollees	46.15%↑	36,630	16,903	56.40%↑	55,049	31,046	52.64%↑	53,883	28,363
Enrolled at Least 6 Months Continuously: Age 5	33.33%↑	6	2	45.40%↑	544	247	41.90%↑	1,191	499
Enrolled at Least 6 Months Continuously: Age 6–9	48.11%↑	11,564	5,563	61.88%↑	14,361	8,887	57.60%↑	13,227	7,619
Enrolled at Least 6 Months Continuously: Age 10–14	49.03%↑	15,292	7,497	58.54%↑	21,987	12,872	55.17%↑	21,075	11,628
Enrolled at Least 6 Months Continuously: Age 15–18	39.32%↑	9,768	3,841	49.79%↑	18,157	9,040	46.86%↑	18,390	8,617
Enrolled at Least 11 Months Continuously: All Enrollees	48.31%↑	28,174	13,611	60.58%↑	33,426	20,251	56.53%↑	38,207	21,600

Table A-8. 2022 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 11 Months Continuously: Age 5	0.00%	1	NA	100%↑	1	1	50.64%↑	156	79
Enrolled at Least 11 Months Continuously: Age 6–9	51.12%↓	8,273	4,229	66.12%↑	8,467	5,598	61.37%↑	9,348	5,737
Enrolled at Least 11 Months Continuously: Age 10–14	51.01%↓	12,162	6,204	62.70%↑	13,682	8,578	58.87%↑	15,222	8,961
Enrolled at Least 11 Months Continuously: Age 15–18	41.07%↓	7,738	3,178	53.87%↑	11,276	6,074	50.61%↑	13,481	6,823
Preventive Dental Services									
Enrolled at Least 1 Month: All Enrollees	37.71%↓	46,480	17,528	43.04%↑	82,910	35,686	40.84%↑	73,308	29,940
Enrolled at Least 1 Month: Age 5**	17.49%↑	852	149	24.45%↑	2,315	566	23.40%↑	3,090	723
Enrolled at Least 1 Month: Age 6–9	40.09%↑	14,672	5,882	48.71%↑	21,746	10,593	45.41%↑	18,251	8,288
Enrolled at Least 1 Month: Age 10–14	40.91%↑	18,840	7,707	45.53%↑	32,486	14,791	43.87%↑	27,957	12,265
Enrolled at Least 1 Month: Age 15–18	31.28%↑	12,116	3,790	36.93%↑	26,363	9,736	36.08%↑	24,010	8,664
Enrolled at Least 3 Months Continuously: All Enrollees	40.70%↑	42,254	17,190	48.13%↑	71,225	34,281	45.10%↑	64,821	29,233
Enrolled at Least 3 Months Continuously: Age 5	21.87%↑	567	124	32.89%↑	1,423	468	30.71%↑	2,159	663
Enrolled at Least 3 Months Continuously: Age 6–9	43.46%↑	13,269	5,767	54.26%↑	18,650	10,119	50.31%↑	16,046	8,073
Enrolled at Least 3 Months Continuously: Age 10–14	43.78%↑	17,287	7,569	50.66%↑	28,123	14,247	47.95%↑	25,031	12,002

Table A-8. 2022 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	33.51%↑	11,131	3,730	41.02%↑	23,029	9,447	39.36%↑	21,585	8,495
Enrolled at Least 6 Months Continuously: All Enrollees	43.79%↑	36,630	16,042	53.52%↑	55,049	29,460	49.92%↑	53,883	26,898
Enrolled at Least 6 Months Continuously: Age 5	33.33%↑	6	2	43.01%↑	544	234	40.39% ↑	1,191	481
Enrolled at Least 6 Months Continuously: Age 6–9	46.61%↓	11,564	5,390	60.25%↑	8,653	60.25%	55.75%↑	13,227	7,374
Enrolled at Least 6 Months Continuously: Age 10–14	46.80%↓	15,292	7,156	56.03%↑	21,987	12,319	52.90%↑	21,075	11,149
Enrolled at Least 6 Months Continuously: Age 15–18	35.77%↓	9,768	3,494	45.46%↑	18,157	8,254	42.93%↑	18,390	7,894
Enrolled at Least 11 Months Continuously: All Enrollees	45.94%↓	28,174	12,942	57.89%↑	33,426	19,349	53.83%↑	38,207	20,565
Enrolled at Least 11 Months Continuously: Age 5	0.00%	1	NA	100%↑	1	1	50.00%↑	156	78
Enrolled at Least 11 Months Continuously: Age 6–9	49.56%↓	8,273	4,100	64.66%↑	8,467	5,475	59.67%↑	9,348	5,578
Enrolled at Least 11 Months Continuously: Age 10–14	48.77%↓	12,162	5,931	60.42%↑	13,682	8,266	56.74%↑	15,222	8,637
Enrolled at Least 11 Months Continuously: Age 15–18	37.62%↑	7,738	2,911	49.73%↑	11,276	5,607	46.52%↑	13,481	6,272
Dental Treatment Services									
Enrolled at Least 1 Month: All Enrollees	48.31%↑	46,480	18,643	17.71%↑	82,910	14,687	16.70%↑	73,308	12,245
Enrolled at Least 1 Month: Age 5**	19.13%↑	852	163	8.12%↑	2,315	188	8.06%↑	3,090	249

Table A-8. 2022 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 1 Month: Age 6–9	41.66%↑	14,672	6,113	21.56%↑	21,746	4,688	20.00%↑	18,251	3,651
Enrolled at Least 1 Month: Age 10–14	43.29%↑	18,840	8,156	17.14%↑	32,486	5,567	16.13%↑	27,957	4,510
Enrolled at Least 1 Month: Age 15–18	34.76%↑	12,116	4,211	16.10%↑	26,363	4,244	15.97%↑	24,010	3,835
Enrolled at Least 3 Months Continuously: All Enrollees	43.08%↑	42,254	18,202	19.80%↑	71,225	14,103	18.46%↑	64,821	11,964
Enrolled at Least 3 Months Continuously: Age 5	23.81%↑	567	135	10.47%↑	1,423	149	10.70%↑	2,159	231
Enrolled at Least 3 Months Continuously: Age 6–9	45.03%↑	13,269	5,975	24.14%↑	18,650	4,503	22.11%↑	16,046	3,547
Enrolled at Least 3 Months Continuously: Age 10–14	46.12%↑	17,287	7,973	19.04%↑	28,123	5,356	17.71%↑	25,031	4,434
Enrolled at Least 3 Months Continuously: Age 15–18	37.00%↑	11,131	4,119	17.78%↑	23,029	4,095	17.38%↑	21,585	3,752
Enrolled at Least 6 Months Continuously: All Enrollees	46.15%↑	36,630	16,903	21.90%↑	55,049	12,053	20.44%↑	53,883	11,011
Enrolled at Least 6 Months Continuously: Age 5	33.33%↑	6	2	13.60%↑	544	74	14.02%↑	1,191	167
Enrolled at Least 6 Months Continuously: Age 6–9	48.11%↑	11,564	5,563	26.73%↑	14,361	3,839	24.70%↑	13,227	3,267
Enrolled at Least 6 Months Continuously: Age 10–14	49.03%↑	15,292	7,497	20.89%↑	21,987	4,593	19.50%↑	21,075	4,109
Enrolled at Least 6 Months Continuously: Age 15–18	39.32%↑	9,768	3,841	19.54%↑	18,157	3,547	18.86%↑	18,390	3,468
Enrolled at Least 11 Months	48.31%↑	28,174	13,611	23.31%↑	33,426	7,790	22.25%↑	38,207	8,501

Table A-8. 2022 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Continuously: All Enrollees									
Enrolled at Least 11 Months Continuously: Age 5	0.00%	1	NA	100%↑	1	1	19.23%↑	156	30
Enrolled at Least 11 Months Continuously: Age 6–9	51.12%↑	8,273	4,229	28.43%↑	8,467	2,407	26.59%↑	9,348	2,486
Enrolled at Least 11 Months Continuously: Age 10–14	51.01%↑	12,162	6,204	22.00%↑	13,682	3,010	21.09%↑	15,222	3,211
Enrolled at Least 11 Months Continuously: Age 15–18	41.07%↑	7,738	3,178	21.04%↑	11,276	2,372	20.58%↑	13,481	2,774
Dental Sealants (The age 5 and age 15–18 stratifications do not apply to this measure.)									
Enrolled at Least 1 Month: All Enrollees	9.46%↑	46,480	4,398	12.60%↑	54,232	6,832	9.50%↓	46,208	4,389
Enrolled at Least 1 Month: Age 6–9	11.19%↑	14,672	1,642	13.78%↑	21,746	2,997	13.37%↑	18,251	2,440
Enrolled at Least 1 Month: Age 10–14	10.57%↑	18,840	1,992	11.81%↑	32,486	3,835	6.97%↓	27,957	1,949
Enrolled at Least 3 Months Continuously: All Enrollees	10.21%↑	42,254	4,315	14.09%↑	46,773	6,590	10.46%↓	41,077	4,295
Enrolled at Least 3 Months Continuously: Age 6–9	12.18%↑	13,269	1,616	15.52%↑	18,650	2,895	14.80%↑	16,046	2,375
Enrolled at Least 3 Months Continuously: Age 10–14	11.27%↑	17,287	1,949	13.14%↑	28,123	3,695	7.67%↓	25,031	1,920
Enrolled at Least 6 Months Continuously: All Enrollees	11.11%↑	36,630	4,068	15.58%↑	36,342	5,661	11.69%↓	34,302	4,010
Enrolled at Least 6 Months Continuously: Age 6–9	13.12%↑	11,564	1,517	17.31%↑	14,361	2,486	16.61%↑	13,227	2,197
Enrolled at Least 6 Months	12.10%↑	15,292	1,850	14.44%↑	21,981	3,175	8.60%↓	21,075	1,813

Table A-8. 2022 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Continuously: Age 10–14									
Enrolled at Least 11 Months Continuously: All Enrollees	11.93%↓	28,174	3,361	16.97%↑	22,149	3,759	12.57%↓	24,570	3,088
Enrolled at Least 11 Months Continuously: Age 6–9	15.00%↓	8,273	1,241	19.26%↑	8,467	1,631	17.62%↓	9,348	1,647
Enrolled at Least 11 Months Continuously: Age 10–14	12.60%↑	12,162	1,532	15.55%↑	13,682	2,128	9.47%↓	15,222	1,441
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	3.36%↑	46,480	1,561	86.17%↑	54,232	46,733	9.98%↓	42,756	4,266
Enrolled at Least 1 Month: Age 6–9	7.80%↓	14,672	1,144	77.18%↑	21,746	16,784	14.75%↑	15,978	2,356
Enrolled at Least 1 Month: Age 10–14	2.21%↑	18,840	417	92.19%↑	32,486	29,949	7.13%↓	26,778	1,910
Enrolled at Least 3 Months Continuously: All Enrollees	3.49%↓	42,254	1,473	84.90%↑	46,773	39,708	11.03%↑	37,848	4,174
Enrolled at Least 3 Months Continuously: Age 6–9	8.12%↓	13,269	1,078	74.96%↑	18,650	13,980	16.48%↑	13,916	2,293
Enrolled at Least 3 Months Continuously: Age 10–14	2.28%↑	17,287	395	91.48%↑	28,123	25,728	7.86%↓	23,932	1,881
Enrolled at Least 6 Months Continuously: All Enrollees	3.76%↓	36,630	1,376	83.32%↑	36,342	30,281	12.39%↓	31,415	3,892
Enrolled at Least 6 Months Continuously: Age 6–9	8.67%↓	11,564	1,003	72.29%↑	14,361	10,382	18.66%↑	11,341	2,116
Enrolled at Least 6 Months Continuously: Age 10–14	2.44%↑	15,292	373	90.53%↑	21,981	19,899	8.85%↑	20,074	1,776
Enrolled at Least 11 Months	4.22%↓	28,174	1,188	81.69%↑	22,149	18,093	13.40%↑	22,310	2,990

Table A-8. 2022 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Continuously: All Enrollees									
Enrolled at Least 11 Months Continuously: Age 6–9	10.44%↓	8,273	864	69.13%↑	8,467	5,853	19.99%↑	7,887	1,577
Enrolled at Least 11 Months Continuously: Age 10–14	2.66%↓	12,162	324	89.46%↑	13,682	12,240	9.80%↓	14,423	1,413
Diagnostic Dental Services									
Enrolled at Least 1 Month: All Enrollees	38.28%↑	46,480	17,791	44.82%↑	82,910	37,160	41.18%↑	73,308	30,189
Enrolled at Least 1 Month: Age 5**	18.08%↑	852	154	25.83%↑	2,315	598	24.34%↑	3,090	752
Enrolled at Least 1 Month: Age 6–9	40.65%↑	14,672	5,964	49.98%↑	21,746	10,868	45.96% ↑	18,251	8,388
Enrolled at Least 1 Month: Age 10–14	41.41%↑	18,840	7,802	47.04%↑	32,486	15,282	44.04%↑	27,957	12,311
Enrolled at Least 1 Month: Age 15–18	31.95%↑	12,116	3,871	39.49%↑	26,363	10,068	36.39%↑	24,010	8,738
Enrolled at Least 3 Months Continuously: All Enrollees	41.20%↑	42,254	17,409	50.00%↑	71,225	35,613	45.42%↑	64,821	29,444
Enrolled at Least 3 Months Continuously: Age 5	22.40%↑	567	127	34.72%↑	1,423	494	31.73%↑	2,159	685
Enrolled at Least 3 Months Continuously: Age 6–9	43.99%↑	13,269	5,837	55.57%↑	18,650	10,363	50.87%↑	16,046	8,163
Enrolled at Least 3 Months Continuously: Age 10–14	44.23%↑	17,287	7,646	52.23%↑	28,123	14,688	48.11%↑	25,031	12,042
Enrolled at Least 3 Months Continuously: Age 15–18	34.13%↑	11,131	3,799	43.72%↑	23,029	10,068	39.63%↑	21,585	8,554
Enrolled at Least 6 Months	44.28%↑	36,630	16,220	55.34%↑	55,049	30,462	50.18%↑	53,883	27,039

Table A-8. 2022 PMV Results: DBMs									
Measure	**Argus**			**DentaQuest**			**MCNA**		
	Rate (%)	**Den.***	**Num.***	**Rate (%)**	**Den.**	**Num.**	**Rate (%)**	**Den.**	**Num.**
Continuously: All Enrollees									
Enrolled at Least 6 Months Continuously: Age 5	33.33%↑	6	2	44.30%↑	544	241	41.31%↑	1,191	492
Enrolled at Least 6 Months Continuously: Age 6–9	47.12%↑	11,564	5,449	61.42%↑	14,361	8,821	56.33%↑	13,227	7,451
Enrolled at Least 6 Months Continuously: Age 10–14	47.21%↑	15,292	7,220	57.53%↑	21,987	12,649	52.98%↑	21,075	11,165
Enrolled at Least 6 Months Continuously: Age 15–18	36.33%↑	9,768	3,549	48.20%↑	18,157	8,751	43.13%↑	18,390	7,931
Enrolled at Least 11 Months Continuously: All Enrollees	46.37%↓	28,174	13,064	59.62%↑	33,426	19,930	54.02%↑	38,207	20,639
Enrolled at Least 11 Months Continuously: Age 5	0.00%	1	NA	100%↑	1	1	49.36%↑	156	77
Enrolled at Least 11 Months Continuously: Age 6–9	50.11%↓	8,273	4,146	65.68%↑	8,467	5,561	60.13%↑	9,348	5,621
Enrolled at Least 11 Months Continuously: Age 10–14	49.14%↑	12,162	5,977	61.82%↑	13,682	8,458	56.75%↑	15,222	8,639
Enrolled at Least 11 Months Continuously: Age 15–18	38.01%↓	7,738	2,941	52.41%↑	11,276	5,910	46.75%↑	13,481	6,302
Any Dental or Oral Health Service									
Enrolled at Least 1 Month: All Enrollees	40.07%↑	46,480	18,623	43.04%↑	82,910	35,686	43.53%↑	73,308	31,909
Enrolled at Least 1 Month: Age 5**	19.13%↑	852	163	24.45%↑	2,315	566	25.15%↑	3,090	777
Enrolled at Least 1 Month: Age 6–9	41.61%↑	14,672	6,105	48.71%↑	21,746	10,593	47.38%↑	18,251	8,648
Enrolled at Least 1 Month:	43.25%↑	18,840	8,148	45.53%↑	32,486	14,791	46.16%↑	27,957	12,905

Table A-8. 2022 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Age 10–14									
Enrolled at Least 1 Month: Age 15–18	34.72%↑	12,116	4,207	36.93%↓	26,363	9,736	39.90%↑	24,010	9,579
Enrolled at Least 3 Months Continuously: All Enrollees	43.03%↑	42,254	18,182	48.13%↑	71,225	34,281	47.89%↑	64,821	31,042
Enrolled at Least 3 Months Continuously: Age 5	23.81%↑	567	135	32.89%↑	1,423	468	32.47%↑	2,159	701
Enrolled at Least 3 Months Continuously: Age 6–9	44.97%↑	13,269	5,967	54.26%↑	18,650	10,119	52.32%↑	16,046	8,395
Enrolled at Least 3 Months Continuously: Age 10–14	46.08%↑	17,287	7,965	50.66%↑	28,123	14,247	50.34%↑	25,031	12,601
Enrolled at Least 3 Months Continuously: Age 15–18	36.97%↑	11,131	4,115	41.02%↓	23,029	9,447	43.29%↑	21,585	9,345
Enrolled at Least 6 Months Continuously: All Enrollees	46.11%↑	36,630	16,890	53.52%↑	55,049	29,460	52.64%↑	53,883	28,363
Enrolled at Least 6 Months Continuously: Age 5	33.33%↑	6	2	43.01%↑	544	234	41.90%↑	1,191	499
Enrolled at Least 6 Months Continuously: Age 6–9	48.06%↑	11,564	5,558	60.25%↑	14,361	8,653	57.60%↑	13,227	7,619
Enrolled at Least 6 Months Continuously: Age 10–14	48.99%↑	15,292	7,492	56.03%↑	21,987	12,319	55.17%↑	21,075	11,628
Enrolled at Least 6 Months Continuously: Age 15–18	39.29%↑	9,768	3,838	45.46%↓	18,157	8,254	46.86%↑	18,390	8,617
Enrolled at Least 11 Months Continuously: All Enrollees	48.27%↓	28,174	13,600	57.89%↑	33,426	19,349	56.53%↑	38,207	21,600
Enrolled at Least 11 Months Continuously: Age 5	0.00%	1	NA	100%↑	1	1	50.64%↑	156	79

Table A-8. 2022 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 11 Months Continuously: Age 6–9	51.07%↓	8,273	4,225	64.66%↑	8,467	5,475	61.37%↑	9,348	5,737
Enrolled at Least 11 Months Continuously: Age 10–14	50.97%↑	12,162	6,199	60.42%↑	13,682	8,266	58.87%↑	15,222	8,961
Enrolled at Least 11 Months Continuously: Age 15–18	41.04%↑	7,738	3,176	49.73%↓	11,276	5,607	50.61%↑	13,481	6,823

** 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 A-9. Improvements Since the 2021 PMV by MCO/DBM

MCO/DBM	Measure	Quality	Timeliness	Access	2021 Measure Result	2022 Measure Result
Aetna	Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care	✓	✓	✓	NA	66.67%
	Contraceptive Care – Postpartum Women Ages 15−20 (CCP): Most or moderately effective contraception – 3 days	✓	✓	✓	NA	50.00%
	Contraceptive Care – Postpartum Women Ages 15−20 (CCP): Most or moderately effective contraception – 60 days	✓	✓	✓	NA	50.00%
	Contraceptive Care – Postpartum Women Ages 15−20 (CCP): Long-acting reversible method of contraception (LARC) – 3 days	✓	✓	✓	NA	50.00%
	Contraceptive Care – Postpartum Women Ages 15−20 (CCP): LARC – 60 days	✓	✓	✓	NA	50.00%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM): Blood Glucose Testing: 12–17 Years	✓	✓		56.60%	66.91%

	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Alcohol Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	✓	✓	✓	NA	46.67%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Opioid Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	✓	✓	✓	NA	100%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Other Drug Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	✓	✓	✓	39.02%	53.75%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Alcohol Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	✓	✓	✓	NA	31.25%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Opioid Abuse or Dependence: Initiation of AOD Treatment Total	✓	✓	✓	NA	100%
CCP	Asthma Medication Ratio (AMR): 5–11 Years	✓			NA	85.00%
	Asthma Medication Ratio (AMR): 12–18 Years	✓			NA	77.78%
	Asthma Medication Ratio (AMR): Total	✓			NA	82.76%
	Appropriate Testing for Pharyngitis (CWP): 18–64 Years	✓	✓		NA	69.23%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD): Initiation Phase	✓	✓		NA	31.65%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD): Continuation and Maintenance Phase	✓	✓		NA	45.45%
	Follow-Up After Hospitalization for Mental Illness (FUH): 30-Day Follow-Up: 6–17 Years	✓	✓		58.14%	74.47%

