April 2024

2023 Annual

Quality Review Technical Report

Florida Healthy Kids Children's Health Insurance Program

Review Period: January 1, 2022 – December 31, 2022

Final

HealthyKids™

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Table of Contents

Table of Contents

List of Tables

Acknowledgements, Acronyms, and Initialisms[1]

AAAHC ..... Accreditation Association for Ambulatory Health Care
AAB ..... Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
ACA ..... Affordable Care Act
ADD ..... Improving Care Coordination to Improve Follow-Up Care for Children Prescribed ADHD Medication
ADD-E ..... Follow-Up Care for Children Prescribed ADHD Medication
ADV ..... Annual Dental Visit
Aetna ..... Aetna Better Health of Florida
AHCA ..... Agency for Healthcare 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 abuse/dependence
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
BH ..... Behavioral Health
BR ..... Biased Rate
CA ..... Compliance Assessment
CAHPS® ..... Consumer Assessment of Healthcare Providers & Systems
CAP ..... Corrective Action Plan
CCP ..... Community Care Plan
CCP ..... Contraceptive Care – Postpartum Women Ages 15−20
CCW ..... Contraceptive Care – All Women Ages 15−20
CDF-CH ..... 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 / Manager
CMS ..... Centers for Medicare & Medicaid Services
CPC ..... CAHPS Health Plan Survey 5.1H, Child Version
CWP ..... Appropriate Testing for Pharyngitis
CY ..... Calendar Year
DentalTrac™ ..... a registered trademark of MCNA Systems Corporation
DentaQuest ..... DentaQuest of Florida, Inc.
DMH ..... Diagnosed Mental Health Disorders
DOH ..... Department of Health
DSC ..... Dental Services Contract
DSF-E ..... Depression Screening and Follow-up for Adolescents and Adults
DSU ..... Diagnosed Substance Use Disorders
ED ..... Emergency Department
EI ..... Enrollee Information
EQR ..... External Quality Review
EQRO ..... External Quality Review Organization
ER ..... Enrollee Rights and Protections
ER ..... Emergency Room
FAR ..... Final Audit Report
FFS ..... Fee-For-Service
FHKC ..... Florida Healthy Kids Corporation

[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.*

FPL ..... Federal Poverty Level
FUA ..... Follow-up After Emergency Department Visit for Drug Abuse or Dependence
FUH ..... Follow-up After Hospitalization for Mental Illness
FUM ..... Follow-Up After Emergency Department Visit for Mental Illness
HEDIS® ..... Healthcare Effectiveness Data and Information Set, a registered trademark of the NCQA
HHS ..... U.S. Department of Health and Human Services
HNS ..... Health Needs Screening
IDSS ..... Interactive Data Submission System
IET ..... Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
IMA ..... Immunizations for Adolescents
IOP ..... Intensive Outpatient
IS ..... Information System(s)
ISCA ..... Information Systems Capability Assessment
ISCAT ..... Information Systems Capability Assessment Tool
IT ..... Information Technology
Liberty ..... Liberty Dental Plan
LTSS ..... Long Term Support Services
MCNA ..... Managed Care of North America
MMA ..... Managed Medical Assistance
MSC ..... Medical Services Contract
MY ..... Measurement Year
N ..... No/Number
NA ..... Not Applicable
NA ..... Small Denominator
NCQA ..... National Committee for Quality Assurance
NCQA HEDIS Compliance Audit™ ..... a trademark of NCQA
NP ..... Nurse Practitioner
NPI ..... National Provider Identifier
NQ ..... Not Required (PMV)
NR ..... Not Reported (PMV)
OPA ..... Office of Population Affairs
PA ..... Physician's Assistant
P&P ..... Policy and Procedure
PC-02 ..... Cesarean Birth
PCP ..... Primary Care Provider/Physician
PDENT ..... Enrolled Children Receiving Preventive Dental Services
PDSA ..... Plan-Do-Study-Act
PHP ..... Partial Hospitalization
PIP ..... Performance Improvement Project
PMV ..... Performance Measure Validation
PPC ..... Prenatal and Postpartum Care
QAPI ..... Quality Assessment and Performance Improvement
QI ..... Quality Improvement
QP ..... Quality Performance
Qsource® ..... EQRO, a registered trademark
R ..... Reportable Rate
Roadmap ..... Record of Administrative Data Management and Processes
SEAL ..... Enrolled Children Receiving Dental Sealants on Permanent Molars – With Exclusions
Simply ..... Simply Healthcare Plans, Inc.
SQL ..... Structured Query Language
SUD ..... Substance Use Disorder
TDENT ..... Enrolled Children Receiving Dental Treatment Services
TJC ..... The Joint Commission
URAC® ..... Utilization Review Accreditation Commission
URI ..... Appropriate Treatment for Upper Respiratory Infection
WCC ..... Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
WCV ..... Child and Adolescent Well-Care Visits

Overview

In accordance with Title 42 *Code of Federal Regulations* (CFR) § 438.364, Qsource has produced this *2023 Annual External Quality Review Organization (EQRO) Technical Report* to summarize the quality, timeliness, and accessibility of care furnished to enrollees in the Florida Healthy Kids program by the managed care organizations (MCOs) and dental benefit managers (DBMs) contracted by the Florida Healthy Kids Corporation (FHKC) and to identify areas for improvement and recommend interventions to improve the process and outcomes of care. Title 42 of the CFR governs that states providing Children's Health Insurance Program (CHIP) services through contracts with MCOs/DBMs are required by federal mandate (42 CFR §§ 438.310–438.370, incorporated in § 457.1250) to conduct external quality review activities and ensure that the results of those activities are used to perform an external, independent assessment and produce an annual report. This section provides a brief history of FHKC, the organization's strategy for the Florida Healthy Kids program, EQR activities conducted in 2023, the guidelines for this report, and intended uses for this report.

Florida Healthy Kids Background

Created in 1990 by the Florida legislature, FHKC aims to improve access to medical and dental health insurance for the state's uninsured children, ages 5 to 18 years. In 1997, Florida Healthy Kids became one of three state programs grandfathered into the original CHIP legislation created through Title XXI of the *Social Security Act* and reauthorized in 2009. FHKC is one of four Florida KidCare partners: Florida Healthy Kids, Medicaid, MediKids, and Children's Medical Services. Together, these four state healthcare programs for children make up the Florida KidCare program, covering children from birth through age 18. Florida Healthy Kids includes subsidized health and dental insurance for children ages five through 18 years whose families exceed the income eligibility threshold for Medicaid but whose income does not exceed 200% of the federal poverty level. Florida Healthy Kids also includes a full-pay option that is not part of CHIP and is available to Florida children whose family income exceeds 200% of the federal poverty level.

As of June 2023, Florida has enrolled 4,751,303 individuals in Medicaid and CHIP — a net increase of 28.58% since the first Marketplace Open Enrollment Period and related Medicaid program changes in October 2013. Florida has adopted one or more of the targeted enrollment strategies outlined in guidance CMS issued on May 17, 2013, designed to facilitate enrollment in Medicaid and CHIP. All Plans, with the exception of Community Care Plan (CCP), service all 67 counties in Florida. CCP provides services for Florida Healthy Kids enrollees in eight counties (Broward, Indian River, Martin, Miami-Dade, Monroe, Okeechobee, Palm Beach, and St. Lucie).

In 2022, the measurement year (MY) under review, three MCOs and three DBMs operated in Florida:

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

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

FHKC Quality Strategy Plan

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

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

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

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

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

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

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

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

Table 1. Quality Strategy Goals and Alignment

FHKC Goals	Primary Area of Focus	CMS Quality Strategy Alignment	FHKC Steps
Quality: Ensure child-centered standards of health care excellence in all Florida Healthy Kids plans.	Quality Assurance	Quality of Care	FHKC monitors quality assurance for the Florida Healthy Kids program through continuous quality improvement requirements for the Plans as well as annual EQR activities. FHKC's Plans must maintain an ongoing quality improvement plan that meets the following requirements: ♦ Objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered; ♦ Promotes quality of care and quality patient outcomes; and ♦ Demonstrates specific interventions to better manage the care of and promote healthier outcomes for enrollees. These qualities ensure health care excellence from all Plans.
Satisfaction: Fulfill child health care insurance		Quality of Care, Timeliness of Care, and Access to Care	FHKC's Plans are required to maintain quality improvement plans that include written policies and procedures for effective health care management including anticipation, identification,

Table 1. Quality Strategy Goals and Alignment

FHKC Goals	Primary Area of Focus	CMS Quality Strategy Alignment	FHKC Steps
expectations and the needs of families.			monitoring, measurement, and evaluation of enrollees' health care needs, as well as effective action to promote quality of care. The Plans define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management. It is FHKC's belief that satisfying the needs of patients and providers can only occur through the constant monitoring and improvement of these aspects.
Leadership: Provide direction and guidance to efforts that enhance child health care in Florida.		Quality of Care and Access to 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 Plans to meet network adequacy time and distance standards established in the Quality Strategy Plan and supported by the Plan contracts. FHKC also requires each Plan to demonstrate its capacity to service the expected population of Florida Healthy Kids enrollees and to adhere to time standards for providing 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.
Growth: Increase enrollment and retention.	Access to Quality Care	Quality of Care, Timeliness of Care, and Access to Care	Access to care is just as critical for enrollee health outcomes as quality of care, both of which are lynchpins in enrollment

Table 1. Quality Strategy Goals and Alignment

FHKC Goals	Primary Area of Focus	CMS Quality Strategy Alignment	FHKC Steps
			and retention. Access to care and quality of care may be monitored through the following EQR activities: ♦ Annual Network Adequacy ♦ Annual Compliance Assessment ♦ Performance Improvement Projects ♦ Performance Measure Validation
Effectiveness: Ensure an appropriate structure and the processes to accomplish the mission.		Quality of Care and Access to Care	For quality care to be effective, it must be delivered in an appropriate timely manner. Thus, various standards for timely care were monitored through Plan compliance with federal and state and contractual regulations; the Plans' network adequacy to deliver services timely; and Plan timeliness in processing prior authorization requests, claims, grievances, and appeals. These aspects are monitored through the following annual EQR activities: ♦ Annual Compliance Assessment ♦ Annual Network Adequacy
Advancement: Maintain necessary resources and authority to achieve the mission.		Quality of Care	Serving as an EQRO for the CMS EQR Protocol activities, FHKC has partnered with Qsource to provide FHKC and its MCOs and DBMs with technical assistance as defined by 42 CFR § 438.358 and incorporated by 42 CFR § 457.1250. In this capacity, Qsource maintained ongoing, collaborative communication with FHKC and supported the Plans in their EQR activities. Qsource also helps FHKC and its Plans with advancement of education, conducting three health and dental All-Plan meetings that were attended by FHKC, MCO, and DBM staff.

Quality Strategy Conclusions

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

EQR Activities

As set forth in Title 42 *Code of Federal Regulations,* Section 438, Part 358 (42 § 438.358), incorporated by 42 CFR § 457.1250, there are four mandated and six optional EQR activities. In addition, a state agency can assign other responsibilities to its designated EQRO. This section summarizes the mandatory activities that Qsource performed for FHKC in 2023, in accordance with the CMS *External Quality Review Protocols* (released in 2019).

EQR Mandatory Activities

Following the CMS Protocols published in October 2019, Qsource conducted the EQR activities shown in **Table 2**.

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

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

Table 2. EQR Activities Conducted in 2023

Protocol #	Activity Name	Mandatory or Optional	Measurement Period
1	Validation of Performance Improvement Projects	Mandatory	January 1, 2022 – December 31, 2022
2	Validation of Performance Measures	Mandatory	January 1, 2022 – December 31, 2022
3	Review of Compliance	Mandatory	January 1, 2022 – December 31, 2022
4	Validation of Network Adequacy	Mandatory	January 1, 2022–

			December 31, 2022

Technical Report Guidelines

Qsource is responsible for the creation and production of this *2023 Annual EQRO Technical Report*, which compiles the results of these EQR activities. To assist both EQROs and state agencies, CMS supplemented the requirements of 42 CFR § 438.364, as incorporated by 42 CFR § 457.1250, and provided guidelines in the 2019 EQR Protocols for producing annual technical reports.

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

- Protocol 1. Validation of Performance Improvement Projects
- Protocol 2. Validation of Performance Measures
- Protocol 3. Annual Compliance Assessment
- Protocol 4. Validation of Network Adequacy

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

1. A brief description of the data collection, aggregation, and analyses for each of the EQR compliance activities;
2. A summary of findings from each review;
3. Strengths and weaknesses demonstrated by each Plans in providing healthcare services to enrollees;
4. Recommendations for improving the quality of these services, including how FHKC can target goals and objectives in achieving the goals of the quality strategy to better support improvement; and
5. Comparative information regarding the Plans, consistent with CMS EQR Protocol guidance.

The *2023 Annual EQRO Technical Report* provides FHKC with substantive, unbiased data on the Plans as well as recommendations for action toward far-reaching performance improvement. This report is based on detailed findings that can be reviewed in the individual EQR activity reports provided to FHKC. Recommendations for how to utilize Qsource's findings can be found in the **Conclusions and Recommendations** section of this report.

The appendices provide additional EQR activity information:

- **Appendix A** | PMV Measure Rates
- **Appendix B** | 2023 Sample Assessment Tools and Instructions
- **Appendix C** | ACA Quality Performance (QP) Tool with NCQA Crosswalk

EQRO Team

The review team included the following staff:

- Rebel McKnight, Qsource, EQRO Director
- Hira Siddiqui, Qsource, Florida Program Manager

- Jazzmin Kennedy, Qsource, Clinical Quality Improvement Advisor
- Albert Kennedy, Qsource, Technical Writer
- Fidencio Caballero, Qsource, Healthcare Quality Analyst

Performance Improvement Project (PIP) Validation

Overview

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

As part of its external quality review contract with the Florida Health Kids Corporation, Qsource annually validates the PIPs of the managed care entities providing services for FHKC Medicaid members. Qsource's *Annual PIP Validation Reports* present validation findings by MCO or DBM Plan.

The primary objective of PIP validation is to determine each PIP's compliance with the requirements set forth in Title 42 of the *Code of Federal Regulations*, Section 438.330(d). Plans must conduct PIPs that are designed to achieve, through ongoing measurements and interventions, significant and sustained improvement in clinical and nonclinical care areas. The improvement is expected to have a favorable effect on health outcomes and enrollee satisfaction. PIP study topics must reflect enrollment in terms of demographic characteristics and, if applicable, in terms of the prevalence and potential consequences (risks) of disease as well as enrollee needs for specific services. Each PIP must be completed within a timeframe that allows PIP success-related data in the aggregate to produce new information on quality of care every year. PIPs are further defined in 42 CFR § 438.330(d) to include all the following:

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

Technical Methods of Data Collection and Analysis

Each Plan was contractually required to submit PIP studies annually to FHKC as requested. Submitted PIPs should include

the necessary documentation for data collection, data analysis plans, and an interpretation of all results. Plans should also address threats to validity of data analysis and include an interpretation of study results.

Each Plan submitted a continuation of their established PIPs as PIPs are typically conducted over a three-year period. Some of the PIPs were in their initial year with new topics being evaluated. To validate PIPs, Qsource assembled a validation team of experienced staff specializing in clinical quality improvement and a healthcare data analyst. The validation process included a review of each PIP's study design and approach, an evaluation of each PIP's compliance with the analysis plan, and an assessment of the effectiveness of interventions.

The PIP validation was based on *Centers for Medicare & Medicaid Services EQR Protocol 1: Validating Performance Improvement Projects (PIPs) 2019*. Qsource developed a PIP Summary Form (with accompanying PIP Summary Form Completion Instructions) and a PIP Validation Tool to standardize the process by which each Plan delivers PIP information to FHKC and how the information is assessed. Using Qsource's PIP Summary Form, each Plan submitted the PIP studies and supplemental information in August 2023. The MY for this validation was January 1, 2022, through December 31, 2022.

Qsource's scoring methodology determines whether a PIP is valid by rating the PIP's percentage of compliance with the *CMS EQR Protocol 1: Validating Performance Improvement Projects (PIPs) 2019.* Qsource developed a PIP Validation Tool used internally by members of the validation team to standardize the process by which each PIP is evaluated across all Plans. Each PIP involves nine required activities, and each activity consists of one or more elements essential to the successful completion of a PIP. The elements within each activity are scored as Met, Not Met, or Not Applicable.

Table 3 presents the validation status criteria for the PIPs.

Table 3. PIP Validation Status Criteria

Status	Criteria
High Confidence	Of all elements assessed, 90–100% were met across all activities.
Moderate Confidence	Of all elements assessed, 80–<90% were met across all activities.
Low Confidence	Of all elements assessed, 70–<80% were met across all activities.
No Confidence	Less than 70% of all elements were met.

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

Table 4. PIP Assessment Steps

Step	PIP Activity
1	State the Selected PIP Topic
2	State the PIP Aim Statement

3	Identify the PIP Population
4	Describe the Sampling Method
5	Describe the Selected PIP Variables and Performance Measures
6	Describe Valid and Reliable Data Collection Procedures
7	Analyze Data and Interpret PIP Results
8	Describe Improvement Strategies
9	Assess for Significant and Sustained Improvement

Validation of PIP Topics

The Plans are required to produce a non-clinical PIP and a clinical PIP topic. Qsource received and assessed PIP Summary forms for the following PIP topics in **Table 5**.

Table 5. 2023 PIP Validation Rating and Overall Score

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 Hospitalized for Mental Illness 7-day (FUH 7-day)	✓	✓		High Confidence	100%
CCP	Clinical	Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)	✓	✓		Low Confidence	79.10%
	Nonclinical	Timely Follow-up for Patients After Hospitalized for Mental Illness 7-day (FUH 7-day)	✓	✓		High Confidence	94.74%
DentaQuest	Clinical	Preventative Dental	✓	✓	✓	High Confidence	93.48%
	Nonclinical	Increasing After-hours Care	✓		✓	Moderate Confidence	88.40%
Liberty	Clinical	Increase the Percentage of Enrollees Receiving Preventive Dental Services	✓	✓	✓	High Confidence	96.77%

	Nonclinical	Access to Care in Rural and Urban Counties		✓	✓	High Confidence	96.55%
MCNA	Clinical	Preventative Dental Visit	✓	✓	✓	High Confidence	100%
	Nonclinical	Annual Dental Visit (ADV)	✓	✓	✓	High Confidence	100%
Simply	Clinical	Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)	✓	✓		High Confidence	100%
	Nonclinical	Improving Care Coordination to Improve Follow-Up Care for Children Prescribed ADHD Medication (ADD)	✓	✓		High Confidence	100%

Strengths, Weaknesses and Recommendations

Table 6 includes strengths and Table 7 includes weaknesses and recommendations. Strengths for the PIP validation indicate that the Plans demonstrated proficiency on a given activity and can be identified regardless of validation rating. The lack of an identified strength should not be interpreted as a shortcoming on the part of a Plan. Weaknesses, or Areas of Noncompliance (AONs), arise from evaluation elements that receive a Not Met score, indicating that those elements were not in full compliance with CMS Protocols. The recommendations were created by Qsource to address the weaknesses evaluated in the PIPs. Strengths, weaknesses, and recommendations are useful to the Plan in determining whether to continue or retire a specific PIP. Any PIP topic not listed had no strengths and/or weaknesses identified.

Table 6. PIP Strengths

MCO/DBM	PIP Title	Strengths
Aetna	*Timely Follow-up for Patients After They Have Been Hospitalized for Mental Illness—7 Days (FUH 7-day)*	**Step 3.** The MCO's approach in selecting the PIP population demonstrated progressive thought in capturing participants that fit into the criteria for this PIP. The PIP population strategy focused on "all continuously enrolled FHK members (6 years of age or older as of the date of discharge) with an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm during the measurement year."

Table 7. PIP Weaknesses (AONs) and Recommendations		
MCO/DBM	**PIP Title**	**AONs and Recommendations**
CCP	*Timely Follow-up for Patients After They Have Been Hospitalized for Mental Illness—7 Days (FUH 7-day)*	**Step 2.** The MCO should clearly specify the PIP Aim Statement.
		Step 7. The MCO should compare results across multiple entities and include a comprehensive analysis and interpretation of results consistent with the data analysis plan.
	Screening for Depression and Follow-Up Plan Ages 12 to 17 (CDF-CH)	**Step 6.** The MCO stated data was collected administratively and through medical record review/hybrid data collection; however, no information regarding Elements 9, 10, and 11 was provided. The MCO should include information regarding medical record review/hybrid data collection.
		Step 7. The MCO should compare results across multiple entities and include a comprehensive analysis and interpretation of results consistent with the data analysis plan.
		Step 8. The MCO should address the evidence basis of the improvement strategies selected. The MCO should describe how the strategies were related to causes/barriers identified through data analysis. The MCO should include evidence of how the strategies were implemented on a Plan-Do-Study-Act (PDSA) cycle. The MCO should describe how the member-focused strategies were culturally and linguistically appropriate. The MCO should address how the improvement strategies accounted for major confounding factors identified. The MCO should describe the level of success of the strategies and identify follow-up activities planned.
		Step 9. The MCO should include information on whether sustained improvement was demonstrated.
DentaQuest	*Preventative Dental*	**Step 9.** The DBM should ensure improvement strategies are modified to achieve improvement.
	Increasing After Hours Care	**Step 8.** The DBM should ensure improvement strategies are designed to account or adjust for any major confounding factors that could have an obvious impact on PIP outcomes. MCO should ensure improvement strategies are consistent.

Table 7. PIP Weaknesses (AONs) and Recommendations		
MCO/DBM	**PIP Title**	**AONs and Recommendations**
		Step 9. The DBM should ensure improvement strategies are modified to achieve improvement.
Liberty	*Increase the Percentage of Enrollees Receiving Preventive Dental Services*	**Step 5.** The DBM should provide baseline, benchmark, and goal rates for the PIP.
	Access to Care in Rural and Urban Counties	**Step 5.** The DBM should provide baseline, benchmark, and goal rates for the PIP.

Interventions

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

Table 8. 2023 PIP Interventions		
MCO/DBM	**PIP Title**	**Interventions**
Aetna	*Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)*	ABHFL distributed provider bulletins to all FHK providers notifying them of the reimbursement rates for the depression screening codes.
	Timely Follow-up for Patients After They Have Been Hospitalized for Mental Illness—7 Days (FUH 7-day)	Member Outreach calls placed by ABHFL BH Liaisons to members (or their parents/guardians) during or after the child's acute BH hospitalization or BH residential treatment to obtain and if need be, verify aftercare appointment information (date/time/provider) OR to coordinate aftercare appointments with a licensed MH professional within 7 or 30 days of discharge if appointment has not been made by facility within the specified time frame.
CCP	*Screening for Depression and Follow-Up Plan Ages 12 to 17 (CDF-CH)*	Education of provider offices on coding the depression screening completion on encounter submissions or submitting a separate data file pulled from their EHR.
		Collect medical records as non-standard supplemental data.

Table 8. 2023 PIP Interventions		
MCO/DBM	**PIP Title**	**Interventions**
DentaQuest	*Preventative Dental*	Orthodontist educates DQ patient (members) who have not received preventive 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 preventive 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 preventive visit. DQ hoped the RX Tear pads would increase PDENT visits among the members.
		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. DQ sought to increase the PDENT rate among these members.
		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. DQ sought to increase the PDENT score among these members.
		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. DQ sought to increase the PDENT score among these members.
		Live calls with scheduling assistance to members aged 6-14 in Broward County.
		Members receive notification of their assigned a Primary Dental Home provider that includes contact information to facilitate scheduling a visit. This will remove any barriers and accompanying frustration around researching and finding a provider and their contact information. This notification educates members and prompts them to schedule a preventive visit.
		IVR calls members overdue for preventive dental visit.
		Provider Notification of non-compliant membership
	Increasing After Hours Care	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.

Table 8. 2023 PIP Interventions		
MCO/DBM	**PIP Title**	**Interventions**
		Members with no dental visit in the previous 6 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.
		Providers were contacted by members of the DQ provider 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.
		Providers that offered care to FHKC members during regular business hours were contacted by DQ provider engagement team and inquired if have expanded their hours beyond normal business hours and if not, requested to expand hours.
		Providers that offered care to FHKC members were contacted by DQ and offered a $5 fee increase on four preventative dental codes, including D0150, D1110, D1120, and D1351.
MCNA	*Preventative Dental Visit*	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 preventive 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 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.
		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.
		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.
		Quarterly profiling report that educates offices on their performance and assists clinicians and their staff to eliminate administrative inefficiencies and showcase their utilization rates in comparison with their peers.