	Follow-Up After Hospitalization for Mental Illness (FUH): 7-Day Follow-Up: 18–64 Years	✓	✓		NA	25.00%
	Follow-Up After Hospitalization for Mental Illness (FUH): 30-Day Follow-Up: 18–64 Years	✓	✓		NA	25.00%
	Follow-Up After Hospitalization for Mental Illness (FUH): Total	✓	✓		60.42%	70.59%
	Follow-Up After Emergency Department Visit for Mental Illness (FUM): 7-Day Follow-Up: 6–17 Years	✓	✓		NA	14.29%
	Follow-Up After Emergency Department Visit for Mental Illness (FUM): 30-Day Follow-Up: 6–17 Years	✓	✓		NA	28.57%
	Follow-Up After Emergency Department Visit for Mental Illness (FUM): 7-Day Follow-Up Total	✓	✓		NA	14.29%
	Follow-Up After Emergency Department Visit for Mental Illness (FUM): 30-Day Follow-Up Total	✓	✓		NA	28.57%
	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP): 12–17 Years	✓		✓	NA	60.00%
	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP): Total	✓		✓	NA	50.00%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM): Blood Glucose Testing: 1–11 Years	✓	✓		NA	14.29%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM): Blood Glucose Testing: 12–17 Years	✓	✓		NA	75.00%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM): Cholesterol Testing: 12–17 Years	✓	✓		NA	75.00%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM): Blood Glucose and Cholesterol Testing:	✓	✓		NA	66.67%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM): 12–17 Years	✓	✓		NA	52.63%

	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM): Blood Glucose Testing Total	✓	✓		NA	47.37%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM): Cholesterol Testing Total	✓	✓		NA	42.11%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Alcohol Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	✓	✓	✓	NA	100%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Engagement of AOD Treatment: 13–17 Years	✓	✓	✓	NA	100%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Other Drug Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	✓	✓	✓	NA	81.82%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): 13–17 Years Total	✓	✓	✓	NA	81.82%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Other Drug Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	✓	✓	✓	NA	40.00%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Initiation of AOD Treatment: 18+ Years Total	✓	✓	✓	NA	33.33%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Alcohol Abuse or Dependence: Initiation of AOD Treatment Total	✓	✓	✓	NA	50.00%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Alcohol Abuse or Dependence: Engagement of AOD Treatment Total	✓	✓	✓	NA	50.00%

	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Other Drug Abuse or Dependence: Initiation of AOD Treatment Total	✓	✓	✓	NA	68.75%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Initiation of AOD Treatment Total	✓	✓	✓	NA	64.71%
Simply	Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care	✓	✓	✓	NA	66.67%
	Contraceptive Care – Postpartum Women Ages 15−20 (CCP): Most or moderately effective contraception – 60 days	✓	✓	✓	NA	17.00%
	Follow-Up After Emergency Department Visit for Mental Illness (FUM): 7-Day Follow-Up: 18–64 Years	✓	✓		NA	14.29%
	Follow-Up After Emergency Department Visit for Mental Illness (FUM): 30-Day Follow-Up: 18–64 Years	✓	✓		NA	28.57%
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA): 30-Day Follow-Up: 13–17 Years	✓	✓		NA	13.33%
	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP): 1–11 Years	✓		✓	NA	58.82%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM): Blood Glucose Testing: 1–11 Years	✓	✓		38.64%	51.43%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM): Blood Glucose Testing: 12–17 Years	✓	✓		53.65%	65.26%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM): Blood Glucose Testing Total	✓	✓		50.85%	63.11%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Alcohol Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	✓	✓	✓	NA	64.71%

	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Opioid Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	✓	✓	✓	NA	100%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Alcohol Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	✓	✓	✓	NA	33.33%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Opioid Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	✓	✓	✓	NA	100%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Alcohol Abuse or Dependence: Initiation of AOD Treatment Total	✓	✓	✓	NA	60.00%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Opioid Abuse or Dependence: Initiation of AOD Treatment Total	✓	✓	✓	NA	100%
Argus	Preventive Dental: Enrolled at Least 6 Months Continuously Enrollees aged 5†	✓	✓	✓	0.00%	33.33%
	Any Dental Service: Enrolled at Least 1 Month- All enrollees	✓	✓	✓	35.11%	48.31%
	Any Dental Service: Enrolled at Least 6 Months Continuously Enrollees aged 5†	✓	✓	✓	0.00%	33.33%
	Dental Diagnostic Service: Enrolled at Least 6 Months Continuously Enrollees aged 5†	✓	✓	✓	0.00%	33.33%
	Any Preventive Dental or Oral Health Service: Enrolled at Least 6 Months Continuously	✓	✓	✓	0.00%	33.33%
DentaQuest	Dental Sealants – With Exclusions: Enrolled at Least 1 Month- All enrollees	✓	✓	✓	12.61%	86.17%

	Dental Sealants – With Exclusions: Enrolled at Least 1 Month- Enrollees aged 6 to 9	✓	✓	✓	14.68%	77.18%
	Dental Sealants – With Exclusions: Enrolled at Least 1 Month- Enrollees aged 10 to 14	✓	✓	✓	11.36%	92.19%
	Dental Sealants – With Exclusions: Enrolled at Least 3 Months Continuously- All enrollees	✓	✓	✓	14.15%	84.90%
	Dental Sealants – With Exclusions: Enrolled at Least 3 Months Continuously- Enrollees aged 6 to 9	✓	✓	✓	16.79%	74.96%
	Dental Sealants – With Exclusions: Enrolled at Least 3 Months Continuously- Enrollees aged 10 to 14	✓	✓	✓	12.61%	91.48%
	Dental Sealants – With Exclusions: Enrolled at Least 6 Months Continuously- All enrollees	✓	✓	✓	15.56%	83.32%
	Dental Sealants – With Exclusions: Enrolled at Least 6 Months Continuously- Enrollees aged 6 to 9	✓	✓	✓	19.00%	72.29%
	Dental Sealants – With Exclusions: Enrolled at Least 6 Months Continuously- Enrollees aged 10 to 14	✓	✓	✓	13.64%	90.53%
	Dental Sealants – With Exclusions: Enrolled at Least 11 Months Continuously- All enrollees	✓	✓	✓	17.95%	81.69%
	Dental Sealants – With Exclusions: Enrolled at Least 11 Months Continuously- Enrollees aged 6 to 9	✓	✓	✓	23.62%	69.13%
	Dental Sealants – With Exclusions: Enrolled at Least 11 Months Continuously- Enrollees aged 10 to 14	✓	✓	✓	15.13%	89.46%
	Preventive Dental: Enrolled at Least 11 Months Continuously- Enrollees aged 5†	✓	✓	✓	0.00%	100%
	Any Dental Service: Enrolled at Least 11 Months Continuously- Enrollees aged 5†	✓	✓	✓	0.00%	100%

	Dental Treatment Service: Enrolled at Least 11 Months Continuously- Enrollees aged 5†	✓	✓	✓	0.00%	100%
	Dental Diagnostic Service: Enrolled at Least 11 Months Continuously- Enrollees aged 5†	✓	✓	✓	0.00%	100%
	Any Preventive Dental or Oral Health Service: Enrolled at Least 11 Months Continuously- Enrollees aged 5†	✓	✓	✓	0.00%	100%
MCNA	Any Dental Service: Enrolled at Least 11 Months Continuously- Enrollees aged 5†	✓	✓	✓	40.09%	50.64%
	Any Preventive Dental or Oral Health Service: Enrolled at Least 11 Months Continuously- Enrollees aged 5†	✓	✓	✓	40.09%	50.64%

ACA

ACA Standards

Table A-10 displays each MCOs and DBMs compliance score for each section of the 2022 ACA and the overall compliance score for 2022. The score shows the level of compliance with federal statutes and standards established by FHKC.

Table A-10. ACA Standard Results 2022: MCOs and DBMs

Standard	MCOs			DBMs		
	Aetna	Community Care	Simply Healthcare	Argus	DentaQuest	MCNA
Coordination and Continuity of Care	100%	99.00%	100%	85.00%	100%	100%
Coverage and Authorization of Services	100%	100%	100%	100%	100%	100%
Subcontractual Relationships and Delegation	100%	100%	100%	NA	100%	NA
2022 Overall Compliance Standard Score	100%	99.60%	100%	92.50%	100%	100%

File Review

The results in Table A-11 present each MCO's and DBM's compliance with each denial file review for the 2022 ACA.

Table A-11. ACA File Review Results 2022: MCOs and DBMs

File Review	MCOs			DBMs		
	Aetna	Community Care	Simply Healthcare	Argus	DentaQuest	MCNA
Denials	100%	100%	100%	96.08%	100%	100%

Table A-12 includes strengths for each MCO/DBM from the 2022 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 2022 ACA.

Table A-12. 2022 ACA Individual MCO/DBM Strengths

Standard and Element	Strength	Quality	Timeliness	Access
Aetna				
Coverage and Authorization of Services Element 02: Service Limitations	Policy #7100.05 makes specific reference to the Florida Administrative code and Federal regulations. Additional references to AHCA Statewide Medicaid Managed Care Contract and NCQA guidelines were noted for reference.		✓	✓
Coverage and Authorization of Services Element 03: Authorization of Services	References to NCQA guidelines indicate that Aetna is working toward ensuring additional national accreditation guidelines are met. In addition, Aetna's Quality Management Oversight Committee meets and updates quality management and utilization management program descriptions, work plans, and evaluations on an annual basis. The Quality Management/Utilization Management Committee (QMUM) also submits semi-annual reports to Aetna's board of directors for approval.		✓	✓
Coverage and Authorization of Services Element 04: Application of Review Criteria	Aetna has adopted evidence-based clinical practice guidelines from nationally recognized sources such as Milliman Care Guidelines (MCG), State and Federal Regulatory agencies, Clinical Policies and Guidelines, and Level of Care Utilization System (LOCUS).		✓	✓
Coverage and Authorization of Services Element 05: Utilization Management Controls	The policy references other policies such as policy #7000.30 which addresses the process for approving and applying the medical necessity criteria appropriately. Medical director oversight was also noted as a resource for case managers reviewing requests for services.		✓	✓
Coverage and Authorization of Services Element 06: Appropriate Reviewer Expertise	Aetna provides frequent opportunities for utilization management (UM) training to associates as evidenced by the timing in which the courses are offered. Frequent opportunities for training can assist Aetna associates with a higher level of understanding of the medical necessity criteria which in turn may attribute to higher inter-rater reliability (IRR) scores over time.		✓	✓

Table A-12. 2022 ACA Individual MCO/DBM Strengths

Standard and Element	Strength	Quality	Timeliness	Access
Coverage and Authorization of Services Element 07: Notice of Adverse Benefit Determination	Aetna's timeliness chart within policy #7100.05 is in alignment with guidelines set out by NCQA and the MCS 22-6-1 contract.		✓	✓
Coverage and Authorization of Services Element 27: Disease and Case Management	Multiple methods of identifying members for care management (CM) and disease management (DM) services was listed within the policy. These include but are not limited to reviews of claims/encounters, use of predictive modeling tools, and wellness/health coaching programs, etc.		✓	✓
Coverage and Authorization of Services Element 30: Cultural Competency Plan	Aetna identified that it submits an annual cultural competency plan to FHKC by Novembe[r] 1st each year for approval as listed directly in the policy language.		✓	✓
Coordination and Continuity of Care Element 17: Disease and Case Management Services	Early collaboration with state entities and vendors may lead to better outcomes when transitioning member services.	✓	✓	✓
CCP				
Coverage and Authorization of Services Element 03: Authorization of Services	FHK UM 001 policy clearly identifies the various evidence-based criterion utilized to manage their population of members.		✓	✓
Coverage and Authorization of Services Element 07: Notice of Adverse Benefit Determination	The policy included a copy of the adverse determination letter that is sent to members which meet requirements consistent with 42 CRF 438.04(a).		✓	✓
Coverage and Authorization of Services Element 41: Enrollee Handbook	The policy notes that the process for fulfilling new enrollee information needs begins within six hours of receipt of the enrollment data. Furthermore, the policy provided reported that the Vendor is required to process the order within three business days of receipt. Tracking is completed through "secret shoppers" to ensure delivery is timely to all new enrollees.		✓	✓
Coverage and Authorization of Services Element 44: Enrollee Handbook Content-3	The information submitted was inclusive of the timeframe to submit appeals and provided information to the member regarding timeframes of resolution for both grievances and appeals.		✓	✓

Table A-12. 2022 ACA Individual MCO/DBM Strengths

Standard and Element	Strength	Quality	Timeliness	Access
Coverage and Authorization of Services Element 46: Information Delivery Methods	Information was posted on the website regarding member handbook and forms.		✓	✓
Coverage and Authorization of Services Element 50: Pharmacy Information	CCP provided information related to medication tier levels to ensure compliance with the Element as specified which goes beyond the requirements currently in place for the FHKC health plans.		✓	✓
Coordination and Continuity of Care Element 09: HRA Incentive Plan	Actively engaged to improve on HRA incentive plan as evidenced by the plan having implemented a PIP for this requirement.	✓	✓	✓
Coordination and Continuity of Care Element 10: Assessment of Enrollee Needs	During the virtual review CCP reported that they have implemented a performance improvement plan specifically related to health risk assessments of enrollees. CCP is working to have improved completion of the HRA through providing a HRA incentive plan. The performance improvement plan started in early 2021 and is ongoing at the present time.	✓	✓	✓
Subcontractual Relationships and Delegation Element 01: Contract Compliance	Each Element in the Delegation Agreements presented as supporting documentation were clearly identified and labeled.	✓	✓	✓
Simply				
Coverage and Authorization of Services Element 04: Application of Review Criteria	There is an inter-reliability review process. An annual assessment for review criteria is established. Florida medical directors conduct 18 assessments annually. The enterprise level committee reports to the IRR governance committee. The policies and guidelines adopted by policy and technology committee are used. The Medical Policy & Technology Assessment Committee (MPTAC) develops assessments. Each assessment is January to November for each year. The cases are based on actual cases but are hypothetical. The goal is identifying the correct clinical criteria and to make correct coverage decisions. Medical directors receive credit for 80% correct response rate. UM reviewers are tested once annually and must pass the IRR at 90%.		✓	✓

Table A-12. 2022 ACA Individual MCO/DBM Strengths

Standard and Element	Strength	Quality	Timeliness	Access
Coverage and Authorization of Services Element 12: Covered Outpatient Drug Decisions	Prescribers contact pharmacy department, and the authorization is based on standardized criteria. After review, cases are either approved or denied within 24 hours. Enrollees are informed of the decision within this time frame as well. Hourly monitoring is conducted. 24-hour turnaround time is kept by reaching out to the assigned pharmacist. The workflow process document from InGenioRX included the dates and times in which reports are ran in order to capture information regarding outpatient drug requests.		✓	✓
Coverage and Authorization of Services Element 24: Behavioral Health Educational Materials	Simply Health website has behavioral health topic listed linking to resources. Simply Healthy Lines created by American Chapter of Pediatrics focusing on sadness, uncertainty, substance abuse, etc. Beacon also provides resources on their websites linking to Simply Health. Programs offered by Simply Health include major depression, schizophrenia, etc. These are clear examples of the educational materials available to enrollees.		✓	✓
Coverage and Authorization of Services Element 26: Social Determinants of Health	Social determinants of health (SDOH) screening tool generates a report listing responses to members needing support. Upon review of the report, enrollees are then referred to the various services they may need.		✓	✓
Coverage and Authorization of Services Element 30: Cultural Competency Plan	Simply has been participating in a pilot program with NCQA for multicultural healthcare distinction. During the pilot program, Simply developed standards for the plan to ensure the needs for diverse members are met. Simply has had 2 weekly calls with NCQA until recently. They continue to speak with NCQA once weekly at the present to track the progress made in the pilot program.		✓	✓
Coverage and Authorization of Services Element 38: Provider Termination Notice	Personal Identifiable Information (PII) was redacted in the example of the letter mailed to the member.		✓	✓
Coverage and Authorization of Services Element 39: Provider Incentive Plans	Simply shared that paid for performance services are available. The goal is to improve quality of care. Simply Health partners with their legal team to ensure compliance with state and federal regulations.		✓	✓

Table A-12. 2022 ACA Individual MCO/DBM Strengths

Standard and Element	Strength	Quality	Timeliness	Access
Coverage and Authorization of Services Element 53: Certificates of Creditable Coverage	Member information was redacted for presentation during the review. Both English and Spanish languages were represented in the text of the document submitted as evidence of compliance.		✓	✓
Coordination and Continuity of Care Element 05: Transition of Care Policy	During the virtual review, a discussion occurred regarding the transition of care policy. CCP advised that when a patient comes from another plan, a nurse to nurse reach out is made to the other managed care organization for a smooth transition of the case. When members age out of the plan, approximately 6 months beforehand, case managers work to assist members as they apply to long care treatment or waiver and advise members on benefits of both. There is also a 60-day continuity of care when a new member transitions from an old plan so that previously approved treatments continue to be authorized for 60 days.	✓	✓	✓
Coordination and Continuity of Care Element 08: Initial Health Risk Assessment (HRA)	CCP contracts with IVR welcome call specialists for new members with FHKC plan. An IVR call is made daily with 2 calls maximum per day. Once the call is completed it is loaded into Care Compass and can be reviewed by case management.	✓	✓	✓
Coordination and Continuity of Care Element 13: Special Healthcare Needs Assessment	During a discussion in the virtual review, CCP stated that when the HRA is completed in Eliza (a member engagement engine), issues such as bipolar disorder, schizophrenia, or suspicion of domestic violence lets Simply offer case management services to the member. If the member is identified as “high risk” the Care Compass system is monitored by team lead for case management and referrals are sent as a result of the information obtained from ELIZA.	✓	✓	✓
Coordination and Continuity of Care Element 14: Treatment or Service Plan	Simply Health is maintaining Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) standards. Their efforts go beyond expectations as FHKC does not require Simply to cover EPSDT type services under their CHIP plan.	✓	✓	✓
Coordination and Continuity of Care Element 15: Enrollee Direct Access to Specialist	Simply Health works with members when they want specialists. Simply encourages member to discuss concerns with their PCP. Simply Health provides referrals to specialists. Simply also reported that transportation services are coordinated as well. Care Compass can send referrals directly to specialists’ portal.	✓	✓	✓

Table A-12. 2022 ACA Individual MCO/DBM Strengths

Standard and Element	Strength	Quality	Timeliness	Access
Coordination and Continuity of Care Element 16: Social Determinants of Health	CMS age screening tool is used in SDOH. Member concerns about SDOH are referred to Simply Health case management services. There is also a resource for the Gardiner scholarship. Complex members can apply to the scholarship to supply coverage for complex therapy services for children.	✓	✓	✓
Subcontractual Relationships and Delegation Element 03: Subcontract Availability	Simply Health works with subcontractors holding joint meetings regarding submitting FHKC and ACA documentation. Within the subcontractor addendum provided, regulatory language is included. There is also sub delegation agreement information for subcontractors (i.e., UM). Simply Health verifies and tracks the dates of submission of the documentation, and monitors audits of subcontractors. The Simply Health team is focused solely on the Florida market that oversees subcontractor delegation management of activities.	✓	✓	✓
Subcontractual Relationships and Delegation Element 06: Regulatory Compliance	Compliance 360 is used by Simply. All providers for known areas will see if there is any impact to the laws or regulations. Confirmation of the impact is verified so compliance is checked. Alerts are sent and stored within Simply's internal systems.	✓	✓	✓
Subcontractual Relationships and Delegation Element 08: Delegated Coverage of Services and Claims Payment	Simply has robust data mining tools built in house. This gives access to claims data for vendors. Tools are used for vendors as well. Spider Web tool allows vendors to have access to Text Illness Monitoring (TIM) and Master Patient Index (MPI).	✓	✓	✓
Subcontractual Relationships and Delegation Element 12: Quarterly Monitoring Summary	Annual audits of delegates are done before new contracts are offered. The algorithm within the system triggers annual audits. These are reconciled monthly. For quarterly reports, when monthly audits are done, these will be rolled into the quarterly report going to FHKC. Any corrective action plan must be reviewed by the compliance team. Oversight of vendors includes monthly and quarterly reports are part of the contract with FHKC (service level agreements [SLAs] and others).	✓	✓	✓
Argus				
Coverage and Authorization of Services Element 01: Service Protections	Policy information presented made clear reference to 42 CRF 238.210 (a)(3)(i) under practice guidelines. There was also clear reference to no arbitrary denial or reduction of services as a result of diagnosis type of illness or condition of		✓	✓

Table A-12. 2022 ACA Individual MCO/DBM Strengths

Standard and Element	Strength	Quality	Timeliness	Access
	enrollee, including those with special needs. In addition to this information the policy indicates that all enrollees, providers, and staff involved in UM decisions receive an Affirmative Statement regarding Argus's practice guidelines			
Coordination and Continuity of Care: Element 08: Disenrollment	Policy addressed Element 08c by stating the following, "Argus does not make any disenrollment determinations or other considerations influenced the decision to request the review, including an adverse change in the enrollee's health status, utilization of services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the enrollee's special needs."	✓	✓	✓
DentaQuest				
Coverage and Authorization of Services. Element 04: Authorization of Services	The policy outlined the clinical guidelines for each service provided within the context of the policy language.		✓	✓
Coverage and Authorization of Services. Element 13: Compensation for Utilization Management Activities	The policy was clear and addresses not only how DentaQuest does not promote denials through incentives, but the policy also addresses the hiring and retention of staff. Furthermore, the policy indicates that it promotes independent impartial judgement by clinical reviewers.		✓	✓
MCNA				
Coverage and Authorization of Services. Element 01: Service Protections	The information was easily identifiable within the text and elements were clearly labeled.		✓	✓
Coverage and Authorization of Services. Element 15: Subsequent Screening and Treatment	The information presented clearly outlined that members are not held accountable for subsequent screening and treatments.		✓	✓
Coverage and Authorization of Services. Element 30: Enrollee Handbook	The policy states that the member materials will be mailed within 5 calendar days as opposed to 5 business days which would potentially cause the member to receive the new member materials sooner than expected.		✓	✓

Table A-12. 2022 ACA Individual MCO/DBM Strengths

Standard and Element	Strength	Quality	Timeliness	Access
Coverage and Authorization of Services. Element 39: Staff Education and Training	MCNA sends information to clinical reviewers on a monthly basis to keep them informed of any new changes to the clinical guidelines and/or criteria. This ongoing process of sending updated information monthly will help to ensure that reviewers are consistently applying the correct criteria as they review cases in their day to day		✓	✓

Table A-13 includes areas of noncompliance (AONs), or weaknesses, for each MCO/DBM from the 2022 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 2022 ACA.

Table A-13. 2022 ACA Individual MCO/DBM Weaknesses

Standard and Element	Weakness	Quality	Timeliness	Access
CCP				
Coverage and Authorization of Services. Element 43: Enrollee Handbook Content-2	Based on the way in which the information is documented in the member and provider handbooks it is unclear if the member is required to obtain a referral for family planning providers. CCP should update both the member and provider handbooks to clearly indicate that members do not need a referral for family planning services. Members are informed of the limitations on family planning services for out of network providers, but the information pertaining to referrals before choosing a family planning provider is unclear.		✓	✓
Coverage and Authorization of Services. Element 48: MCO Secure Website for Enrollees	CCP does not track copayments for the Florida Healthy Kids lines of business. Per MSC 21: “Cost sharing accumulator information i. Insurer shall track the Enrollees’ cost share contributions to assist families in tracking their progress towards the out-of-pocket maximum.” CCP should update their policy and		✓	✓

Table A-13. 2022 ACA Individual MCO/DBM Weaknesses

Standard and Element	Weakness	Quality	Timeliness	Access
	procedures to include information regarding the cost sharing accumulator. The references in response to the cost sharing accumulator is not related to the lifetime limit. The out-of-pocket maximum is 5% of an enrollee's family income per FHKC. Per FHKC feedback received in response to the information provided for Element 48 from CCP the plan must track the enrollee's cost share contributions to help the family keep track of where they are in relation to family income.			
Argus				
Coverage and Authorization of Services. Element 11: Expedited Authorization Extension	Per the information listed in UM_59d-APS allows for two additional business days for extensions on expedited authorization requests. This is more stringent than indicated in the criteria. This practice could likely cause burden on the enrollee if having to pursue an appeal as a result of the DBM not fully utilizing the 14 days to receive additional information for the enrollee's request.		✓	✓
Coverage and Authorization of Services. Element 15: Subsequent Screening and Treatment	Argus failed to identify and/or submit documentation as evidence of compliance with Element 15 Subsequent Screening and Treatment for the initial desk review. Following the discussion with Argus in the virtual review, they were provided an opportunity to submit additional documentation to show compliance with the element as stated. No additional documentation was received for Element 15 Subsequent Screening and Treatment. Argus should develop policies regarding the subsequent screening and treatments, the provider's role, and not holding enrollees liable for payment for subsequent screening and treatment to stabilize the enrollee.		✓	✓
Coverage and Authorization of Services. Element 16: Enrollee Transfer or Discharge	Argus failed to identify and/or submit documentation as evidence of compliance with Element 16 Enrollee Transfer or Discharge. When discussing this section with Argus during the virtual review, Argus shared that this is again an element that is covered under the medical portion of FHKC. When compared to other DBM's operating under FHKC, Argus is the only DBM that did not have policy information that speaks to the emergency physician being responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that the DBM is responsible for coverage and payment.		✓	✓

Table A-13. 2022 ACA Individual MCO/DBM Weaknesses

Standard and Element	Weakness	Quality	Timeliness	Access
Coverage and Authorization of Services. Element 17: Post stabilization Care Services	Argus failed to identify and/or submit documentation as evidence of compliance with Element 17 Poststabilization Care Services. Without the supporting documentation we are unable to confirm that Argus is in compliance with the Element as stated. This element was discussed during the virtual review. Argus stated that this is covered by medical under FHKC, not dental. Argus was provided an opportunity to submit additional documentation following the virtual review. No additional documentation was provided for review of Element 17 Poststabilization Care Services-1. Argus should ensure they have developed policies with language specific to poststabilization of care following an emergency for an enrollee to include references about subsequent treatment and screening, the role of the emergency provider, and member's responsibility for payment of said services.		✓	✓
Coverage and Authorization of Services. Element 28: Provider Incentive Plans	Although Argus provided a document following the virtual review regarding value-based contracting, the document was dated 4/26/2022 which did not confirm that this practice was not conducted during the lookback period. It is reasonable to assume that Argus did not engage in this practice during the lookback period, but without policy information to confirm we are unable to state that Argus is in compliance with Element 28 Provider Incentive Plans for the 2021 plan year.		✓	✓
Coverage and Authorization of Services Element. 40: Compliance with Federal and State Laws	The documents submitted provided no reference to the following Federal regulations: 45 CRF part 80 or Civil Rights Act of 1964 , 45 CRF part 91, Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Titles II and III, Section 1557 of the Patient Protection and Affordable Care Act, Section 645 of the Omnibus Budget Reconciliation Act of 1981, or Title XXI of the Federal Social Security Act. The policy provided information related to several other regulations that are followed. Argus also provided a statement that Argus complies with all Federal and State requirement, but these specific requirements were not included in the policy information presented for review. Argus should update the policy information to include those regulations identified in the element as stated.		✓	✓

Table A-14. Improvements Since the 2021 ACA by MCO/DBM

MCO/DBM	Standard and Element	2021 AON	MCO/DBM's Action	Quality	Timeliness	Access
CCP	**Availability of Services. Element 07: 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	Policy #PO-1817: Provider Network was updated to include appropriate information.		✓	✓
	Availability of Services. Element 10: 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.	2022 Cultural Competency Plan: Florida Healthy Kids Corporation and Policy #QM-529: Cultural Competency Plan were updated to include appropriate information.		✓	✓
Simply	**Availability of Services. Element 03: Second Opinion**	The MCO should update its enrollee handbook to communicate that the second opinion is provided at no cost to the enrollee.	The Enrollee Handbook was updated to include the required information in an insert and approved by Florida Healthy Kids Corporation (FHKC).		✓	✓
	Grievance and Appeals. Element 08: Authority to File – Provider or Authorized Representative	The MCO should update 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.	P&P Member Complaints and Grievances has been updated to include the required information.			✓
	Grievance and Appeals. Element 23: Timeframe for Standard Appeal Resolution	The MCO should update P&P Member Appeals – FL to include that standard resolution of appeals	P&P Member Appeals – FL has been updated to include the required information.			✓

		occurs as expeditiously as the enrollee's health condition requires.				
	Grievance and Appeals. Element 30: Independent External Review Timeframe	The MCO should update P&P Member Appeals – FL to specifically reference independent external reviews for Florida Healthy Kids enrollees.	P&P Member Appeals – FL has been updated to include the required information.			✓
	Grievance and Appeals. Element 37: 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.	P&P Member Appeals – FL has been updated to include the required information.			✓
	Grievance and Appeals. Element 38: 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.	P&P Member Appeals – FL has been updated to include the required information.			✓
Argus	**Availability of Services. Element 08: Indian Healthcare Providers (IHIs)**	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	Policy and Procedure (P&P) #PR_79: IHCP Attestation was created to include appropriate information.		✓	✓

		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.				
	Grievance and Appeals. Element 07: 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.	P&P #GA_9.2: Grievance and Appeal Process – FHK was updated to include appropriate information.			✓
	Grievance and Appeals. Element 10: 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 CFR regulation changed in 2021 to	P&P #GA_9.2: Grievance and Appeal Process – FHK indicates that an appeal is a written or verbal request from an enrollee or their authorized representative to seek review of an adverse benefit determination taken by the DBM. The CFR regulation			✓

		the provision that the enrollee may request an appeal either orally or in writing, with no written requirement.	requiring written follow-up to a verbal request no longer exists.			
	Grievance and Appeals. Element 14: 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.	P&P #GA_9.2: Grievance and Appeal Process – FHK was updated to include appropriate information.			✓
	Grievance and Appeals. Element 17: 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.	P&P #GA_9.2: Grievance and Appeal Process – FHK indicates that an appeal is a written or verbal request from an enrollee or their authorized representative to seek review of an adverse benefit determination taken by the DBM. The CFR regulation requiring written follow-up to a verbal request no longer exists.			✓
	Grievance and Appeals. Element 21: 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 are sent to the enrollee as expeditiously as the enrollee's health condition requires.	P&P #GA_9.2: Grievance and Appeal Process – FHK was updated to include appropriate information.			✓
	Grievance and Appeals. Element 34: 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	P&P #GA_9.2: Grievance and Appeal Process – FHK was updated to include appropriate information.			✓

		within two calendar days, including the right to file a grievance for denials of requests for expedited appeal resolution.				
	Grievance and Appeals. Element 35: 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.	P&P #GA_9.2: Grievance and Appeal Process – FHK was updated to include appropriate information.			✓
	Grievance and Appeals. Element 36: 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 CMS.	P&P #GA_9.2: Grievance and Appeal Process – FHK was updated to include appropriate information.			✓
	Grievance and Appeals. Element 37: 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.	P&P #GA_9.2: Grievance and Appeal Process – FHK was updated to include appropriate information.			✓
	Grievance and Appeals. Element 38: 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.	P&P #GA_9.2: Grievance and Appeal Process – FHK was updated to include appropriate information.			✓
	Health Information System. Element 03: 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 DBM submitted P&P IT_124: Encounter Data and P&P CL_14: Claims Reporting as its action for this corrective action plan (CAP). P&P	✓	✓	✓

		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.	#CL_14: Claims Reporting described the DBM's reporting of claims and related processes, with mention of Policy: Claims Monitoring, which was stated in P&P #CL_14 as outlining monitoring reports and related auditing processes. However, the monitoring processes were not described in P&P #CL_14. In addition, the policy references all relate to Medicare rather than Florida Healthy Kids or Medicaid. P&P #IT_124: Encounter Data meets the intent of the AON, describing that the DBM had the capability to troubleshoot encounter data to determine if anomalies occurred and that the DBM required timely submissions from its providers as a condition of capitation payment. This P&P also described the DBM's requirements for complete and accurate encounters via its automated and integrated encounter data system.			
	Quality Assessment and Performance Improvement. **Element 01: Basic Elements Required**	The DBM should update the PIP to address collection and submission of required performance measure data to FHKC.	The PIP 2020 noted the required performance measures relative to PIPs but did not address collection and submission of required performance measure data to FHKC. The DBM provided its Quality Management Program Evaluation 2020 for review, which stated that its gap-in-	✓	✓	✓

			care report for Florida Healthy Kids should be completed no less than quarterly to enable the DBM to evaluate and report objective quality indicators, implement interventions for quality improvement, evaluate intervention effectiveness, plan and initiate activities to increase or sustain improvement for HEDIS® ADV and CMS-416 PDENT and SEAL performance measures and successful PIPs.			
	Quality Assessment and Performance Improvement. **Element 06: Overall QAPI Program Assessment**	The DBM should ensure that FHKC-program-specific results are included in the Quality Management Program Evaluation.	The Quality Management Program Evaluation 2020 provided for review included the required information.	✓	✓	✓
DentaQuest	**Practice Guidelines. Element 02: 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.	Policy and Procedure (P&P) #MKT03-INS-COM: Member Communications Distribution was updated to include the required information. The DBM also updated its website to include the required information for potential enrollees. The DBM indicated its Customer Service Article also will be updated.	✓	✓	✓
MCNA	**Availability of Services. Element 07: 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.	Policy and Procedure (P&P) #5.106: Availability and Accessibility of Services has been updated to include the required information.		✓	✓

	Availability of Services. Element 08: Indian Healthcare Providers (IHCPs)	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.	The DBM provided P&P #5.107: Indian Healthcare providers, which includes the required information.			
	Grievance and Appeals. Element 13: Processes for Grievances and Appeals	The DBM should update the enrollee handbook to indicate that appeals will be acknowledged upon receipt.	The enrollee handbook has been updated to include the required information.			✓

	Grievance and Appeals. Element 22: 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.	P&P #13.200: Utilization Management (UM) Appeals (Member Appeals) has been updated to include the standard resolution timeframe for enrollee appeals as within 30 days of receipt. However, the timeframe for Florida Healthy Kids should be 30 *calendar* days. CAP is approved as submitted, with the caveat that the DBM will add the word *calendar* to the 30-day standard appeal resolution timeframe.			✓
	Grievance and Appeals. Element 24: Extension of Timeframes	The DBM should update the enrollee handbook to indicate the 14-calendar-day extension process.	The enrollee handbook was updated to include the 14-day extension process. However, the timeframe for Florida Healthy Kids should be 14 *calendar* days. CAP is approved as submitted, with the caveat that the DBM will add the word *calendar* to the 14-day extension process.			✓
	Grievance and Appeals. Element 29: Independent External Review Timeframe	The DBM should update P&P #13.200 to reflect a 120 calendar-day timeframe to request an None Qsource has not received or reviewed an updated version of P&P #13.200.	P&P #13.200 has been updated to include the required information. The appeal resolution letter template was not provided for Qsource review. CAP is not approved as submitted; the DBM should submit the updated appeal resolution letter template for Qsource 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 Table A-15, Table A-16, Table A-17, and Table A-18 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-15 includes the time analysis results by MCO, and Table A-16 includes the distance analysis results by MCO. Table A-19 and Table A-20 include results from the appointment availability and accessibility review.

Table A-15. 2022 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	99.27%	**83.75%**	100%	100%	99.58%	92.95%
PCP – Pediatrics	98.87%	92.50%	100%	100%	99.50%	97.44%
Allergy & Immunology	93.20%	**81.25%**	97.39%	**80.00%**	97.07%	92.95%
Dermatology	96.44%	93.75%	100%	**50.00%**	94.22%	97.44%
Obstetrics & Gynecology	99.43%	**81.88%**	100%	100%	99.83%	**83.97%**
Optometry	99.11%	100%	100%	**80.00%**	99.58%	95.51%
Otolaryngology	**89.55%**	92.50%	99.53%	**50.00%**	94.89%	**83.33%**
Behavioral Health – Pediatric	95.14%	98.13%	100%	**50.00%**	97.82%	100%
Behavioral Health – Other	98.79%	100%	100%	100%	99.92%	100%
Specialist – Pediatric	98.14%	100%	99.76%	**30.00%**	93.80%	**74.36%**
Specialist – Other	98.95%	**84.38%**	100%	**80.00%**	99.25%	**89.10%**
Hospital	98.38%	91.25%	100%	90.00%	99.75%	**87.18%**

Table A-15. 2022 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
Pharmacy	99.03%	**86.25%**	99.53%	100%	99.41%	**87.18%**

Table A-16. 2022 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	99.35%	**87.50%**	100%	100%	99.75%	95.51%
PCP – Pediatrics	99.19%	95.00%	100%	100%	99.75%	99.36%
Allergy & Immunology	96.28%	**70.63%**	97.87%	**80.00%**	98.99%	**89.10%**
Dermatology	97.65%	**88.75%**	100%	**50.00%**	96.65%	92.31%
Obstetrics & Gynecology	99.60%	**86.25%**	100%	100%	100%	**87.18%**
Optometry	99.51%	99.38%	100%	**80.00%**	99.83%	90.38%
Otolaryngology (ENT)	92.63%	**89.38%**	100%	**50.00%**	97.57%	**76.28%**
Behavioral Health – Pediatric	96.68%	93.13%	100%	**50.00%**	98.74%	100%
Behavioral Health – Other	99.43%	100%	100%	100%	100%	100%
Specialist – Pediatric	98.79%	98.75%	100%	**30.00%**	95.47%	**63.46%**
Specialist – Other	99.27%	90.00%	100%	**80.00%**	99.83%	94.87%
Hospital	96.36%	94.38%	100%	90.00%	98.91%	91.67%
Pharmacy	98.22%	**73.75%**	99.29%	90.00%	98.74%	**75.64%**

Table A-17 includes results from the time analysis by DBM, and Table A-18 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-17. 2022 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	99.17%	97.08%	98.68%	95.42%	98.90%	98.72%
Orthodontists	93.29%	73.72%	97.50%	71.76%	98.28%	89.10%
Dental Specialists	89.64%	49.64%	87.95%	38.93%	89.18%	39.10%

Table A-18. 2022 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	99.59%	98.54%	99.19%	95.42%	99.22%	100%
Orthodontists	88.40%	62.04%	93.09%	61.83%	95.53%	78.21%
Dental Specialists	91.80%	34.31%	90.82%	32.06%	91.22%	29.49%

Table A-19 includes results from the review of appointment availability standards by MCO/DBM. Table A-20 includes results of the appointment availability standards provider and enrollee communication review.

Table A-19. 2022 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.	Met	Met	Met	Met	Met	Met
Urgently needed care shall be provided within 24 hours.	Met	Met	Met	Met	Met	Met

Table A-19. 2022 Appointment Availability Standards Review Results						
Standard	**Standard Met or Not Met**					
	Aetna	**Community Care**	**Simply Healthcare**	**Argus**	**DentaQuest**	**MCNA**
Routine care shall be provided within seven calendar days of the enrollee's request for services.	Met	Met	Met	Met	Met	Met
Well-child visits, as recommended by the American Academy of Pediatrics, shall be provided within four weeks of the enrollee's request.	Met	Met	Met	Met	Met	Met
Follow-up care shall be provided as medically appropriate.	Met	Met	Met	Met	Met	Met

Table A-20. 2022 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.	Met	Met	Met	Met	Met	Met
Urgently needed care shall be provided within 24 hours.	Met	Met	Met	Met	Met	Met
Routine care shall be provided within seven calendar days of the enrollee's request for services.	Met	Met	Met	Met	Met	Met
Well-child visits, as recommended by the American Academy of Pediatrics, shall be	Met	Met	Met	Met	Met	Met

Table A-20. 2022 Appointment Availability Standards Provider and Enrollee Communication Review Results

Standard	Standard Met or Not Met					
	Aetna	Community Care	Simply Healthcare	Argus	DentaQuest	MCNA
provided within four weeks of the enrollee's request.						
Follow-up care shall be provided as medically appropriate.	Met	Met	Met	Met	Met	Met
Enrollee Handbook						
Emergency care shall be provided immediately.	Met	Met	Met	Met	Met	Met
Urgently needed care shall be provided within 24 hours.	Met	Met	Met	Met	Met	Met
Routine care shall be provided within seven calendar days of the enrollee's request for services.	Met	Met	Met	Met	Met	Met
Well-child visits, as recommended by the American Academy of Pediatrics, shall be provided within four weeks of the enrollee's request.	Met	Met	Met	Met	Met	Met
Follow-up care shall be provided as medically appropriate.	Met	Met	Met	Met	Met	Met

Table A-21. Improvements Since the 2021 ANA by MCO/DBM

MCO/DBM	Standard and Element	2021 Recommendation for Improvement	MCO/DBM's Action	Quality	Timeliness	Access
Aetna	Network Adequacy: Time and Distance Standards	Qsource recommends that Aetna evaluate the potential and take appropriate action to improve access for rural enrollees to allergy and immunology, dermatology, obstetrics and gynecology, and hospitals. Aetna should continue to monitor its provider network and implement corrective action for identified deficiencies.	Allergy and Immunology: FHKC has approved waivers for this specialty for regions 2,6, and 8 through December 31, 2021. In addition, Aetna has requested again waivers for this specialty as of January 1, 2022. Extensive search of PML, National Provider Identifier (NPI) registry, competitor directories and internet searches did not result in any additional providers to recruit to improve access for this specialty (not interested in contracting with a Medicaid plan, unresponsiveness, unavailable licensed providers with this specialty in this area). Psychiatric Hospital (Free-Standing Psychiatric Facilities): Aetna has completed the negotiations with the following psychiatric hospital and are in the onboarding process (credentialing and/or loading provider record) because of in-sourcing behavioral health services. • BayCare • Jackson Memorial Hospital • Baptist- Pensacola • Baptist- Jacksonville • HCA Healthcare • Nemours Children's Hospital Current Negotiations • Advent Health • Stewart Health In addition, Aetna is promoting and incorporating Telemedicine to the Network. Telemedicine modality is used as an alternative platform when appropriate and offered through MDLive		✓	✓