Table 8. 2023 PIP Interventions		
MCO/DBM	**PIP Title**	**Interventions**
Simply	*Annual Dental Visit (ADV)*	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 preventive 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 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.
		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.
		MCNA 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.
		Conduct outbound calls to members who have not had a dental visit within the last six months to encourage them to schedule an appointment.
	Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)	The Plan identify enrollees with an outpatient visit ages 12 to 17 with a current Behavioral Health dx. Identification of these individuals and follow-up education the provider to promote compliance is expected to contribute to improvement in compliance, as the provider can ensure appropriate screening tools are being utilized and correct codes are submitted.
	Improving Care Coordination to Improve Follow-Up Care for Children Prescribed ADHD Medication (ADD)	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 BH Providers. This was designed to address gaps in communication among PCPs and BH prescribers.

Comparison PIP Improvements

Table 9 compares PIP scores from MY 2021 to MY 2022. Notable improvements from the previous measurement year are indicated using a green upward arrow (↑) and notable decreases in performance are indicated using a red downward arrow (↓). Liberty is not included in the table as MY 2022 was its first year to submit PIPs.

Table 9. PIP Performance Comparison

MCO/DBM	PIP Name	MY 2021 Validation Rating	MY 2022 Validation Rating	MY 2021 Overall Score	MY 2022 Overall Score
Aetna	Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH)	High Confidence	High Confidence	100%	100%
	Timely Follow-up for Patients After Hospitalization for Mental Illness 7-day (FUH 7-day)	High Confidence	High Confidence	100%	100%
CCP	Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)	High Confidence	Low Confidence	90.91%	79.10% ↓
	Timely Follow-up for Patients After Hospitalization for Mental Illness 7-day (FUH 7-day)	Low Confidence	High Confidence	78.72%	94.74% ↑
DentaQuest	Preventative Dental	High Confidence	High Confidence	100%	93.48% ↓
	Increasing After-hours Care	High Confidence	Moderate Confidence	100%	88.40% ↓
MCNA	Increase the Percentage of Enrollees Receiving Preventive Dental Services	High Confidence	High Confidence	97.78%	100% ↑
	Access to Care in Rural and Urban Counties	High Confidence	High Confidence	100%	100%

Table 9. PIP Performance Comparison					
MCO/DBM	**PIP Name**	**MY 2021 Validation Rating**	**MY 2022 Validation Rating**	**MY 2021 Overall Score**	**MY 2022 Overall Score**
Simply	Preventative Dental Visit	High Confidence	High Confidence	93.33%	100% ↑
	Annual Dental Visit (ADV)	High Confidence	High Confidence	93.47%	100% ↑

Table 10 shows how the plans addressed recommendations from MY 2021 in MY 2022. Liberty is not included in the table as MY 2022 was their first year to submit PIPs.

Table 10. MY 2021 Recommendations Addressed in MY 2022	
Aetna	♦ In MY 2021, Aetna submitted two PIPs, one clinical and one non-clinical. Each PIP received 100% High Confidence rating with no AONs, or recommendations noted. ♦ In MY 2022, Aetna submitted the same two PIPs and each PIP received 100% High Confidence rating with no AONs or recommendations noted. ♦ Aetna did an excellent job ensuring all step elements were captured and well communicated throughout the PIPs.
CCP	♦ In MY 2021, CCP submitted a clinical PIP, Screening for Depression and Follow-Up Plan Ages 12 to 17 (CDF-CH) and received a score of 90.91% and a rating of High Confidence. ♦ In MY 2022, CCP submitted the same PIP, CDF-CH and received a score of 79.10% and a rating of Low Confidence. ♦ The Suggestions and AONs from MY 2021 evaluation were not addressed in the MY 2022 PIP. ♦ Suggestions were noted for Steps 7 and 8 and an AON was administered on Step 8 for MY 2021. In MY 2022, AONs were noted for Step 6, Step 7, and Step 8. ♦ In MY 2021, CCP submitted a non-clinical PIP, Timely Follow-up for Patients After They Have Been Hospitalized for Mental Illness—7 Days (FUH 7-day) and received a score of 78.72% and a rating of Low Confidence. AONs were noted for Step 1, 5, 8 and 9.

Table 10. MY 2021 Recommendations Addressed in MY 2022	
	♦ In MY 2022, CCP submitted an updated PIP for FUH 7-day and received a score of 94.74% with a rating of High Confidence. AONs were given for Step 2 and 7. ♦ The Suggestions and AONs from MY 2021 evaluation were not addressed in the MY 2022 PIP.
MCNA	♦ In MY 2021, MCNA submitted a clinical PIP, Preventative Dental Visit and received a score of 97.78% and a rating of High Confidence. ♦ In MY 2022, MCNA submitted the same PIP, Preventative Dental Visit and received a score of 100% and a rating of High Confidence. ♦ MCNA followed Qsource's recommendations from MY 2021 and improved their PIP scores to 100%. MCNA did an excellent job ensuring all step elements were captured and well communicated throughout the PIPs.
Simply	♦ In MY 2021, Simply submitted a clinical PIP, Screening for Depression and Follow-Up Plan Ages 12 to 17 (CDF-CH) and received a score of 93.33% and a rating of High Confidence. ♦ In MY 2022, Simply submitted the same PIP, Preventative Dental Visit and received a score of 100% and a rating of High Confidence. ♦ Simply followed Qsource's recommendations from MY 2021 and improved their PIP scores to 100%. Simply did an excellent job ensuring all step elements were captured and well communicated throughout the PIPs. ♦ In MY 2021, Simply submitted a non-clinical PIP, Improving Care Coordination to Improve Follow-Up Care for Children Prescribed ADHD Medication (ADD) and received a score of 93.47% and a rating of High Confidence. ♦ In MY 2022, Simply submitted the same PIP, ADD, and received a score of 100% and a rating of High Confidence. ♦ Simply followed Qsource's recommendations from MY 2021 and improved their PIP scores to 100%. Simply did an excellent job ensuring all step elements were captured and well communicated throughout the PIPs.

Conclusions and Recommendations

Aetna

Aetna submitted complete and thorough PIPs for both their non-clinical and clinical. Aetna demonstrated a sound study design for their two PIPs and created the foundation for Aetna to continue implementing improvement strategies and achieving real, sustainable study outcomes. Each of the PIPs received a score of 100%.

Aetna appropriately conducted and selected the sampling and data collection activities. These activities ensured that Aetna correctly defined and collected the necessary data to produce accurate study indicator results. In general, the MCO utilized accurate methodology across all the PIPs, which factored into improvement over the course of 2022.

Aetna plans to incorporate new interventions to achieve sustained, real improvement as the PIP evolves over the course of implementation.

CCP

CCP's PIP submissions were the same for MY 2022 as MY 2021. CCP received an average score of 86.92% for MY 2022, an increase from the MY 2021 average of 84.82%.

CCP did not include information or documentation for several steps. The missing information compromised the PIP results and the validity of the studies.

The PIP scores for each submitted PIP indicated that CCP must address the AONs noted by Qsource before the PIP can aid in increasing quality of care, timeliness of care, and access of care for enrollees.

The following recommendations should be incorporated into CCP's PIP activities:

1. The MCO should define their data collection procedures to ensure that the data used to measure performance is valid and reliable.
2. The MCO should conduct cause and barrier analyses more frequently and incorporate quality improvement science such as Plan-Do-Study-Act (PDSA) cycles into its improvement strategies and action plans. The data and results of specific PDSA cycles should be included in the PIP documentation.
3. The MCO should ensure completion of all the PIP steps.

DentaQuest

DentaQuest's PIP submissions for MY 2022 show an overall decrease from MY 2021. In MY 2021, DentaQuest scored 100% on both PIPs; however, in MY 2022, the clinical PIP scored 93.48% and the nonclinical PIP scored 88.40%. While DentaQuest appropriately conducted and selected the data collection activities, the improvement strategies that were put

into place for MY 2022 lacked modification to account for confounding factors or consistency.

The following recommendations should be incorporated into DentaQuest's PIP activities:

1. The DBM should ensure improvement strategies are designed to account or adjust for any major confounding factors that could have an obvious impact on PIP outcomes. MCO should ensure improvement strategies are consistent.
2. The DBM should ensure improvement strategies are modified to achieve improvement.

Liberty

MY 2022 was the first year for Liberty to submit PIPs to the EQRO. Overall, Liberty's two PIPs were well planned and followed their strategy for both PIPs. Liberty scored an average of 96.66% on their PIPs.

MCNA

MCNA demonstrated sound study design for their PIPs and created the foundation for continuous implementation of improvement strategies and achieving real, sustainable study outcomes. Each of the PIPs received a score of 100%, which was an increase for the *Increase the Percentage of Enrollees Receiving Preventive Dental Services* PIP, which scored 97.78% in MY 2021.

Simply

Simply demonstrated a sound study design for their PIPs and created the foundation for continued implementation of improvement strategies and achieving real and sustained study outcomes. Simply's PIPs for MY 2022 were evaluated as High Confidence with a score of 100%, an increase from the MY 2021 average of 93.40%. Simply appropriately conducted and selected the sampling and data collection activities. These activities ensured that Simply properly defined and collected the necessary data to produce accurate study indicator rates.

Performance Measure Validation (PMV)

Overview

The Balanced Budget Act of 1997 established certain managed care quality safeguards that were further described by Title 42 of the Code of Federal Regulations, Section 438.320 (42 CFR § 438.320), which defines "external quality review" as the "analysis and evaluation … of aggregated information on quality, timeliness, and access to health care services. To satisfy CMS Protocols for the Plans and to meet the requirements set forth in 42 CFR § 438.330(c), FHKC selected a process for an

objective, comparative review of performance measures related to quality-of-care outcomes. The primary aim of PMV is to evaluate the accuracy of MCO- and DBM-reported performance measures and to determine whether those measures were calculated according to required technical specifications. To satisfy CMS protocol for MCOs/DBMs and to meet the requirements set forth in 42 CFR § 438.330(c), as incorporated by 42 CFR § 457.1250, FHKC selected a process for an objective, comparative review of quality measures.

The PMV included validation of performance measures for the Plans providing care services for enrollees. The measurement year for this validation was January 1, 2022, through December 31, 2022 (MY 2022).

The 2023 PMV, which validates performance measures for MY 2022, was conducted virtually. The validation activities for these measures were conducted as outlined in Centers for Medicare & Medicaid Services' *EQR Protocol 2: Validation of Performance Measures (October 2019)*. Per the protocol, the Plans should complete an Information Systems Capabilities Assessment Tool (ISCAT) that the EQRO uses to validate information systems, processes, and data. Protocol guidance indicates that the EQRO may review results from a recent comprehensive, independent assessment of the Plan's information systems, such as the HEDIS Compliance Audit, conducted in the previous two years provided that the HEDIS measures were calculated using National Committee for Quality Assurance HEDIS-certified software and all non-HEDIS rates were included under the scope of the HEDIS audit.

Description of Performance Measures Data Obtained for Validation

FHKC identified for validation 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 2023 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 2023 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 2023 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

Pre-Review Strategy

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 2023 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:** If the DBM completed an ISCAT in 2022, CMS does not require another one to be completed for 2 years unless significant system changes occur during the review year. Completed ISCATs from 2022 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. 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; and
  - A closing session summarizing preliminary findings and recommendations.

Description of Data Obtained

Table 11 lists the audited measures for MCOs, and Table 12 lists the audited measures for DBMs. Age stratifications that do not apply to the Florida Healthy Kids population (ages 5–18 years) have been omitted. In the case that a measure had an overlapping age stratification that does apply to Florida Healthy Kids enrollees, data for that category 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 11. 2023 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 11. 2023 PMV: MCO Performance Measures			
Quality	**Timeliness**	**Access**	**Measure**
✓	✓		Chlamydia Screening in Women (CHL)
✓	✓		Immunizations for Adolescents (IMA-E)
✓	✓	✓	Child and Adolescent Well-Care Visits (WCV)
			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
✓	✓		Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)
✓			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-E)
✓	✓		Depression Screening and Follow-up for Adolescents and Adults (DSF-E)
✓	✓		Follow-Up After Hospitalization for Mental Illness (FUH)
✓	✓		Follow-Up After Emergency Department Visit for Mental Illness (FUM)
✓	✓		Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
✓		✓	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

Table 11. 2023 PMV: MCO Performance Measures			
Quality	**Timeliness**	**Access**	**Measure**
✓	✓		Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
✓	✓	✓	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
✓			Diagnosed Substance Use Disorders (DSU)
✓			Diagnosed Mental Health Disorders (DMH)
			Experience of Care
✓			CAHPS Health Plan Survey 5.1H, Child Version (CPC)

Table 12. 2023 PMV: DBM Performance Measures			
Quality	**Timeliness**	**Access**	**Measure**
✓	✓	✓	Enrolled Children Receiving Dental Sealants on Permanent Molars (SEAL)
✓	✓	✓	Enrolled Children Receiving Dental Sealants on Permanent Molars – With Exclusions (SEAL – 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 2022 PMV to the 2023 PMV. To better identify trends for these measures, the use of green and red arrows is used to indicate this year's result for each measure as compared to results from 2022. Table 13 and Table 14 indicate an increase (↑), decrease (↓), or no change (←→) from the previous year's rate.

Compared to 2022, 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 49 measures trending positively in 2023. CCP was also noted to have 30 measures with significant (>10.00%) improvement between MY 2021 to MY 2022, the most among the MCOs. CCP had less measures trending down (16) compared to Aetna and Simply during the same time. Simply reported 31 measures as trending positively compared to Aetna's reported 26 measures. Aetna also reported 54 measures trending down while Simply reported 46 measures trending down for 2023.

Similar to the MCOs (with the exception of CCP), DBMs had more measures decline than improve in the same measurement period. For the DBMs, MCNA had the most improvements for MY 2022 with a total of 58 measures improving from MY 2021, while 71 measures declined. DentaQuest improved performance in 31 measures while declining in 98. MY 2022 was Liberty's first PMV; therefore, comparison to the previous year was not applicable.

Table 13. 2022 and 2023 PMV Measure Results: MCOs

Measure	Aetna		Community Care		Simply Healthcare	
	2022	2023	2022	2023	2022	2023
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	84.74%	93.78% ↑	NA	90.00% ↑	88.06%	87.62% ↓
BMI Percentile: 12–17 Years	84.16%	89.11% ↑	NA	88.56% ↑	84.76%	88.04% ↑
BMI Percentile Total	84.43%	91.48% ↑	NA	89.29% ↑	86.37%	87.83% ↑
Chlamydia Screening in Women (CHL)						
16–20 Years	48.65%	52.67% ↑	55.91%	56.99% ↑	49.66%	52.63% ↑
Immunizations for Adolescents (IMA)						
Meningococcal	79.32%	78.59% ↓	NA	83.94% ↑	82.48%	80.78% ↓
Tdap	93.67%	93.19% ↓	NA	93.92% ↑	95.38%	91.48% ↓

Table 13. 2022 and 2023 PMV Measure Results: MCOs						
Measure	Aetna		Community Care		Simply Healthcare	
	2022	2023	2022	2023	2022	2023
Human Papillomavirus (HPV)	42.34%	37.47% ↓	NA	38.44% ↑	43.31%	44.04% ↑
Combination #1 (Meningococcal and Tdap/Td)	78.83%	78.59% ↓	NA	83.21% ↑	81.75%	80.29% ↓
Combination #2 (Meningococcal, Tdap/Td, and HPV)	39.90%	36.50% ↓	NA	36.98% ↑	40.63%	41.85% ↓
Child and Adolescent Well-Care Visits (WCV)						
3–11 Years	68.67%	67.97% ↓	69.32%	70.42% ↑	70.23%	67.71% ↓
12–17 Years	66.33%	65.53% ↓	68.11%	70.26% ↑	68.08%	65.98% ↓
18–21 Years	50.94%	49.84% ↓	57.96%	62.70% ↑	51.74%	51.43% ↓
Total	66.14%	65.25% ↓	67.99%	69.83% ↑	67.78%	65.57% ↓
Maternal and Perinatal Health						
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	66.67%	50.00% ↓	NA	NA	66.67%	16.67% ↓
Postpartum Care	NA	NA	NA	NA	NA	66.67% ↑
Cesarean Birth (PC-02)						
Cesarean Birth	NR	NR	NA	NA	0.00%	NA
Contraceptive Care – Postpartum Women Ages 15–20 (CCP)						
Most or moderately effective contraception – 3 days	50.00%	0.00% ↓	NA	NA	0.00%	0.00%
Most or moderately effective contraception – 60 days	50.00%	50.00%←→	NA	NA	17.00%	60.00% ↑
Long-acting reversible method of contraception (LARC) – 3 days	50.00%	0.00% ↓	NA	NA	0.00%	0.00%←→
LARC – 60 days	50.00%	0.00% ↓	NA	NA	0.00%	20.00% ↑
Contraceptive Care – All Women Ages 15–20 (CCW)						
Most effective or moderately effective method of contraception	17.52%	15.00% ↓	5.29%	11.46% ↑	16.00%	15.68% ↓
LARC	1.30%	1.00% ↓	0.07%	0.42% ↑	1.00%	1.08% ↑
Care of Acute and Chronic Conditions						

Table 13. 2022 and 2023 PMV Measure Results: MCOs						
Measure	Aetna		Community Care		Simply Healthcare	
	2022	2023	2022	2023	2022	2023
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)						
3 months–17 years	NA	42.90%	NA	35.94%	NA	42.23%
Total	NA	42.36%	NA	34.81%	NA	42.06%
Asthma Medication Ratio (AMR)						
5–11 Years	88.15%	88.34% ↑	85.00%	100% ↑	86.33%	84.74% ↓
12–18 Years	81.82%	75.11% ↓	77.78%	81.25% ↑	78.17%	77.42% ↓
Total	85.02%	81.84% ↓	82.76%	91.89% ↑	82.42%	81.41% ↓
Appropriate Testing for Pharyngitis (CWP)						
3–17 Years	74.32%	75.58% ↑	48.68%	68.31% ↑	71.97%	74.25% ↑
18–64 Years	61.94%	75.89% ↑	69.23%	40.00% ↓	64.79%	67.08% ↑
Total	73.52%	75.59% ↑	50.30%	64.71% ↑	71.52%	73.87% ↓
Appropriate Treatment for Children with Upper Respiratory Infection (URI)						
3 Months – 17 Years	93.81%	93.08% ↓	90.37%	90.51% ↑	94.72%	93.20% ↓
18–64 Years	88.00%	83.90% ↓	85.71%	89.19% ↑	86.67%	89.63% ↑
Total	93.60%	92.82% ↓	90.25%	90.47% ↑	94.44%	93.11% ↓
Ambulatory Care: Emergency Department Visits (AMB-ED) – Visits / 1,000 Enrollee Months						
1–9 Years	21.37%	352.58 (2.94%) ↓	16.39%	NA	20.14%	355.53 (2.96%) ↓
10–19 Years	20.64%	285.34 (2.38%) ↓	13.67%	NA	19.79%	274.19 (2.29%) ↓
Behavioral Healthcare						
Depression Screening and Follow-up for Adolescents and Adults (DSF-E)						
Ages 12–17 Screening	NA	8.00% ↑	NA	7.03%	NA	NA
Ages 12–17 Follow-up	NA	0.00%	NA	NA	NA	NA
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)						
Initiation Phase	38.84%	45.38% ↑	31.65%	39.29% ↑	44.28%	48.15% ↑
Continuation and Maintenance Phase	51.97%	49.30% ↓	45.45%	41.67% ↓	68.42%	64.03% ↓
Follow-Up After Hospitalization for Mental Illness (FUH)						
7-Day Follow-Up: 6–17 Years	50.00%	40.23% ↓	42.55%	42.86% ↑	41.88%	47.34% ↑

Table 13. 2022 and 2023 PMV Measure Results: MCOs						
Measure	Aetna		Community Care		Simply Healthcare	
	2022	2023	2022	2023	2022	2023
30-Day Follow-Up: 6–17 Years	71.04%	61.47% ↓	74.47%	61.90% ↓	70.48%	71.79% ↑
7-Day Follow-Up: 18–64 Years	46.88%	35.71% ↓	25.00%	50.00% ↑	32.00%	53.85% ↑
30-Day Follow-Up: 18–64 Years	68.75%	53.57% ↓	25.00%	50.00% ↑	44.00%	84.62% ↑
7-Day Follow-Up Total	49.82%	39.90% ↓	41.18%	43.48% ↑	41.34%	47.59% ↑
30-Day Follow-Up Total	70.91%	60.89% ↓	70.59%	60.87% ↓	69.05%	72.29% ↑
Follow-Up After Emergency Department Visit for Mental Illness (FUM)						
7-Day Follow-Up: 6–17 Years	34.07%	39.29% ↑	14.29%	16.67% ↑	35.58%	40.38% ↑
30-Day Follow-Up: 6–17 Years	45.05%	60.71% ↑	28.57%	50.00% ↑	53.85%	57.69% ↑
7-Day Follow-Up: 18–64 Years	18.18%	50.00% ↑	NA	NA	14.29%	0.00% ↓
30-Day Follow-Up: 18–64 Years	45.45%	50.00% ↑	NA	NA	28.57%	0.00% ↓
7-Day Follow-Up Total	32.35%	39.66% ↑	14.29%	16.67% ↑	33.33%	38.89% ↑
30-Day Follow-Up Total	45.10%	60.34% ↑	28.57%	50.00% ↑	51.39%	55.56% ↑
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)						
7-Day Follow-Up: 13–17 Years	4.55%	22.22% ↑	NA	50.00% ↑	0.00%	26.32% ↑
30-Day Follow-Up: 13–17 Years	4.55%	33.33% ↑	NA	50.00% ↑	13.33%	47.37% ↑
7-Day Follow-Up: ≥18 Years	0.00%	0.00% ↔	NA	NR	0.00%	0.00% ↔
30-Day Follow-Up: ≥18 Years	0.00%	16.67% ↑	NA	NR	0.00%	0.00% ↔
7-Day Follow-Up Total	3.23%	19.05% ↑	NA	50.00% ↑	0.00%	19.23% ↑
30-Day Follow-Up Total	3.23%	30.95% ↑	NA	50.00% ↑	9.52%	34.62% ↑
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)						
1–11 Years	50.00%	23.81% ↓	0.00%	NR	58.82%	47.37% ↓
12–17 Years	60.53%	52.85% ↓	60.00%	33.33% ↓	54.17%	51.72% ↓
Total	58.82%	48.61% ↓	50.00%	33.33% ↓	54.87%	50.65% ↓
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)						
Blood Glucose Testing: 1–11 Years	32.61%	42.86% ↓	14.29%	75.00% ↑	51.43%	40.00% ↓
Cholesterol Testing: 1–11 Years	30.43%	42.86% ↓	0.00%	75.00% ↑	31.43%	30.00% ↓
Blood Glucose and Cholesterol Testing: 1–11 Years	23.91%	39.29% ↓	0.00%	75.00% ↑	31.43%	26.67% ↓

Table 13. 2022 and 2023 PMV Measure Results: MCOs						
Measure	Aetna		Community Care		Simply Healthcare	
	2022	2023	2022	2023	2022	2023
Blood Glucose Testing: 12–17 Years	66.91%	63.16% ↓	75.00%	71.43% ↓	65.26%	63.33% ↓
Cholesterol Testing: 12–17 Years	45.72%	37.72% ↓	75.00%	47.62% ↓	46.32%	44.67% ↓
Blood Glucose and Cholesterol Testing: 12–17 Years	42.75%	36.84% ↓	66.67%	47.62% ↓	42.63%	42.00% ↓
Blood Glucose Testing Total	61.90%	60.94% ↓	52.63%	72.00% ↑	63.11%	59.44% ↓
Cholesterol Testing Total	43.49%	38.28% ↓	47.37%	52.00% ↑	44.00%	42.22% ↓
Blood Glucose and Cholesterol Testing Total	40.00%	37.11% ↓	42.11%	52.00% ↑	40.89%	39.44% ↓
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)						
Alcohol Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	46.67%	30.77% ↓	100%	NR ↓	64.71%	41.67% ↓
Alcohol Abuse or Dependence: Engagement of AOD Treatment: 13–17 Years	0.00%	0.00%←→	100%	NR ↓	0.00%	16.67% ↑
Opioid Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	100%	50.00% ↓	NA	NR←→	100%	50.00% ↓
Opioid Abuse or Dependence: Engagement of AOD Treatment: 13–17 Years	0.00%	50.00% ↑	NA	NR←→	0.00%	0.00%←→
Other Drug Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	53.75%	40.45% ↓	81.82%	100% ↑	67.37%	62.82% ↓
Other Drug Abuse or Dependence: Engagement of AOD Treatment: 13–17 Years	6.25%	5.62% ↓	9.09%	25.00% ↑	15.79%	20.51% ↑
Initiation of AOD Treatment: 13–17 Years Total	51.72%	38.46% ↓	81.82%	80.00% ↓	64.76%	57.69% ↓
Engagement of AOD Treatment: 13–17 Years Total	5.75%	5.13% ↓	9.09%	20.00% ↑	14.29%	19.23% ↑
Alcohol Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	31.25%	28.57% ↓	0.00%	NR←→	33.33%	20.00% ↓

Table 13. 2022 and 2023 PMV Measure Results: MCOs						
Measure	Aetna		Community Care		Simply Healthcare	
	2022	2023	2022	2023	2022	2023
Alcohol Abuse or Dependence: Engagement of AOD Treatment: 18+ Years	6.25%	0.00% ↓	0.00%	NR←→	0.00%	0.00%←→
Opioid Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	N/A	0.00%←→	0.00%	NR←→	100%	0.00% ↓
Opioid Abuse or Dependence: Engagement of AOD Treatment: 18+ Years	N/A	0.00%←→	0.00%	NR←→	0.00%	0.00%←→
Other Drug Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	37.25%	36.84% ↓	40.00%	NR ↓	47.62%	45.00% ↓
Other Drug Abuse or Dependence: Engagement of AOD Treatment: 18+ Years	11.76%	10.53% ↓	0.00%	NR←→	14.29%	10.00% ↓
Initiation of AOD Treatment: 18+ Years Total	32.79%	33.33% ↑	33.33%	NR ↓	46.67%	40.00% ↓
Engagement of AOD Treatment: 18+ Years Total	9.84%	7.41% ↓	0.00%	NR←→	13.33%	8.00% ↓
Alcohol Abuse or Dependence: Initiation of AOD Treatment Total	38.71%	30.30% ↓	50.00%	0.00% ↓	60.00%	37.93% ↓
Alcohol Abuse or Dependence: Engagement of AOD Treatment Total	3.23%	0.00% ↓	50.00%	0.00% ↓	0.00%	13.79% ↑
Opioid Abuse or Dependence: Initiation of AOD Treatment Total	100%	33.33% ↓	0.00%	NR←→	100%	50.00% ↓
Opioid Abuse or Dependence: Engagement of AOD Treatment Total	0.00%	33.33% ↑	0.00%	NR←→	0.00%	0.00%←→
Other Drug Abuse or Dependence: Initiation of AOD Treatment Total	47.33%	39.81% ↓	68.75%	100.00% ↑	61.31%	59.18% ↓
Other Drug Abuse or Dependence: Engagement of AOD Treatment Total	8.40%	6.48% ↓	6.25%	25.00% ↑	15.33%	18.37% ↑
Initiation of AOD Treatment Total	43.92%	37.50% ↓	64.71%	80.00% ↑	59.33%	54.26% ↓
Engagement of AOD Treatment Total	7.43%	5.56% ↓	5.88%	20.00% ↑	14.00%	17.05% ↑

NA = Small Denominator: The MCO followed the specifications, but the denominator was too small (<30) to report a valid rate. For utilization measures that count enrollee months, this result is reported when the denominator is <360 enrollee months.
NR = Not Reported.