			(telemedicine vendor) or specialty providers that comply with the telemedicine requirements.			
	Appointment Availability and Accessibility Standards	Qsource also recommends that the MCO update its P&P and provider manual to specify the seven-calendar-day requirement for routine appointments, and address follow-up care requirements in the P&P. Qsource suggests consider ation of review of the MCO's appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.	Updates were made to the manual to include reference to the seven-calendar day requirement for appointment access		✓	✓
CCP	Network Adequacy: Time and Distance Standards	Qsource recommends that Community Care evaluate the potential and take appropriate action to improve access to dermatology, obstetrics and gynecology, otolaryngology, specialist – pediatric, and hospital provider types for rural enrollees. Community Care should continue to monitor its provider network and implement corrective action for identified deficiencies.	Allergy and immunology: Waivers are in place with FHK to address this deficiency. Dermatology: Waivers are in place with FHK to address this deficiency. Otolaryngology: CCP is meeting the time and distance standards in this provider type/area. Performance Guarantee 20 documentation was provided as supporting documentation. Behavioral health: Pediatric – CCP is meeting time and distance standards in this provider type/area. Performance Guarantee 20 documentation was provided as supporting documentation. Specialist other – Waivers are in place with FHK to address this deficiency.		✓	✓
	Appointment Availability and Accessibility	Community Care should update its P&P and the provider manual to address the appointment	Policy and procedure documents were updated to include the calendar day specification as it pertains to routine care appointments and time standards for well-child visits.		✓	✓

	Standards	availability standard for follow-up care (as medically appropriate), update the P&P to specify the calendar day designation for routine care appointments, and update the provider manual to include the four-week time standard for well-child visits. Qsource also suggests consideration of review of the MCO's appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.				
Simply	Network Adequacy: Time and Distance Standards	Qsource recommends that Simply Healthcare evaluate the potential and take appropriate action to improve access to allergy and immunology, obstetrics and gynecology, specialist – pediatric, and pharmacy provider types for rural enrollees. Simply Healthcare should continue to monitor its provider network and implement corrective action for identified deficiencies.	Based on Simply's internal review of network adequacy, member access for the 4 targeted specialties are as follows: Without waivers: • Rural – Allergy & Immunology – (93% time; 89% distance) • Rural – Obstetrics & Gynecology – (92% time; 94% distance) • Rural – **Pediatric Specialist** (86% time; 75% distance) • Rural – Specialist - Other – (99% time; 99% distance) • Rural – Pharmacy – (96% time; 89% distance) • Rural – Hospital – (90% time; 93%) With waivers applied: • Rural – Allergy & Immunology – (93% time; 93% distance) • Rural – Obstetrics & Gynecology – (96% time; 94% distance) • Rural – **Pediatric Specialist**– (95% time; 97% distance)		✓	✓

			• Rural – Pharmacy – (96% time; 94% distance) Simply has performed analysis and will be taking the below steps to cure the issues identified. Simply is active statewide in FL. The rural counties are Baker, Bradford, Calhoun, Columbia, DeSoto, Dixie, Franklin, Gadsden, Gilchrist, Glades, Gulf, Hamilton, Hardee, Hendry, Highlands, Holmes, Jackson, Jefferson, Lafayette, Levy, Liberty, Madison, Monroe, Okeechobee, Suwannee, Taylor, Union, Wakulla, Walton, and Washington. The report identified disparities in access between urban and rural enrollees, particularly for Allergy/Immunology, OB/GYN, **Pediatric Specialist** and Specialist – Other. For the Specialist – Other category, Simply is passing internally for both urban (100% Time; 100% Distance) and rural (99% Time; 99% Distance) counties. The main difference seems to be related to including the Internal Medicine and General Surgery specialties under the Specialist – Other bucket when running internal network adequacy. For the Hospital category Simply is passing internally for both urban (100% Time; 100% Distance) and rural (90% Time; 93% Distance) counties. The disparities in access to these provider types are due to lack of the provider types within the rural counties. In most cases Simply has secured all available providers in the county. Simply submitted waiver requests to Florida Healthy Kids for all quarters of the year 2020 and 2021, as well for Q1 on April 14, 2022, and Q2 on July 14, 2022, where there are no additional providers to recruit in order to meet the access requirements. **Allergy & Immunology**			

			Waiver requests submitted on July 14, 2022, Q2 2022 for region 2 for distance only. The Health Plan is contracted with two allergists in this multi-rural region. Participating providers in Leon and Bay Counties provide access to this specialty, as there are limited practitioners in this area that are willing to contract with the plan despite offering enhanced rates. The DOH lists four eligible providers in Leon County. One provider is contracted. One provider is not willing to participate with the health plan and two providers have refused to contract after multiple attempts to contract. There are no providers listed in Madison County. Members have access to the Leon County provider. There are no providers listed in Calhoun, Franklin, Gulf, Jackson, or Liberty Counties. Taylor County: The DOH lists one eligible provider who has contracted with the plan as a PCP Pediatric provider. The plan has confirmed that this provider no longer practices allergy and immunology. **Obstetrics & Gynecology** Waiver requests submitted on July 14, 2022, Q2 2022 for region 2 for time only The Health Plan is contracted with 28 OB/GYN specialists in the Region. Members without access average 29.6 travel miles and 31.4 minutes to OB/GYN providers in this region. Participating providers in Leon County provide access to this specialty for members in Jefferson, Madison and Taylor and Wakulla Counties, as there are no practitioners in these counties.			

			Leon County is the normal pattern of care for member to travel. Participating providers in Bay County provide access to this specialty for Calhoun, Holmes, and Franklin Counties as there are no providers in Calhoun and Holmes, and Franklin has retired, or deceased providers listed in the FL DOH search. **Pediatric Specialists** Waiver requests submitted on July 14, 2022, Q2 2022 for region 2, 3 and 4 for both time and distance. <u>Region 2</u> Since last quarter, the Health Plan **Pediatric Specialists** has 53.83% members accessing these specialists within distance parameters and 57.9% members accessing with time parameters. Members access average 28.58 travel miles and 33.28 minutes to **Pediatric Specialists** providers in this region. Participating providers in Leon County provide access to this specialty, as there are limited practitioners in Region 2 that are willing to contract with the plan despite offering enhanced rates. The DOH search results show no records of this provider type for Calhoun, Franklin, Gulf, and Liberty Counties. Member's traditional pattern of care is for member to travel outside of counties to Bay or Leon County. <u>Region 3</u> A total of 83 Pediatric Specialists were found in the Region. Pediatric Specialists in this region are found in Alachua, Hernando, Lake, and Marion Counties, with deficiencies in Citrus, Dixie, Putnam, and Gilchrist Counties. For Hamilton and Lafayette County there are no eligible pediatric specialists are found to contract. No Pediatric specialists were found in Gilchrist, Dixie, Levy, and Citrus Counties. <u>Region 4</u> The Health Plan gained 17 specialists after Q1 reporting and is now contracted with 108 Pediatric specialists. Pediatric specialists in this region are found in Clay, Duval, St. Johns, and Volusia Counties,			

			with deficiencies in Flagler, Nassau, and St. Johns Counties where no eligible pediatric specialists were found to contract. Additional waiver requests for Q2 2022 were submitted for Region 6, 8, 9 and 11 in rural counties for distance only. <u>Region 6</u> The Health Plan is contracted with 161 Pediatric specialists. Members without access are in Highlands County for distance only, with an average of 22.3 travel miles to Pediatric specialty providers in this region. Pediatric specialists in this region are found in Hillsborough, Manatee and Polk Counties. <u>Region 8</u> The rural counties of Glades and Hendry continue to not have pediatric specialists, causing an average distance of 33.8 miles for members without access in Glades County and 27.9 miles for members without access in Hendry County. There are no eligible pediatric specialists in these counties to contract. <u>Region 9</u> Pediatric specialists in this region are found with deficiencies in Okeechobee County for distance only, where no eligible pediatric specialists are found to contract. <u>Region 11</u> Pediatric specialists in this region are found in Miami-Dade County, with deficiencies in rural Monroe County where no eligible pediatric specialists are found to contract. **Pharmacy** Region 2 submitted waiver requests in July Q2 2022 for distance only. Network adequacy requirements are met for all counties in Region 2 except for:			

			Calhoun County: There are two pharmacies available in this county according to the NCPDP database, both of which are in the FHK pharmacy network. • Golden Pharmacy Inc. • Blountstown Drugs Franklin County: There are two pharmacies available in this county according to the NCPDP database, both of which are in the FHK pharmacy network. • Buy Rite Drugs • CVS Pharmacy Gulf County: There are three pharmacies available in this county according to the NCPDP database, all of which are in the FHK pharmacy network. • Buy Rite Drugs • CVS Pharmacy #05246 Jackson County: There are 10 pharmacies available in this county according to the NCPDP database, all of which are in the FHK network. • Cook Discount Drugs • Paramores Pharmacy • CVS Pharmacy • Yates Pharmacy & Gifts • Kelson Discount Drug • Walmart Pharmacy • Winn-Dixie Pharmacy • Sneads Pharmacy • Care Rite Pharmacy • Pancare Rx Malone Jefferson County: There are two pharmacies available in this county according to the NCPDP database, both of which are in the FHK			

			network. • CVS Pharmacy #04099 • Winn-Dixie Pharmacy Liberty County: There is one pharmacy available in this county according to the NCPDP database, and it is in the FHK pharmacy network. • Buy Rite Drugs Madison County: There are four pharmacies available in this county according to the NCPDP database, all of which are in the FHK pharmacy network. • North Florida Pharmacy • CVS Pharmacy • Winn-Dixie Pharmacy • Jay's Pharmacy of Madison Washington County: There are four pharmacies available in this county according to the NCPDP database, all of which are in the FHK network. • King's Discount Drug • Vernon Discount Drug • CVS Pharmacy #04480 • Walmart Pharmacy Holmes County: There are two pharmacies available in this county according to the NCPDP database, all of which are on the FHK network. • Johnson's Pharmacy • A Plus Pharmacy Please note that for Region 2, there were nine counties that did not meet the network adequacy requirements. There are no opportunities to contract with additional pharmacies in any of these counties since the pharmacies that exist in these counties are			

			already in our network. Simply will continue to monitor the provider network. The Provider Relations team continuously reviews the network and the market to identify new providers and to address changes to ensure a compliant network. Network adequacy is monitored through a monthly Network Gap workgroup and through reports to the FL Compliance committee.			
	Appointment Availability and Accessibility Standards	Qsource suggests consideration of review of the MCO's appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.	Policy and procedures were inclusive of information requirements regarding time and distance to access providers.		✓	✓
Argus	Network Adequacy: Time and Distance Standards	Qsource recommends that Argus evaluate the potential and take appropriate action to improve access to orthodontists and dental specialists for rural enrollees.	Argus improved upon Pediatric Dentist time and distance access as evidenced by the increase from 63.81% in 2021 to 94.16% in 2022 for rural time standards. Rural distance standards also improved from 73.44% in 2021 to 97.81% in 2022 for the same category.		✓	✓
	Appointment Availability and Accessibility Standards	Argus should continue to monitor its provider network and implement corrective action for identified deficiencies. Qsource also suggests consideration of review of the DBM's appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.	Argus policies and procedures were inclusive of appropriate time and distance standards.		✓	✓

DentaQuest	Network Adequacy: Time and Distance Standards	Qsource recommends that DentaQuest evaluate the potential and take appropriate action to improve access to orthodontists and dental specialists for rural enrollees.	DentaQuest is committed to ensuring that all Florida Healthy Kids enrollees in rural areas receive oral care. If an enrollee needs to see a specialist, our Member Placement Representatives have a process to place the enrollee with an appropriate provider. During 2021 and 2022, DentaQuest successfully placed all Florida Healthy Kids members with an in-network provider. DentaQuest has a commitment to constantly monitor network participation. DentaQuest continually recruits as part of the expansion goals in Florida. Some of the ways DentaQuest recruits is to use multiple sources like the Florida Board of Dentistry license verification tool, the American Board of Oral and Maxillofacial Surgery tool, the American Board of Orthodontics locator tool, the American Board of Endodontics site, the Provider Master List from the Agency for Health Care Administration, competitors' directories and leads DentaQuest receive from participating providers, from DentaQuest members, and from current clients. Also, as part of DentaQuest ongoing recruiting process, DentaQuest works with Dental Schools (University of Florida, Lake Erie College of Osteopathic Medicine & Nova Southeastern University) to help recognize new providers entering the system, identify where they will reside and collaborate on how DentaQuest can partner together to expand the network. DentaQuest recognizes the importance of network compliance and meeting access goals for targeted areas. The network development team is doing additional research for each deficient area using available tools to ensure that all providers have been contacted. In the event a special financial arrangement is needed for compliance; a non-panel arrangement is initiated. DentaQuest will negotiate with the provider or group to achieve the most favorable financial arrangement for the plan. Special Fee arrangements are reviewed and approved by DentaQuest management and Underwriting. DentaQuest has identified two principal barriers while meeting specialist access in rural counties. However, DentaQuest's utilization patterns demonstrate Florida Healthy Kids enrollees are certainly receiving dental care in rural counties. DentaQuest review showed 100% of members had access to a dental provider and		✓	✓

			were able to access care with an in-network provider. While most General Dentists and Pediatric Dentists also provide specialty services, we continue to pay close attention to opportunities to increase access in these areas as it is our policy to ensure an appropriate range of services with properly credentialed and licensed dentists available to all enrolled members. The two identified barriers are: Time and Distance Standard: The obligation established under the current contract is limited and restricted for rural areas. Dental industry standards in these counties are usually 3 times more for Dental Specialist, extending access to 90 miles instead of 30 miles, and almost double for Orthodontist, extending access to 90 miles instead of 50 miles. The inability to meet the current established benchmark often results in a low percentage rate. Dentist Shortage: Circumstances related to meeting access requirement in rural areas are often outside of DentaQuest's control due to lack of certified dental professionals practicing in most of these counties. The second biggest barrier while recruiting is the limited pool of oral health care providers residing in rural areas. For example, Baker, Bradford, Calhoun, DeSoto, Dixie, Franklin, Gilchrist, Glades, Gulf, Hamilton, Hardee, Hendry, Holmes, Jackson, Jefferson, Lafayette, Levy, Liberty, Madison, Suwannee, Taylor, Union, Wakulla, and Washington have very limited to no specialists residing in the county. The most recent Florida Workforce Survey of Dentist can be found here: https://www.floridahealth.gov/programs-and-services/community-health/dental-health/reports/_documents/FloridaWorkforceSurveyReportofDentists2017-2018FINAL.pdf (floridahealth.gov). The survey shows available specialists by county to facilitate a better understanding of the dental workforce in Florida. This report identifies the supply of workforce professionals practicing in Florida and examines factors related to dental practice location and career plans. While a new survey has not come out yet, DentaQuest has confirmed through its			

			recruitment plan that access is more limited now in 2022. The COVID-19 pandemic had a profound impact on all aspects of the oral health care system, limiting the availability of dental practitioner in certain areas. DentaQuest's appointment availability survey process and result on a quarterly basis, DentaQuest monitors completion of the access survey to ensure compliance with scheduling time frames. DentaQuest regularly monitor access and availability of locations to provide the covered services to DentaQuest's current and expected enrollment in each service area. Access and Availability surveys are given to one-fourth of all active Provider locations each quarter to ensure the entire network is surveyed at least annually. The results of these monitoring efforts are documented and presented to the Quality Oversight Committee for review. When a provider location is found to be non-compliant/non-responsive, information is given to the Provider Engagement team to develop a corrective action plan with the group. Noncompliant providers receive a call from the assigned Provider Partner to address contract requirements and any possible barriers. A follow-up email is sent outlining the applicable network standards and requirements and the subject provider's audit results. The Provider is scheduled for a follow-up audit the following quarter. Providers who are unable to meet appointment requirements are changed to existing patients only (EPO) and scheduled for a follow-up survey the following quarter. EPO status is maintained until the provider is able to comply with appointment requirement standards. If a provider is unable to maintain EPO status and appointment availability standards for existing patients, additional corrective action may result.			
	Appointment Availability and Accessibility Standards	DentaQuest should continue to monitor its provider network and implement corrective action for identified deficiencies. Qsource also suggests consideration of review of the DBM's	DentaQuest policies and procedures were inclusive of appropriate time and distance standards.		✓	✓

		appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.				
MCNA	Network Adequacy: Time and Distance Standards	Qsource recommends that MCNA evaluate the potential and take appropriate action to improve access to orthodontists and dental specialists for rural enrollees. MCNA should continue to monitor its provider network and implement corrective action for identified deficiencies.	MCNA would like to highlight the fact there is no dental specialist in most rural areas and that certain specialty types are not typically treating children. There are 18 rural counties with no specialists, and 15 are in the panhandle.		✓	✓
	Appointment Availability and Accessibility Standards	Qsource recommends that the DBM update its P&P to specify the routine appointment standard of seven-calendar days and update its provider manual to address the requirement of providing follow-up care as medically appropriate. Qsource suggests consideration of review of the DBM's appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.	MCNA policies and procedures were inclusive of the correct time and distance standards.		✓	✓

Appendix B | 2022 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 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. 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 2022 PIP Validation Tool was used to assess applicable MCO and DBM PIPs in accordance with CMS protocol.

2022 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**	**N/A[2*]**
01	Reflects comprehensive analysis of enrollee needs, care, and services	☐	☐	☐
02	Considers performance on CMS Child or Adult Core Set measures	☐	☐	☐
03	Considers input from enrollees or providers who are users of, or concerned with, specific service areas	☐	☐	☐
04	Addresses care of special populations or high-priority services, as appropriate	☐	☐	☐
05	Aligns with priority areas identified by the Department of Health and Human Services (HHS) and/or CMS	☐	☐	☐
Step 1 Results:	**Total**	**Met**	**Not Met**	**N/A**
Elements	5			
Comment:	<Type comment here>.			
Strength:	<Type strength here>.			

**Not applicable*

[2] Area of Non-compliance

2022 PIP Validation Tool—<MCO/DBM Name> <PIP Title>	
AON:	<Type AON here>.
Suggestion	<Type suggestions here>.

2022 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**	**N/A**
01	Clearly specifies the PIP improvement strategy	☐	☐	☐
02	Clearly specifies the PIP population	☐	☐	☐
03	Clearly specifies the PIP time period	☐	☐	☐
04	Is concise	☐	☐	☐
05	Is answerable (includes a realistic and unambiguous goal)	☐	☐	☐
06	Is measurable	☐	☐	☐

Step 2 Results:		**Total**	**Met**	**Not Met**	**N/A**
Elements		6			
Comment:	<Type comment here>.				
Strength:	<Type strength here>.				
AON:	<Type AON here>.				
Suggestion:	<Type suggestion here>.				

2022 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**	**N/A**
01	Is clearly defined in terms of the PIP aim statement	☐	☐	☐
02	Includes the entire eligible population or a representative and generalizable sample	☐	☐	☐
03	Captures all enrollees to whom the PIP aim statement applies, if the entire population is included	☐	☐	☐
Step 3 Results:	**Total**	**Met**	**Not Met**	**N/A**
Elements	3			
Comment:	<Type comment here>.			
Strength:	<Type strength here>.			
AON:	<Type AON here>.			
Suggestion:	<Type suggestion here>.			

2022 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**	**N/A**
01	Frame contains a complete, recent, and accurate list of the target PIP population	☐	☐	☐
02	Method considers and specifies the true or estimated frequency of the event, the confidence interval to be used, and the acceptable margin of error	☐	☐	☐
03	Contains a sufficient number of enrollees to account for non-response (if applicable)	☐	☐	☐
04	Method assesses the representativeness of the sample according to subgroups	☐	☐	☐
05	Techniques are valid and protect against bias	☐	☐	☐

Step 4 Results:		**Total**	**Met**	**Not Met**	**N/A**
Elements		5			
Comment:	<Type comment here>.				
Strength:	<Type strength here>.				
AON:	<Type AON here>.				
Suggestion:	<Type suggestion here>.				

2022 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**	**N/A**
01(a)	Objective, clearly defined, and time specific	☐	☐	☐
01(b)	Available to measure performance and track improvement over time	☐	☐	☐
	Performance measures:			
02	Assess an important aspect of care that will make a difference to enrollees' health or functional status	☐	☐	☐
03	Are appropriate based on the availability of data and resources to collect the data	☐	☐	☐
04	Are based on current clinical knowledge or health services research	☐	☐	☐
05	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	☐	☐	☐
06	Consider existing measures	☐	☐	☐
07	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	☐	☐	☐
08	Capture changes in enrollee satisfaction or experience of care (if applicable)	☐	☐	☐
09	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	☐	☐	☐

2022 PIP Validation Tool—<MCO/DBM Name> <PIP Title>				
Step 5 Results:	**Total**	**Met**	**Not Met**	**N/A**
Elements	11			
Comment: <Type comment here>.				
Strength: <Type strength here>.				
AON: <Type AON here>.				
Suggestion: <Type suggestion here>.				

2022 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**	**N/A**
01	Includes a systematic method for collecting valid and reliable data that represent the PIP population	☐	☐	☐
02	Specifies the frequency of data collection	☐	☐	☐
03	Clearly specifies the data sources	☐	☐	☐
04	Clearly identifies the data elements to be collected	☐	☐	☐
05	Connects to the data analysis plan to ensure appropriate data are available	☐	☐	☐
06	Includes data collection instruments that allow for consistent and accurate data collection over PIP time periods	☐	☐	☐
07	Specifies well-defined methods to collect meaningful and useful information, if qualitative data collection methods were used	☐	☐	☐
08	Includes an estimated degree of data completeness for administrative data collection	☐	☐	☐
09	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**	**N/A**
Elements	11			
Comment:	<Type comment here>.			
Strength:	<Type strength here>.			
AON:	<Type AON here>.			
Suggestion:	<Type suggestion here>.			

2022 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**	**N/A**
01	Are conducted in accordance with the data analysis plan	☐	☐	☐
02	Include discussion of the baseline measurement and remeasurement(s) of performance measures	☐	☐	☐
03	Include a discussion of the statistical significance of any differences between baseline and repeat measurement(s)	☐	☐	☐
04	Identify any factors that may influence comparability of initial and repeat measurements	☐	☐	☐
05	Identify factors that threaten internal or external validity of findings	☐	☐	☐
06	Compare results across multiple entities, if applicable	☐	☐	☐
07	Are presented in a concise and easily understood manner	☐	☐	☐
08	Include lessons learned about less-than-optimal performance	☐	☐	☐
Step 7 Results:	**Total**	**Met**	**Not Met**	**N/A**
Elements	8			
Comment:	<Type comment here>.			
Strength:	<Type strength here>.			
AON:	<Type AON here>.			
Suggestion:	<Type suggestion here>.			

2022 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**	**N/A**
01	Evidence based	☐	☐	☐
02	Related to causes/barriers identified through data analysis and quality improvement processes	☐	☐	☐
03	Implemented on a rapid-cycle, Plan-Do-Study-Act (PDSA) basis	☐	☐	☐
04	Culturally and linguistically appropriate	☐	☐	☐
05	Reflective of major confounding factors that could have an obvious impact on PIP outcomes	☐	☐	☐
06	Successful in terms of improvement with follow-up activities identified	☐	☐	☐
Step 8 Results:	**Total**	**Met**	**Not Met**	**N/A**
Elements	6			
Comment:	<Type comment here>.			
Strength:	<Type strength here>.			
AON:	<Type AON here>.			
Suggestion:	<Type suggestion here>.			

2022 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**	**N/A**
01	Whether the remeasurement methodology is the same as the baseline methodology	☐	☐	☐
02	Whether there is quantitative evidence of improvement in processes or outcomes of care	☐	☐	☐
03	How the reported improvement in performance, if any, is likely to be the result of the selected improvement strategy	☐	☐	☐
04	The statistical evidence that any observed improvement, if any, is the result of the improvement strategy	☐	☐	☐
05	Whether sustained improvement is demonstrated through repeated measurements over time	☐	☐	☐
Step 9 Results:		**Total**	**Met**	**Not Met**	**N/A**
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:

- 2022 Compliance Assessment Standards Survey Tools (MCO and DBM)
- Denial File Review Tool (MCO and DBM)

MCO Compliance Assessment Standard Tools

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
1. Service Protections 42 *Code of Federal Regulations* (CFR) 438.210(a)(3)(i)-(ii) 42 CFR 440.230(b) Medical Services Contract (MSC) Section 22	The managed care organization (MCO): a. must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished; and b. may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee.	☐ a. Sufficient services to achieve purpose ☐ b. No arbitrary denial or reduction of services ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Service Limitations 42 CFR 438.210(a)(4)(i)-(ii)	The MCO may place appropriate limits on a service on the basis of criteria applied under the Florida Healthy Kids Corporation (FHKC) plan, such as medical necessity, or for the purpose of utilization control, provided that:	☐ a. Services furnished can reasonably achieve their purpose	**0.333**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
42 CFR 440.230(d) MSC 22	a. the services furnished can reasonably achieve their purpose, as required in paragraph 42 CFR 438.210(a)(3)(i) b. the services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services c. family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR 441.20.	☐ b. Services authorized in a manner that reflects the enrollee's ongoing need ☐ c. Family planning services provided in a manner protecting enrollee choice ☐ Not Applicable	**0.333** **0.334** **0.000**		
Findings **Strength** **AON** **Suggestion**					
3. Authorization of Services 42 CFR 438.210(b)(1) MSC 22-6	For the processing of requests for initial and continuing authorizations of services, the MCO and its subcontractors have in place, and follow, written policies and procedures and practice guidelines.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
4. Application of Review Criteria 42 CFR 438.210(b)(2)(i)-(iii) MSC 22-6	The MCO must: a. have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and b. consult with the requesting provider for medical services when appropriate.	☐ a. Mechanisms to ensure consistent application of review criteria ☐ b. Requesting provider consulted, when appropriate ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
5. Utilization Management Controls MSC 22-1	The MCO must establish utilization management controls to: a. ensure enrollees receive appropriate care; and b. allow for consideration of factors specific to individual enrollees such as age and medical history.	☐ a. Ensure enrollees receive appropriate care ☐ b. Allow for consideration of factors specific to individual enrollees ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
6. Appropriate Reviewer Expertise 42 CFR 438.210(b)(3) MSC 22-1	The MCO must ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested: a. be made by individuals who have appropriate clinical expertise in addressing the enrollee's medical or behavioral health needs. b. be conducted in a manner that results in interrater reliability sufficient to indicate the appropriateness and validity of the process; and c. include the training given to the reviewers.	☐ a. Decisions made by individuals with appropriate clinical expertise ☐ b. Conducted in a manner resulting in interrater reliability ☐ c. Reviewer training included ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
7. Notice of Adverse Benefit Determination 42 CFR 438.210(c) 42 CFR 438.404(a) MSC 22-6-1	The MCO must notify the requesting provider and provide the enrollee timely and adequate written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The enrollee's notice must meet the requirements of 42 CFR 438.404.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
8. Timeframe for Standard Authorization Decisions 42 CFR 438.210(d)(1) 42 CFR 438.404(c)(3) MSC 22-6-1	For standard authorization decisions, the MCO must provide notice as expeditiously as the enrollee's condition requires and within FHKC-established timeframes that may not exceed 14 calendar days following receipt of the request for service.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
9. Standard Authorization Extension 42 CFR 438.210(d)(1)(i)-(ii) 42 CFR 438.404(c)(4)(i)-(ii) MSC 22-6-1	The MCO may extend the timeframe for standard authorization decisions up to 14 additional calendar days, if the enrollee or the provider requests an extension or the MCO justifies to FHKC, upon request, a need for additional information and how the extension is in the enrollee's interest, provided that both conditions are met: 1. The MCO gives the enrollee written notice of the reason for the decision to extend the timeframe and informs the enrollee of the right to file a grievance. 2. The MCO carries out the determination as expeditiously as the enrollee's health condition requires, but no later than the date the extension expires.	☐ a. Written notice to the enrollee of reason for decision and right to file a grievance ☐ b. Determination carried out as expeditiously as the enrollee's health condition requires but no later than the date the extension expires ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
AON					
Suggestion					
10. Timeframe for Expedited Authorization Decisions 42 CFR 438.210(d)(2)(i) 42 CFR 438.404(c)(6) MSC 22-6-1	For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
11. Expedited Authorization Extension 42 CFR 438.210(d)(2)(ii) MSC 22-6-1	The MCO may extend the 72-hour time period by up to 14 calendar days if the enrollee or provider requests an extension, or if the MCO justifies to FHKC, upon request, a need for additional information and how the extension is in the enrollee's interest.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
12. Covered Outpatient Drug Decisions	The MCO must provide notice of a decision in response to a request for authorization of outpatient drugs by telephone or other telecommunication device	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
42 CFR 438.210(d)(3) MSC 22-6-1	within 24 hours of the request, in accordance with Section 1927(d)(5)(A) of the *Social Security Act*.	☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
13. Compensation for Utilization Management Activities 42 CFR 438.210(e) MSC 22-1	The MCO must provide that, consistent with 42 CFR 438.3(i) and 42 CFR 422.208, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
14. Termination, Suspension, or Reduction of Services 42 CFR 438.404(c)(1) 42 CFR 431.211 42 CFR 431.213(a)-(h)	For termination, suspension, or reduction of previously authorized Medicaid-covered services, the MCO must send a notice at least 10 days before the date of action, except when: a. The MCO has factual information confirming the death of the enrollee; b. The MCO receives a clear written statement signed by an enrollee that the enrollee no longer wishes to receive services, or the enrollee gives	☐ a. Death of enrollee ☐ b. Signed enrollee statement forgoing services ☐ c. Enrollee admission to institution rendering the enrollee ineligible for services	**0.111** **0.111** **0.111**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
MSC 22-6-1	information that requires termination or reduction of services and indicates that the enrollee understands that this must be the result of supplying that information; c. The enrollee has been admitted to an institution where they are ineligible under the plan for further services; d. The enrollee's whereabouts are unknown, and the post office returns MCO mail directed to the enrollee indicating no forwarding address; e. The MCO establishes the fact that the enrollee is enrolled in Florida Healthy Kids in another region or has been accepted for services by another jurisdiction, state, territory, or commonwealth; f. A change in the level of medical care is prescribed by the enrollee's physician; g. The notice involves an adverse determination made with regard to the preadmission screening requirements of Section 1919(e)(7) of the *Social Security Act*; or h. The date of action will occur in less than 10 days, in accordance with 42 CFR 483.15(b)(4)(ii) and (b)(8), which provides exceptions to the 30 days' notice requirements of 42 CFR 483.15(b)(4)(i); or i. The MCO has facts, verified through secondary	☐ d. Enrollee's whereabouts unknown ☐ e. Enrollee enrolled in another MCO ☐ f. Change in level of care prescribed by enrollee's physician ☐ g. Adverse benefit determination made with regard to preadmission screening ☐ h. Date of action in less than 10 days ☐ i. Probable fraud by enrollee and notice provided at least five calendar days before the date of action	**0.111** **0.111** **0.111** **0.111** **0.111** **0.112**		

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
	sources when possible, indicating that action should be taken because of probable fraud by the enrollee, in which case the notice must be provided at least five calendar days before the date of action.	☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
15. Denial of Payment 42 CFR 438.404(c)(2) MSC 22-6-1	For denial of payment, the MCO must provide the notice of adverse benefit determination at the time of any action affecting the claim.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
16. Decisions Exceeding Timeframes 42 CFR 404(c)(5) MSC 22-6-1	For service authorization decisions not reached within the timeframes specified in 42 CFR 438.210(d), which constitutes a denial and is thus an adverse benefit determination, the MCO must provide the notice on the date that the timeframes expire.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
Suggestion					
17. Emergency Services 42 CFR 438.114(c)(1)(i)-(ii) MSC Attachment A	The MCO must: a. cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO; and b. not deny payment for treatment obtained under either of the following circumstances: 1. an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (1), (2), and (3) of the definition of emergency medical condition in 42 CFR 438.114(a); or 2. a representative of the MCO instructs the enrollee to seek emergency services.	☐ a. Coverage and payment for emergency services ☐ b. Payment not denied for treatment ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
18. Emergency Services External to Case Management 42 CFR 438.114(c)(2)	The MCO must allow enrollees to obtain emergency services outside the primary care case management system regardless of whether the case manager referred the enrollee to the provider that furnishes the services.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
Strength **AON** **Suggestion**					
19. Emergency Service Limitations 42 CFR 438.114(d)(1)(i)-(ii) MSC Attachment A	In compliance with Florida Statutes Section 641.513 and 42 CFR 438.114, the MCO may not do any of the following: a. Limit what constitutes an emergency medical condition with reference to 42 CFR 438.414(d), on the basis of lists of diagnoses or symptoms. b. Use terms such as “life threatening” or “bona fide” to qualify the type of emergency that is covered. c. Indicate that emergencies are covered only if care is secured within a certain period of time. d. Deny payment based on the enrollee’s failure to provide the MCO advanced notification of seeking treatment. e. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee’s primary care provider, MCO, or FHKC of the enrollee’s screening and treatment within 10 calendar days of presentation for emergency services or based on the enrollee’s failure to provide the MCO notification within a certain period of time after care is provided. f. Require prior authorization for emergency.	☐ a. Does not limit what constitutes an emergency medical condition ☐ b. Does not use qualifying terminology ☐ c. Does not indicate emergency coverage is provided only if care is sought within a specific timeframe ☐ d. Does not deny payment based on enrollee lack of notification ☐ e. Does not refuse to cover emergency services based on lack of provider and/or enrollee notification	**0.166** **0.166** **0.166** **0.166** **0.166**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
	transportation or services.	☐ f. Does not require prior authorization for emergency or transportation services ☐ Not Applicable	**0.167** **0.000**		
Findings **Strength** **AON** **Suggestion**					
20. Subsequent Screening and Treatment 42 CFR 438.114(d)(2) MSC Attachment A	The MCO may not hold an enrollee who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
21. MCO Responsibility for Poststabilization Services 42 CFR 438.114(d)(3)	The MCO is responsible for any poststabilization services administered to maintain, improve, or resolve the enrollee's stabilized position, regardless of the facility or provider's network status when: a. such services were pre-approved by the MCO or	☐ a. Attending/treating provider responsible for determining enrollee transfer or discharge	**0.333**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
MSC Attachment A	the MCO's representative; or b. the treating facility or provider sought approval for such services; and c. the MCO failed to respond within one hour of the request.	☐ b. MCO responsible for coverage and payment ☐ c. MCO responsible for payment of poststabilization services ☐ Not Applicable	**0.333** **0.334** **0.000**		
Findings **Strength** **AON** **Suggestion**					
22. Financial Responsibility for Poststabilization Services 42 CFR 438.114(d)(3) MSC Attachment A	The MCO must agree that: a. the attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, b. this determination is binding on the MCO as responsible for coverage and payment; and c. the MCO is responsible for payment of poststabilization services that it has not preapproved until any of the following conditions have been met: 1. An in-network provider with privileges at the	☐ a. Attending/treating provider responsible for determining enrollee transfer or discharge ☐ b. MCO responsible for coverage and payment ☐ c. MCO responsible for payment of poststabilization services	**0.333** **0.333** **0.334**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
	treating facility assumes responsibility for the enrollee's care. 2. An in-network provider assumes responsibility for the enrollee's care through transfer. 3. The enrollee is discharged.	☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
23. Behavioral Health Policies and Procedures MSC 22-2	The MCO must maintain policies and procedures that support all of the following: a. Early identification of behavioral healthcare needs through the use of valid assessments. b. The use of services that enhance the enrollee's likelihood of positive outcomes, improved ability to function at home, school, and in the community, and to live drug-free. c. Enrollees' ability to receive services in the least restrictive and most normal environment that is clinically appropriate. d. The use of care or case management and coordination of services. e. A smooth transition to adult behavioral healthcare, for older enrollees.	☐ a. Early identification through valid assessments ☐ b. Services that enhance likelihood of improved outcomes and ability to function and live drug-free ☐ c. Services in least restrictive, most normal, clinically appropriate environment ☐ d. Care or case management and coordination	**0.200** **0.200** **0.200** **0.200**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
		☐ e. Transition to adult behavioral healthcare	**0.200**		
		☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
24. Behavioral Health Educational Materials MSC 22-2	The MCO must make educational materials about recognizing child and adolescent behavioral healthcare needs and how to obtain access to treatment and support services available to enrollees.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
25. Telehealth MSC 22-5	The MCO must not apply any policies or procedures to telehealth services that are significantly more restrictive or stringent than those applied to in-person services unless such differences are required to maintain the intent and functionality of a policy or procedure that applies to in-person services.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
26. Social Determinants of Health MSC 22-9	The MCO must: a. have a mechanism to address social services needs of enrollees through available community-based social service resources; and b. not require enrollees to access community-based social service resources instead of covered benefits.	☐ a. Mechanism to address social services needs ☐ b. Enrollees not required to access services instead of covered benefits ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
27. Disease and Case Management MSC 22-10	The MCO must have policies and procedures in place for identifying and enrolling enrollees likely to benefit from disease and case management services.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
28. Information Format 42 CFR 438.10(c)(1) MSC 21-3	The MCO must provide all required information to enrollees and potential enrollees in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees in accordance with 42 CFR 457.1207.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
AON					
Suggestion					
29. Culturally Competent Communication MSC 20	The MCO must provide services, including oral and written communication to enrollees, in a culturally competent manner appropriate for the population, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
30. Cultural Competency Plan MSC 20	The MCO must maintain a comprehensive written cultural competency plan describing how the MCO and its providers, employees, and systems effectively provide services to enrollees of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes, affirms, and respects the worth of the enrollee and protects and preserves the dignity of each.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
31. Electronic	The MCO must ensure all of the following conditions	☐ a. Accessible format	**0.200**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
Information 42 CFR 438.10(c)(6) MSC 21	are met for information provided electronically to enrollees: a. The format is readily accessible. b. The information is placed in a location on the MCO's website that is prominent and readily accessible. c. The information is provided in an electronic form that can be electronically retained and printed. d. The information is consistent with content and language requirements for enrollee information. e. The MCO informs the enrollee that the information is available in paper form without charge upon request and provides it upon request within five business days.	☐ b. Prominently placed and readily accessible on MCO website ☐ c. Can be electronically retained and printed ☐ d. Meets content and language requirements ☐ e. Enrollee informed that information is available in paper form without charge upon request, to be received within five business days ☐ Not Applicable	**0.200** **0.200** **0.200** **0.200** **0.000**		
Findings **Strength** **AON** **Suggestion**					
32. Enrollee Assistance 42 CFR 438.10(c)(7) MSC 22	The MCO must have in place mechanisms to help enrollees and potential enrollees understand the requirements and benefits of the plan.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**X.XXX**
Findings					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
Strength					
AON					
Suggestion					
33. Enrollee Material Language 42 CFR 438.10(d)(2) MSC 21-2 MSC 21-3	The MCO must do the following: a. Make oral interpretation available in all languages and written translation available in each prevalent non-English language. b. Make all written materials available in English, Spanish, and all other prevalent non-English languages (any language in the MCO's service area spoken by 5% or more of the Florida Healthy Kids population). c. Ensure that written materials that are critical to obtaining services for potential enrollees include taglines in the prevalent non-English languages in the state, explaining the availability of written translations or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and the toll-free telephone number of the entity providing choice counseling services as required by 42 CFR 438.71(a). d. Ensure that taglines for written materials critical to obtaining services are printed in a conspicuously visible font size (no smaller than 18 point).	☐ a. Oral interpretation and written translation available ☐ b. Written materials available in English, Spanish, and all other prevalent non-English languages ☐ c. Taglines included, in prevalent non-English languages, and with information to request aids and services ☐ d. Conspicuously visible tagline font size ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
AON					
Suggestion					
34. Written Material Requirements 42 CFR 438.10(d)(3) MSC 21-2 MSC 21-3	For written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, the MCO must do the following: a. Make written materials available in the prevalent non-English languages in its particular service area. b. Make written materials available in alternative formats upon request of the potential enrollee or enrollee at no cost. c. Include taglines in the prevalent non-English languages in the state and in a conspicuously visible font size (no smaller than 18 point) explaining the availability of written translation or oral interpretation in the prevalent non-English languages in the service areas, as well as in large print, to understand the information provided. d. Include information on how to request auxiliary aids and services. e. Include the toll-free and telecommunications device for the deaf (TTY/TDY) telephone number	☐ a. Available in the prevalent non-English languages ☐ b. Available in alternative formats upon request ☐ c. Taglines in the prevalent non-English languages and visible font size ☐ d. Information about auxiliary aids and services ☐ e. Toll-free and TTY/TDY telephone number included ☐ f. Auxiliary aids and services available upon request ☐ g. Nondiscrimination notice	**0.142** **0.142** **0.142** **0.142** **0.142** **0.142** **0.143**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
	of the MCO's enrollee/customer service unit. f. Make auxiliary aids and services available upon request of the potential enrollee or enrollee at no cost. g. Include a notice of nondiscrimination.	☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
35. Notification of Materials to Enrollee 42 CFR 438.10(d)(5)(i)-(iii) MSC 21-3	The MCO must notify its enrollees of the following: a. That oral interpretation is available for any language and written translation is available in prevalent languages. b. That auxiliary aids and services are available upon request and at no cost for enrollees. c. How to access these services.	☐ a. Translation availability ☐ b. Auxiliary aid and service availability ☐ c. How to access services ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
36. Written Material Format 42 CFR 438.10(d)(6)(i)-(iii) MSC 21-3	The MCO must provide all written materials for potential enrollees and enrollees meet all of the following: a. Easily understood language and format. b. Use a font size no smaller than 12 point. c. Be available in alternative formats and through the	☐ a. Easily understood language and format ☐ b. Font size no smaller than 12 point ☐ c. Available in alternative formats	**0.333** **0.333** **0.334**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
	provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency.	☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
37. Enrollee Material Best Practices MSC 21-3	The MCO must agree to follow best practices related to accessibility of materials insofar as such best practices are reasonable and practicable.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
38. Provider Termination Notice 42 CFR 438.10(f)(1) MSC 21-3-1-F	The MCO must notify each enrollee who received their primary care from, or was seen on a regular basis by, a terminating provider within the past six months, at least 60 calendar days before the effective date of termination. When such notice is not possible, the MCO must make a good faith effort to provide written notice to enrollees who received primary or regular care from a terminating network provider within 15 calendar days of receipt or issuance of the provider termination notice.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
AON					
Suggestion					
39. Provider Incentive Plans 42 CFR 438.10(f)(3) MSC 24-5	The MCO must do the following: a. Comply with 42 CFR 457.1201(h) incorporating through 42 CFR 438.3(i) references to 42 CFR 422.208 and 42 CFR 422.210, and any other applicable federal or state laws and regulations related to provide incentive plans. b. Not make specific payments, directly or indirectly, to a provider or provider group as an inducement to reduce or limit medically necessary services furnished to an enrollee. c. Provide enrollees with a disclosure that includes whether the MCO uses a provider incentive plan that affects the use of referral services, the type of incentive arrangement, and whether stop-loss protection is provided, upon request.	☐ a. Compliance with CFR and other applicable laws and regulations ☐ b. No payments as inducement to reduce or limit enrollee services ☐ c. Provider incentive plan disclosure to enrollee, upon request ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
40. Enrollee Identification Card MSC 21-3-1-A	Without requiring that the enrollee first request it, the MCO must mail each enrollee a hardcopy of their enrollee identification (ID) that includes: a. the MCO's name b. the enrollee's name	☐ a. MCO name ☐ b. Enrollee name ☐ c. ID number ☐ d. Coverage date	**0.142** **0.142** **0.142** **0.142**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
	c. ID number d. effective date of coverage e. the MCO's contact information f. identification of the enrollee as a Florida Healthy Kids member g. no potentially misleading information, such as references to non-Florida Healthy Kids programs.	☐ e. MCO contact information ☐ f. Florida Healthy Kids member identification ☐ g. No potentially misleading information ☐ Not Applicable	**0.142** **0.142** **0.143** **0.000**		
Findings **Strength** **AON** **Suggestion**					
41. Enrollee Handbook 42 CFR 438.10(g)(1) MSC 21-3-1-B	The MCO must provide each enrollee an enrollee handbook based on the model enrollee handbook provided by FHKC that: a. is provided within a reasonable time after receiving notice of the enrollee's enrollment; and b. is provided in electronic format on its publicly available website with access to Florida Healthy Kids information.	☐ a. Each enrollee provided an enrollee handbook within a reasonable time ☐ b. Enrollee handbook available on MCO's publicly available website ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
42. Enrollee Handbook Content – 1 42 CFR 438.10(g)(2)(i)-(iv) MSC 21-3-1-B	The MCO's enrollee handbook must, at a minimum, include the following: a. Benefits provided by the MCO. b. How and where to access any benefits provided by FHKC, including any cost sharing, and how transportation is provided. c. The amount, duration, scope, and limitations of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled. d. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.	☐ a. Benefits provided by the MCO ☐ b. How and where to access benefits and transportation ☐ c. Amount, duration, scope, and limitations of available benefits ☐ d. Procedures for obtaining benefits ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
43. Enrollee Handbook Content – 2 42 CFR 438.10(g)(2)(v)-(viii) MSC 21-3-1-B	The MCO's enrollee handbook must, at a minimum, include all of the following: a. The extent to which, and how after-hours and emergency services, including poststabilization services, are provided, including: 1. what constitutes an emergency medical condition and emergency services; 2. the fact that prior authorization is not required	☐ a. Extent to which, and how, after-hours and emergency coverage are provided ☐ b. Restrictions on enrollee's choice among network providers	**0.250** **0.250**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
	for emergency services; and 3. the fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care. b. Any restrictions on the enrollee's freedom of choice among network providers. c. The extent to which and how enrollees may obtain benefits, including family planning services and supplies from out-of-network providers. This includes an explanation that the MCO cannot require an enrollee to obtain a referral before choosing a family planning provider. d. Cost sharing, if any is imposed under the FHKC plan.	☐ c. Extent to which, and how, enrollees may obtain benefits, including explanation about not needing referral for family planning provider ☐ d. Cost sharing, if applicable ☐ Not Applicable	**0.250** **0.250** **0.000**		
Findings **Strength** **AON** **Suggestion**					
44. Enrollee Handbook Content – 3 42 CFR 438.10(g)(2)(ix)-(xii) MSC 21-3-1-B	The MCO's enrollee handbook must at a minimum include: a. Enrollee rights and responsibilities, including the elements specified in 42 CFR 438.100. b. The process of selecting and changing the enrollee's primary care provider.	☐ a. Enrollee rights and responsibilities ☐ b. Process of selecting and changing enrollee's primary care provider	**0.333** **0.333**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
	c. Grievance, appeal, and independent external review procedures and timeframes, consistent with subpart F of this part, in an FHKC-developed or -approved description. Such information must include: 1. The right to file grievances and appeals. 2. The requirements and timeframes for filing a grievance or appeal. 3. The availability of assistance in the filing process. 4. The right to request an independent external review after the MCO has made a determination on an enrollee's appeal that is adverse to the enrollee. 5. The fact that, when requested by the enrollee, benefits that the MCO seeks to reduce or terminate will continue if the enrollee files an appeal or a request for an independent external review within the timeframes specified for filing, and that the enrollee may, consistent with FHKC policy, be required to pay the cost of services furnished while the appeal or independent external review is pending if the final decision is adverse to the enrollee.	☐ c. FHKC-developed or -approved grievance, appeal, and external review procedures and timeframes ☐ Not Applicable	**0.334** **0.000**		
Findings					
Strength					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
AON					
Suggestion					
45. Enrollee Handbook Content – 4 42 CFR 438.10(g)(2)(xiii)-(xvi) MSC 21-1-3-B	The MCO's enrollee handbook must include, at a minimum: a. how to access auxiliary aids and services, including additional information in alternative formats or languages; b. the toll-free telephone number for enrollee services, medical management, and any other unit providing services directly to enrollees; c. information on how to report suspected fraud or abuse; and d. any other content required by FHKC.	☐ a. How to access auxiliary aids and services ☐ b. Toll-free numbers ☐ c. How to report suspected fraud or abuse ☐ d. Other FHKC-required content ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
46. Information	The information required to be provided to the enrollee in an enrollee handbook will be considered to	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
Delivery Methods 42 CFR 438.10(g)(3)(i)-(iv)	be provided if the MCO: a. mails a printed copy of the information to the enrollee's mailing address; b. provides the information by email after obtaining the enrollee's agreement to receive the information by email; c. posts the information on its website and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or d. provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.	☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
47. MCO Publicly Available Website MSC 21	The MCO must provide a publicly available website with access to Florida Healthy Kids information that includes: a. a link to FHKC's Florida Healthy Kids website; and b. any other information that may be needed by enrollees or potential enrollees.	☐ a. Link to Florida Healthy Kids website ☐ b. Any other necessary information ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
Strength **AON** **Suggestion**					
48. MCO Secure Website for Enrollees MSC 21	The MCO must provide a website with secure access for enrollees that includes: a. the ability for enrollees to print a temporary ID card; b. the ability for enrollees to request a new ID card; c. enrollee educational materials (unless the MCO chooses to make such materials available on the publicly available website); and d. cost-sharing accumulator information (MCO must track enrollees' cost-share contributions to assist families in tracking their progress towards the out-of-pocket maximum).	☐ a. Ability to print temporary ID card ☐ b. Ability to request new ID card ☐ c. Enrollee education materials ☐ d. Cost-sharing accumulator information ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
49. Notice of Changes 42 CFR 438.10(g)(4) MSC 21-3-1-E	The MCO must give each enrollee notice of any change that FHKC defines as significant in the information in the enrollee handbook, at least 30 calendar days before the intended effective date of the change.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
Suggestion					
50. Pharmacy Information 42 CFR 438.10(i)(1)-(2) MSC 21-3-1-D	The MCO must make available in electronic or print format the following information: a. which medications are covered (both generic and name brand); and b. what tier each medication is on.	☐ a. Covered medications ☐ b. Medication tier ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
51. Pharmacy Drug Lists 42 CFR 438.10(i)(1)-(2) MSC 21-3-1-D	As specified by the Secretary of Health and Human Services, the MCO must make its drug lists available on its website in a machine-readable file and format.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
52. Pharmacy Drug List Change Notification to Enrollees MSC 21-3-1-D	The MCO must notify enrollees who have filled a prescription in the last 12 months for a medication that is being removed from the pharmacy drug list or for which additional utilization management requirements will apply 60 calendar days prior to the effective date of change, but not before receiving FHKC approval.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
AON					
Suggestion					
53. Certificates of Creditable Coverage MSC 21-3-1-H	The MCO is responsible for issuing certificates of creditable coverage to enrollees upon the enrollee's request.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
54. Enrollee Right to Information 42 CFR 438.100(b)(2)(i),(iii)-(v) MSC 19	An enrollee has the right to: a. receive information in accordance with 42 CFR 438.10; b. receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand; c. participate in decisions regarding their healthcare, including the right to refuse treatment; d. be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion; and	☐ a. Information in accordance with 42 CFR 438.10 ☐ b. Information on available treatment options and alternatives in manner appropriate to enrollee's condition and ability to understand ☐ c. Participation in healthcare-related decisions, including refusal of treatment	**0.200** **0.200** **0.200**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
	e. request and receive a copy of their medical records and request that such medical records be amended or corrected.	☐ d. Free from any form of restraint or seclusion ☐ e. Copy of medical records, and amending or correcting them ☐ Not Applicable	**0.200** **0.200** **0.000**		
Findings **Strength** **AON** **Suggestion**					
55. MCO Cost Responsibility MSC 22	The MCO must not avoid costs for services covered under the MCO's MSC, including immunization requirements, by referring enrollees to publicly supported healthcare resources and requiring the enrollee to utilize those resources.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
56. Utilization Management Controls MSC 22-1	The MCO must establish utilization management controls to ensure enrollees receive appropriate care and that allow for consideration of factors specific to individual enrollees such as age and medical history.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
AON					
Suggestion					
57. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Information Requirements 42 CFR 441.56(a)(1)-(4)	The MCO must: a. provide for a combination of written and oral methods designed to inform effectively all Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible individuals (or their families) about the EPSDT program; b. using clear and nontechnical language, provide information about the following: 1. the benefits of preventive healthcare; 2. the services available under the EPSDT program and where and how to obtain those services; 3. that the services provided under the EPSDT program are without cost to eligible individuals	☐ a. Combination of written and oral methods ☐ b. Clear and nontechnical language informing enrollee of EPSDT services ☐ c. Effective information for blind, deaf, or limited English proficiency individuals ☐ d. Assurance to CMS	**0.250** **0.250** **0.250** **0.250**	**1.000**	**X.XXX**