DBM-specific PMV results appear in **Table 14**. The green and red arrows indicate an increase (↑), decrease (↓), or (←→) from the previous year's rate. Liberty has no comparisons as 2023 was the first year that they were measured.

Table 14. 2023 PMV Measure Results: DBMs

Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
All Dental Visits (ADV)									
All Enrollees	35,059	20,893	59.59% ↓	N/A	N/A	N/A	28,078	15,856	56.00% ↓
Enrollees Aged 5 to 6†	1,954	1,247	42.01% ↓	N/A	N/A	N/A	1,589	922	58.00% ↑
Enrollees Aged 7 to 10	9,594	6,527	54.23% ↓	N/A	N/A	N/A	7,156	4,607	64.00% ↓
Enrollees Aged 11 to 14	11,359	6,902	48.99% ↓	N/A	N/A	N/A	8,865	5,208	59.00% ↑
Enrollees Aged 15 to 18	12,152	6,217	40.75% ↓	N/A	N/A	N/A	10,471	5,122	47.00% ↓
Dental Sealants*									
Enrolled at Least 1 Month: All enrollees	41,821	5,053	12.08% ↓	18,802	716	3.81%	34,596	3,060	8.84% ↓
Enrolled at Least 1 Month: Enrollees aged 6 to 9	16,468	2,219	13.47% ↓	8,095	329	4.06%	13,527	1,700	12.57% ↓
Enrolled at Least 1 Month: Enrollees aged 10 to 14	25,353	2,834	11.18% ↓	10,707	387	3.61%	21,069	1,360	6.45% ↓
Enrolled at Least 3 Months Continuously: All enrollees	37,760	4,963	13.14% ↓	15,321	666	4.35%	30,460	3,006	9.87% ↓
Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	14,764	2,174	14.73% ↓	6,559	305	4.65%	11,805	1,671	14.16% ↓
Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	22,996	2,789	12.13% ↓	8,762	361	4.12%	18,655	1,335	7.16% ↓

Table 14. 2023 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 6 Months Continuously: All Enrollees	32,583	4,663	14.31% ↓	N/A	N/A	N/A	25,273	2,762	10.93% ↓
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	12,617	2,041	16.18% ↓	N/A	N/A	N/A	9,725	1536	15.79% ↓
Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	19,966	2,622	13.13% ↓	N/A	N/A	N/A	15,548	1226	7.89% ↓
Enrolled at Least 11 Months Continuously: All Enrollees	24,086	3,715	15.42% ↓	N/A	N/A	N/A	17,993	2,204	12.25% ↓
Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	9,310	1,619	17.39% ↓	N/A	N/A	N/A	6,834	1,224	17.91% ↑
Enrolled at Least 11 Months Continuously: Enrollees aged 10 to 14	14,776	2,096	14.19% ↓	N/A	N/A	N/A	11,159	980	8.78% ↓
Dental Sealants – With Exclusions*									
Enrolled at Least 1 Month: All Enrollees	41,821	5,053	12.08% ↓	18,802	716	3.81%	31,599	2,954	9.35% ↓
Enrolled at Least 1 Month: Enrollees aged 6 to 9	16,468	2,219	13.47% ↓	8,095	329	4.06%	11,594	1,631	14.07% ↓
Enrolled at Least 1 Month: Enrollees aged 10 to 14	25,353	2,834	11.18% ↓	10,707	387	3.61%	20,005	1,323	6.61% ↓
Enrolled at Least 3 Months Continuously: All Enrollees	37,760	4,963	13.14% ↓	15,321	666	4.35%	27,643	2,900	10.49% ↓
Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	14,764	2,174	14.73% ↓	6,559	305	4.65%	10,003	1,602	16.02% ↓

Table 14. 2023 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	22,996	2,789	12.13% ↓	8,762	361	4.12%	17,640	1,298	7.36% ↓
Enrolled at Least 6 Months Continuously: All Enrollees	32,587	4,663	14.31% ↓	N/A	N/A	N/A	22,760	2,662	11.70% ↓
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	12,621	2,041	16.17% ↓	N/A	N/A	N/A	8,129	1472	18.11% ↓
Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	19,966	2,622	13.13% ↓	N/A	N/A	N/A	14,631	1190	8.13% ↓
Enrolled at Least 11 Months Continuously: All Enrollees	24,086	3,715	15.42% ↓	N/A	N/A	N/A	16,046	2,116	13.19% ↓
Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	9,310	1,619	17.39% ↓	N/A	N/A	N/A	5,611	1,166	20.78% ↑
Enrolled at Least 11 Months Continuously: Enrollees aged 10 to 14	14,776	2,096	14.19% ↓	N/A	N/A	N/A	10,435	950	9.10% ↓
Preventative Dental									
Enrolled at Least 1 Month: All Enrollees	65,473	28,946	44.21% ↑	27,350	3,975	14.53%	56,354	23,059	40.92% ↑
Enrolled at Least 1 Month: Enrollees aged 5†	2,454	754	30.73% ↑	1,542	225	14.59%	2,436	565	23.19% ↓
Enrolled at Least 1 Month: Enrollees aged 6 to 9	16,468	8,373	50.84% ↑	8,095	1,417	17.50%	13,527	6,294	46.53% ↑
Enrolled at Least 1 Month: Enrollees aged 10 to 14	25,353	12,029	47.45% ↑	10,707	1,637	15.29%	21,069	9,341	44.34% ↓

Table 14. 2023 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 1 Month: Enrollees aged 15 to 18	21,198	7,790	36.75% ↓	7,006	696	9.93%	19,325	6,862	35.51% ↓
Enrolled at Least 3 Months Continuously: All Enrollees	58,941	28,320	48.05% ↓	22,036	3,618	16.42%	49,424	22,468	45.46% ↑
Enrolled at Least 3 Months Continuously: Enrollees aged 5†	1,784	681	38.17% ↑	1,090	196	17.98%	1,585	502	31.67% ↑
Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	14,764	8,175	55.37% ↑	6,559	1,304	19.88%	11,805	6,116	51.81% ↑
Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	22,996	11,776	51.21% ↑	8,762	1,499	17.11%	18,655	9,131	48.95% ↑
Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	19,397	7,688	39.63% ↓	5,625	619	11.00%	17,382	6,722	38.67% ↓
Enrolled at Least 6 Months Continuously: All Enrollees	50,572	26,437	52.28% ↓	N/A	N/A	N/A	40,830	20,454	50.10% ↓
Enrolled at Least 6 Months Continuously: Enrollees aged 5†	1,062	518	48.78% ↑	N/A	N/A	N/A	887	355	40.02% ↓
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	12,617	7,616	60.36% ↑	N/A	N/A	N/A	9,725	5,551	57.08% ↑
Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	19,966	11,031	55.25% ↓	N/A	N/A	N/A	15,548	8,311	53.45% ↑
Enrolled at Least 6 Months Continuously: Enrollees aged 15 to 18	16,927	7,272	42.96% ↓	N/A	N/A	N/A	14,673	6,240	42.53% ↓

Table 14. 2023 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 11 Months Continuously: All Enrollees	36,806	20,980	57.00% ↓	N/A	N/A	N/A	28,767	15,718	54.64% ↑
Enrolled at Least 11 Months Continuously: Enrollees aged 5†	136	75	55.15% ↓	N/A	N/A	N/A	121	55	45.45% ↓
Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	9,310	6,088	65.39% ↑	N/A	N/A	N/A	6,834	4,255	62.26% ↑
Enrolled at Least 11 Months Continuously: Enrollees aged 10 to 14	14,776	8,859	59.96% ↓	N/A	N/A	N/A	11,159	6,453	57.83% ↑
Enrolled at Least 11 Months Continuously: Enrollees aged 15 to 18	12,584	5,958	47.35% ↓	N/A	N/A	N/A	10,656	4,958	46.53% ↑
Any Dental Services									
Enrolled at Least 1 Month: All Enrollees	65,473	11,055	16.88% ↓	27,350	4,828	17.65%	56,354	24,666	43.77% ↑
Enrolled at Least 1 Month: Enrollees aged 5†	2,454	222	9.05% ↓	1,542	257	16.67%	2,436	600	24.63% ↓
Enrolled at Least 1 Month: Enrollees aged 6 to 9	16,468	3,386	20.56% ↓	8,095	1,623	20.05%	13,527	6,558	48.48% ↑
Enrolled at Least 1 Month: Enrollees aged 10 to 14	25,353	4,304	16.98% ↓	10,707	1,972	18.42%	21,069	9,890	46.94% ↑
Enrolled at Least 1 Month: Enrollees aged 15 to 18	21,198	3,143	14.83% ↓	7,006	976	13.93%	19,325	7,621	39.44% ↑
Enrolled at Least 3 Months Continuously: All Enrollees	58,941	10,776	18.28% ↓	22,036	4,361	19.79%	49,424	23,944	48.45% ↑
Enrolled at Least 3 Months Continuously: Enrollees aged 5†	1,784	202	11.32% ↓	1,090	220	20.18%	1,585	525	33.12% ↑

Table 14. 2023 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	14,764	3,295	22.32% ↓	6,559	1,484	22.63%	11,805	6,355	53.83% ↑
Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	22,996	4,201	18.27% ↓	8,762	1,801	20.55%	18,655	9,636	51.65% ↑
Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	19,397	3,078	15.87% ↓	5,625	856	15.22%	17,382	7,431	42.75% ↓
Enrolled at Least 6 Months Continuously: All Enrollees	50,572	10,090	19.95% ↓	N/A	N/A	N/A	40,830	21,641	53.00% ↑
Enrolled at Least 6 Months Continuously: Enrollees aged 5†	1,062	160	15.07% ↓	N/A	N/A	N/A	887	366	41.26% ↓
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	12,617	3,101	24.58% ↓	N/A	N/A	N/A	9,725	5,732	58.94% ↑
Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	19,966	3,930	19.68% ↓	N/A	N/A	N/A	15,548	8,721	56.09% ↑
Enrolled at Least 6 Months Continuously: Enrollees aged 15-18	16,927	2,899	17.13% ↓	N/A	N/A	N/A	14,673	6,825	46.51% ↓
Enrolled at Least 11 Months Continuously: All Enrollees	36,806	21,934	59.59% ↓	N/A	N/A	N/A	28,767	16,543	57.51% ↑
Enrolled at Least 11 Months Continuously: Enrollees aged 5†	136	76	55.88% ↓	N/A	N/A	N/A	121	55	45.45% ↓

Table 14. 2023 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	9,310	6,221	66.82% ↑	N/A	N/A	N/A	6,834	4,379	64.08% ↑
Enrolled at Least 11 Months Continuously: Enrollees aged 10 to 14	14,776	9,175	62.09% ↓	N/A	N/A	N/A	11,159	6,732	60.33% ↑
Enrolled at Least 11 Months Continuously: Enrollees aged 15 to 18	12,584	6,462	51.35% ↓	N/A	N/A	N/A	10,656	5,380	50.49% ↓
Dental Treatment Service									
Enrolled at Least 1 Month: All Enrollees	65,473	11,055	16.88% ↓	27,350	1,500	5.48%	56,354	9,220	16.36% ↓
Enrolled at Least 1 Month: Enrollees aged 5†	2,454	222	9.05% ↓	1,542	60	3.89%	2,436	173	7.10% ↓
Enrolled at Least 1 Month: Enrollees aged 6 to 9	16,468	3,386	20.56% ↓	8,095	476	5.88%	13,527	2,589	19.14% ↓
Enrolled at Least 1 Month: Enrollees aged 10 to 14	25,353	4,304	16.98% ↓	10,707	619	5.78%	21,069	3,442	16.34% ↑
Enrolled at Least 1 Month: Enrollees aged 15 to 18	21,198	3,143	14.83% ↓	7,006	345	4.92%	19,325	3,019	15.62% ↓
Enrolled at Least 3 Months Continuously: All Enrollees	58,941	10,776	18.28% ↓	22,036	1,349	6.12%	49,424	9,009	18.23% ↓
Enrolled at Least 3 Months Continuously: Enrollees aged 5†	1,784	202	11.32% ↓	1,090	51	4.68%	1,585	154	9.72% ↓
Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	14,764	3,295	22.32% ↓	6,559	430	6.56%	11,805	2,532	21.45% ↓

Table 14. 2023 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	22,996	4,201	18.27% ↓	8,762	563	6.43%	18,655	3,373	18.08% ↑
Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	19,397	3,078	15.87% ↓	5,625	305	5.42%	17,382	2,953	16.99% ↓
Enrolled at Least 6 Months Continuously: All Enrollees	50,572	10,090	19.95% ↓	N/A	N/A	N/A	40,830	8,221	20.13% ↓
Enrolled at Least 6 Months Continuously: Enrollees aged 5†	1,062	160	15.07% ↑	N/A	N/A	N/A	887	119	13.42% ↓
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	12,617	3,101	24.58% ↓	N/A	N/A	N/A	9,725	2,291	23.56% ↓
Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	19,966	3,930	19.68% ↓	N/A	N/A	N/A	15,548	3,076	19.78% ↑
Enrolled at Least 6 Months Continuously: Enrollees aged 15 to 18	16,927	2,899	17.13% ↓	N/A	N/A	N/A	14,673	2,738	18.66% ↓
Enrolled at Least 11 Months Continuously: All Enrollees	36,806	7,983	21.69% ↓	N/A	N/A	N/A	28,767	6,332	22.01% ↓
Enrolled at Least 11 Months Continuously: Enrollees aged 5†	136	21	15.44% ↓	N/A	N/A	N/A	121	15	12.40% ↓
Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	9,310	2,483	26.67% ↓	N/A	N/A	N/A	6,834	1,795	26.27% ↓

Table 14. 2023 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 11 Months Continuously: Enrollees aged 10 to 14	14,776	3,144	21.28% ↓	N/A	N/A	N/A	11,159	2,392	21.44% ↑
Enrolled at Least 11 Months Continuously: Enrollees aged 15 to 18	12,584	2,335	18.56% ↓	N/A	N/A	N/A	10,656	2,133	20.02% ↓
Dental Diagnostic Services									
Enrolled at Least 1 Month: All Enrollees	65,473	30,068	45.92% ↑	27,350	4,160	15.21%	56,354	23,182	41.14% ↓
Enrolled at Least 1 Month: Enrollees aged 5†	2,454	783	31.91% ↑	1,542	242	15.69%	2,436	581	23.85% ↓
Enrolled at Least 1 Month: Enrollees aged 6 to 9	16,468	8,548	51.91% ↑	8,095	1,465	18.10%	13,527	6,335	46.83% ↑
Enrolled at Least 1 Month: Enrollees aged 10 to 14	25,353	12,369	48.79% ↑	10,707	1,655	15.46%	21,069	9,344	44.35% ↑
Enrolled at Least 1 Month: Enrollees aged 15 to 18	21,198	8,368	39.48% ↓	7,006	798	11.39%	19,325	6,925	35.83% ↑
Enrolled at Least 3 Months Continuously: All Enrollees	58,941	29,359	49.81% ↓	22,036	3,765	17.09%	49,424	22,549	45.62% ↑
Enrolled at Least 3 Months Continuously: Enrollees aged 5†	1,784	705	39.52% ↑	1,090	207	18.99%	1,585	511	32.24% ↑
Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	14,764	8,328	56.41% ↑	6,559	1,341	20.45%	11,805	6,149	52.09% ↑
Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	22,996	12,091	52.58% ↑	8,762	1,517	17.31%	18,655	9,117	48.87% ↓

Table 14. 2023 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	19,397	8,235	42.46% ↓	5,625	700	12.44%	17,382	6,775	38.98% ↓
Enrolled at Least 6 Months Continuously: All Enrollees	50,572	27,331	54.04% ↓	N/A	N/A	N/A	40,830	20,503	50.22% ↑
Enrolled at Least 6 Months Continuously: Enrollees aged 5†	1,062	532	50.09% ↑	N/A	N/A	N/A	887	360	40.59% ↓
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	12,617	7,737	61.32% ↓	N/A	N/A	N/A	9,725	5,584	57.42% ↑
Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	19,966	11,304	56.62% ↓	N/A	N/A	N/A	15,548	8,299	53.38% ↑
Enrolled at Least 6 Months Continuously: Enrollees aged 15 to 18	16,927	7,758	45.83% ↓	N/A	N/A	N/A	14,673	6,263	42.68% ↓
Enrolled at Least 11 Months Continuously: All Enrollees	36,806	21,623	58.75% ↓	N/A	N/A	N/A	28,767	15,738	54.71% ↑
Enrolled at Least 11 Months Continuously: Enrollees aged 5†	136	75	55.15% ↓	N/A	N/A	N/A	121	55	45.45% ↓
Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	9,310	6,179	66.37% ↑	N/A	N/A	N/A	6,834	4,278	62.60% ↑
Enrolled at Least 11 Months Continuously: Enrollees aged 10 to 14	14,776	9,049	61.24% ↓	N/A	N/A	N/A	11,159	6,443	57.74% ↑

Table 14. 2023 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 11 Months Continuously: Enrollees aged 15 to 18	12,584	6,320	50.22% ↓	N/A	N/A	N/A	10,656	4,965	46.59% ↓
Any Dental or Oral Health Services									
Enrolled at Least 1 Month: All Enrollees	65,473	28,946	44.21% ↑	27,350	4,828	17.65%	56,354	24,666	43.77% ↑
Enrolled at Least 1 Month: Enrollees aged 5†	2,454	754	30.73% ↑	1,542	257	16.67%	2,436	600	24.63% ↑
Enrolled at Least 1 Month: Enrollees aged 6 to 9	16,468	8,373	50.84% ↑	8,095	1,623	20.05%	13,527	6,558	48.48% ↓
Enrolled at Least 1 Month: Enrollees aged 10 to 14	25,353	12,029	47.45% ↑	10,707	1,972	18.42%	21,069	9,890	46.94% ↓
Enrolled at Least 1 Month: Enrollees aged 15 to 18	21,198	7,790	36.75% ↓	7,006	976	13.93%	19,325	7,621	39.44% ↓
Enrolled at Least 3 Months Continuously: All Enrollees	58,941	28,320	48.05% ↓	22,036	3,290	14.93%	49,424	23,944	48.45% ↓
Enrolled at Least 3 Months Continuously: Enrollees aged 5†	1,784	681	38.17% ↑	1,090	220	20.18%	1,585	525	33.12% ↑
Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	14,764	8,175	55.37% ↑	6,559	1,484	22.63%	11,805	6,355	53.83% ↑
Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	22,996	11,776	51.21% ↑	8,762	1,801	20.55%	18,655	9,636	51.65% ↑
Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	19,397	7,688	39.63% ↓	5,625	856	15.22%	17,382	7,431	42.75% ↓

Table 14. 2023 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 6 Months Continuously: All enrollees	50,572	26,437	52.28% ↓	N/A	N/A	N/A	40,830	21,641	53.00% ↓
Enrolled at Least 6 Months Continuously: Enrollees aged 5†	1,062	518	48.78% ↑	N/A	N/A	N/A	887	366	41.26% ↓
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	12,617	7,616	60.36% ↑	N/A	N/A	N/A	9,725	5,732	58.94% ↑
Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	19,966	11,031	55.25% ↓	N/A	N/A	N/A	15,548	8,721	56.09% ↑
Enrolled at Least 6 Months Continuously: Enrollees aged 15 to 18	16,927	7,272	42.96% ↓	N/A	N/A	N/A	14,673	6,825	46.51% ↑
Enrolled at Least 11 Months Continuously: All Enrollees	36,806	20,980	57.00% ↓	N/A	N/A	N/A	28,767	16,543	57.51% ↑
Enrolled at Least 11 Months Continuously: Enrollees aged 5†	136	75	55.15% ↓	N/A	N/A	N/A	121	55	45.45% ↓
Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	9,310	6,088	65.39% ↑	N/A	N/A	N/A	6,834	4,379	64.08% ↑
Enrolled at Least 11 Months Continuously: Enrollees aged 10 to 14	14,776	8,859	59.96% ↓	N/A	N/A	N/A	11,159	6,732	60.33% ↑
Enrolled at Least 11 Months Continuously: Enrollees aged 15 to 18	12,584	5,958	47.35% ↓	N/A	N/A	N/A	10,656	5,380	50.49% ↑

** The age 5 and age 15–18 stratifications do not apply to this measure.*
† The age range for this stratification is 3–5 years; as ages 3 and 4 years do not apply to the Florida Healthy Kids population, the stratification has been renamed Age 5 for this report.

Strengths, Weaknesses, and Improvements

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

Strengths and Weaknesses

All MCOs and DBMs were deemed fully compliant with all NCQA-defined Information System Standards for HEDIS-applied data and processes. No particular strengths were noted for MCOs. For DBMs, DentaQuest was lauded for its subject-matter experts which contributed to performance measure data reporting. It was also praised for the Windward system, which further supported successful measure production and reporting.