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Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
	under 21 years of age, except for any enrollment fee, premium, or similar charge that may be imposed on medically needy beneficiaries; and 4. that necessary transportation and scheduling assistance described in 42 CFR 441.62 of this subpart is available to the EPSDT eligible individual upon request; c. effectively inform those individuals who are blind or deaf, or who cannot read or understand the English language; and d. provide assurance to the Centers for Medicare & Medicaid Services (CMS) that processes are in place to effectively inform individuals as required under this paragraph, generally, within 60 days of the individual's initial Medicaid eligibility determination and in the case of families that have not utilized EPSDT services, annually thereafter.	☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
58. EPSDT Screening Requirements 42 CFR 441.56(b)(1)(i)-	The MCO must provide to eligible EPSDT enrollees who request it, screening (periodic comprehensive child health assessments); that is, regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and	☐ a. Comprehensive health and developmental history	**0.166**	**1.000**	**X.XXX**

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Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
(vi)	nutritional status of infants, children, and youth. (See 42 CFR 441.56(c)(3) for requirements relating to provision of immunization at the time of screening.) As a minimum, these screenings must include, but are not limited to: a. comprehensive health and developmental history; b. comprehensive unclothed physical examination; c. appropriate vision testing; d. appropriate hearing testing; e. appropriate laboratory tests; and f. dental screening services furnished by direct referral to a dentist for children beginning at five years of age.	☐ b. Comprehensive physical examination ☐ c. Vision testing ☐ d. Hearing testing ☐ e. Laboratory tests ☐ f. Dental screening services ☐ Not Applicable	**0.166** **0.166** **0.166** **0.166** **0.167** **0.000**		
Findings **Strength** **AON** **Suggestion**					
59. EPSDT Provision of Screening Services 42 CFR 441.56(b)(2)	The MCO must provide screening services in 42 CFR 441.56(b)(1) in accordance with reasonable standards of medical and dental practice determined by FHKC after consultation with recognized medical and dental organizations involved in child healthcare.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
60. EPSDT Diagnosis	In addition to any diagnostic and treatment services	☐ a. Vision and hearing	**0.333**	**1.000**	**X.XXX**

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Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
and Treatment 42 CFR 441.56(c)(1)-(3)	included in the plan, the MCO must provide to eligible EPSDT enrollees, the following services, the need for which is indicated by screening, even if the services are not included in the plan: a. diagnosis of and treatment for defects in vision and hearing, including eyeglasses and hearing aids; b. dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health; and c. appropriate immunizations. (If it is determined at the time of screening that immunization is needed and appropriate to provide at the time of screening, then immunization treatment must be provided at that time.)	☐ b. Dental care ☐ c. Appropriate immunizations ☐ Not Applicable	**0.333** **0.334** **0.000**		
Findings **Strength** **AON** **Suggestion**					
61. EPSDT Accountability 42 CFR 441.56(d)(1)-(3)	The MCO must maintain as required by 42 CFR 431.17 and 42 CFR 431.18: a. records and program manuals; b. a description of its screening package under 42 CFR 441.56(b); and c. copies of rules and policies describing the methods used to assure that the informing requirement of 42 CFR 441.56(a)(1) is met.	☐ a. Records and program manuals ☐ b. Screening package description ☐ c. Copies of rules and policies ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**
Findings					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
Strength **AON** **Suggestion**					
62. Treatment of Requests for EPSDT Screening Services 42 CFR 441.59(a)-(b)	The MCO: a. must provide the screening services described in 42 CFR 441.56(b) upon the request of an eligible enrollee; and b. to avoid duplicate screening services, need not provide requested screening services to an EPSDT eligible if written verification exists that the most recent age-appropriate screening services, due under FHKC's periodicity schedule, have already been provided to the eligible.	☐ a. Screening services provided upon request of eligible enrollee ☐ b. Duplicate screening services avoided ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
63. EPSDT Continuing Care Provider 42 CFR 441.60(a)(1)-(5)	The MCO must ensure that its providers provide at least the following services to eligible EPSDT enrollees: a. with the exception of dental services required under 42 CFR 441.56, screening, diagnosis, treatment, and referral for follow-up services as required under this subpart; b. maintenance of the enrollee's consolidated health	☐ a. Screening, diagnosis, treatment, and referral for follow-up services ☐ b. Maintenance of the enrollee's consolidated health history	**0.200** **0.200**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
	history, including information received from other providers; c. physicians' services as needed by the enrollee for acute, episodic, or chronic illnesses or conditions; d. at the provider's option, provision of dental services required under 42 CFR 441.56 or direct referral to a dentist to provide dental services required under 42 CFR 441.56(b)(1)(vi). The provider must specify in the agreement whether dental services or referral for dental services is provided. If the provider does not choose to provide either service, then the provider must refer enrollees to the MCO to obtain those dental services required under 42 CFR 441.56; and e. at the provider's option, provision of all or part of the transportation and scheduling assistance as required under 42 CFR 441.62. The provider must specify in the agreement the transportation and scheduling assistance to be furnished. If the provider does not choose to provide some or all of the assistance, then the provider must refer enrollees to the MCO to obtain the transportation and scheduling assistance required under 42 CFR 441.62.	☐ c. Services as needed by the enrollee for acute, episodic, or chronic illnesses or conditions ☐ d. Provision of required dental services or direct referral to a dentist to provide required dental services ☐ e. Provision of all or part of the transportation and scheduling assistance ☐ Not Applicable	**0.200** **0.200** **0.200** **0.000**		
Findings					
Strength					
AON					
Suggestion					

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Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
64. EPSDT FHKC Monitoring 42 CFR 441.60(c)	If the FHKC plan provides for agreements with continuing care providers, the MCO must employ methods described in the FHKC plan to assure the providers' compliance with their agreements.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
65. EPSDT Agreement with Continuing Care Providers 42 CFR 441.60(d)	The MCO must require that: a. to be formally enrolled, an enrollee or enrollee's family agrees to use one continuing care provider to be a regular source of the described set of services for a stated period of time; and b. both the enrollee and the provider sign statements that reflect their obligations under the continuing care arrangement.	☐ a. Enrollee agreement to one continuing care provider ☐ b. Enrollee and provider signed statements ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
66. EPSDT Transportation and Scheduling 42 CFR 441.60(e)	If the agreement in 42 CFR 441.60(a) does not provide for all or part of the transportation and scheduling assistance required under 42 CFR 441.62, or for dental service under 42 CFR 441.56, the MCO must provide for those services to the extent they are not provided for in the agreement.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
Strength					
AON					
Suggestion					
67. EPSDT Utilization of Providers and Coordination with Related Programs 42 CFR 441.61(a)-(c)	The MCO must: a. provide referral assistance for treatment not covered by the plan, but found to be needed as a result of conditions disclosed during screening and diagnosis. This referral assistance must include giving the family or enrollee the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family; b. make available a variety of individual and group providers qualified and willing to provide EPSDT services; and c. make appropriate use of state health agencies, state vocational rehabilitation agencies, and Title V grantees (Maternal and Child Health/Crippled Children's Services). Further, the MCO should make use of other public health, mental health, and education programs and related programs, such as Head Start, Title XX (Social Services) programs, and the Special Supplemental Food Program for Women, Infants, and Children (WIC), to ensure an effective child health program.	☐ a. Referral assistance for treatment not covered but found to be needed ☐ b. Availability of variety of providers qualified and willing to provide EPSDT services ☐ c. Appropriate use of relevant state programs ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element Value**	**Element Score**
Coverage and Authorization of Services					
AON					
Suggestion					
68. EPSDT Transportation and Scheduling Assistance 42 CFR 441.62(a)-(b)	The MCO must offer to the family or enrollee, and provide if the enrollee requests: a. necessary assistance with transportation as required under 42 CFR 431.53; and b. necessary assistance with scheduling appointments for services.	☐ a. Assistance with transportation ☐ b. Assistance with scheduling appointments ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
Coverage and Authorization of Services			**XX.X%**	**68.00**	**X.XXX**