Likewise, Liberty was lauded for demonstrating a thorough understanding of the PMV requirements by providing clear and informative responses. In addition, Liberty staff members provided supporting documentation and system walkthroughs that demonstrated subject matter expertise in each of the system and programming components of the PMV. Finally, Liberty was praised for its expertise in the management of all its systems and procedures, which ensured valid measure rates that enabled reliable year to year trending.

Lastly, MCNA was praised for demonstrating strengths with its internally developed system, DentalTrac. The comprehensive system captured all data required for performance measure reporting, including claims, enrollment, and provider data.

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 2023 PMV, as with the 2022 and 2021 PMV activities.

Improvements

Table 15 includes the MCOs' and DBMs' improvements which were greater than 10.00% vs. the previous year's PMV.

Among MCOs, CCP had the most improvements since the 2022 PMV, with 49 measures trending up. Of those measures with a positive trend, a total of 30 measures improved at a rate of 10% or greater. Aetna also showed improvement across all aspects of care with 26 measures trending positively, 14 improving by 10% or better. Finally, Simply Healthcare had 10 measures with significant (>10%) improvement from its total of 31 measures with positive trends.

DBMs continued to show commitment to quality, access, and timeliness of care with their 2023 PMV results. MCNA had the most improvements in 2023 with a total of 58 measures trending positively. Likewise, DentaQuest showed its commitment to all aspects of care by improving in 31 of its performance measures.

Table 15. Improvements Since MY 2021 PMV by MCO

MCO	Measure	Quality	Timeliness	Access	2022 Measure Result	2023 Measure Result
Aetna	Appropriate Testing for Pharyngitis (CWP): 18 – 64 years	✓	✓	✓	61.94%	75.89%
	Follow-Up After Emergency Department Visit for Mental Illness (FUM): 30-Day Follow-Up: 6 – 17 Years	✓	✓	✓	45.05%	60.71%
	Follow-Up After Emergency Department Visit for Mental Illness (FUM): 7-Day Follow-Up: 18 – 64 Years	✓	✓	✓	18.18%	50.00%
	Follow-Up After Emergency Department Visit for Mental Illness (FUM):30-Day Follow-Up Total	✓	✓	✓	45.10%	60.34%
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA): 7-Day Follow-Up: 13 – 17 Years	✓	✓	✓	4.55%	22.22%
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA): 30-Day Follow-Up: 13 – 17 Years	✓	✓	✓	4.55%	33.33%
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA): 30-Day Follow-Up: ≥18 Years	✓	✓	✓	0.00%	16.67%
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA): 7-Day Follow-Up Total	✓	✓	✓	3.23%	19.05%
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA): 30-Day Follow-Up Total	✓	✓	✓	3.23%	30.95%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM): Blood Glucose Testing: 1 – 11 Years	✓	✓	✓	32.61%	42.86%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM): Cholesterol Testing: 1 – 11 Years	✓	✓	✓	30.43%	42.86%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM): Blood Glucose and Cholesterol Testing: 1 – 11 Years	✓	✓	✓	23.91%	39.29%

Table 15. Improvements Since MY 2021 PMV by MCO

MCO	Measure	Quality	Timeliness	Access	2022 Measure Result	2023 Measure Result
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Opioid Abuse or Dependence: Engagement of AOD Treatment: 13–17 Years	✓	✓	✓	0.00%	50.00%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Opioid Abuse or Dependence: Engagement of AOD Treatment Total	✓	✓	✓	0.00%	33.33%
CCP	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC): BMI Percentile: 3 – 11 Years	✓		✓	NA	90.00%
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC): BMI Percentile: 12 – 17 Years	✓		✓	NA	88.56%
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC): BMI Percentile Total	✓		✓	NA	89.29%
	Immunizations for Adolescents (IMA): Meningococcal	✓	✓	✓	NA	83.94%
	Immunizations for Adolescents (IMA): Tdap	✓	✓	✓	NA	93.92%
	Immunizations for Adolescents (IMA): Human Papillomavirus (HPV)	✓	✓	✓	NA	38.44%
	Immunizations for Adolescents (IMA): Combination #1	✓	✓	✓	NA	83.21%
	Immunizations for Adolescents (IMA): Combination #2	✓	✓	✓	NA	36.98%
	Asthma Medication Ratio (AMR): 5 – 11 Years	✓	✓	✓	85.00%	100%
	Appropriate Testing for Pharyngitis (CWP): 3 – 17 Years	✓	✓	✓	48.68%	68.31%
	Appropriate Testing for Pharyngitis (CWP): Total	✓	✓	✓	50.30%	64.71%
	Follow-Up After Hospitalization for Mental Illness (FUH): 7-Day Follow-Up: 18–64 Years	✓	✓	✓	25.00%	50.00%
	Follow-Up After Hospitalization for Mental Illness (FUH): 30-Day Follow-Up: 18–64 Years	✓	✓	✓	25.00%	50.00%
	Follow-Up After Emergency Department Visit for Mental Illness (FUM): 30-Day Follow-Up: 6–17 Years	✓	✓	✓	28.57%	50.00%

Table 15. Improvements Since MY 2021 PMV by MCO

MCO	Measure	Quality	Timeliness	Access	2022 Measure Result	2023 Measure Result
	Follow-Up After Emergency Department Visit for Mental Illness (FUM): 30-Day Follow-Up Total	✓	✓	✓	28.57%	50.00%
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA): 7-Day Follow-Up: 13–17 Years	✓	✓	✓	NA	50.00%
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA): 30-Day Follow-Up: 13–17 Years	✓	✓		NA	50.00%
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA): 7-Day Follow-Up Total	✓	✓		NA	50.00%
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA): 30-Day Follow-Up Total	✓	✓		NA	50.00%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM): Blood Glucose Testing: 1–11 Years	✓	✓		14.29%	75.00%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM): Cholesterol Testing: 1–11 Years	✓	✓		0.00%	75.00%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM): Blood Glucose and Cholesterol Testing: 1–11 Years	✓	✓		0.00%	75.00%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM): Blood Glucose Testing Total	✓	✓		52.63%	72.00%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Other Drug Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	✓	✓		81.82%	100%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Other Drug Abuse or Dependence: Engagement of AOD Treatment: 13–17 Years	✓	✓		9.09%	25.00%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Engagement of AOD Treatment: 13–17 Years Total	✓	✓		9.09%	20.00%

Table 15. Improvements Since MY 2021 PMV by MCO

MCO	Measure	Quality	Timeliness	Access	2022 Measure Result	2023 Measure Result
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Other Drug Abuse or Dependence: Initiation of AOD Treatment Total	✓	✓		68.75%	100.00%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Other Drug Abuse or Dependence: Engagement of AOD Treatment Total	✓	✓		6.25%	25.00%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Initiation of AOD Treatment Total	✓	✓		64.71%	80.00%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Engagement of AOD Treatment Total	✓	✓		5.88%	20.00%
Simply	Contraceptive Care – Postpartum Women Ages 15−20 (CCP): Most or moderately effective contraception – 60 days	✓	✓	✓	17.00%	60.00%
	Contraceptive Care – Postpartum Women Ages 15−20 (CCP): LARC – 60 Days	✓	✓	✓	0.00%	20.00%
	Follow-Up After Hospitalization for Mental Illness (FUH): 7-Day Follow-Up: 18–64 Years	✓	✓		32.00%	53.85%
	Follow-Up After Hospitalization for Mental Illness (FUH): 30-Day Follow-Up: 18–64 Years	✓	✓		44.00%	84.62%
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA): 7-Day Follow-Up: 13–17 Years	✓	✓		0.00%	26.32%
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA): 30-Day Follow-Up: 13–17 Years	✓	✓		13.33%	47.37%
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA): 7-Day Follow-Up Total	✓	✓		0.00%	19.23%
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA): 30-Day Follow-Up Total	✓	✓		9.52%	34.62%

Table 15. Improvements Since MY 2021 PMV by MCO

MCO	Measure	Quality	Timeliness	Access	2022 Measure Result	2023 Measure Result
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Alcohol Abuse or Dependence: Engagement of AOD Treatment: 13–17 Years	✓	✓		0.00%	16.67%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Alcohol Abuse or Dependence: Engagement of AOD Treatment Total	✓	✓		0.00%	13.79%

Conclusions

Aetna

Aetna underwent a NCQA HEDIS Compliance Audit by a NCQA-Certified HEDIS Compliance Auditor for their performance measures. It was determined that all performance measures conformed to the appropriate technical specifications, and they received a Reportable designation. Subsequently, Aetna has passed the PMV.

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

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

Community Care Plan

CCP underwent a NCQA HEDIS Compliance Audit by a NCQA-Certified HEDIS Compliance Auditor for their performance measures. It was determined that all performance measures conformed to the appropriate technical specifications, and they received a Reportable designation. Subsequently, CCP has passed the PMV.

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

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

Simply

Simply underwent a NCQA HEDIS Compliance Audit by a NCQA-Certified HEDIS Compliance Auditor for their performance measures. It was determined that all performance measures conformed to the appropriate technical specifications, and they received a Reportable designation. Subsequently, Simply has passed the PMV.

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

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

DentaQuest

DentaQuest was fully compliant with the PMV Claims/Encounters data systems, eligibility data system findings, provider data systems, and data integration. Qsource performed primary source verification on a random sample of 10 services with an oversample of five for each of the selected CMS-416 measures, specifically, TDENT and SEAL. All data attributes required for measure reporting, including member age, date of service, procedure code, and tooth number were verified. The validated processes used to develop these measures were aggregated to all measures. No discrepancies were identified. DentaQuest utilized internal, proprietary source code written in SQL for measure production. Qsource conducted source code review to verify that the algorithms used to calculate and report the performance measures, including denominator, numerator, and rates, complied with measure specifications.

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

Liberty

Liberty was fully compliant with the PMV requirements for Claims/Encounter data systems, enrollment/eligibility data systems, provider credentialling/contracting data systems, and data integration and control. Qsource performed primary source verification on a random sample of 10 services with an oversample of five for each of the selected CMS-416 measures, specifically TDENT and SEAL. All data attributes required for measure reporting, including member age, date of service, procedure code, and tooth number were verified. The validated processes used to develop these measures were aggregated to all measures. No discrepancies were identified. Liberty utilized internal, proprietary source code written in Structured Query Language (SQL) for measure production. Qsource conducted a source code review to verify that the algorithms used to calculate and report the performance measures, including denominator, numerator, and rates, complied with measure specifications. Liberty accurately defined and tabulated continuous enrollments of members, including the number of days not enrolled and the number of breaks in enrollment.

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

MCNA

MCNA was fully compliant with the claims data system findings, eligibility data system findings, provider systems review, and data integration. Qsource performed primary source verification on a random sample of 10 services with an oversample of five for each of the selected CMS-416 measures, specifically TDENT and SEAL. All data attributes required for measure reporting, including member age, date of service, procedure code, and tooth number were verified. The validated processes used to develop these measures were aggregated to all measures. No discrepancies were identified. MCNA utilized internal, proprietary source code written in SQL for measure production. Qsource conducted source code review to verify that the algorithms used to calculate and report the performance measures, including denominator, numerator, and rates complied with measure specifications.

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

Annual Compliance Assessment (ACA)

Assessment Background

Qsource conducted the ACA reviews pursuant to the requirements in

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

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

FHKC has chosen for the EQR to review one-third of the compliance standards as shown in **Table 16**. Coordination and Continuity of Care, Coverage and Authorization of Services, and Subcontractual Relationships and Delegation were the standards reviewed and included in this report. Credentialing and Recredentialing file reviews were also completed as part of the assessment.

For a crosswalk demonstrating how Qsource's assessment tools reflect these required standards, see **Appendix C**.

Table 16. Compliance Assessment Standards

Standard	CFR Citations	Quality	Timeliness	Access	Review Year
Availability of Services	42 CFR § 438.206		✓	✓	2021
Assurances of Adequate Capacity and Services	42 CFR § 438.207	✓	✓	✓	2021
Grievance and Appeals System	42 CFR § 438.228			✓	2021
Practice Guidelines	42 CFR § 438.236	✓			2021
Health Information Systems	42 CFR § 438.242	✓	✓	✓	2021
Quality Assessment and Performance Improvement	42 CFR § 438.330	✓	✓	✓	2021
Coordination and Continuity of Care	42 CFR § 438.208	✓	✓	✓	2022
Coverage and Authorization of Services	42 CFR § 438.210		✓	✓	2022
Subcontractual Relationships and Delegation	42 CFR § 438.230	✓	✓	✓	2022
Enrollee Information*	42 CFR § 438.224	✓		✓	2023
Enrollee Rights and Protections*	42 CFR § 438.100	✓	✓	✓	2023
Provider Selection (Credentialing/ Recredentialing)	42 CFR § 438.214	✓	✓		2023

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

Technical Methods for Data Collection and Analysis

The ACA was conducted virtually. Protocols for the 2023 ACA review were guided by CMS's EQR Protocol 3 (October 2019). The ACA was conducted in three phases: pre-virtual review, virtual review, and post-virtual review. Qsource developed evidence-based oversight tools in consultation with FHKC and by referencing the MCO Services Contract, the DBM Services Contract, the MCO and DBM Provider Manuals, and the requirements included in 42 CFR § 438. Qsource provided an ACA Process Overview document, including an agenda for the virtual review, as well as the standard review tools, to explain the process. Throughout the ACA process, Qsource worked closely with FHKC and the Plans to ensure a supportive and coordinated process.

The virtual reviews took place July through September 2023. During the reviews, Plan staff answered questions and provided

information to help surveyors determine the degree of compliance with federal and agreement/contract requirements, explore any issues not fully addressed in the document review, and increase overall understanding of the operations. Qsource surveyors used the tools, along with personal observations, interviews with Plan staff, virtual system demonstrations, and file/document reviews, to facilitate analyses and compilation of findings. Each Plan also provided additional documentation as needed for surveyors during the virtual review. The compliance rating was determined by the percentage score of all elements met, as guided by EQR Protocol 3, and was calculated by dividing the number of elements met by the number of elements assessed. The compliance rating indicates Qsource's confidence (ranging from No Compliance to High Compliance) that the Plans met the elements for the standards reviewed.

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

Table 17 presents the rating criteria used in the CA validation.

Table 1718. Compliance Rating Criteria

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

In addition to compliance standards, the ACA includes reviews of a random sample of provider credentialing/recredentialing files to evaluate how the MCO applies the processes and procedures required in 42 CFR § 422.204 and 438.214 in its operational practice. Qsource asked each Plan to provide the universe of 2023 provider credentialing/recredentialing files, from which Qsource extracted a random sample and an oversample. Files in this selection included 15 provider credentialing/recredentialing files (10 sample and 5 oversample). The file review tool and tool instructions are included in Appendix B.

Description of Data Obtained

Throughout the documentation review and virtual assessment processes, Qsource reviewers used the survey tools to collect information and document findings. Each Plan's compliance with regulatory and contractual standards were validated

through a review of P&Ps, quality studies, reports, medical records/files, and other related Plans documentation. Each standard element had an assigned point value of 1, and Qsource analyzed every element in the survey tools. Qsource determined Plans performance scores by adding the total points earned for each standard element on a scale of 0 to 1. Scores for each standard were calculated by dividing the total points earned for all elements in the standard by the total points possible for all elements in the standard.

MCO and DBM Findings

Compliance Standards

Table 18 includes overall compliance scores for all standards evaluated in 2023 for the ACA.

Table 18. 2023 Compliance Scores and Ratings

Standards	Score	Compliance Rating
Aetna		
Enrollee Information (EI)	100%	High Compliance
Enrollee Rights (ER)	100%	High Compliance
Provider Selection Credentialing/Recredentialing	100%	High Compliance
Aetna Overall Compliance Standard Score	**100%**	**High Compliance**
CCP		
Enrollee Information (EI)	100%	High Compliance
Enrollee Rights (ER)	100%	High Compliance
Provider Selection Credentialing/Recredentialing	97.92%	High Compliance
CCP Overall Compliance Standard Score	**99.31%**	**High Compliance**
DentaQuest		
Enrollee Information (EI)	98.50%	High Compliance
Enrollee Rights (ER)	94.73%	High Compliance
Provider Selection Credentialing/Recredentialing	97.50%	High Compliance
DentaQuest Overall Compliance Standard Score	**96.91%**	**High Compliance**
Liberty		
Enrollee Information (EI)	97.00%	High Compliance
Enrollee Rights (ER)	95.00%	High Compliance
Provider Selection Credentialing/Recredentialing	97.50%	High Compliance
Liberty Overall Compliance Standard Score	**96.50%**	**High Compliance**

Table 18. 2023 Compliance Scores and Ratings		
Standards	**Score**	**Compliance Rating**
MCNA		
Enrollee Information (EI)	100%	High Compliance
Enrollee Rights (ER)	100%	High Compliance
Provider Selection Credentialing/Recredentialing	97.50%	High Compliance
MCNA Overall Compliance Standard Score	99.16%	**High Compliance**
Simply		
Enrollee Information (EI)	100%	High Compliance
Enrollee Rights (ER)	100%	High Compliance
Provider Selection Credentialing/Recredentialing	100%	High Compliance
Simply Overall Compliance Standard Score	**100%**	**High Compliance**

Table 19. 2023 File Review Scores			
MCO/DBM	**File**	**Score**	**Compliance Rating**
Aetna	Credentialing/Recredentialing	96.61%	High Compliance
CCP	Credentialing/Recredentialing	99.42%	High Compliance
MCNA	Credentialing/Recredentialing	92.05%	High Compliance
DentaQuest	Credentialing/Recredentialing	99.44%	High Compliance
Liberty	Credentialing/Recredentialing	98.87%	High Compliance
Simply	Credentialing/Recredentialing	100%	High Compliance

Table 20. 2023 ACA Overall Compliance Scores	
Standard	**Plan Overall Compliance 2023**
Enrollee Information (EI)	99.14%
Enrollee Rights (ER)	98.29%
Provider Selection Credentialing/Recredentialing	96.73%
Credentialing/Recredentialing File Review	97.73%
Total Overall Score	**98.00%**

Conclusions

Strengths and Weaknesses

Scoring for each evaluated Quality Performance (QP) standard and file review reflects each plan's degree of compliance with applicable contractual, state, and federal requirements. In addition, Qsource identifies strengths, suggestions, and AONs (weaknesses) to highlight areas in which a plan excels, areas in which it could improve, and areas in which it must improve to achieve compliance. This information is shown in Table 21. The lack of an identified strength should not be considered a deficiency. AONs are identified when a plan achieves less than 100% compliance on any given QP standard element or file review, and may be accompanied by recommendations for policy, procedure, or process changes. Because the plans are not held accountable for addressing suggestions, suggestions are not included in this report.

Table 2122. ACA Strengths and Weaknesses by Standard

MCO/DBM	Standard Title	Strength/AON
Strengths		
MCNA	Enrollee Information	**Element 22 – Enrollee Handbook**: The policy indicates that the new member materials are delivered within five calendar days following the receipt of the enrollment file from the applicable state agency to each person who is to be newly enrolled or reinstated with the DBM. This policy is more stringent than that stated in the element. This ensures that the enrollee will have received the information earlier than the expectations as stated in the DSC.
		Element 25 – Enrollee Handbook Content 3: The DBM provides extensive information regarding to Grievance and Appeals to assist members in understanding the process and how to move forward with additional appeals through an independent review organization, if applicable.
MCNA	Enrollee Rights and Protections	**Element 3 – Compliance with Federal and State Laws**: The policy clearly identifies each of the laws, regulations, and requirements noted within the CFR. This confirms the DBM's commitment to following all regulations and laws governing healthcare services.

Table 2122. ACA Strengths and Weaknesses by Standard		
MCO/DBM	**Standard Title**	**Strength/AON**
		Element 16 – Post Stabilization Care Services Coverage and Payment: Both policies contained specific references to the CFR citations. In addition to providing the references, language in the policy was consistent with that found in the CFR. By making specific references to the CFR and having similar language as the CFR, will assist the DBM in ensuring that all regulations are followed as intended.
MCNA	Provider Selection Credentialing/Recredentialing	**Element 6 – Exclusions**: Policy No 6.301 provides a full list of primary sources that are verified when reviewing an application to the provider network. This is inclusive of the SSA Death Master file which indicates the DBM is committed to ensuring that only providers that are eligible to participate in the network are in good standing with federal and state agencies.
		Element 8 – Provider Contract Compliance: The policy indicates that providers of the DBM's network must arrange for coverage of their patients when out of office due to vacation, illness, or another situation. This statement helps to ensure that enrollees maintain coverage and have access to services at all times.
DentaQuest	Enrollee Information	**Element 30 – Provider Directory Content**: The DBM's online provider directory provides information regarding age limitations, specialties, languages spoken by the provider, and whether the provider has participated in cultural competency training. In addition to providing this information on the website, the DBM also indicates which providers have been trained in sedation services and treating dually eligible individuals. The DBM also provides additional ways in which to refine the provider search through providers that have experience in working with intellectual disabilities, persons with attention deficit hyperactivity disorder (ADHD), persons with autism, persons with communication disabilities, and more. The directory provided meets all element criteria.

Table 2122. ACA Strengths and Weaknesses by Standard		
MCO/DBM	**Standard Title**	**Strength/AON**
DentaQuest	Provider Selection Credentialing/Recredentialing	**Element 10 – Appropriate Actions**: The Program Evaluation Committee (PEC) Charter provides a detailed review of the process the Committee takes in determining a provider's ability to participate in the DBM's network. Members of the Committee meet on a weekly basis to review information submitted from providers who wish to remain and/or participate in the DBM's network. Frequent meetings help the DBM to ensure that providers are appropriate for the network and the committee takes appropriate action for those deemed not appropriate for network participation. The document also addresses the appeal rights of the provider when an adverse determination is issued.
Liberty	Enrollee Information	**Element 32 – Provider Directory Availability**: The policy submitted included links to websites in which both providers and enrollees can alert the DBM to information that may be incorrect. This allows the DBM to correct provider directory inaccuracies in real time. Providers and members are able to contact the DBM through phone or email to have updates made to the directory.
Liberty	Enrollee Rights and Protections	**Element 1 – Enrollee Rights**: The Florida Healthy Kids Provider Resource Guide makes specific references to 42 CFR 438.10 within the contents of the document. Inclusion of references to the CFR provide clear evidence of the DBM's commitment to maintaining compliance with the federal regulations as set forth by CMS.
		Element 3 – Compliance with State and Federal Laws: The Anti-Discrimination Policy contains information regarding the frequency in which the staff of the DBM receive training to ensure that enrollees are not discriminated against when receiving services from the DBM. Staff of the DBM receive training regarding the anti-discrimination policy and receive additional training in this area on an annual basis.
Liberty	Provider Selection Credentialing/Recredentialing	**Element 3 – License**: Consistent language across policies indicates that the DBM strives to ensure that providers are appropriate for the network.

Table 2122. ACA Strengths and Weaknesses by Standard		
MCO/DBM	**Standard Title**	**Strength/AON**
		Element 7 – Exclusions-Ongoing Monitoring: The Anti-Fraud Program document has detailed information regarding ownership and controlling interest in the DBM. The document clearly outlines all steps taken to confirm there are no exclusions for a provider to participate in the network. Based on information presented for review, the DBM is committed to ensuring that providers participating in the network are appropriate and all checks regarding eligibility to participate in the network are conducted along with frequent monitoring of network eligibility.
		AONs
Aetna	Enrollee Information	**Element 11 – Minimum Requirements for Potential Enrollees – 2**: The submitted policies failed to address benefits provided by the State, and how members are referred for services that are not covered due to moral or religious objections.
		Element 12 – Minimum Requirements for Potential Enrollees – 3: The policy submitted did not address information related to network standards, coordination of care, and enrollee satisfaction. The missing elements should be addressed in future policy submissions to ensure compliance.
CCP	Provider Selection Credentialing/Recredentialing	**Element 5 – Indian Health Care Providers**: The MCO should include the Indian Health Care Providers requirement in policies and procedures showing compliance with the element criteria.
MCNA	Enrollee Information	**Element 11 – Minimum Requirements for Potential Enrollees 1**: The DBM should provide information regarding the length of the enrollment period to enrollees and/or potential enrollees. With approval from FHKC, the Member Handbook could be updated to include information regarding the length of enrollment so that enrollees are fully educated on enrollment timeframes.
MCNA	Provider Selection Credentialing/Recredentialing	**Element 11 – Board Certification Exemption**: The DBM should have policies in place to address board certification exemptions. Additional information regarding denial of entrance into the provider network or termination from the network when board certification has not been obtained should also be included as part of the policy.

Table 2122. ACA Strengths and Weaknesses by Standard		
MCO/DBM	**Standard Title**	**Strength/AON**
		Element 12 – Board Certification Exemption Requests: The DBM should have policies that address board certification exemptions and how that is considered in the credentialing process.
		Element 17 – Verification and Attestations: The DBM should have policies to address the physical and behavioral concerns of providers that could impact treatment for the enrollee.
DentaQuest	Enrollee Information	**Element 11 – Minimum Requirements for Potential Enrollees 1**: The DBM should provide information for potential enrollees regarding any populations that are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program. The DBM should provide mandatory and voluntary populations with information regarding the length of the enrollment period. The DBM should also include the service area that is covered.
		Element 22 – Enrollee Handbook: The DBM should demonstrate compliance with the sub-element regarding FHKC terminology.
DentaQuest	Enrollee Rights and Protections	**Element 10 – Liability for Payment**: The DBM should have policies and/or additional information available which addresses payment liability related to DBM insolvency, covered services should FHKC not pay the DBM, and payments for services from contracted providers who bill more than charges the DBM will cover for the service.
		Element 16 – Criminal Background Checks: The DBM should include documentation that demonstrates that providers are submitting fingerprint requests within 30 days of receipt of the request.
Liberty	Enrollee Information	**Element 5 – Electronic Information**: The DBM's policies should be updated to include reference to the five-business day turnaround time related to printed materials for enrollees for Element 5: Electronic Information.
		Element 10 – Language and Format: The DBM's policies should be updated to address the font requirements for enrollee materials. Specific information related to 12-point font and 18-point font for taglines should be added to ensure consistency with formatting of enrollee materials.

Table 2122. ACA Strengths and Weaknesses by Standard		
MCO/DBM	**Standard Title**	**Strength/AON**
Liberty	Enrollee Rights and Protections	**Element 10 – Liability for Payment**: The DBM should have policies in place that clearly identify that enrollees of the DBM are not liable for payments for all of the reasons listed in the requirements for Element 10: Liability for Payment.
Liberty	Provider Selection Credentialing/Recredentialing	**Element 4 – At-risk Providers 1**: The DBM should incorporate language into current policies to address risk level assessments for providers entering the network and for those that are attempting to recredential. The information presented shows that the DBM makes efforts to review all appropriate databases for background screening, but no information was provided regarding risk-level assessments of providers that have been found to have payment suspensions as a result of credible allegation of fraud, waste, or abuse.

Note: No strengths were identified for Aetna, CCP, or Simply in the 2023 ACA. No AONs were identified for Simply in the 2023 ACA.

Improvements Since the 2022 ACA

Corrective action plans (CAPs) are designed to improve performance and give plans the opportunity to receive help with quality improvement (QI). FHKC may request CAPs at its discretion, but MCOs and DBMs must submit a CAP for any QP standard element or file review scoring less than 100% compliance, regardless of overall performance on the standard or activity. Qsource provided technical assistance to the MCOs and DBMs completing CAPs, submitted CAP evaluations to FHKC for follow-up, and encouraged MCOs and DBMs to monitor CAP activities throughout 2022 to ensure they fully met stated goals and to close compliance gaps within documented timelines. All CAPs submitted after last year's ACA met objectives, as shown in **Table 22**.

Table 22. Improvements Since the 2022 ACA	
2022 AON	**Improvements**
CCP	
Coverage and Authorization of Services: Element #43—Enrollee Handbook Content 2: Community	CCP worked collaboratively with FHKC to make necessary updates to the CCP Enrollee Handbook and Provider Manual. Materials submitted to FHKC

Table 22. Improvements Since the 2022 ACA	
2022 AON	**Improvements**
Care Plan (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.	for those changes were provided to Qsource for review. The proposed updates made to the CCP Enrollee Handbook and Provider Manual satisfy the AON and bring CCP into compliance with Enrollee Handbook Content.
Coverage and Authorization of Services: Element #48—MCO Secure Website for Enrollees: 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. Documents submitted for review did not address the tracking of cost-sharing contributions to assist families in tracking their out-of-pocket maximums.	CCP updated the EPIC system to track cost share contributions. This action fulfilled the CAP.

Annual Network Adequacy (ANA)

Overview

Florida Healthy Kids Corporation (FHKC) administers the Florida Healthy Kids program and has contracted with Qsource, an EQR organization (EQRO), to conduct an annual analysis of its MCOs' provider network adequacy (ANA) as mandated by Title 42 of the Code of Federal Regulations, Sections 457.1218 and 438.68 (42 CFR §§ 457.1218 and 438.68). These sections require that FHKC develop and enforce provider network adequacy standards. The contract between FHKC and its MCOs establishes minimum requirements for services to be provided to Florida Healthy Kids enrollees and includes geographical access time and distance standards for urban and rural primary care, specialty care, hospitals, and ancillary providers as well as appointment availability standards to ensure timely enrollee access to services.

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

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

Methodology

The 2023 ANA review covered the period of January 1 to December 31, Qsource contracted with Quest Analytics, LLC, to assess geographical access to primary care providers (PCPs), high-volume specialty care providers, behavioral health providers and facilities, hospitals, laboratories, and pharmacies by calculating the travel time and distance between MCO or DBM enrollees and providers. The geographical access analyses identify the percentage of enrollees who had access to the various provider types within the travel time and distance standards set by the MCO's or DBM's contract with FHKC.

For the 2023 ANA review for Aetna, Qsource conducted the following:

- analyses of the geographic distribution of the MCO's providers as of June 2023; and
- review of the MCO's appointment availability and accessibility P&Ps, provider manual, and enrollee handbook in place during 2023.

Information and data for the 2023 ANA review were obtained from the MCO's provider file, the enrollment file provided by the enrollment broker, and the MCO's appointment availability P&Ps, provider manual, and enrollee handbook. This report

describes the review of methodologies, findings, and recommendations regarding network adequacy for Florida Healthy Kids enrollees.

Data Collection

The 2023 ANA evaluation included MCO and DBM provider networks as of June 2023. MCO and DBM relevant P&Ps and provider and enrollee communication materials were assessed. The reviewers focused on the following areas:

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

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

Quest Analytics derived the data for quantitative analyses from provider data files as of June 2023, supplied by Aetna, and enrollment/eligibility files as of July 1, 2023, provided by FHKC. To be included in the analysis, an enrollee had to have the following:

- active eligibility and enrollment in the MCO as of July 1, 2023;
- an address within Florida; and
- a valid address as defined by the Quest Analytics Suite™ during data standardization.

To be included in the analysis, a provider had to have the following:

- an active contract with the MCO as of June 2023;
- status as a network provider; and
- a valid address as defined by the Quest Analytics Suite™ during data standardization.

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

Data Standardization

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

- a single provider with multiple addresses was counted once for each address;
- multiple providers at the same address were counted as distinct providers;
- a single provider with more than one specialty was counted for each specialty; and

- providers whose National Provider Identifiers (NPIs) had been deactivated were excluded from the analyses.

All analyses were conducted based on a specified point in time, July 1, 2023. Results were based on the supposition that all variables utilized in the analyses were consistent across the entire period being reviewed.

Results

Network Adequacy

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

Table 23 contains the information about the standards used to evaluate the MCO's provider network for FHKC enrollees. Geographic access standards used in ANA analyses were derived from the Medical Services Contract (MSC) between FHKC and Aetna, section 24-4-2, effective January 1, 2020.

Table 23. MCO Travel Time and Distance Requirements

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

Table 23. MCO Travel Time and Distance Requirements				
Provider Type	**Time (in minutes)**		**Distance (in miles)**	
	Urban	**Rural**	**Urban**	**Rural**
Urgent Care Center	Report*	Report*	Report*	Report*
Telehealth Services	Report†	Report†	Report†	Report†

** FHKC opted to apply hospital access standards to urgent care center access.*
†There are currently no established time and distance standards set by FHKC for this provider type. A separate report is provided by provider.

Table 24 contains information about the standards used to evaluate the DBM's provider network for FHKC enrollees. Geographic access standards used in ANA analyses were derived from the Dental Services Contract (DSC) between FHKC and DentaQuest, section 3-2-3, amended July 1, 2018.

Table 24. DBM Travel Time and Distance Requirements				
Provider Type	**Time (in minutes)**		**Distance (in miles)**	
	Urban	**Rural**	**Urban**	**Rural**
Primary Care Dentists	20	30	20	30
Orthodontists	30	70	20	50
Dental Specialists	20	40	20	30

Table 25 presents the percentage of enrollees for each MCO that had access to care within the required travel time standards for each required provider type.

Table 25. MCO Time Analysis by Required Provider Type						
Provider Type	**% of Enrollees with Access: Aetna**		**% of Enrollees with Access: CCP**		**% of Enrollees with Access: Simply**	
	Urban 2023	**Rural 2023**	**Urban 2023**	**Rural 2023**	**Urban 2023**	**Rural 2023**
Primary Care Provider (PCP) – Family Medicine	99.91%	93.63%	100%	99.64%	99.95%	94.74%
PCP – Pediatrics	99.96%	94.40%	100%	100%	100%	99.91%
Allergy & Immunology	99.99%	84.65%	100%	93.28%	100%	97.50%

Table 25. MCO Time Analysis by Required Provider Type						
Provider Type	**% of Enrollees with Access: Aetna**		**% of Enrollees with Access: CCP**		**% of Enrollees with Access: Simply**	
	Urban 2023	**Rural 2023**	**Urban 2023**	**Rural 2023**	**Urban 2023**	**Rural 2023**
Dermatology	100%	97.02%	100%	43.01%	99.96%	84.34%
Obstetrics & Gynecology	99.91%	87.80%	100%	100%	99.98%	90.38%
Optometry	100%	100%	100%	100%	100%	98.58%
Otolaryngology (ENT)	99.98%	96.92%	100%	100%	99.99%	97.36%
Behavioral Health – Pediatric	99.99%	99.73%	98.32%	21.78%	100%	100%
Behavioral Health – Other	100%	100%	100%	100%	100%	100%
Specialist – Pediatric	99.98%	99.96%	100%	71.32%	99.89%	71.32%
Specialist – Other	99.89%	93.67%	99.99%	99.46%	99.93%	95.87%
Hospital	99.20%	88.23%	100%	60.98%	99.85%	89.65%
Pharmacy	99.84%	92.40%	99.79%	94.37%	99.87%	94.30%

Table 26 displays the percentage of enrollees in each MCO that had access to care within the required distance standards for each provider type.

Table 26. MCO Distance Analysis by Required Provider Type						
Provider Type	**% of Enrollees with Access: Aetna**		**% of Enrollees with Access: Community Care Plan**		**% of Enrollees with Access: Simply**	
	Urban 2023	**Rural 2023**	**Urban 2023**	**Rural 2023**	**Urban 2023**	**Rural 2023**
Primary Care Provider (PCP) – Family Medicine	99.94%	95.23%	100%	100%	99.98	95.61%
PCP – Pediatrics	100%	96.36%	100%	100%	100%	99.97%

Table 26. MCO Distance Analysis by Required Provider Type						
Provider Type	% of Enrollees with Access: Aetna		% of Enrollees with Access: Community Care Plan		% of Enrollees with Access: Simply	
	Urban 2023	Rural 2023	Urban 2023	Rural 2023	Urban 2023	Rural 2023
Allergy & Immunology	99.99%	74.36%	100%	87.84%	100%	93.26%
Dermatology	99.98%	94.02%	100%	42.29%	99.82%	80.56%
Obstetrics & Gynecology	99.99%	91.90%	100%	100%	100%	93.66%
Optometry	100%	99.54%	100%	100%	100%	97.47%
Otolaryngology (ENT)	98.83%	94.75%	100%	100%	99.87%	90.90%
Behavioral Health – Pediatric	99.99%	97.98%	99.49%	19.24%	100%	100%
Behavioral Health – Other	100%	100%	100%	100%	100%	100%
Specialist – Pediatric	99.98%	98.71%	100%	66.06%	99.67%	58.04%
Specialist – Other	99.94%	95.71%	100%	99.82%	99.97%	97.04%
Hospital	99.65%	91.46%	100%	61.52%	99.99%	92.94%
Pharmacy	99.43%	82.26%	99.77%	90.93%	99.55%	84.86%

Table 27 presents the percentage of enrollees for each DBM that had access to care within the required travel time standards for each required provider type.

Table 27. DBM Time Analysis by Required Provider Type

Provider Type	% of Enrollees with Access: DentaQuest		% of Enrollees with Access: Liberty		% of Enrollees with Access: MCNA	
	Urban 2023	Rural 2023	Urban 2023	Rural 2023	Urban 2023	Rural 2023
Primary Care Dentists*	99.99%	93.44%	99.98%	98.48%	99.98%	99.01%
Pediatric Dentists	97.82%	72.38%	93.32%	22.50%	97.98%	64.38%
General Dentists	99.99%	90.00%	99.98%	98.48%	99.98%	99.01%
Orthodontists*	100%	85.33%	100%	88.70%	99.40%	75.73%
Dental Specialists*	98.66%	32.78%	95.82%	43.85%	98.93%	38.55%
Endodontists	91.66%	14.39%	92.60%	29.57%	97.73%	23.53%
Oral Surgeons	92.67%	29.24%	93.79%	34.08%	97.17%	37.62%
Periodontists	83.96%	6.07%	71.74%	8.12%	93.70%	19.96%
Prosthodontists	24.68%	2.60%	53.97%	8.54%	29.03%	14.70%

**Only primary care dental is subject to contracted standards. Other dental specialists were analyzed for informational purposes only.*

Table 28 displays the percentage of enrollees in each DBM that had access to care within the required distance standards for each provider type.

Table 28. DBM Distance Analysis by Required Provider Type

Provider Type	% of Enrollees with Access: DentaQuest		% of Enrollees with Access: Liberty		% of Enrollees with Access: MCNA	
	Urban 2023	Rural 2023	Urban 2023	Rural 2023	Urban 2023	Rural 2023
Primary Care Dentists*	99.99%	95.16%	100%	99.43%	99.99%	99.73%
Pediatric Dentists	98.51%	79.08%	94.07%	32.37%	98.39%	75.62%
General Dentists	99.99%	93.30%	100%	99.43%	99.99%	99.70%
Orthodontists*	100%	71.22%	99.99%	76.89%	99.40%	69.89%
Dental Specialists*	97.88%	21.90%	95.20%	28.76%	98.22%	26.65%
Endodontists	90.89%	8.11%	91.69%	19.60%	96.82%	13.98%
Oral Surgeons	92.11%	20.53%	93.20%	21.17%	96.25%	25.97%
Periodontists	83.11%	4.21%	73.65%	6.07%	93.00%	12.64%
Prosthodontists	34.71%	3.23%	62.69%	4.70%	28.32%	9.76%

**Only primary care dental is subject to contracted standards. Other dental specialists were analyzed for informational purposes only.*

Appointment Availability

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

- Emergency care shall be provided immediately.
- Urgently needed care shall be provided within 24 hours.
- Routine care of enrollees who do not require emergency or urgent care shall be provided within seven (7) calendar days of the enrollee's request for services.
- Routine dental examinations shall be provided within four (4) weeks of the enrollee's request.
- Follow-up care shall be provided as medically appropriate.

Qsource reviewed each MCO's and DBM's P&Ps, provider manual, and enrollee handbook to ensure that appointment availability standards were in place during 2023 and consistent with contract standards. All MCOs and DBMs met these standards; the provider manual and enrollee handbook met all

criteria to ensure appointment availability standards were active during 2023 and consistent with contract standards.

Improvements from 2022 ANA

Based upon the recommendations made by Qsource in the 2022 ANA, the MCOs and DBMs worked to improve their time and distance results for the 2023 ANA. These recommendations and improvements can be seen in **Table 29.**

Table 29. Improvements Since the 2022 ANA by MCO/DBM

MCO/ DBM	Standard and Element	2022 Recommendations 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.	In response to the 2022 Annual Network Adequacy Report, ABH is constantly evaluating and taking appropriate action to improve access for rural enrollees and would like to note the following regarding the overall practitioner network adequacy results: ♦ Allergy and Immunology: FHKC has approved waivers for this specialty for regions 2,6, and 8 through December 31, 2021. In addition, ABHFL has requested again waivers for this specialty as of January 1, 2022. Extensive search of PML, NPI registry, competitor directories and internet searches did not result in any additional providers to recruit to improve access for this specialty (not interested in contracting with a Medicaid plan, unresponsiveness, unavailable licensed providers with this specialty in this area). ♦ Psychiatric Hospital (Free-Standing Psychiatric Facilities): ABH has completed the negotiations with the following psychiatric hospital and are in		✓	✓

Table 29. Improvements Since the 2022 ANA by MCO/DBM

MCO/ DBM	Standard and Element	2022 Recommendations for Improvement	MCO/DBM's Action	Quality	Timeliness	Access
			the onboarding process (credentialing and/or loading provider record) as a result 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, ABH is promoting and incorporating Telemedicine to the Network. Telemedicine modality is used as an alternative platform when appropriate and offered through MDLive (telemedicine vendor) or specialty providers that comply with the telemedicine requirements.			
	Appointment Availability and Accessibility Standards	Qsource recommends continued annual review of Aetna's appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.	Standards were available in the provider manual and the enrollee handbook.		✓	✓

Table 29. Improvements Since the 2022 ANA by MCO/DBM

MCO/ DBM	Standard and Element	2022 Recommendations for Improvement	MCO/DBM's Action	Quality	Timeliness	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.		✓	✓
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	Simply performed analysis after the 2022 ANA and stated that they took the following steps to improve in the recommended areas: ♦ 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 has submitted waiver requests to Florida Healthy Kids for Q1 on April 14, 2022, and Q2 on July 14, 2022, where there are no additional		✓	✓

Table 29. Improvements Since the 2022 ANA by MCO/DBM

MCO/ DBM	Standard and Element	2022 Recommendations for Improvement	MCO/DBM's Action	Quality	Timeliness	Access
		Healthcare should continue to monitor its provider network and implement corrective action for identified deficiencies.	providers to recruit in order to meet the access requirements. Allergy & Immunology: ♦ Simply submitted waiver requests 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. ♦ In Taylor County the DOH lists one eligible provider. This provider is contracted with the plan as a PCP Pediatric provider. The plan has			

Table 29. Improvements Since the 2022 ANA by MCO/DBM						
MCO/ DBM	**Standard and Element**	**2022 Recommendations for Improvement**	**MCO/DBM's Action**	**Quality**	**Timeliness**	**Access**
			confirmed that this provider no longer practices allergy and immunology. Obstetrics & Gynecology: ♦ Simply submitted waiver requests on July 14, 2022, for 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, 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, Franklin, and Holmes Counties. There are no providers in Calhoun and Holmes Counties. Franklin only has retired or deceased providers listed in the FL DOH search. Specialist – Pediatric ♦ Simply submitted waiver requests on July 14, 2022, for Q2 2022 in region 2, 3, and 4 for both time and distance. ♦ Region 2			

Table 29. Improvements Since the 2022 ANA by MCO/DBM						
MCO/ DBM	**Standard and Element**	**2022 Recommendations for Improvement**	**MCO/DBM's Action**	**Quality**	**Timeliness**	**Access**
			▪ Since last quarter, the Health Plan Specialists – Pediatrics 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 Specialists–Pediatrics 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 the member to travel outside of counties to Bay or Leon County. ♦ Region 3 ▪ 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			

Table 29. Improvements Since the 2022 ANA by MCO/DBM

MCO/ DBM	Standard and Element	2022 Recommendations for Improvement	MCO/DBM's Action	Quality	Timeliness	Access
			pediatric specialists found to contract with. No Pediatric specialists were found in Gilchrist, Dixie, Levy, and Citrus Counties. ♦ Region 4: 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 with. ♦ Simply submitted waiver requests for Q2 2022 for regions 6, 8, 9, and 11 in rural counties for distance only. ♦ Region 6: 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. ♦ Region 8: The rural counties of Glades and Hendry continue to not have pediatric specialists, causing an average distance of 33.8 miles for members without access in Glades County and 27.9 miles for members without access in Hendry			

Table 29. Improvements Since the 2022 ANA by MCO/DBM						
MCO/ DBM	**Standard and Element**	**2022 Recommendations for Improvement**	**MCO/DBM's Action**	**Quality**	**Timeliness**	**Access**
			County. There are no eligible pediatric specialists in these counties to contract with. ♦ Region 9: Pediatric specialists in this region are found with deficiencies in Okeechobee County for distance only, where no eligible pediatric specialists are found to contract with. ♦ Region 11: Pediatric specialists in this region are found in Miami-Dade County, with deficiencies in rural Monroe County where no eligible pediatric specialists are found to contract with. Pharmacy ♦ Simply submitted waiver requests in July Q2 2022 for region 2 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. ▪ Franklin County: There are two pharmacies available in this county according to the NCPDP database, both of which are in the FHK pharmacy network. ▪ Gulf County: There are three pharmacies available in this county according to the			

Table 29. Improvements Since the 2022 ANA by MCO/DBM						
MCO/ DBM	**Standard and Element**	**2022 Recommendations for Improvement**	**MCO/DBM's Action**	**Quality**	**Timeliness**	**Access**
			NCPDP database, all of which are in the FHK pharmacy network. ▪ Jackson County: There are 10 pharmacies available in this county according to the NCPDP database, all of which are in the FHK network. ▪ Jefferson County: There are two pharmacies available in this county according to the NCPDP database, both of which are in the FHK network. ▪ Liberty County: There is one pharmacy available in this county according to the NCPDP database, and it is in the FHK pharmacy network. ▪ Madison County: There are four pharmacies available in this county according to the NCPDP database, all of which are in the FHK pharmacy network. ▪ Washington County: There are four pharmacies available in this county according to the NCPDP database, all of which are in the FHK network. ▪ Holmes County: There are two pharmacies available in this county according to the NCPDP database, all of which are on the FHK network. ▪ Please note that for region 2, there were nine counties that did not meet the			

Table 29. Improvements Since the 2022 ANA by MCO/DBM						
MCO/ DBM	**Standard and Element**	**2022 Recommendations for Improvement**	**MCO/DBM's Action**	**Quality**	**Timeliness**	**Access**
			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.			
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 is no longer a part of FHKC's DBM network. This is no longer applicable.		✓	✓
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	DentaQuest identified two principal barriers while meeting specialist access in rural counties. DentaQuest's review showed 100% of members had access to a dental provider and were able to access care with an in-network provider, noting that most General Dentists and Pediatric Dentists also provide specialty services. The two identified barriers are:		✓	✓

Table 29. Improvements Since the 2022 ANA by MCO/DBM

MCO/ DBM	Standard and Element	2022 Recommendations for Improvement	MCO/DBM's Action	Quality	Timeliness	Access
		enrollees.	♦ 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 Specialists, extending access to 90 miles instead of 30 miles, and almost double for Orthodontists, 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 requirements in rural areas are often outside of DentaQuest's control due to lack of certified dental professionals practicing in most of these counties. Our 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 limited to no specialists residing in the county.			
MCNA	Network Adequacy: Time and	Qsource recommends that MCNA evaluate the potential and take	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		✓	✓

Table 29. Improvements Since the 2022 ANA by MCO/DBM						
MCO/ DBM	**Standard and Element**	**2022 Recommendations for Improvement**	**MCO/DBM's Action**	**Quality**	**Timeliness**	**Access**
	Distance Standards	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.	rural counties with no specialists, and 15 are in the panhandle.			

Conclusions and Recommendations

The ANA review assists FHKC, Qsource, and the MCO or DBM in identifying recommendations for improvement in addition to network adequacy scores. These can be found in **Table 30**.