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
1. Appropriate Source of Care 42 *Code of Federal Regulations* (CFR) 438.208(b)(1) Medical Services Contract (MSC) 18-2-3-1	The managed care organization (MCO) must ensure that each enrollee has: a. a choice of primary care providers (PCPs) who meet the credentialing, access, and appointment standards of the MCO's Medical Services Contract (MSC) with the Florida Healthy Kids Corporation (FHKC); b. an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee; and c. information on how to contact their designated person or entity.	☐ a. Choice of PCP ☐ b. Ongoing source of care appropriate to needs and primary coordinator of services ☐ c. Designated entity contact information ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Assignment of Primary Care Provider (PCP) MSC 18-2-3-1	The MCO must permit enrollees to select another PCP, if the MCO elects to auto-assign enrollees to PCPs.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
3. PCP Assignment Requirements MSC 18-2-3-1	The MCO must consider the following when auto-assigning enrollees to PCPs: a. the enrollee's last PCP assignment, if known; b. time and distance from the enrollee's home address; c. sibling assignments; and d. the enrollee's age and any age limitations with the PCP.	☐ a. Enrollee's last PCP assignment ☐ b. Time and distance from enrollee's address ☐ c. Sibling assignments ☐ d. Enrollee's age and PCP age limitations if any ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
4. Service Coordination 42 CFR 438.208(b(2)(i)-(iv) MSC 22-11 MSC 9-4-2	The MCO must coordinate services it furnishes to the enrollee: a. between settings of care, including appropriate discharge planning for short- and long-term hospital and institutional stays; b. with the services the enrollee receives from any other healthcare coverage or liable third parties; and c. with the services the enrollee receives from community and social support providers.	☐ a. Services between settings of care ☐ b. Services from any other healthcare coverage or liable third party ☐ c. Services from community and social support providers ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
Findings **Strength** **AON** **Suggestion**					
5. Transition of Care Policy MSC 22-11	The MCO must: a. implement a transition of care policy consistent with the transition of care policy adopted by FHKC, subject to FHKC approval; and b. include summaries of the transition of care policy in its enrollee handbook and relevant notices.	☐ a. Transition of care policy consistent with FHKC's policy ☐ b. Summaries in enrollee handbook and relevant notices ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
6. Liability for Previously Authorized and Ongoing Services MSC 22-11	The MCO must be liable for the cost of any previously authorized, ongoing course of treatment provided to an enrollee by any provider, regardless of whether such provider has a contract with the MCO, without any further authorizations, for an additional 60 calendar days after termination or expiration of any prior MCO's contract covering such enrollees.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
7. Dental Coordination MSC 22-12 MSC 9-4-2	The MCO must: a. coordinate care with enrollees' Florida Healthy Kids dental insurance carriers to provide comprehensive dental care benefits to enrollees, including the provision of prescription coverage for prescriptions prescribed by the enrollee's dental provider; and b. enter into data-sharing agreements and exchange data with FHKC's contracted dental insurance carriers as directed by FHKC, including sharing medical encounters for fluoride varnish services.	☐ a. Care coordination with Florida Healthy Kids dental insurance carriers to provide dental care benefits, including prescriptions ☐ b. Data-sharing agreements and exchange of data ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
8. Initial Health Risk Assessment (HRA) 42 CFR 438.208(b)(3) MSC 18-2-3-3	The MCO must make a best effort to conduct an initial HRA of each enrollee's needs, within 90 calendar days of the coverage effective date for all new enrollees, including subsequent attempts if the first attempt to contact the enrollee is unsuccessful.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
9. HRA Incentive Plan MSC 18-2-3-3	The MCO must: a. conduct an HRA incentive plan, as approved by FHKC, to increase the percentage of new enrollees who complete an HRA within the first 90 days of enrollment; b. include in its HRA incentive plan an annual goal reflecting year-over-year improvement; and c. report on the HRA completion rate quarterly.	☐ a. Incentive plan conducted ☐ b. Annual goal included in plan ☐ c. Quarterly reporting to FHKC ☐ Not Applicable	**0.333** **0.333** **0.334**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
10. Assessment of Enrollee Needs 42 CFR 438.208(b)(4) MSC 18-2-3-3	The MCO must: a. accept such information as assessed by another MCO in the Florida Healthy Kids program from FHKC; and b. share with FHKC or other MCOs serving the enrollee the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities, upon FHKC's request.	☐ a. Accept assessment by another Florida Healthy Kids MCO ☐ b. Share assessment results with FHKC or other MCOs, at FHKC's request ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
11. Enrollee Health Record 42 CFR 438.208(b)(5)	The MCO must ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
12. Enrollee Privacy 42 CFR 438.208(b)(6)	The MCO must ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
13. Special Healthcare Needs Assessment 42 CFR 438.208(c)(2) MSC 18-2-3-3	The MCO must implement mechanisms to comprehensively assess each Florida Healthy Kids enrollee identified by FHKC as having special healthcare needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
14. Treatment or Service Plan 42 CFR 438.208(c)(3)(iii)-(v)	The MCO must produce a treatment or service plan meeting the following criteria for enrollees with special healthcare needs that are determined through assessment to need a course of treatment or regular care monitoring: a. approved by the MCO in a timely manner, if this approval is required by the MCO; b. in accordance with any applicable FHKC quality assurance and utilization review standards; and c. reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee per 42 CFR 441.301(c)(3).	☐ a. Timely MCO approval, if required ☐ b. In accordance with applicable FHKC standards ☐ c. Reviewed and revised at least every 12 months ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
15. Enrollee Direct Access to Specialists 42 CFR 438.208(c)(4) MSC 18-2-3-3	The MCO must have mechanisms in place to assess enrollees and provide those determined to have special healthcare needs through an assessment [consistent with paragraph 438.208(c)(2)] with direct access to a specialist (for example, through a standing referral or an approved number of visits) in a manner that is appropriate for the enrollee's condition and identified needs. Direct access may include a standing referral or an approved number of visits.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
AON					
Suggestion					
16. Social Determinants of Health MSC 22-9	The MCO must: a. have a mechanism to address social services needs of enrollees through available community-based social service resources; and b. not require enrollees to access community-based social service resources instead of covered benefits.	☐ a. Mechanism to address enrollee social service needs ☐ b. Enrollees not required to substitute social service resources for covered benefits ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
17. Disease and Case Management Services MSC 22-10	The MCO must: a. provide disease and case management services; and b. inform FHKC of any addition or removal of such programs 60 calendar days prior to the change.	☐ a. Provision of disease and case management services ☐ b. Notification to FHKC of addition or removal of programs 60 calendar days prior to change ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
18. Disease and Case Management Policies and Procedures MSC 22-10	The MCO must have policies and procedures in place for identifying and enrolling enrollees likely to benefit from disease and case management services.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
Coordination and Continuity of Care			**XX.X%**	**18.000**	**X.XXX**

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
1. Contract Compliance 42 *Code of Federal Regulations* (CFR) 438.230(b)(1) Medical Services Contract (MSC) Section 5	The managed care organization (MCO) must maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its Medical Services Contract (MSC) with Florida Healthy Kids Corporation (FHKC), notwithstanding any relationship(s) the MCO may have with any subcontractor.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. New or Amended Subcontracts MSC 5	The MCO must submit any proposed new or amended subcontracts to FHKC for review at least 90 calendar days before the proposed effective date of the delegation or amendment, unless FHKC, at its sole discretion, waives the submission timeframe upon MCO request and evidence of good cause.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
3. Subcontract Availability MSC 5-1	The MCO must provide any executed subcontracts to FHKC within seven business days after request of such documents.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
Strength **AON** **Suggestion**					
4. Subcontractor Disclosures 42 CFR 438.608(c)(1)-(3) MSC 5	The MCO must ensure that: a. its subcontractors provide written disclosures of any prohibited affiliation under 42 *Code of Federal Regulations* (CFR) 438.610; b. its subcontractors provide written disclosures of information on ownership and control required under 42 CFR 455.104; and c. it reports to FHKC within 60 calendar days when the MCO has identified capitation payments or other payments in excess of amounts specified in the contract.	☐ a. Written disclosures of prohibited affiliation ☐ b. Written disclosures of information on ownership and control ☐ c. Reporting of excessive payments to FHKC within 60 calendar days ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
5. Delegation of Activities 42 CFR	If any of the MCO's activities or obligations under its MSC are delegated to a subcontractor: a. the delegated activities or obligations, including related reporting responsibilities, are specified in the	☐ a. Delegated activities specified in contract	**0.250**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
438.230(c)(1)(i)-(iii) MSC 5-1	subcontract or written agreement; b. the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's contract obligations; c. the subcontract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where FHKC or the MCO determines that the subcontractor has not performed satisfactorily; and d. the subcontractor agrees to maintain complete and accurate records.	☐ b. Subcontractor agreement to compliance with MCO's MSC ☐ c. Provision for revocation of delegation of activities ☐ d. Subcontractor agreement to record maintenance ☐ Not Applicable	**0.250** **0.250** **0.250** **0.000**		
Findings **Strength** **AON** **Suggestion**					
6. Regulatory Compliance 42 CFR 438.230(c)(2) MSC 5-1	The subcontractor must agree to comply with all applicable Children's Health Insurance Plan laws and regulations, including applicable subregulatory guidance and contract provisions.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
7. Grievance and Appeal Process 42 CFR 438.414 MSC 5	The MCO must provide the following information about its grievance and appeal process to applicable subcontractors upon entrance into the subcontract, in accordance with 42 CFR 457.1260, which incorporates 42 CFR 438.414: a. The right to file grievances and appeals. b. The requirements and timeframes for filing a grievance or appeal. c. The availability of assistance in the filing process. d. The right to request an independent review after the MCO has made an adverse appeal determination.	☐ a. Right to file grievances and appeals ☐ b. Requirements and timeframes for filing ☐ c. Assistance in the filing process ☐ d. Right to request an independent review ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
8. Delegated Coverage of Services and Claims Payment MSC 5-1	If the subcontractor delegation involves coverage of services and claims payment, the subcontract must require the subcontractor to implement and maintain arrangements or procedures designed to detect and prevent fraud, waste, and abuse.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
Suggestion					
9. Delegated Management of Covered Services MSC 5-1	If the subcontractor delegation is for management of covered services, including pharmacy benefits management, durable medical equipment, or behavioral health services, the MCO must include the following in the subcontractor approval request: a. documentation supporting network adequacy and capacity to serve, as applicable for the specific delegations; b. copy of applicable licensure, as appropriate; c. specification of the regions covered by the subcontractor; d. description of the MCO's plan to monitor compliance; and e. confirmation of the subcontractor's ability to accurately process and pass claims and encounter data to the MCO in a manner that can be stored and utilized by the MCO, including seamless passthrough to FHKC, the Florida Agency for Health Care Administration, and their designees. The confirmation must include a summary description of the MCO's testing activities with the proposed subcontractor.	☐ a. Documentation supporting network adequacy ☐ b. Applicable licensure ☐ c. Regions covered ☐ d. MCO compliance monitoring plan ☐ e. Subcontractor ability to process claims and encounter data in such a way to be utilized by the MCO ☐ Not Applicable	**0.200** **0.200** **0.200** **0.200** **0.200** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
10. Delegated Management of Covered Behavioral Health Services MSC 5-1	The MCO must, for subcontractors delegated any functions related to behavioral health covered services, provide: a. an analysis of the subcontractor's compliance with 42 CFR 457.496; and b. a plan to assure continued compliance with parity of nonquantitative treatment limitations should the subcontractor or MCO make any changes to utilization management controls or other aspects impacting nonquantitative treatment limitations.	☐ a. Subcontractor compliance analysis ☐ b. Assurance plan ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
11. Risk Assessments MSC 5-2	The MCO must: a. conduct risk assessments of all subcontractors and their delegated activities related to the MCO's MSC; and b. use the outcome of the risk assessment to directly inform its subcontractor monitoring plan.	☐ a. Risk assessments conducted ☐ b. Outcome used in monitoring plan ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
12. Quarterly	The MCO must provide to FHKC a quarterly summary of subcontractor monitoring, including any findings and	☐ Yes	**1.000**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Monitoring Summary MSC 5-2	corrective action taken during the quarter.	☐ No ☐ Not Applicable	**0.000** **0.000**		
Findings **Strength** **AON** **Suggestion**					
13. Routine and Non-Routine Monitoring MSC 5-2	The MCO must conduct: a. routine monitoring of all subcontractors; and b. non-routine monitoring, as needed.	☐ a. Routine monitoring ☐ b. Non-routine monitoring ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
14. Contingency Plan MSC 5-2	The MCO must have a contingency plan for each subcontractor to safeguard performance of the delegated obligations should the subcontractor cease to perform or adequately perform its obligations under the subcontract.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
15. Subcontractor Audit 42 CFR 438.230(c)(3)(i)-(iv) MSC 5-1	The subcontractor must agree that: a. FHKC, the Centers for Medicare & Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, which pertain to any aspect of services and activities performed, or determination of amounts payable under the MCO's MSC; b. the subcontractor will make available, for purposes of an audit, evaluation, or inspection under 42 CFR 438.230(c)(3)(i), its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid enrollees; c. the right to audit under 42 CFR 438.230(c)(3)(i) will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later; and d. if FHKC, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, FHKC, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.	☐ a. FHKC, CMS, HHS Inspector General, Comptroller General, and designee right to audit ☐ b. Availability of subcontractor premises and facilities ☐ c. Right to audit for 10 years ☐ d. Right to inspect, evaluate, and audit any time there is reasonable possibility of fraud or similar risk ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Suggestion					
16. Correction of Subcontractor Noncompliance MSC 5-2	If FHKC determines a subcontractor is not in compliance with the requirements of the MCO's MSC, the MCO must promptly correct the subcontractor's noncompliance.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
17. Notification of Subcontractor Termination MSC 5-2	The MCO must inform FHKC of any subcontractor termination, in whole or in part, within the following timeframes: a. for subcontractors delegated management of a covered benefit: 90 calendar days prior to termination; b. for subcontractors terminated for cause: one business day of the earlier of the date the MCO notifies the subcontractor of intention to terminate or the date of termination; and c. for all others: 30 calendar days prior to termination.	☐ a. 90 calendar days for covered benefit subcontractor ☐ b. One business day for subcontractor terminated for cause ☐ c. 30 calendar days for all other subcontractors ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON**					

2022 Annual Compliance Assessment: <MCO Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Suggestion					
18. Subcontractor Solvency MSC 5-3	If the MCO learns that a subcontractor has become insolvent or is at unacceptable risk for insolvency it must: a. promptly cease delegation of any obligations directly or indirectly related to the MCO's MSC to the subcontractor; and b. notify FHKC within one business day of the insolvency or the filing of a petition for bankruptcy by or against a principal subcontractor.	☐ a. Promptly cease delegation of any obligations ☐ b. Notify FHKC within one business day ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
Subcontractual Relationships and Delegation			**XX.X%**	**18.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
1. Service Protections 42 *Code of Federal Regulations* (CFR) 438.210(a)(3) (i)-(ii) 42 CFR 440.230(b) Dental Services Contract (DSC) Amendment 3 Section 3-5	The dental benefit manager (DBM): a. must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished; and b. may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee.	☐ a. Sufficient services to achieve purpose ☐ b. No arbitrary denial or reduction of services ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. DBM Non-Refusal to Cover Benefits or	The DBM must not object or otherwise refuse to provide a benefit or service covered under its Dental Services Contract (DSC) with Florida Healthy Kids	☐ a. No objection on moral or religious grounds	**0.333**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Services DSC 3-5 DSC Amendment 3 Section 3-26	Corporation (FHKC): a. on moral or religious grounds, or b. on the basis of the enrollee's past or present health status or need for healthcare services; or c. refuse to provide coverage to, or use any policy or practice that has the effect of discriminating against, any enrollee on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability, or whether an enrollee has executed an advance directive.	☐ b. No objection based on past or present health status or needs of the enrollee	**0.333**		
		☐ c. No refusal of coverage or use of any policy or practice that effectively discriminates against an enrollee	**0.334**		
		☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
3. Service Limitations 42 CFR	The DBM may place appropriate limits on a service on the basis of criteria applied under the FHKC plan, such as medical necessity, or for the purpose of utilization control, provided that:	☐ a. Services can reasonably achieve their purpose	**0.333**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
438.210(a)(4)(i)-(ii) 42 CFR 440.230(d) DSC Amendment 3 Section 3-5	a. the services furnished can reasonably achieve their purpose, as required in paragraph 42 CFR 438.210(a)(3)(i); b. the services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services; and c. family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR 441.20.	☐ b. Services authorized in a manner that reflects enrollee's ongoing need ☐ c. Family planning services provided in a manner protecting enrollee choice ☐ Not Applicable	**0.333** **0.334** **0.000**		
Findings **Strength** **AON** **Suggestion**					
4. Authorization of Services 42 CFR 438.210(b)(1) DSC Amendment 3 Section 3-5	For the processing of requests for initial and continuing authorizations of services, the DBM and its subcontractors have in place, and follow, written policies and procedures and practice guidelines.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
5. Application of Review Criteria 42 CFR 438.210(b)(2)(i)-(ii) DSC Amendment 3 Section 3-5	The DBM must: a. have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and b. consult with the requesting provider for medical services when appropriate.	☐ a. Mechanisms to ensure consistent application of review criteria ☐ b. Requesting provider consulted, when appropriate ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
6. Appropriate Reviewer Expertise 42 CFR 438.210(b)(3) DSC Amendment 3 Section 3-5	The DBM must ensure that utilization management activities, including any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested: a. be made by individuals who have appropriate clinical expertise in addressing the enrollee's medical or behavioral health needs; b. be conducted in a manner that results in interrater reliability sufficient to indicate the appropriateness and validity of the process; and c. include the training given to the reviewers.	☐ a. Decisions made by individuals who have appropriate clinical expertise ☐ b. Conducted in a manner resulting in interrater reliability ☐ c. Reviewer training included ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**
Findings					

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Strength **AON** **Suggestion**					
7. Notice of Adverse Benefit Determination 42 CFR 438.210(c) 42 CFR 438.404(a)	The DBM must notify the requesting provider and give the enrollee written notice of any decision by the DBM to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The enrollee's notice must meet the requirements of 42 CFR 438.404.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
8. Timeframe for Standard Authorization Decisions 42 CFR 438.210(d)(1) 42 CFR 438.404(c)(3) DSC Amendment 3 Section 3-5	For standard authorization decisions that deny or limit services, the DBM must provide notice as expeditiously as the enrollee's condition requires not to exceed 14 calendar days following receipt of the request for service.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
9. Standard Authorization Extension 42 CFR 438.210(d)(1)(i)-(ii) 42 CFR 438.404(c)(4)(i)-(ii) DSC Amendment 3 Section 3-5	The DBM may extend the timeframe for standard authorization decisions up to 14 additional calendar days, if the enrollee or the provider requests an extension or the DBM justifies to FHKC, upon request, a need for additional information and how the extension is in the enrollee's interest, provided that: a. the DBM gives the enrollee written notice of the reason for the decision to extend the timeframe and informs the enrollee of the right to file a grievance; and b. the DBM carries out the determination as expeditiously as the enrollee's health condition requires, but no later than the date the extension expires.	☐ a. Written notice to enrollee of reason for decision and right to file a grievance	**0.500**	**1.000**	**X.XXX**
		☐ b. Determination carried out as expeditiously as the enrollee's health condition requires but no later than the date the extension expires	**0.500**		
		☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
10. Timeframe for Expedited Authorization	For cases in which a provider indicates, or the DBM determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health	☐ Yes	**1.000**	**1.000**	**X.XXX**
		☐ No	**0.000**		

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Decisions 42 CFR 438.210(d)(2)(i) 42 CFR 438.404(c)(6) DSC Amendment 3 Section 3-5	or ability to attain, maintain, or regain maximum function, the DBM must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.	☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
11. Expedited Authorization Extension 42 CFR 438.210(d)(2)(ii) DSC Amendment 3 Section 3-5	The DBM may extend the 72-hour time period by up to 14 calendar days if the enrollee or provider requests an extension, or if the DBM justifies to FHKC, upon request, a need for additional information and how the extension is in the enrollee's interest.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
12. Covered Outpatient Drug	For all covered outpatient drug authorization decisions, the DBM must provide notice as described	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Decisions 42 CFR 438.210(d)(3)	in section 1927(d)(5)(A) of the *Social Security Act*.	☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
13. Compensation for Utilization Management Activities 42 CFR 438.210(e) DSC Amendment 3 Section 3-5	The DBM must provide that, consistent with 42 CFR 438.3(i) and 42 CFR 422.208, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
14. Emergency Services 42 CFR 438.114(c)(1)(i)-(ii) DSC Amendment 3 Section 3-31-1	The DBM must: a. cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the DBM; and b. not deny payment for treatment obtained under either of the following circumstances:	☐ a. Coverage and payment for emergency services ☐ b. Payment not denied for treatment	**0.500** **0.500**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
	1. an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (1), (2), and (3) of the definition of emergency medical condition in 42 CFR 438.114(a); or 2. a representative of the DBM instructs the enrollee to seek emergency services.	☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
15. Subsequent Screening and Treatment 42 CFR 438.114(d)(2)	The DBM may not hold an enrollee who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
16. Enrollee Transfer or Discharge 42 CFR 438.114(d)(3)	The DBM must agree that the attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the DBM as responsible for coverage and payment.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Findings **Strength** **AON** **Suggestion**					
17. Poststabilization Care Services – 1 42 CFR 438.114(e)	The DBM must ensure that poststabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c).	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
18. Poststabilization Care Services – 2 42 CFR 438.10(c)(1) DSC Amendment 3 Section 3-19	The DBM must provide all required information to enrollees and potential enrollees in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
19. Culturally Competent	The DBM must provide services, including oral and written communication to enrollees, in a culturally competent manner appropriate for the population.	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Communication DSC Amendment 3 Section 3-19-2-A		☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
20. Electronic Information 42 CFR 438.10(c)(6)(i)-(v)	The DBM must ensure all of the following conditions are met for information provided electronically to enrollees: a. the format is readily accessible; b. the information is placed in a location on the DBM's website that is prominent and readily accessible; c. the information is provided in an electronic form that can be electronically retained and printed; d. the information is consistent with content and language requirements for enrollee information; and	☐ a. Accessible format ☐ b. Prominently placed and readily accessible on DBM website ☐ c. Can be electronically retained and printed ☐ d. Meets content and language requirements	**0.200** **0.200** **0.200** **0.200**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
	e. the DBM informs the enrollee that the information is available in paper form without charge upon request and provides it upon request within five business days.	☐ e. Enrollee informed that information is available in paper form without charge upon request, to be received within five business days ☐ Not Applicable	**0.200** **0.000**		
Findings **Strength** **AON** **Suggestion**					
21. Enrollee Assistance 42 CFR 438.10(c)(7) DSC 3-5 DSC 3-11	The DBM must have in place mechanisms to help enrollees and potential enrollees understand the requirements and benefits of the plan.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
22. Written Material Language Requirements 42 CFR 438.10(d)(2)-(3) DSC 3-19-2-B DSC Amendment 3 Section 3-19-2 DSC Amendment 3 Section 3-19-2-B	For written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, the DBM must: a. make oral interpretation available in all languages and written translation available in the prevalent non-English languages in its particular service area; b. make them available in alternative formats upon request of the potential enrollee or enrollee at no cost; c. include taglines in the prevalent non-English languages in the state and in a conspicuously visible font size (no smaller than 18 point) explaining the availability of written translation or oral interpretation to understand the information provided; d. include information on how to request auxiliary aids and services; e. include the toll-free and telecommunication device for the deaf (TTY/TDY) telephone number of the DBM's enrollee/customer service unit; f. include the toll-free telephone number of the entity	☐ a. Oral interpretation available in all languages and written translation available in the prevalent non-English languages in service area ☐ b. Available in alternative formats upon request at no cost ☐ c. Taglines in the prevalent non-English languages and conspicuously visible font size ☐ d. Information about auxiliary aids and services	**0.142** **0.142** **0.142** **0.142**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
	providing choice counseling services as required by 42 CFR 438.71(a); and g. make auxiliary aids and services available upon request of the potential enrollee or enrollee at no cost.	☐ e. Toll-free and TTY/TDY telephone number included for customer service ☐ f. Toll-free telephone number of the entity providing choice counseling services ☐ g. Auxiliary aids and services available upon request at no cost ☐ Not Applicable	**0.142** **0.142** **0.143** **0.000**		
Findings **Strength** **AON** **Suggestion**					
23. Notification to Enrollee of	The DBM must notify its enrollees that information is available in alternative formats:	☐ a. At no cost upon request	**0.333**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Alternate Formats Available 42 CFR 438.10(d)(5)(i)-(iii) DSC Amendment 3 Section 3-19-2	a. at no cost upon request; b. including auxiliary aids and services, oral interpretation in any language, and written interpretation in the language(s) prevalent in the service area; and c. how to access those formats.	☐ b. Availability of auxiliary aids and services, including oral and written interpretation ☐ c. How to access formats ☐ Not Applicable	**0.333** **0.334** **0.000**		
Findings **Strength** **AON** **Suggestion**					
24. Written Material Content Requirements 42 CFR 438.10(d)(6)(i)-(iii) DSC Amendment 3 Section 3-19-2	The DBM must provide all written materials for potential enrollees and enrollees consistent with the following: a. use easily understood language and format; b. use a font size no smaller than 12 point; and c. be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency.	☐ a. Easily understood language and format ☐ b. Font size no smaller than 12 point ☐ c. Available in alternative formats that take enrollee special needs into consideration	**0.333** **0.333** **0.334**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
		☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
25. Enrollee Material Best Practices DSC Amendment 3 Section 3-19-2	The DBM must follow best practices related to accessibility of materials, including readability and access by those with physical disabilities, insofar as such best practices are reasonable and practicable.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
26. Minimum Requirements for Enrollee Notification DSC 3-19-2-C DSC Amendment 4 Section 3-19-2-C-4	At a minimum, the DBM must ensure that all enrollees are made aware of: a. the rights and responsibilities of both the enrollee and the DBM; b. the role of the primary care dentist; c. what to do in an emergency or urgent medical situation; d. how to request a grievance or appeal, or request an independent review;	☐ a. Rights and responsibilities of both enrollee and DBM ☐ b. Role of primary care dentist ☐ c. What to do in an emergency or urgent medical situation	**0.111** **0.111** **0.111**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
	e. how to report fraud and abuse; f. procedures for referrals and prior authorizations; g. any additional telephone numbers or contact information for reaching the DBM; h. eligibility compliance requirements under the program, specifically for payment of premiums and renewal; and i. how to access other program services not covered by the DBM, such as other healthcare services, to at least include information about contacting the Florida KidCare enrollee call center.	☐ d. How to request a grievance or appeal, or request an independent review ☐ e. How to report fraud and abuse ☐ f. Procedures for referrals and prior authorizations ☐ g. Any additional telephone numbers or contact information for reaching the DBM ☐ h. Eligibility compliance requirements under the program, specifically for payment of premiums and renewal	**0.111** **0.111** **0.111** **0.111** **0.111**		

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
		☐ i. How to access other program services not covered by the DBM	**0.112**		
		☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
27. Provider Termination Notice 42 CFR 438.10(f)(1) DSC Amendment 3 Section 3-19-2	Using the model enrollee notice provided by FHKC, the DBM must: a. make a good faith effort to provide written notice of termination of a contracted provider to each enrollee who received their primary care from, or was seen on a regular basis by, the terminated provider; and b. provide notice to the enrollee within 15 calendar days of receipt or issuance of the provider termination notice.	☐ a. Good faith effort to provide written notice	**0.500**	**1.000**	**X.XXX**
		☐ b. Written notice provided within 15 calendar days of receipt or issuance of the provider termination notice	**0.500**		
		☐ Not Applicable	**0.000**		
Findings **Strength**					

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
AON					
Suggestion					
28. Provider Incentive Plans 42 CFR 438.10(f)(3) DSC 3-4 DSC Amendment 3 Section 3-4	The DBM must make available, upon request, any provider incentive plans in place as set forth in 42 CFR 438.3(i), and any other applicable federal or state laws and regulations.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
29. Enrollment with a Primary Dental Care Provider DSC 3-2-1	The DBM must provide each enrollee the following minimum information within five business days of notification of enrollment: a. notification of the enrollee's primary dental care assignment, including contact information for the provider if the DBM has chosen to auto assign. If the DBM does not auto assign, the DBM must provide all relevant information to the enrollee such that the enrollee may choose a primary dental care provider; b. the enrollee's ability to select another provider from the DBM's network;	☐ a. Notification of enrollee's primary dental care assignment, including contact information if auto assigned; relevant information so enrollee may choose provider if not auto assigned	**0.250**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
	c. a provider directory; and d. the procedures for changing providers.	☐ b. Enrollee's ability to select another provider from the DBM's network ☐ c. Provider directory ☐ d. Procedures for changing providers ☐ Not Applicable	**0.250** **0.250** **0.250** **0.000**		
Findings **Strength** **AON** **Suggestion**					
30. Enrollee Handbook 42 CFR 438.10(g)(1) DSC Amendment 3 Section 3-11-B DSC Amendment 3 Section 3-19-2	The DBM must provide each enrollee a model enrollee handbook provided by FHKC that: a. is provided within five business days of receipt of an enrollment file; b. complies with any federal or state requirements; c. uses FHKC-developed definitions for managed care terminology; and d. serves a similar function as the summary of benefits and coverage described in 45 CFR 147.200(a).	☐ a. Within five business days ☐ b. Complies with any federal or state requirements ☐ c. Uses FHKC-developed managed care terminology definitions	**0.250** **0.250** **0.250**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
		☐ d. Serves a similar function as the summary of benefits and coverage described in 45 CFR 147.200(a)	**0.250**		
		☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
31. Enrollee Handbook Content – 1 42 CFR 438.10(g)(2)(i)-(iv)	The DBM's enrollee handbook must include, at a minimum: a. benefits provided by the DBM; b. how and where to access any benefits provided by FHKC, including any cost sharing, and how transportation is provided; c. the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled; and d. procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.	☐ a. Benefits provided by the DBM	**0.250**	**1.000**	**X.XXX**
		☐ b. How and where to access benefits and transportation	**0.250**		
		☐ c. Amount, duration, and scope of available benefits	**0.250**		
		☐ d. Procedures for obtaining benefits	**0.250**		
		☐ Not Applicable	**0.000**		

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Findings **Strength** **AON** **Suggestion**					
32. Enrollee Handbook Content – 2 42 CFR 438.10(g)(2)(v)-(viii)	The DBM's enrollee handbook must include, at a minimum: a. the extent to which, and how, after-hours and emergency coverage are provided, including: 1. what constitutes an emergency medical condition and emergency services; 2. the fact that prior authorization is not required for emergency services; and 3. the fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care; b. any restrictions on the enrollee's freedom of choice among network providers; c. the extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers. This includes an explanation that the DBM cannot require an enrollee to obtain a referral before choosing a family planning provider; and d. cost sharing, if any is imposed under the Florida Healthy Kids plan.	☐ a. Extent to which, and how, after-hours and emergency coverage are provided ☐ b. Restrictions on enrollee's choice among network providers ☐ c. Extent to which, and how, enrollees may obtain benefits, including explanation about not needing a referral before choosing a family planning provider ☐ d. Cost sharing, if applicable ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Findings **Strength** **AON** **Suggestion**					
33. Enrollee Handbook Content – 3 42 CFR 438.10(g)(2)(ix)-(xii)	The DBM's enrollee handbook must include, at a minimum: a. enrollee rights and responsibilities, including the elements specified in 42 CFR 438.100; b. the process of selecting and changing the enrollee's primary dental care provider; and c. grievance, appeal, and independent external review procedures and timeframes, consistent with subpart F of this part, in an FHKC-developed or FHKC-approved description. Such information must include: 1. the right to file grievances and appeals; 2. the requirements and timeframes for filing a grievance or appeal; 3. the availability of assistance in the filing process;	☐ a. Enrollee rights and responsibilities ☐ b. Process of selecting and changing enrollee's primary dental care provider ☐ c. FHKC-developed or -approved grievance, appeal, and independent external review procedures and timeframes	**0.333** **0.333** **0.334**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
	4. the right to request an independent external review after the DBM has made a determination on an enrollee's appeal that is adverse to the enrollee; and 5. the fact that, when requested by the enrollee, benefits that the DBM seeks to reduce or terminate will continue if the enrollee files an appeal or a request for an independent external review within the timeframes specified for filing, and that the enrollee may, consistent with FHKC policy, be required to pay the cost of services furnished while the appeal or an independent external review is pending if the final decision is adverse to the enrollee.	☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
34. Enrollee Handbook Content – 4 42 CFR 438.10(g)(2)(xiii)-(xvi)	The DBM's enrollee handbook must include, at a minimum: a. how to access auxiliary aids and services, including additional information in alternative formats or languages; b. the toll-free telephone number for enrollee	☐ a. How to access auxiliary aids and services ☐ b. Toll-free telephone numbers	**0.250** **0.250**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
	services, medical management, and any other unit providing services directly to enrollees; c. information on how to report suspected fraud or abuse; and d. any other content required by FHKC.	☐ c. How to report suspected fraud or abuse ☐ d. Other FHKC-required content, if any ☐ Not Applicable	**0.250** **0.250** **0.000**		
Findings					
Strength					
AON					
Suggestion					

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
35. Information Delivery Methods 42 CFR 438.10(g)(3)(i)-(iv)	The information required to be provided to the enrollee in an enrollee handbook will be considered to be provided if the DBM: a. mails a printed copy of the information to the enrollee's mailing address; b. provides the information by email after obtaining the enrollee's agreement to receive the information by email; c. posts the information on its website and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or d. provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
36. Notice of Changes 42 CFR 438.10(g)(4) DSC Amendment 3 Section 3-19-2	Using the model enrollee notice provided by FHKC, the DBM must give each enrollee notice of any change that FHKC defines as significant in the information in the enrollee handbook, at least 30 days before the intended effective date of the change.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
Findings **Strength** **AON** **Suggestion**					
37. Certificates of Creditable Coverage DSC Amendment 3 Section 3-19-2	The DBM is responsible for issuing certificates of creditable coverage to enrollees, upon request or upon the enrollee's coverage termination.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
38. Enrollee Right to Information 42 CFR 438.100(b)(2)(i),(iii)-(v) DSC 3-4	An enrollee has the right to: a. receive information in accordance with 42 CFR 438.10; b. receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand; c. participate in decisions regarding their healthcare, including the right to refuse treatment; and d. be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other	☐ a. Information in accordance with 42 CFR 438.10 ☐ b. Information on available treatment options and alternatives in a manner appropriate to enrollee's condition and ability to understand	**0.250** **0.250**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
	federal regulations on the use of restraints and seclusion.	☐ c. Participation in healthcare-related decisions, including refusal of treatment	**0.250**		
		☐ d. Free from any form of restraint or seclusion	**0.250**		
		☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
39. Staff Education and Training DSC Amendment 3 Section 3-1	The DBM must provide education and training to its staff, as appropriate and applicable to the staff members' duties, including but not limited to, enrollee rights.	☐ Yes	**1.000**	**1.000**	**X.XXX**
		☐ No	**0.000**		
		☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
40. Compliance with Federal and	The DBM must comply with any other applicable federal and state laws, including Title VI of the *Civil Rights Act of 1964* as implemented by regulations at	☐ Yes	**1.000**	**1.000**	**X.XXX**
		☐ No	**0.000**		

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coverage and Authorization of Services					
State Laws 42 CFR 438.100(d) DSC 4-12	45 CFR part 80; the *Age Discrimination Act of 1975* as implemented by regulations at 45 CFR part 91; the *Rehabilitation Act of 1973*; Title IX of the *Education Amendments of 1972* (regarding education programs and activities); titles II and III of the *Americans with Disabilities Act*; section 1557 of the *Patient Protection and Affordable Care Act*; Section 654 of the *Omnibus Budget Reconciliation Act of 1981*; Title XXI of the federal *Social Security Act*; and all applicable state and federal laws and regulations governing FHKC.	☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
Coverage and Authorization of Services			**XX.X%**	**40.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
1. Appropriate Source of Care 42 *Code of Federal Regulations* (CFR) 438.208(b)(1) Dental Services Contract (DSC) Section 3-2-1 DSC Amendment 3 Section 3-2-1	The dental benefit manager (DBM) must ensure that each enrollee has: a. a choice of primary care dental providers, either a general dentist experienced in pediatric or adolescent dental care or a pediatric dentist who meets the credentialing, access, and appointment standards of the DBM's Dental Services Contract (DSC) with the Florida Healthy Kids Corporation (FHKC); b. an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee; and c. information on how to contact their designated person or entity.	☐ a. Choice of primary dental care provider ☐ b. Ongoing source of care ☐ c. Designated entity contact information ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Assignment of Primary Dental Provider (PDP) DSC 3-2-1	The DBM must permit enrollees to select another primary dental provider (PDP) within the DBM's network, if the DBM elects to auto-assign enrollees to a PDP.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
3. PDP Assignment Requirements DSC 3-2-1	The DBM must consider the following if auto-assigning enrollees to PDPs: a. the enrollee's last PDP assignment, if known; b. time and distance from the enrollee's home address; c. sibling assignments; and d. the enrollee's age.	☐ a. Enrollee's last PDP assignment ☐ b. Time and distance from enrollee address ☐ c. Sibling assignments ☐ d. Enrollee's age ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
4. Enrollee Health Record 42 CFR 438.208(b)(5) DSC 3-18	The DBM must ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
5. Enrollee Privacy 42 CFR 438.208(b)(6)	The DBM must ensure that in the process of coordinating care, each enrollee's privacy is	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
	protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.	☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
6. Coordination of Care DSC Amendment 3 Section 3-2-6 DSC Amendment 4 Section 2-1	The DBM must: a. coordinate, or provide for the coordination of, services between settings of care; with services enrollees receive from other dental care coverage; other liable third parties in accordance with Section 1902(a)(25) of the *Social Security Act*, including cost avoidance and pay-and-chase requirements; and with services enrollees receive from community and social support providers; b. notify FHKC of any enrollees the DBM identifies as covered under other health insurance by the 15th of each month in a manner specified by FHKC; and c. coordinate benefits with any DBM under contract with FHKC to provide comprehensive dental benefits to enrollees, including the provision of prescription coverage for prescriptions prescribed by the enrollee's dental provider.	☐ a. Coordination of services ☐ b. Notification to FHKC by the 15th day of each month ☐ c. Coordination of benefits with other Florida Healthy Kids DBMs ☐ Not Applicable	**0.333** **0.333** **0.334** **0.000**	**1.000**	**X.XXX**
Findings **Strength**					

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
AON **Suggestion**					
7. Transition of Care Policy DSC Amendment 3 Section 3-2-7	The DBM must: a. implement a transition of care policy consistent with the transition of care policy adopted by FHKC, subject to FHKC approval; and b. include summaries of the transition of care policy in the enrollee handbook and relevant notices.	☐ a. Transition of care policy consistent with FHKC's policy ☐ b. Policy summaries in enrollee handbook and relevant notices ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
8. Disenrollment DSC Amendment 3 Section 3-9	The DBM may not request disenrollment of an enrollee for any reason other than a request for eligibility review, for which the DBM must: a. request in writing that FHKC review the eligibility of an enrollee if the DBM has reasonable cause to believe that enrollee is not eligible for the Florida Healthy Kids program because that enrollee should be placed in a different state or federal program for such services, for which eligibility would	☐ a. Written request from DBM ☐ b. Reason for eligibility review request ☐ c. Confirmation that no other considerations about the enrollee influenced the DBM's decision	**0.333** **0.333** **0.334**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Coordination and Continuity of Care					
	render that enrollee ineligible for Florida Healthy Kids; b. provide the reason for the eligibility review request, including how the relevant considerations were discovered; and c. confirm no other considerations influenced the DBM's decision to request the review, including an adverse change in the enrollee's health status, utilization of services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the enrollee's special needs.	☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
Coordination and Continuity of Care			**XX.X%**	**8.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
1. Contract Compliance *42 Code of Federal Regulations* (CFR) 438.230(b)(1) Dental Services Contract (DSC) 3-30-C	The dental benefit manager (DBM) must maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its Dental Services Contract (DSC) with Florida Healthy Kids Corporation (FHKC), notwithstanding any relationship(s) the DBM may have with any subcontractor.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Delegation of Activities 42 CFR 438.230(c)(1)(i)-(iii) DSC 3-30	If any of the DBM's activities or obligations under its DSC with FHKC are delegated to a subcontractor: a. the delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement; b. the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with	☐ a. Delegated activities specified in contract or written agreement ☐ b. Subcontractor agreement to perform delegated activities	**0.333** **0.333**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
	the DBM's DSC obligations; and c. the contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where FHKC or the DBM determines that the subcontractor has not performed satisfactorily.	☐ c. Provision for revocation of delegation of activities in contract or written agreement ☐ Not Applicable	**0.334** **0.000**		
Findings **Strength** **AON** **Suggestion**					
3. Regulatory Compliance 42 CFR 438.230(c)(2)	The subcontractor must agree to comply with all applicable Children's Health Insurance Plan laws and regulations, including applicable subregulatory guidance and contract provisions.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
4. Subcontractor Audit 42 CFR 438.230(c)(3)(i)-	The subcontractor must agree that: a. FHKC, the Centers for Medicare & Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to	☐ a. Subcontractor agreement to FHKC's and/or other specified entities' right to audit	**0.250**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
(iv)	audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the DBM's DSC; b. the subcontractor will make available, for purposes of an audit, evaluation, or inspection under 42 CFR 438.230(c)(3)(i), its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Florida Healthy Kids enrollees; c. the right to audit under 42 CFR 438.230(c)(3)(i) will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later; and d. if FHKC, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, FHKC, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.	☐ b. Subcontractor audit availability ☐ c. Subcontractor agreement to 10-year post-contract right to audit ☐ d. Subcontractor agreement to FHKC's and/or other specified entities' right to audit at any time there is a possibility of fraud or similar risk	**0.250** **0.250** **0.250**		
	Findings **Strength**				

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
AON					
Suggestion					
5. Notification of Agreement Termination DSC 3-30-D	The DBM must provide FHKC with timely notice of termination of agreements with any subcontractor or affiliate.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
6. Notice of Intent to Subcontract DSC 3-30-E	The DBM must provide FHKC with: a. timely notice of the DBM's intent to contract with any new subcontractors or affiliates for services covered; and b. prior to execution, any proposed agreement for services with subcontractors or affiliates, for FHKC's review and approval.	☐ a. Timely notice to FHKC ☐ b. Proposed agreement provided to FHKC for review ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
7. Annual Subcontractor	The DBM must provide FHKC with an annual report listing, for the previous calendar year, all subcontractors or affiliates that performed	☐ Yes ☐ No	**1.000** **0.000**	**1.000**	**X.XXX**

2022 Annual Compliance Assessment: <DBM Name>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Subcontractual Relationships and Delegation					
Report DSC 3-30-F	services under the DSC, by July 1.	☐ Not Applicable	**0.000**		
Findings **Strength** **AON** **Suggestion**					
8. Subcontractor Agreement Availability DSC 3-30	The DBM must make any agreement it has with a subcontractor or affiliate available to FHKC within seven business days of FHKC's request.	☐ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
Subcontractual Relationships and Delegation			**XX.X%**	**8.000**	**X.XXX**

MCO and DBM Denials File Review Tool

Utilization Management Denials File Review Tool																			
MCO/DBM: <MCO/DBM Name>																	Date:	<MM/DD/YY>	
1	2	3	4		5			6		7		8	9	10	11	12		13	
File #	Case ID*	Date Request Received	Appropriate Review Criteria Used		Requesting Provider Consulted			Final Denial Decision by Qualified Professional		Decision NOT Arbitrary = Yes		E/S**	Date Notified	# of Days for Notification	Notification Time Standard	Notification Time Standard Met		NABD†† Content Complete	
			Y	N	Y	N	N/A †	Y	N	Y	N					Y	N	Y	N
1																			
2																			
3																			
4																			
5																			
6																			
7																			
8																			
9																			
10																			
Compliant Answers			0		0			0		0						0		0	
Applicable Answers			0		0			0		0						0		0	

Total Compliant:	0
Total Applicable:	0
Percent Compliant:	#DIV/0!

** Case identifications (IDs) have been used to protect enrollee information.*

† Not applicable

*** Expedited or standard*

†† Notification of adverse benefit determination

ANA

The ANA tool templates for appointment availability were used to assess appointment availability for FHKC's MCOs and DBMs as part of the 2022 ANA.

2022 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.		

2022 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), 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
Pediatric Specialists	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
Pediatric Specialist	
Pediatric Cardiology	P008

MCO Provider/Specialty Types and Provider Categories

Specialty Type	Specialty Code
Pediatric Endocrinology	P012
Pediatric Gastroenterology	P014
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

MCO Provider/Specialty Types and Provider Categories	
Specialty Type	**Specialty Code**
Neurology	019
Oncology	021
Ophthalmology	023
Orthopedic Surgery	025
Podiatry	028
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
Prosthodontists	206
Orthodontists	202