Table 30. ANA Conclusions and Recommendations	
Aetna	**Strengths** ♦ Aetna met the appointment availability standards. The provider manual and enrollee handbook met all criteria to ensure appointment availability standards were active and consistent with contract standards. ♦ Aetna demonstrated comprehensive access (at least 94.00%) for time and distance standards to PCPs for both urban and rural enrollees. ♦ Urban access to all required specialties/specialty categories were at least 98.00% and showed an increase in all required specialties/specialty categories. **Recommendations**

Table 30. ANA Conclusions and Recommendations	
	♦ Qsource recommends that Aetna evaluate its potential and take appropriate actions to improve access for rural enrollees to allergy & immunology and obstetrics and gynecology.
CCP	**Strengths**
	♦ CCP met the appointment availability standards. The provider manual and enrollee handbook met all criteria to ensure appointment availability standards were active and consistent with contract standards. ♦ CCP demonstrated comprehensive access for time and distance standards to PCPs (at least 99.00%) for time and distance standards to PCPs for both urban and rural enrollees.
	Recommendations
	♦ Qsource recommends that CCP evaluate the potential and take appropriate actions to improve access to allergy & immunology, behavioral-pediatric and hospitals.
Simply	**Strengths**
	♦ Simply met the appointment availability standards. The provider manual and enrollee handbook met all criteria to ensure appointment availability standards were active and consistent with contract standards. ♦ Simply provided comprehensive access (at least 94.00%) for time and distance standards to PCPs for both urban and rural enrollees.
	Suggestions
	♦ Qsource recommends that Simply Healthcare evaluate the potential and take appropriate actions to improve access to dermatology, pediatric–specialists, acute care hospitals and pharmacy provider types for rural enrollees.
DentaQuest	**Strengths**
	♦ DentaQuest met the appointment availability standards. The provider manual and enrollee handbook met all criteria to ensure appointment availability standards were active and consistent with contract standards. ♦ DentaQuest provided comprehensive access (at least 93.00%) to primary care dentists for both urban and rural enrollees. ♦ Urban access to orthodontists was complete at 100%. ♦ For any dental specialist, urban access was comprehensive for distance and limited for time standards.

Table 30. ANA Conclusions and Recommendations	
	Suggestions
	♦ Qsource recommends that DentaQuest take appropriate actions to improve access to orthodontists and dental specialists for rural enrollees.
Liberty	**Strengths**
	♦ Liberty met the appointment availability standards. The provider manual and enrollee handbook met all criteria to ensure appointment availability standards were active and consistent with contract standards. ♦ Liberty provided comprehensive coverage for urban and rural enrollees in time and distance. Over 98.00% of urban and rural enrollees had access to primary care dental providers.
	Suggestions
	♦ Qsource recommends that Liberty take appropriate actions to improve access to orthodontists and dental specialists for rural enrollees. Access to orthodontists and dental specialists for rural enrollees was low, with dental specialists having the lowest overall rates at 28.76%.
MCNA	**Strengths**
	♦ MCNA met the appointment availability standards. The provider manual and enrollee handbook met all criteria to ensure appointment availability standards were active and consistent with contract standards. ♦ MCNA provided comprehensive access (at least 99.00%) to PCDs for both urban and rural enrollees.
	Suggestions
	♦ Qsource recommends that MCNA take appropriate actions to improve access to orthodontists, pediatric dentists, endodontists, oral surgeons, periodontists and prosthodontists and dental specialists for rural enrollees.

2023 EQR Conclusions and Recommendations

Qsource conducted mandatory EQR activities for FHKC's plans for MY 2022. The results of 2023 EQR activities demonstrate that FHKC's managed care plans are well qualified and committed to facilitating timely, accessible, and high-quality healthcare for FHKC members. Achieving high or perfect compliance scores in all assessment activities, implementing innovative and successful programs and initiatives for improvement, and acting quickly to correct any noted deficiencies, the plans exemplify FHKC's Core Values and strive continuously to fulfill the goals of its Quality Strategy. Qsource recommends that FHKC continue to use stringent measures from the ANA review, ACA, PMV, and PIP validation as the primary means for assessing the Quality Strategy's success as applied to the integrated physical and behavioral health services delivered by its plans. The 2023 EQR assessment results, including the identification of plan strengths, recommendations, and CAPs, attest to the positive impact of FHKC's strategy in monitoring plan compliance, improving quality, and aligning healthcare goals.

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

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

PIP Validation

FHKC Quality Strategy goals of Quality, Satisfaction, and Growth outline specific steps to monitor quality improvement in order to maintain high standards and improve the health of enrollees. Qsource's analysis of each PIP revealed that the Plans demonstrated an understanding of the improvement process by providing descriptions of the intervention, barriers, and likelihood to create a change, as well as future considerations for the interventions implemented. At the same time, weaknesses were noted in a handful of PIPs regarding clear written AIM statements, missing or incomplete information, and purposeful improvement strategies; all of which compromised the ability of Qsource to fully evaluate and make conclusions about the results and the validity of those studies. For the 2023 EQR evaluation, Qsource developed a PIP Summary Form (with accompanying PIP Summary Form Completion Instructions) and a PIP Validation Tool to standardize the process by which each MCO and DBM delivers PIP information to FHKC and how the information was assessed. Qsource views the results as a learning opportunity for the Plans and will assist in education of the Plans to achieve better results next measurement year. FHKC should continue to monitor the Plans PIPs as part of its Quality

Strategy to ensure quality, timeliness, and access to care for its enrollees.

PMV

PMV is designed to assess the accuracy of reported performance measures and determine the extent to which the reported rates follow the measure specifications and reporting requirements. FHKC identified 23 performance measures for MCOs and 8 for DBMs. Qsource defined the scope of the validation to include the FHKC required metrics as part of its validation, which included data source, reporting frequency, and format. In addition to document review, the Qsource audit included system demonstrations, review of data output files, observation of data processing, and review of data reports.

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

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

All Plans met all specifications for the designated measures. In addition, the data integration, control, and performance measure documentation reviewed indicated an overall high confidence in each's ability to provide quality and timely care for its enrollees. No weaknesses were noted in any MCO's or DBM's processes for data collection and performance measure reporting.

ACA

Enrollee Information, Enrollee Rights and Protections, and Provider Selection (Credentialing/Recredentialing) were the areas evaluated during the 2023 ACA activities. With the exception of one standard for one DBM, all MCOs and DBMs achieved a high level of compliance at 90.00% or greater in all 2023 ACA standards.

ANA

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

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

Based on the analyses of the MCO and DBM's geographical network adequacy, Qsource concluded that all Plans met the geographic requirements for urban accessibility to providers. Qsource recommends that MCO's work to improve rural access to allergy and immunology, obstetrics and gynecology, pharmacy-type providers, behavioral-pediatric, dermatology, pediatric–specialists, hospitals, and acute care hospitals. Toward achievement of Quality Strategy Plan goals, Qsource recommends that the Plans be proactive in monitoring and adding providers to their network to ensure a robust provider network for all their enrollees.

Overall, the results of the 2023 EQR activities demonstrated that the Plans were well-qualified and committed to facilitating timely, accessible, and high-quality healthcare for all enrollees.

Appendix A | 2023 PMV Audited Measures

MCO Performance Measures

The HEDIS measures validated by Qsource for MY2022 (January 1, 2022 – December 31, 2022) are listed and defined by their category of care in **Table A-1**. The measures are collected and reported by the MCO annually. Measure definitions are based on the following:

- HEDIS measures: NCQA's HEDIS® Measurement Year 2022 Volume 2: Technical Specifications for Health Plans
- CMS, The Joint Commission (TJC), Office of Population Affairs (OPA), and Agency for Healthcare Research and Quality (AHRQ) measures – Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2022 Reporting

Table A-1. 2023 PMV: MCO Performance Measures

Measure Name	Measure Steward and Definition
Primary Care Access and Preventive Care	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	NCQA: WCC measures the percentage of enrollees 3 to 17 years of age who had an outpatient visit with a primary care provider (PCP) or obstetrician/gynecologist (OB/GYN) and who had evidence of three indicators: body mass index (BMI) percentile documentation, counseling for nutrition, and counseling for physical activity during the MY. For WCC, a total rate and two age stratifications are reported for each indicator (only one indicator, BMI, is required for reporting for the Florida Healthy Kids population): ♦ 3–11 years ♦ 12–17 years
Chlamydia Screening in Women (CHL)	NCQA: CHL measures the percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the MY. This measure calculates a total rate as well as two age stratifications (only one applies to the Florida Healthy Kids population): ♦ Women ages 16–24
Immunizations for Adolescents (IMA-E)	NCQA: IMA measures the percentage of adolescents 13 years of age who had

Table A-1. 2023 PMV: MCO Performance Measures	
Measure Name	**Measure Steward and Definition**
	one dose of meningococcal vaccine; one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine; and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.
Child and Adolescent Well-Care Visits (WCV)	NCQA: WCV measures the percentage of enrollees 3 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the MY. For each product line, report the following stratifications by race and total, and stratifications by ethnicity and total. For WCV, report three age stratifications and total rate: ♦ 3–11 years ♦ 12–17 years ♦ 18–21 years
Maternal and Perinatal Health	
Prenatal and Postpartum Care (PPC)	NCQA: PPC measures the percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care: ♦ Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, 280–176 days prior to delivery, on or before the enrollment start date or within 42 days of enrollment in the organization. ♦ Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. Report the stratifications by race and total.
Contraceptive Care – Postpartum Women Ages 15−20 (CCP)	OPA: CCP measures the percentage of female enrollees 15 to 44 years of age who had a live birth and were provided postpartum contraceptive care. Four rates are reported as the percentage of female enrollees who had a live birth that were provided contraceptive care:

Table A-1. 2023 PMV: MCO Performance Measures	
Measure Name	**Measure Steward and Definition**
	♦ Most or moderately effective contraception: 3 days ♦ Most or moderately effective contraception: 60 days ♦ Long-acting reversible method of contraception (LARC): days ♦ LARC: 60 days This measure is reported for two age stratifications (only one age stratification applies to the Florida Healthy Kids population): ♦ Women ages 15–20
Cesarean Birth (PC-02)	TJC: PC-02 measures the percentage of nulliparous female enrollees with a term, singleton baby in a vertex position delivered by cesarean birth (C-section).
Contraceptive Care – All Women Ages 15–20 (CCW)	OPA: CCW measures the percentage of female enrollees 15 to 44 years of age at risk of unintended pregnancy who were provided contraceptive care. Two rates are reported: ♦ Most effective or moderately effective method of contraception ♦ LARC This measure is reported for two age stratifications (only one age stratification applies to the Florida Healthy Kids population): ♦ Women ages 15–20
Care of Acute and Chronic Conditions	
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	NCQA: Assesses the percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event. This measure calculates a total rate as well as four age stratifications (only two apply to the Florida Healthy Kids population): ♦ 3 months–17 years ♦ 18–64 years

Table A-1. 2023 PMV: MCO Performance Measures	
Measure Name	**Measure Steward and Definition**
Asthma Medication Ratio (AMR)	NCQA: AMR measures the percentage of enrollees 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the MY. This measure calculates a total rate as well as four age stratifications (only two apply to the Florida Healthy Kids population): ♦ 5–11 years ♦ 12–18 years
Appropriate Testing for Pharyngitis (CWP)	NCQA: CWP measures the percentage of episodes for members 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode. A total rate and three age stratifications are reported for CWP (only two apply to the Florida Healthy Kids population): ♦ 3–17 years ♦ 18–64 years
Appropriate Treatment for Upper Respiratory Infection (URI)	NCQA: URI measures the percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event. The measure is reported as an inverted rate [1– (numerator/eligible population)]. A higher rate indicates appropriate URI treatment (i.e., the proportion of episodes that did not result in an antibiotic dispensing event.) A total rate and three age stratifications are reported for URI (only two apply to the Florida Healthy Kids population): ♦ 3 months–17 years ♦ 18–64 years
Ambulatory Care: Emergency Department Visits (AMB-ED)	NCQA: AMB-ED summarizes utilization of ambulatory care for enrollees in the category of emergency department (ED) visits. This measure is reported in visits per 1,000 enrollee months. For AMB-ED, a total rate and nine age

Table A-1. 2023 PMV: MCO Performance Measures	
Measure Name	**Measure Steward and Definition**
	stratifications are reported (only two apply to the Florida Healthy Kids population): ♦ 1–9 years ♦ 10–19 years
Behavioral Healthcare	
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	NCQA: The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported: ♦ Initiation Phase: The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. ♦ Continuation and Maintenance Phase: The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.
Depression Screening and Follow-up for Adolescents and Adults (DSF-E)	CMS: The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care: ♦ Depression Screening. The percentage of members who were screened for clinical depression using a standardized instrument. ♦ Follow-Up on Positive Screen. The percentage of members who received follow-up care within 30 days of a positive depression screen finding.
Follow-Up After Hospitalization for Mental Illness (FUH)	NCQA: FUH measures the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness

Table A-1. 2023 PMV: MCO Performance Measures	
Measure Name	**Measure Steward and Definition**
	or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: ♦ The percentage of discharges for which the member received follow-up within 30 days after discharge. ♦ The percentage of discharges for which the member received follow-up within 7 days after discharge. For FUH, a total rate and three age stratifications are reported (only two apply to the Florida Healthy Kids population): ♦ 6–17 years ♦ 18–64 years
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	NCQA: FUM measures the percentage of ED visits for enrollees 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported: ♦ The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). ♦ The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days). For FUM, a total rate and three age stratifications are reported (only two apply to the Florida Healthy Kids population): ♦ 6–17 years ♦ 18–64 years
Follow-Up After Emergency Department Visit for Substance Use (FUA)	NCQA: FUA measures the percentage of emergency department (ED) visits among members aged 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported: ♦ The percentage of ED visits for which the member received follow-up

Table A-1. 2023 PMV: MCO Performance Measures	
Measure Name	**Measure Steward and Definition**
	within 30 days of the ED visit (31 total days). ♦ The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days). For FUA, a total rate and two age stratifications are reported: ♦ 13–17 years ♦ 18 years and older
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	NCQA: APP measures the percentage of enrollees 1 to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment. For APP, a total rate and two age stratifications are reported: ♦ 1–11 years ♦ 12–17 years
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	NCQA: The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: ♦ The percentage of children and adolescents on antipsychotics who received blood glucose testing. ♦ The percentage of children and adolescents on antipsychotics who received cholesterol testing. ♦ The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing. 1–17 years as of December 31 of the measurement year. Report two age stratifications and a total rate for each of the three indicators: ♦ 1–11 years. ♦ 12–17 years.

Table A-1. 2023 PMV: MCO Performance Measures	
Measure Name	**Measure Steward and Definition**
	♦ Total
Initiation and Engagement of Substance Use Disorder Treatment (IET)	NCQA: IET measures the percentage of adolescent and adult enrollees who demonstrated a new episode of alcohol or other drug (AOD) abuse or dependence and received the following during the intake period of January 1 through November 14 of the MY: ♦ Initiation of AOD Treatment: Initial treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis. ♦ Engagement of AOD Treatment: Initial treatment and engaged in ongoing AOD treatment within 34 days of the initiation visit. For IET, a total rate and two age stratifications are reported for each indicator: ♦ 13–17 years ♦ ≥ 18 years For the total rate and each age stratification, a total rate and three diagnosis categories are reported for each indicator: ♦ Alcohol abuse or dependence ♦ Opioid abuse or dependence ♦ Other drug abuse or dependence
Diagnosed Substance Use Disorders (DSU)	NCQA: DSU summarizes the percentage of members 13 years of age and older who were diagnosed with a substance use disorder during the measurement year. Four rates are reported: ♦ The percentage of members diagnosed with an alcohol disorder. ♦ The percentage of members diagnosed with an opioid disorder.

Table A-1. 2023 PMV: MCO Performance Measures	
Measure Name	**Measure Steward and Definition**
	♦ The percentage of members diagnosed with a disorder for other or unspecified drugs. ♦ The percentage of members diagnosed with any substance use disorder. For DSU, a total rate and three age stratifications are reported for each indicator (only two apply to the Florida Healthy Kids population): ♦ 13–17 years ♦ 18–24 years
Diagnosed Mental Health Disorders (DMH)	NCQA: DMH summarizes the percentage of members 1 year of age and older who were diagnosed with a mental health disorder during the measurement year. A total rate and four age stratifications are reported for each indicator (only two apply to the Florida Healthy Kids population): ♦ 1-17 years ♦ 18-64 years
Experience of Care	
CAHPS Health Plan Survey 5.1H, Child Version (CPC)	AHRQ: CPC provides information on parents' experience with their child's healthcare in the Florida Healthy Kids program and gives a general indication of how well the healthcare meets their needs. Results summarize enrollee experiences through ratings, composites, and individual question summary rates. Four global rating questions reflect overall satisfaction: ♦ Ratings for all healthcare ♦ Rating of health plan ♦ Rating of personal doctor ♦ Rating of specialist seen most often

Table A-1. 2023 PMV: MCO Performance Measures	
Measure Name	**Measure Steward and Definition**
	♦ Four composite scores summarize responses in the following areas: ♦ Customer service ♦ Getting care quickly ♦ Getting needed care ♦ How well doctors communicate Item-specific question summary rates are reported for the rating questions and each composite question. Question Summary Rates are also reported individually for one item summarizing the following concept: Coordination of Care.

DBM Performance Measures

Qsource validated seven CMS-416 measures and one Healthcare Effectiveness Data and Information Set (HEDIS) dental performance measure identified by FHKC for the 2023 PMV activities for the DBMs. These measures are listed and defined in **Table A-2.**

Table A-2. 2023 PMV: DBM Performance Measures	
Measure Name	**Measure Steward and Definition**
Enrolled Children Receiving Dental Sealants on Permanent Molars (SEAL)	CMS-416: SEAL measures the percentage of enrollees in age categories 6–9 and 10–14 years who received a sealant on a permanent molar tooth during the federal fiscal year.
Enrolled Children Receiving Dental Sealants on Permanent Molars – With Exclusions (SEAL – With Exclusions)	CMS-416: SEAL – Modified– With Exclusions measures the percentage of enrollees in age categories 6–9 and 10–14 years who received a sealant on a permanent molar tooth during the federal fiscal year, excluding from the denominator any enrollees who had molars previously sealed, restored, or extracted.
Enrolled Children Receiving Preventive Dental Services (PDENT)	CMS-416: PDENT measures the percentage of enrollees who received at least one preventive dental service during the federal fiscal year.

Table A-2. 2023 PMV: DBM Performance Measures	
Measure Name	**Measure Steward and Definition**
Enrolled Children Receiving Any Dental Services	CMS-416: Enrolled Children Receiving Any Dental Services measures the percentage of enrollees who received at least one dental service during the federal fiscal year.
Enrolled Children Receiving Dental Treatment Services (TDENT)	CMS-416: TDENT measures the percentage of enrollees who received at least one dental treatment service during the federal fiscal year.
Enrolled Children Receiving Diagnostic Dental Services	CMS-416: Enrolled Children Receiving Diagnostic Dental Services measures the percentage of enrollees who received at least one diagnostic dental service during the federal fiscal year.
Enrolled Children Receiving Any Preventive Dental or Oral Health Service	CMS-416: Enrolled Children Receiving Any Preventive Dental or Oral Health Service measures the percentage of enrollees who received either a preventive dental service by or under the supervision of a dentist or a preventive oral health service by a qualified healthcare practitioner who is neither a dentist nor providing services under the supervision of a dentist during the federal fiscal year.
Annual Dental Visit (ADV)	NCQA: ADV measures the percentage of enrollees 2–20 years of age who had at least one dental visit during the measurement year. For ADV, a total rate and six age stratifications are reported (only four apply to the Florida Healthy Kids population): ♦ 4–6 years ♦ 7–10 years ♦ 11–14 years ♦ 15–18 years

Appendix B | 2023 Sample EQR Assessment Tools

ACA MCO Tools

2023 Annual Compliance Assessment: <MCO>					
Enrollee Information					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
1. Information Format *42 Code of Federal Regulations (CFR) 438.10(c)(1), Medical Services Contract (MSC) 3.19.2*	The managed care organization (MCO) must provide all required information to enrollees and potential enrollees in a language that is clear and non-technical and in a format that may be easily understood and is readily accessible by such enrollees and potential enrollees in accordance with 42 CFR 438.10.	☐ Easily Understood	0.500	1.000	
		☐ Readily Accessible	0.500		
Findings Strength AON Suggestion					
2. Beneficiary Support System *42 CFR 438.71(d)*	The beneficiary support system must perform outreach to beneficiaries and/or authorized representatives and be accessible in multiple ways including phone, internet, in-person, and via auxiliary aids and services when requested. A state	☐ Choice counseling for all beneficiaries	0.333	1.000	
		☐ Assistance for Enrollees in	0.333		

	beneficiary support system must include at a minimum: a. Choice counseling for all beneficiaries. b. Assistance for enrollees in understanding managed care. c. Assistance as specified for enrollees who use or express a desire to receive Long Term Support Services (LTSS) in paragraph (d) of this section.	understanding managed care; and			
		☐ Assistance as specified for enrollees who use, or express a desire to receive, LTSS	0.334		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
3. 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.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					

4. Choice Counseling *42 CFR 438.71(c)*	a. Choice counseling, as defined in § 438.2, must be provided to all potential enrollees and enrollees who disenroll from an MCO, prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), primary care case management (PCCM) or PCCM entity for reasons specified in § 438.56(b) and (c). b. If an individual or entity provides choice counseling on the State's behalf under a memorandum of agreement or contract, it is considered an enrollment broker as defined in § 438.810(a) and must meet the independence and freedom from conflict-of-interest standards in § 438.810(b)(1) and (2). c. An entity that receives non-Medicaid funding to represent beneficiaries at hearings may provide choice counseling on behalf of the State so long as the State requires firewalls to ensure that the requirements for the provision of choice counseling are met.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
		☐ Accessible format	0.200	1.000	

5. Electronic Information *42 CFR 438.10(c)(6)(i) - (v), MSC 21.3*	The MCO 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 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.	☐ Prominently placed and readily accessible on MCO website	0.200		
		☐ Can be electronically retained and printed	0.200		
		☐ Meets content and language requirements	0.200		
		☐ Enrollee informed that information is available in paper form without charge upon request, to be received within five business days	0.200		
Findings Strength AON Suggestion					
6. Enrollee Assistance *42 CFR 438.10(c)(7), MSC 21*	The MCO must have in place mechanisms to help enrollees and potential enrollees understand the requirements and benefits of the plan. The MCO also must comply with the guidance issued by the Office for Civil Rights (OCR) of the United States Department of Health and Human Services regarding the availability of information and	☐ Mechanisms in place to help enrollees and potential enrollees	0.500	1.000	
		☐ Compliance with OCR guidance	0.500		

	assistance for persons with limited English proficiency.				
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
7. Language Identification *42 CFR 438.10(d)(1)*	The MCO must detail the methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in each MCO, PIHP, PAHP, or PCCM entity service area.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					
8. Translation Services and Enrollee Communications *42 CFR*	The MCO must: a. Make oral interpretation available in all languages and written translation available in each prevalent non-English language. b. Make interpretation services available free of charge to each enrollee, including oral interpretation and the use of auxiliary aids such as teletypewriter/Telecommunications Device	☐ Make oral interpretation available in all languages and written translation available in each prevalent non-English language	0.200	1.000	

438.10(d)(2)-(4), MSC 21.3	for the Deaf (TTY/TDY) and American Sign Language (oral interpretation requirements apply to all non-English languages, not just those that Florida Healthy Kids Corporation [FHKC] identifies as prevalent). c. Ensure that all written materials for enrollees include taglines in the prevalent non-English languages in the service area, as well as large print of no less than 18-point font size, explaining the availability of written translations and oral interpretation to understand information provided and the toll-free and TTY/TDY telephone number of the entity providing choice counseling services as required by 42 CFR 438.71(a). d. Make all its written materials available in English, Spanish, and all appropriate foreign languages. e. Make its 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, available in the prevalent non-English languages in its particular service area.	☐ Make interpretation services available free of charge to each enrollee	0.200		
		☐ Written materials include taglines in prevalent non-English languages in print no less than 18-point font size and explain availability of translation services	0.200		
		☐ All written materials available in English, Spanish, and all other appropriate foreign languages	0.200		
		☐ Materials that are critical to obtaining services are available in the prevalent non-English languages in its particular service area	0.200		

Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
9. Language and Format *42 CFR 438.10(d)(2)-(4), MSC 21.3*	The MCO must: a. Ensure enrollee information is in an easily understood language and format, including a font size no smaller than 12 point. b. Make its written materials available in alternative formats upon request of the potential enrollee or enrollee—taking into consideration enrollees' special needs, including those who are visually impaired or have limited reading proficiency—at no cost). c. Notify all enrollees that information is available at no cost upon request in alternative formats, including auxiliary aids and services, oral interpretation in any language, and written interpretation in the language(s) prevalent in the service area, and how to access those formats.	☐ Easily understood language and format, with no smaller than 12-point font size	0.250	1.000	
		☐ Written materials available in prevalent non-English languages in service area	0.250		
		☐ Written materials available in alternative formats upon request at no cost	0. 250		
		☐ Notification to enrollees of availability of information in alternative formats	0. 250		

		and how to access those formats			
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
10. Minimum Requirements for Potential Enrollees - 1 *442 CFR 438.10(e) (2) (i) - (iv), 2 CFR 438.10(d)(2)-(4), MSC 21.3*	The information for potential enrollees must include, at a minimum, all of the following: a. Information about the potential enrollee's right to disenroll consistent with the requirements of § 438.56 and which clearly explains the process for exercising this disenrollment right, as well as the alternatives available to the potential enrollee based on their specific circumstance. b. The basic features of managed care: i. Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program. For mandatory and voluntary populations, the length of the enrollment period and all disenrollment opportunities available to the enrollee must also be specified. ii. The service area covered by each MCO, PIHP, PAHP, PCCM, or PCCM entity.	☐ Right to disenroll	0.200	1.000	
		☐ Populations excluded from enrollment	0.200		
		☐ Length of enrollment period	0.200		
		☐ Disenrollment opportunities	0.200		
		☐ Service area	0.200		

Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
11. Minimum Requirements for Potential Enrollees - 2 *42 CFR 438.10(e)(2)(v)(A) – (C), MSC 21.3*	The information for potential enrollees must include, at a minimum, all of the following: a. Covered benefits including: i. Which benefits are provided by the MCO, PIHP, or PAHP. ii. Which, if any, benefits are provided directly by the State. iii. For a counseling or referral service that the MCO, PIHP, or PAHP does not cover because of moral or religious objections, the State must provide information about where and how to obtain the service.	☐ Benefits provided	0.333	1.000	
		☐ State provided benefits if any	0.333		
		☐ Counseling and/or referral services available due to objection of moral or religions reasons	0.334		
Findings Strength AON Suggestion					
12. Minimum Requirements for Potential Enrollees - 3	The information for potential enrollees must include, at a minimum, all of the following: a. The provider directory and formulary information required in paragraphs (h) and (i) of this section;	☐ Provider directory	0.200	1.000	
		☐ Any cost-sharing that will be imposed	0.200		

42 CFR 438.10(e)(2) (vi)-(x), MSC 21.3	b. Any cost-sharing that will be imposed by the MCO, PIHP, PAHP, PCCM, or PCCM entity consistent with those set forth in the State plan; c. The requirements for each MCO, PIHP or PAHP to provide adequate access to covered services, including the network adequacy standards established in § 438.68; d. The MCO, PIHP, PAHP, PCCM and PCCM entity's responsibilities for coordination of enrollee care; and e. To the extent available, quality and performance indicators for each MCO, PIHP, PAHP and PCCM entity, including enrollee satisfaction.	☐ Network standards	0.200		
		☐ Coordination of care	0.200		
		☐ Enrollee satisfaction	0.200		
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
13. Provider Directory Minimum Requirements - 1 *42 CFR 438.10(h)(1), MSC 21.3.1(c)*	Each MCO, PIHP, PAHP, and when appropriate, the PCCM entity, must make available in paper form upon request and electronic form, the following information about its network providers: a. The provider's name as well as any group affiliation b. Street address(es) c. Telephone number(s) d. Web site URL, as appropriate e. Specialty, as appropriate	☐ Provider name	0.090	1.000	
		☐ Street address	0.090		
		☐ Phone Number	0.090		
		☐ Website	0.090		
		☐ Specialty	0.090		
		☐ Accepting new patients	0.090		

	f. Whether the provider will accept new enrollees g. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office h. Age limitation i. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment j. Office Hours k. Whether the provider has completed cultural competency training	☐ Cultural and linguistic capabilities	0.090		
		☐ Accommodations for people with physical disabilities	0.090		
		☐ Age limitations	0.090		
		☐ Office hours	0.090		
		☐ Whether the provider has completed cultural competency training	0.090		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
14. Provider Directory Minimum Requirements - 2 *42 CFR*	The provider directory must include the following provider types covered under the contract: a. Physicians, including specialists b. Hospitals c. Pharmacies d. Behavioral Health Providers e. LTSS provides, as appropriate	☐ Physicians and specialists	0.200	1.000	
		☐ Hospitals	0.200		
		☐ Pharmacies	0.200		
		☐ Behavioral health providers	0.200		

438.10(h)(2), MSC 21.3.1(c)		☐ LTSS providers, as appropriate	0.200		
Findings Strength AON Suggestion					
15. Provider Directory Minimum Requirements - 3 *42 CFR 438.10(h)(3)-(4), MSC 21.3.1(c)*	Information included in: i. A paper provider directory must be updated at least: a. Monthly, if the MCO, PIHP, PAHP, or PCCM entity does not have a mobile-enabled, electronic directory; or b. Quarterly, if the MCO, PIHP, PAHP, or PCCM entity has a mobile-enabled, electronic provider directory. ii. Information included in an electronic provider directory must be updated no later than 30 calendar days after the MCO, PIHP, PAHP, or PCCM entity receives updated provider information. Provider directories must be made available on the MCO's, PIHP's, PAHP's, or, if applicable, PCCM entity's web site in a machine-readable file and format.	☐ Paper directory is updated monthly or quarterly if mobile is enabled	0.333	1.000	
		☐ Electronic directory is updated every 30 days	0.333		
		☐ Directory is available online	0.334		
Findings Strength AON Suggestion					
	Criteria	Criteria Met		Element	

Evaluation Elements			Criteria Value	Value	Score
16. Minimum Requirements for Enrollee Notification *MCS 21.3.1(b)*	At a minimum, the MCO must ensure that all enrollees are made aware of: a. The rights and responsibilities of both the enrollee and MCO. b. The role of the primary care provider (PCP). c. What to do in an emergency or urgent medical situation. d. How to request a grievance or appeal or contact the Independent Review Organization (IRO). e. How to report fraud and abuse. f. Procedures for referrals and prior authorizations, including prescription coverage. g. How to acquire behavioral health and substance abuse services. h. Any additional telephone numbers or contact information for reaching the MCO. i. Eligibility compliance requirements under the program, specifically for payment of premiums and renewal.	☐ Rights and responsibilities of both enrollee and MCO	0.111	1.000	
		☐ Role of PCP	0.111		
		☐ What to do in emergency or urgent medical situation	0.111		
		☐ How to request grievance or appeal, or request independent review	0.111		
		☐ How to report fraud and abuse	0.111		
		☐ Procedures for referrals and prior authorizations, including prescription coverage	0.111		
		☐ How to acquire behavioral health and substance abuse services	0.111		

		☐ Any additional telephone numbers or contact information for reaching MCO	0.111		
		☐ Eligibility compliance requirements under program, specifically for payment of premiums and renewal	0.111		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
17. Provider Termination Notice *42 CFR 438.10(f)(1), MSC 3.19.2*	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.	☐ Written notice to enrollee	0.500	1.000	
		☐ Notice provided within 15 calendar days	0.500		

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Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
18. Advance Directives *MSC 21.3.1(g)*	The MCO must provide adult enrollees with written information on advance directive policies, including a description of applicable Florida law, within five business days of the enrollee's 18th birthday or enrollment, if enrollee enrolled as an adult. Such information must be updated to reflect changes in state law within 90 calendar days of the effective date of such change.	☐ Adult enrollees provided with written information on advance directive policies, including applicable Florida law, within five business days of enrollee's 18th birthday or enrollment, if enrollee enrolled as adult	0.500	1.000	
		☐ Information updated to reflect changes in state law within 90 calendar days	0.500		

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AON Suggestion					
19. Certificates of Creditable Coverage *MSC 21.3.1(h)*	The MCO is responsible for issuing certificates of creditable coverage to enrollees, upon request or upon the enrollee's coverage termination.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					
20. Physician Incentive Plan *42 CFR 438.10(f)(3), MSC 24.5*	The MCO must make available, upon request, any physician incentive plans in place as set forth in 42 CFR 438.3(i).	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score

21. Enrollee Handbook *42 CFR 438.10(g)(1), MSC Attachment C: PG-8*	Within five business days of receipt of an enrollment file, the MCO must provide each enrollee a model enrollee handbook provided by FHKC that complies with any federal or state requirements, uses FHKC-developed definitions for managed care terminology, and serves a similar function as the summary of benefits and coverage described in 45 CFR 147.200(a).	☐ Model enrollee handbook provided by FHKC provided to enrollees within five business days of receipt of enrollment file	0.250	1.000	
		☐ Complies with any federal and state requirements	0.250		
		☐ Uses FHKC-developed managed care terminology definitions	0.250		
		☐ Serves similar function as summary of benefits and coverage described in 45 CFR 147.200(a)	0.250		
Findings Strength AON Suggestion					

22. Enrollee Handbook Content - 1 *42 CFR 438.10(g)(2)(i) - (iv), MSC 21.3.1(b)*	The MCO's enrollee handbook must include, at a minimum: a. Benefits provided by the MCO. b. How and where to access any benefits provided by FHKC, including any cost sharing, and how transportation is provided. c. The amount, duration, and scope 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 PCP.	☐ Benefits provided by MCO	0.250	1.000	
		☐ How and where to access benefits and transportation	0.250		
		☐ Amount, duration, and scope of available benefits	0.250		
		☐ Procedures for obtaining benefits	0.250		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
23. Enrollee Handbook Content - 2 *42 CFR 438.10(g)(2)(v) - (viii), MCS 21.3.1(b)*	The MCO'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	☐ Extent to which, and how, after-hours and emergency coverage are provided	0.250	1.000	
		☐ Restrictions on enrollee's choice among network providers	0.250		

	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, with 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.	☐ Extent to which, and how, enrollees may obtain benefits, including explanation about not needing referral for family planning provider	0.250		
		☐ Cost sharing, if applicable	0.250		
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
24. Enrollee Handbook Content - 3 *42 CFR 438.10(g)(2)(ix) -*	The MCO's enrollee handbook must include, at a minimum: a. Enrollee rights and responsibilities, including the elements specified in 42 CFR 438.100. b. The process of selecting and changing the enrollee's PCP. c. Grievance, appeal, and independent review procedures and timeframes in an FHKC-	☐ Enrollee rights and responsibilities	0.250	1.000	
		☐ Process of selecting and changing enrollee's PCP	0.250		

(xii), MSC 21.3.1(b)	developed or -approved description, to 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 use of an IRO or the federal review process after the MCO has made a determination on an enrollee's appeal that is averse 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 to use an IRO or the federal review process 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 IRO/federal review process is pending if the final decision is adverse to the enrollee. d. How to exercise an advance directive, as set forth in 42 CFR 438.3(j).	☐ FHKC-developed or -approved grievance, appeal, and independent review procedures and timeframes	0.250		
		☐ How to exercise advance directive	0.250		
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	

				Value	Score
25. Enrollee Handbook Content - 4 *42 CFR 438.10(g) (2) (xiii) -(xvi), MSC 21.3.1(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. d. Other content required by FHKC in its Plan Model Enrollee Handbook.	☐ How to access auxiliary aids and services	0.250	1.000	
		☐ Toll-free numbers	0.250		
		☐ How to report suspected fraud or abuse	0.250		
		☐ Other FHKC-required content in Plan Model Enrollee Handbook	0.250		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
26. Information Delivery Methods *42 CFR 438.10(g) (3) (i) -(iv), MSC 21*	The information required to be provided to the enrollee in an enrollee handbook will be considered to be provided if the MCO: a. Mails a printed copy of the information to the enrollee's mailing address. b. Provides the information by email after obtaining the enrollee's agreement to receive the information by email. c. Posts the information on its website and advises	☐ Yes	1.000	1.000	
		☐ No	0.000		

	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. d. Provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.				
Findings Strength AON Suggestion					
27. Pharmacy Information *42 CFR 438.10(i)(1)-(2), MSC 3.19.2*	The MCO must make available in electronic or print format the following information: a. Which medications are covered, both generic and name brand.	☐ Covered medications	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					
28. Pharmacy Drug Lists *42 CFR*	As specified by the Secretary of Health and Human Services and in accordance with state and federal regulations, the MCO must make its drug lists available on its website in a machine-readable file and format.	☐ Yes	1.000	1.000	
		☐ No	0.000		

438.10(h)(4), MSC 3.19.2					
Findings Strength AON Suggestion					
Enrollee Information Total			***XX***	***28.000***	***XX***

2023 Annual Compliance Assessment: <MCO>					
Enrollee Rights and Protections					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
1. Enrollee Rights *42 CFR 438.100(b)(1)-(3), MSC 19*	An enrollee of the MCO has the right to: a. Receive information in accordance with 42 CFR 438.10. b. Be treated with respect and with due consideration for their dignity and privacy. c. Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. 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. e. Request and receive a copy of their medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526, if the privacy rule, as set forth in 45	☐ Information per 42 CFR 438.10	0.142	1.000	
		☐ Treated with respect and consideration for dignity and privacy	0.142		
		☐ Information on available treatment options and alternatives in manner appropriate to enrollee's condition and ability to understand	0.142		
		☐ Participation in healthcare-related decisions, including refusal of treatment	0.142		

	CFR parts 160 and 164 subparts A and E, applies. f. Be furnished healthcare services in accordance with 42 CFR 438.206 through 438.210.	☐ Free from any form of restraint or seclusion	0.142		
		☐ Copy of medical records and right to request amendments or corrections	0.142		
		☐ Healthcare services per 42 CFR 438.206 through 438.210	0.142		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
2. Freedom to Exercise Rights *42 CFR 438.100(c), MSC 19*	An enrollee of the MCO has the freedom to exercise their rights without being adversely treated by the MCO.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength					

AON Suggestion					
3. Compliance with Federal and State Laws *42 CFR 438.100(d), MSC 4.12, MSC 30*	The MCO 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 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.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
4. Staff Education and Training	The MCO must provide education and training to its staff, as appropriate and applicable to the staff	☐ Yes	1.000	1.000	

MSC 12, MSC 19	members' duties, including but not limited to enrollee rights and advance directive policies and procedures.	☐ No	0.000		
Findings Strength AON Suggestion					
5. Provider–Enrollee Communication *42 CFR 438.102(a) (1) (i) - (iv), MSC 24.6*	The MCO must not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice from advising or advocating on behalf of an enrollee who is their patient, for: a. the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; b. any information the enrollee needs to decide among all relevant treatment options; c. the risks, benefits, and consequences of treatment or non-treatment; and d. the enrollee's right to participate in decisions regarding their healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.	☐ Enrollee's health status, medical care, or treatment options	0.250	1.000	
		☐ Information needed to decide on treatment option	0.250		
		☐ Risks, benefits, and consequences of treatment and non-treatment	0.250		
		☐ Participation in healthcare-related decisions, including refusal of treatment	0.250		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
6. MCO Non-Refusal to Cover Benefits or Services *MSC 21.3(b), (c), MSC 24.3.10*	The MCO must not object or otherwise refuse to provide a benefit or service covered under its contract with FHKC on moral or religious grounds. Insurer shall allow any Enrollee who is eligible to receive services from a network IHCP to choose the IHCP as his or her PCP so long as the IHCP has the capacity to provide the services. Insurer must also allow any Enrollee who is eligible to receive services from an IHCP to obtain services covered under the Contract from an out-of-network IHCP.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					
7. Marketing Material Requirements *42 CFR 438.104(b) (1) (i) -(v), MSC 17.3, MSC 17.4*	The MCO must: a. obtain approval of any marketing materials from FHKC prior to distribution; b. distribute the materials to its entire service area as indicated in its contract with FHKC; c. comply with the information requirements of 42 CFR 438.10 to ensure that, before enrolling, the beneficiary receives, from FHKC, the accurate oral and written information the enrollee needs to make an informed decision on whether to enroll;	☐ FHKC approval of marketing materials prior to distribution	0.200	1.000	
		☐ Materials to entire service area	0.200		
		☐ Ensure potential enrollee receives oral and written information to make	0.200		

	d. avoid seeking to influence enrollment in conjunction with the sale or offering of any private insurance; and e. avoid engaging directly or indirectly in door-to-door, telephone, email, texting, or other cold-call marketing activities.	decision about enrolling			
		☐ No offering of private insurance	0.200		
		☐ No engaging in marketing activities	0.200		
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
8. Marketing Material Requirements – Prohibited Statements *MSC 17.1, MSC 17.2*	The MCO must: a. Avoid using absolute superlatives in marketing materials unless such use is substantiated with supporting data provided to FHKC as a part of the marketing activities review process. b. Avoid using superlatives in its logos or product tag lines. c. Avoid comparing itself to another MCO unless: i. Such comparison is contained in an independent study, a copy of which has been provided for prior review to FHKC.	☐ No use of absolute superlatives in marketing materials unless such use is substantiated with supporting data provided to FHKC	0.333	1.000	
		☐ No use of superlatives in DBM's logos or product tag lines	0.333		

	ii. The MCO has received written concurrence from all other MCOs being compared. The MCO must provide this documentation to FHKC for prior review.	☐ No comparison of MCO to other MCOs	0.334		
Findings Strength AON Suggestion					
9. Marketing Materials – Professional Integrity *42 CFR 438.104(b)(2)(i) - (ii), MSC 17.2*	The MCO must ensure FHKC that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud enrollees or FHKC. Inaccurate, false, or misleading information includes, but is not limited to, suggesting that enrollees must enroll in the MCO to obtain or retain benefits or that the MCO is endorsed by the Centers for Medicare & Medicaid Services (CMS), the federal or state government, FHKC, or a similar entity.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
10. Liability for Payment	The MCO must provide that its Florida Healthy Kids enrollees are not held liable for any of the following:	☐ MCO debts	0.333	1.000	

MSC 9.3	a. The MCO's debts, in the event of the MCO's insolvency. b. Covered services provided to the enrollee, for which: 1. FHKC does not pay the MCO, or 2. FHKC or the MCO does not pay the individual or healthcare provider that furnished the services under a contractual, referral, or other arrangement. c. Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the MCO covered the services directly.	☐ Covered services provided to enrollee	0.333		
		☐ Payments for covered services	0.334		
Findings Strength AON Suggestion					
11. Protections from Collection *MSC 9.3*	The MCO and any representative of the MCO must not collect or attempt to collect from an enrollee any money for services covered by the Florida Healthy Kids program or any monies owed by FHKC to the MCO: a. If the enrollee receives a covered service from a provider under the MCO's contract with FHKC in accordance with the Covered	☐ If enrollee receives covered service from provider but provider is not paid by MCO, enrollee not held liable for monies owed to provider by MCO	0.333	1.000	

	Benefits under Attachment D, but the provider is not paid by the MCO, the enrollee must not be held liable for monies owed to the provider by the MCO. b. If the provider is paid less than billed charges, neither the provider nor the MCO may hold the enrollee liable for the rest of the fee except for any co-payment as specified in Attachment D of the MCO's contract with FHKC. c. The MCO must include such a prohibition in all provider contracts serving FHKC enrollees.	☐ If provider is paid less than billed charges, neither provider nor MCO may hold enrollee liable for remaining fee except any applicable co-payment	0.333		
		☐ Prohibition included in all provider contracts serving FHKC enrollees	0.334		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
12. Emergency and Post-Stabilization Services *42 CFR 422.113 (2)(i),*	The MCO must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO.	☐ Yes	1.000	1.000	
		☐ No	0.000		

438.114(c)(1)(i), MSC Attachment A					
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
13. Emergency and Post-Stabilization Services – Denial of Payment *42 CFR 438.114(c)(1)(ii)(A)-(B)*	The MCO may not deny payment for treatment obtained under either of the following circumstances: a. An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have placed the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; resulted in serious impairment to bodily functions; or caused serious dysfunction of any bodily organ or part. b. A representative of the MCO instructs the enrollee to seek emergency services.	☐ Emergency medical condition	0.500	1.000	
		☐ Enrollee instructed to seek emergency services	0.500		
Findings Strength AON Suggestion					

14. Emergency Service Limitations *42 CFR 438.114(d)(1)(i)-(ii), MSC Attachment A*	The MCO must not: a. limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms; or b. refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's PCP, the MCO, or FHKC of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.	☐ No limitation of what constitutes emergency medical condition on basis of lists of diagnoses or symptoms	0.500	1.000	
		☐ No refusal to cover emergency services based on emergency room provider's lack of notification	0.500		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
15. Emergency Medical Condition Screening and Treatment *42 CFR 438.114(d)(3), MSC Attachment A*	The MCO must 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	1.000	1.000	
		☐ No	0.000		

Findings Strength AON Suggestion					
16. Responsibility for Emergency Coverage and Payment *42 CFR 438.114(d)(3), MSC Attachment A*	The MCO must be bound as responsible for coverage and payment of the determination of when the enrollee is sufficiently stabilized for transfer or discharge, whether the determination is made by the attending emergency physician or the provider actually treating the enrollee.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					
17. Post-Stabilization Care Services Coverage and Payment *42 CFR 438.114(d)(3), MSC Attachment A*	The MCO must provide coverage and payment for post-stabilization care services in accordance with provisions set forth in 42 CFR 422.113(c).	☐ Yes	1.000	1.000	
		☐ No	0.000		

Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
18. Enrollee Confidentiality *42 CFR 438.224, MSC 7.1*	The MCO must: a. Use and disclose medical records and any other health and enrollment information that identifies a particular enrollee in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable; b. Treat all information obtained through its performance under its contract with FHKC as confidential to the extent such information is protected under Florida and federal law; c. Not use any information except as necessary for the proper discharge of its obligations under its contract with FHKC; d. Not use or disclose any protected health information (PHI), personally identifiable information (PII), or other identified information obtained through its performance under its contract with FHKC, except as allowed under the contract and Florida and federal laws, including HIPAA, Florida Statutes sections 624.91 and 409.821, and Florida Statutes Chapter 119; and e. Not disclose such information without the written consent of FHKC, the applicant, or the	☐ Use and disclose medical records and any other health and enrollment information that identifies a particular enrollee in accordance with privacy requirements in 45 CFR parts 160 and 164, subparts A and E	0.200	1.000	
		☐ Treat all information obtained through performance under contract with FHKC as confidential to extent such information is protected under	0.200		

	enrollee, except as otherwise required under Florida or federal law.	Florida and federal law			
		☐ No use of any information except as necessary for proper discharge of obligations under contract with FHKC	0.200		
		☐ No use or disclosure of any PHI, PII, or other identified information obtained through performance under contract with FHKC, except as allowed under contract and Florida and federal laws, including HIPAA, Florida Statutes	0.200		

		sections 624.91 and 409.821, and Florida Statutes Chapter 119			
		☐ No disclosure of such information without written consent of FHKC, applicant, or enrollee, except as otherwise required under Florida or federal law	0.200		
Findings Strength AON Suggestion					
Enrollee Rights and Protections Total			***XX***	***18.00***	***XX***

2023 Annual Compliance Assessment: <MCO>					
Credentialing					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
1. Delivery Network – Provider Credentialing *42 CFR 438.206(b)(6), Florida Healthy Kids Uniform Credentialing and Recredentialing Policy (UCRP)*	The MCO must demonstrate that its network providers are credentialed as required by 42 CFR 438.214. The MCO's PCP network must include only: a. Board-certified pediatricians b. Board-certified family practice physicians c. Physician extenders working under the direct supervision of a board-certified practitioner d. Providers who have recently completed a National Board for Certification of Training Administrators of Graduate Medical Education Programs approved residency program in pediatrics or family practice and are eligible for board certification but have not yet achieved board certification. Such providers must become board certified within three years of joining the network to remain eligible to function as a PCP for the Florida Healthy Kids population. e. Providers who have been granted a waiver to the board-certification requirement in accordance with FHKC's policies and procedures.	☐ Yes	1.000	1.000	
		☐ No	0.000		

Findings Strength AON Suggestion					
2. Delivery Network – Provider Credentialing, Mental Health and Substance Abuse *MCS 24.6, UCRP*	MCO network shall also include: 1) Board-certified child psychiatrists; or Practitioners licensed to practice medicine, osteopathic medicine, psychology, clinical social work, mental health counseling, or marriage and family therapy with a minimum of two years' full-time, post-graduate, experience providing mental health and/or substance abuse services in a setting that specializes in providing mental health and/or substance abuse services to children and/or adolescents; and/or a certified addiction professional certified in accordance with Chapter 397, Florida Statutes, providing substance abuse services in a setting that specializes in providing substance abuse services to children and/or adolescents.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
	Facilities used for enrollees must meet applicable	☐ Yes	1.000	1.000	

3. Facility Standards *UCRP*	accreditation and licensure requirements and meet facility regulations specified by the Agency for Health Care Administration (AHCA).	☐ No	0.000		
Findings Strength AON Suggestion					
4. Mental Healthcare and Substance Abuse Providers *UCRP*	The MCO must ensure that all direct behavioral health services provided to children and adolescents under the MCO's contract with FHKC are delivered by individuals or entities who meet the minimal licensure and credentialing standards set forth in statutes and rules of the Department of Children and Families, the Department of Health, and the Division of Health Quality Assurance of AHCA, pertinent to the treatment and prevention of mental health and substance abuse disorders in children and adolescents.	☐ Yes ☐ No	1.000 0.000	1.000	
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score

5. Indian Health Care Providers *UCRP*	Insurer shall maintain sufficient numbers of Indian Health Care Providers (IHCPs) in Insurer's Provider network to ensure timely access to services from such Providers to Enrollees eligible to receive such services. Insurer shall provide a quarterly attestation and supporting documentation to FHKC demonstrating compliance with this requirement.	☐ Indian Health Providers included in the network	0.500	1.000	
		☐ Quarterly attestation to FHKC	0.500		
Findings Strength AON Suggestion					
6. License *42 CFR 438.214(b) (2), UCRP*	The MCO must maintain written policies and procedures (P&Ps) for credentialing and recredentialing of network providers. At a minimum, the MCO's credentialing and recredentialing P&Ps must verify provider licenses, including licenses issued in states other than Florida. Verification must confirm that: a. the license is not expired; and b. there are no current limitations on the provider's license.	☐ Confirmation that provider license is not expired	0.500	1.000	
		☐ Confirmation that there are no current limitations on provider's license	0.500		
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score

7. At-Risk Providers – 1 *UCRP*	The MCO's credentialing and recredentialing P&Ps must establish categorical risk levels for providers and provider categories who pose an increased financial risk of fraud, waste, and abuse: a. Criminal background checks, including fingerprints, must be conducted for providers, and any person with at least five percent direct or indirect ownership interest in the provider, when such person meets the criteria for a "high" risk. b. Risk levels must be adjusted from "limited" or "moderate" to "high" when any of the following occurs: 1. a provider has a payment suspension imposed based on a credible allegation of fraud, waste, or abuse; 2. the provider has an existing Medicaid or Children's Health Insurance Program (CHIP) overpayment; 3. the provider has been excluded by the Department of Health and Human Services (HHS) or a state Medicaid or CHIP program within the previous 10 years; or 4. a temporary moratorium has been lifted in the previous six months for a particular provider type or provider.	☐ Criminal background checks, including fingerprints, conducted for providers and any person with at least five percent direct or indirect ownership interest in provider, when such person meets criteria for "high" risk	0.500	1.000	
		☐ Risk levels adjusted from "limited" or "moderate" to "high" when warranted	0.500		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
8. At-Risk Providers – 2 *UCRP*	The MCO's credentialing and recredentialing P&Ps must include pre- and post-enrollment site visits to verify the accuracy of information submitted by providers who are designated as moderate or high categorical risks to the Florida Healthy Kids program and to determine compliance with state and federal enrollment requirements: a. The MCO must require providers to allow CMS, FHKC, their agents, and their designated contractors to conduct unannounced onsite inspections of any and all provider locations. b. Providers must be denied enrollment in the network or terminated from the network if the provider fails to permit access to provider locations for any site visits, unless FHKC determines that denial or termination of the provider is not in the best interests of the program and documents such determinations in writing.	☐ MCO requires providers to allow CMS, FHKC, their agents, and their designated contractors to conduct unannounced onsite inspections of any and all provider locations	0.500	1.000	
		☐ Providers denied enrollment in network or terminated from network if provider fails to permit access to provider locations for any site visits, unless FHKC determines that denial or termination of provider is not in program's best interests and documents such	0.500		

		determinations in writing			
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
9. Exclusions *UCRP*	The MCO's credentialing and recredentialing P&Ps must confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through checks of the following federal databases upon enrollment and recredentialing: • Social Security Agency's death master file • National Plan and Provider Enumeration System (NPPES) • List of Excluded Individuals/Entities (LEIE) • Excluded Parties List System (EPLS)	☐ Confirm identity of provider or any person with ownership or control interest or who is agent of managing employee of provider	0.500	1.000	
		☐ Determine exclusion status of provider or any person with ownership or control interest or who is agent of managing employee of provider	0.500		
Findings Strength AON Suggestion					

10. Exclusions – Ongoing Monitoring *UCRP*	The MCO's credentialing and recredentialing P&Ps must confirm the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through checks of the LEIE and EPLS databases on a monthly basis.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					
11. Provider Contract Compliance *UCRP*	The MCO's credentialing and recredentialing P&Ps must monitor providers for compliance with the provider contract, including: a. Appointment timeliness standards b. Maintenance of accurate directory information, including: i. office hours, ii. street address, iii. phone number, and iv. acceptance of new patients c. taking appropriate corrective action with providers.	☐ Monitor provider compliance with appointment timeliness standards	0.333	1.000	
		☐ Monitor provider maintenance of accurate directory information	0.333		
		☐ Take appropriate corrective action with providers	0.334		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
12. Quality Monitoring *UCRP*	The MCO's credentialing and recredentialing P&Ps must develop a process to identify quality deficiencies, including: a. monitoring and evaluating claims and encounter data for patterns of care by individual providers; b. conducting ongoing reviews of providers; and c. taking appropriate corrective action with providers.	☐ Monitoring and evaluating claims and encounter data for patterns of care by individual providers	0.333	1.000	
		☐ Conducting ongoing reviews of providers	0.333		
		☐ Taking appropriate corrective action with providers	0.334		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
13. Appropriate Actions		☐ Yes	1.000	1.000	

UCRP	The MCO's credentialing and recredentialing P&Ps must impose appropriate sanctions, suspension, restriction, and termination of providers, including terminating or denying enrollment because of inability to verify the identity of the provider applicant or upon determination that the provider has falsified any information provided on the application.	☐ No	0.000		
Findings Strength AON Suggestion					
14. Board Certification Exemption *UCRP*	The MCO's credentialing and recredentialing P&Ps must ensure PCPs without board certification are removed from the network or receive an exemption timely.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					
15. Board Certification Exemption Requests *UCRP*	Insurer must submit an exemption request to FHKC for a Provider even if that Provider has an active exemption with another Florida Healthy Kids insurer. Exemptions expire after two (2) years unless a Renewal is approved by FHKC.	☐ Yes	1.000	1.000	
		☐ No	0.000		

Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
16. Recredentialing *UCRP*	The MCO's credentialing and recredentialing P&Ps must: a. recredential providers at least every three years; b. repeat criminal background checks at least every five years; and c. recredential providers, including screening activities, prior to allowing providers who were removed from the network to re-enroll in the network.	☐ Recredential providers at least every three years	0.333	1.000	
		☐ Repeat criminal background checks at least every five years	0.333		
		☐ Recredential providers, including screening activities, prior to allowing providers who were removed from network to re-enroll in network	0.334		
Findings Strength AON Suggestion					

17. Verifications *UCRP*	To be eligible to participate in the MCO's Florida Healthy Kids network, providers must: a. Have a current state license (medical, occupational, or facility) or authority to do business in the state in which they practice. b. Have no revocation, moratorium, or suspension of their license imposed in Florida or any other state. c. Have no sanctions imposed by Medicare or Medicaid unless there is proof of reinstatement or other documentation showing that all obligations under the sanction have been met. d. Provide evidence of professional liability claims history. e. Not be on the state or federal exclusions lists. f. Not have had Medicaid prescribing rights suspended by AHCA. g. Not had enrollment terminated under Title XVIII of the Act or under the Medicaid program or CHIP of any other state. This provision applies only to providers terminated on or after January 1, 2011, from such programs.	☐ Have current state license or authority to do business in state in which they practice	0.142	1.000	
		☐ Have no revocation, moratorium, or suspension of license imposed in Florida or any other state	0.142		
		☐ Have no sanctions imposed by Medicare or Medicaid unless there is proof of reinstatement or other documentation showing that all obligations under sanction have been met	0.142		
		☐ Provide evidence of professional liability claims history	0.142		
		☐ Not on state or federal exclusions lists	0.142		

		☐ Not have had Medicaid prescribing rights suspended by AHCA	0.142		
		☐ Not had enrollment terminated under Title XVIII of the Act or under Medicaid program or CHIP of any other state	0.142		
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
18. Disclosures *UCRP*	To be eligible to participate in the MCO's Florida Healthy Kids network, providers must provide disclosures related to ownership and management, business transactions, and conviction of crimes to the MCO: a. Ownership and management disclosures	☐ Ownership and management disclosures include information required by 42 CFR 455.104(b)	0.333	1.000	

	include the information required by 42 CFR 455.104(b): 1. Providers must provide this information upon submission of an application, execution of a provider agreement, upon FHKC's request, during recredentialing, and within 35 days after any change in ownership. 2. MCOs must deny providers enrollment in the network or terminate them from the network when any person with a five percent or greater direct or indirect ownership interest in the provider, or who is an agent or managing employee of the provider, does not submit timely and accurate information, unless FHKC determines that denial or termination of the provider is not in the best interests of the program and documents such determinations in writing. 3. MCOs must deny providers enrollment in the network or terminate them from the network when any person with a five percent or greater direct or indirect ownership interest in the provider, or who is an agent or managing employee of the provider, fails to cooperate with any required screening methods, including failing to submit sets of fingerprints in the form and manner required within 30 days of request, unless FHKC determines that denial or termination of the provider is not in the best interests of the program and	☐ Business transaction disclosures include information about ownership of any subcontractor with whom provider has had business transactions totaling more than $25,000 during 12-month period and any significant business transactions between provider and any wholly owned supplier, or between provider and any subcontractor during the previous five-year period.	0.333		
		☐ Disclosures related to the conviction of crimes include identity of any person who has ownership or control interest, as	0.334		

	documents such determinations in writing. 4. MCOs must deny providers enrollment in the network or terminate them from the network when any person with a five percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or Title XXI program in the last 10 years, unless FHKC determines that denial or termination of the provider is not in the best interests of the program and documents such determinations in writing. b. Business transaction disclosures include information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period and any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor during the previous five-year period: 1. The provider must provide such disclosures within 35 days of the date of request by CMS, AHCA, or FHKC. 2. MCOs must include a provision to provide this information within the required timeframe in the provider agreement. c. Disclosures related to the conviction of crimes include the identity of any person who has ownership or control interest as defined in 42	defined in 42 CFR 455.101 and 42 CFR 455.102, in provider, or is agent or managing employee of provider, and has been convicted of criminal offense related to person's involvement in any program under Medicare, Medicaid, or Title XX services program since inception of those programs.			

	CFR 455.101 and 42 CFR 455.102, in the provider or is an agent or managing employee of the provider and has been convicted of a criminal offense related to the person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs. d. Providers must provide this information upon entering into a new provider agreement, renewing an existing provider agreement, or upon request by FHKC.				
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
19. Criminal Background Checks *UCRP*	To be eligible to participate in the MCO's Florida Healthy Kids network, providers must consent to criminal background checks, including fingerprinting. Providers and any person with a five percent or more direct or indirect ownership interest in the provider must submit a set of fingerprints in the requested form and manner within 30 days upon request.	☐ Consent to criminal background checks, including fingerprinting	0.500	1.000	
		☐ Providers and any person with five percent or more direct or indirect ownership interest in provider required to submit set of fingerprints in	0.500		

		requested form and manner within 30 days upon request			
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
20. Verifications and Attestations *UCRP*	To be eligible to participate in the MCO's Florida Healthy Kids network, providers must meet the following requirements when the provider is a physician: a. Good standing of privileges at the hospital designated at the primary admitting facility by the physician or if the physician does not have admitting privileges, good standing of privileges at the hospital by another provider with whom the physician has entered into an arrangement for hospital coverage. b. Valid Drug Enforcement Administration (DEA) certificates, when applicable. c. Attestation that the total active patient load for all populations, including Medicaid Fee-for-Service (FFS), Children's Medical Services	☐ Good standing of privileges at hospital designated at primary admitting facility by physician or if physician does not have admitting privileges, good standing of privileges at hospital by another provider with whom physician has entered into arrangement for hospital coverage	0.200	1.000	

	Network, Medicaid Managed Care Plans, Medicare, Florida KidCare, and commercial patients, is no more than 3,000 patients per provider. An active patient is a patient who is seen by the provider at least three times per year. d. Facilities that meet the MCO's standards, including that adequate space, supplies, proper sanitation, smoke-free facilities, and proper fire and safety procedures are in place; evidence that the provider's office meets criteria for access for persons with disabilities; and acceptable medical recordkeeping practices. e. Provide a statement regarding any physical or behavioral health problems that may affect the provider's ability to provide healthcare, any history of chemical dependency/substance use disorder, any history of loss of license and/or felony or misdemeanor convictions, and eligibility to become a Medicaid or CHIP provider.	☐ Valid DEA certificates, when applicable	0.200		
		☐ Attestation that total active patient load for all populations is no more than 3,000 patients per provider	0.200		
		☐ Facilities that meet MCO's standards, evidence that provider's office meets criteria for access for persons with disabilities, and acceptable medical recordkeeping practices.	0.200		

		☐ Statement regarding any physical or behavioral health problems that may affect provider's ability to provide healthcare, any history of chemical dependency/substance use disorder, any history of loss of license and/or felony or misdemeanor convictions, and eligibility to become Medicaid or CHIP provider	0.200		
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
21. Education and Training *UCRP*	The MCO must have a system for the verification and examination of each provider's credentials. This system must maintain documentation (including copies of provider licenses) of all provider	☐ System for verification and examination of each provider's credentials	0.333	1.000	

	requirements listed in the UCRP, as well as each provider's: • education • experience • prior training • ongoing service training • National Provider Identifier (NPI) and taxonomy	☐ Documentation of all provider requirements listed in UCRP	0.333		
		☐ Documentation of each provider's education, experience, prior training, ongoing service training, and NPI and taxonomy	0.334		
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
22. Immunization Registry Enrollment *MSC 24.4.3*	To participate as a PCP in the Florida Healthy Kids program, PCPs in the MCO's network must provide all covered immunizations to enrollees and be enrolled with the Florida State Health Online Tracking System (SHOTS), Florida's statewide online immunization registry. The MCO must ensure that all primary care network providers are registered with the SHOTS program. The MCO must assure that its primary care network providers continue to keep the enrollee's immunization record	☐ All primary care network providers registered with SHOTS program	0.500	1.000	
		☐ Immunizations administered at each provider's office	0.500		

	updated in the SHOTS database. Immunizations must be administered at each provider's office.				
Findings Strength AON Suggestion					
23. Provider Nondiscrimination *42 CFR 438.214(c), MCS 24.1*	The DBM's network provider selection policies and procedures, consistent with 42 CFR 438.12, must not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of their license or certification under applicable state law, solely on the basis of that license or certification, including providers that serve high-risk populations or specialize in conditions that require costly treatment. The DBM must provide affected providers with written notice of the reason for its decision to decline to include individual providers or groups of providers in its provider network.	☐ No discrimination against providers acting within scope of license or certification solely on basis of that license or certification, including providers serving high-risk populations or specializing in conditions that require costly treatment	0.500	1.000	
		☐ Written notice of DBM's decision to decline to include providers or groups of	0.500		

		providers in DBM's network			
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
24. Excluded Providers *42 CFR 438.214(d), MSC 24.3*	The MCO must not employ or contract with providers excluded from participation in federal healthcare programs under either section 1128 or section 1128A of the *Social Security Act*.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					
Credentialing Totals			***XX***	***24.000***	***XX***

ACA DBM Tools

2023 Annual Compliance Assessment: <DBM>					
Enrollee Information					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
1. Information Format *Regulations (CFR) 438.10(c)(1), Dental Services Contract (DSC) 21.3*	The dental benefit manager (DBM) must provide all required information to enrollees and potential enrollees in a language that is clear and non-technical and, 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 438.10.	☐ Easily Understood	0.500	1.000	
		☐ Readily Accessible	0.500		
Findings Strength AON Suggestion					
2. Beneficiary Support System *42 CFR 438.71(d)*	The beneficiary support system must perform outreach to beneficiaries and/or authorized representatives and be accessible in multiple ways including phone, internet, in-person, and via auxiliary aids and services when requested. A state beneficiary support system must include at a minimum:	☐ Choice counseling for all beneficiaries	0.333	1.000	
		☐ Assistance for Enrollees in understanding managed care; and	0.333		

	d. Choice counseling for all beneficiaries. e. Assistance for enrollees in understanding managed care. f. Assistance as specified for enrollees who use or express a desire to receive LTSS in paragraph (d) of this section.	☐ Assistance as specified for enrollees who use, or express a desire to receive, LTSS	0.334		
Findings Strength AON Suggestion					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
3. Culturally Competent Communication *DSC 20*	The DBM must provide services, including oral and written communication to enrollees, in a culturally competent manner appropriate for the population.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					
4. Choice Counseling *42 CFR 438.71(c)*	a. Choice counseling, as defined in § 438.2, must be provided to all potential enrollees and enrollees who disenroll from a DBM, PIHP, PAHP, PCCM or PCCM entity for reasons specified in § 438.56(b) and (c).	☐ Yes	1.000	1.000	

	b. If an individual or entity provides choice counseling on the State's behalf under a memorandum of agreement or contract, it is considered an enrollment broker as defined in § 438.810(a) and must meet the independence and freedom from conflict-of-interest standards in § 438.810(b)(1) and (2). c. An entity that receives non-Medicaid funding to represent beneficiaries at hearings may provide choice counseling on behalf of the State so long as the State requires firewalls to ensure that the requirements for the provision of choice counseling are met.	☐ No	0.000		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
5. Electronic Information *42 CFR 438.10(c)(6)(i) - (v), DSC 21*	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.	☐ Accessible format	0.200	1.000	
		☐ Prominently placed and readily accessible on DBM website	0.200		
		☐ Can be electronically retained and printed	0.200		

	d. The information is consistent with content and language requirements for enrollee information. 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.	☐ Meets content and language requirements	0.200		
		☐ Enrollee informed that information is available in paper form without charge upon request, to be received within five business days	0.200		
Findings Strength AON Suggestion					
6. Enrollee Assistance *42 CFR 438.10(c)(7), DSC 21*	The DBM must have in place mechanisms to help enrollees and potential enrollees understand the requirements and benefits of the plan. The DBM also must comply with the guidance issued by the Office for Civil Rights (OCR) of the United States Department of Health and Human Services regarding the availability of information and assistance for persons with limited English proficiency.	☐ Mechanisms in place to help enrollees and potential enrollees	0.500	1.000	
		☐ Compliance with OCR guidance	0.500		

Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
7. Language Identification *42 CFR 438.10(c)(7), DSC 21*	The DBM must detail the methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in each DBM, PIHP, PAHP, or PCCM entity service area.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					
8. Translation Services and Enrollee Communications *42 CFR 438.10(d)(2)-(4), DSC 21*	The DBM must: a. Make oral interpretation available in all languages and written translation available in each prevalent non-English language. b. Make interpretation services available free of charge to each enrollee, including oral interpretation and the use of auxiliary aids such as teletypewriter / Telecommunications Device for the Deaf (TTY/TDY) and American Sign Language (oral interpretation requirements apply to all non-English languages, not just those that Florida Healthy Kids Corporation [FHKC] identifies as prevalent).	☐ Make oral interpretation available in all languages and written translation available in each prevalent non-English language	0.200	1.000	
		☐ Make interpretation services available	0.200		

	c. Ensure that all written materials for enrollees include taglines in the prevalent non-English languages in the service area, as well as large print of no less than 18-point font size, explaining the availability of written translations and oral interpretation to understand information provided and the toll-free and TTY/TDY telephone number of the entity providing choice counseling services as required by 42 CFR 438.71(a). d. Make all its written materials available in English, Spanish, and all appropriate foreign languages; and e. Make its 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, available in the prevalent non-English languages in its particular service area.	free of charge to each enrollee			
		☐ Written materials include taglines in prevalent non-English languages in print no less than 18-point font size and explain availability of translation services	0.200		
		☐ All written materials available in English, Spanish, and all other foreign languages	0.200		
		☐ Materials that are critical to obtaining services are available in the prevalent non-English languages in its particular service area	0.200		

Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
9. Established Methodology to Identify Non-English-Speaking Enrollees *42 CFR 438.10(c)(7), DSC 21*	Must have an established methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in each DBM, PIHP, PAHP, or PCCM entity service area.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					
10. Language and Format *42 CFR 438.10(d)(2)-(4), DSC 31.9*	The DBM must: d. Ensure enrollee information is in an easily understood language and format, including a font size no smaller than 12 point. e. Make interpretation services available free of charge to each enrollee, including oral interpretation and the use of auxiliary aids such	☐ Easily understood language and format, with no smaller than 12-point font size	0.142	1.000	

	as teletypewriter/ Telecommunications Device for the Deaf (TTY/TDY) and American Sign Language (oral interpretation requirements apply to all non-English languages, not just those that Florida Healthy Kids Corporation [FHKC] identifies as prevalent). f. Ensure that all written materials for enrollees include taglines in the prevalent non-English languages in the service area, as well as large print of no less than 18-point font size, explaining the availability of written translations and oral interpretation to understand information provided and the toll-free and TTY/TDY telephone number of the entity providing choice counseling services as required by 42 CFR 438.71(a). g. Make all its written materials available in English, Spanish, and all appropriate foreign languages. h. Make its 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, available in the prevalent non-English languages in its particular service area. i. Make its written materials available in alternative formats upon request of the potential enrollee or enrollee—taking into	☐ Interpretation services available free of charge	0.142		
		☐ Written materials include taglines in prevalent non-English languages in print no less than 18-point font size and explain availability of translation services	0.142		
		☐ All written materials available in English, Spanish, and all other appropriate foreign languages	0.142		
		☐ Written materials available in prevalent non-English languages in service area	0.142		

	consideration enrollees' special needs, including those who are visually impaired or have limited reading proficiency—at no cost. j. Notify all enrollees that information is available at no cost upon request in alternative formats, including auxiliary aids and services, oral interpretation in any language, and written interpretation in the language(s) prevalent in the service area, and how to access those formats.	☐ Written materials available in alternative formats upon request at no cost	0.142		
		☐ Notification to enrollees of availability of information in alternative formats and how to access those formats	0.142		
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
11. Minimum Requirements for Potential Enrollees -1 *42 CFR 438.10(e)(2)(i) -*	The information for potential enrollees must include, at a minimum, all of the following: i. Information about the potential enrollee's right to disenroll consistent with the requirements of § 438.56 and which clearly explains the process for exercising this disenrollment right, as well as the alternatives available to the	☐ Right to disenroll	0.200	1.000	
		☐ Populations excluded from enrollment	0.200		
		☐ Length of enrollment period	0.200		

(iv), DSC 21.3.1(b)	potential enrollee based on their specific circumstance. ii. The basic features of managed care. iii. Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program. For mandatory and voluntary populations, the length of the enrollment period and all disenrollment opportunities available to the enrollee must also be specified. iv. The service area covered by each DBM, PIHP, PAHP, PCCM, or PCCM entity.	☐ Disenrollment opportunities	0.200		
		☐ Service area	0.200		
Findings Strength AON Suggestion					
12. Minimum Requirements for Potential Enrollees - 2 *42 CFR 438.10(e)(2)(v)(A) – (C), DSC 21.3*	The information for potential enrollees must include, at a minimum, all the following: a. Which benefits are provided by the DBM, PIHP, or PAHP; and b. Which, if any, benefits are provided directly by the State. c. For a counseling or referral service that the DBM, PIHP, or PAHP does not cover because of moral or religious objections, the State must provide information about where and how to obtain the service.	☐ Benefits provided	0.333	1.000	
		☐ State provided benefits if any	0.333		
		☐ Counseling and/or referral services available due to objection of moral or religions reasons	0.334		

Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
13. Minimum Requirements for Potential Enrollees - 3 *42 CFR 438.10(e)(2) (vi)-(x), DSC 21.3*	The information for potential enrollees must include, at a minimum, all the following: a. The provider directory and formulary information required in paragraphs (h) and (i) of this section. b. Any cost-sharing that will be imposed by the DBM, PIHP, PAHP, PCCM, or PCCM entity consistent with those set forth in the State plan. c. The requirements for each DBM, PIHP or PAHP to provide adequate access to covered services, including the network adequacy standards established in §438.68. d. The DBM, PIHP, PAHP, PCCM and PCCM entity's responsibilities for coordination of enrollee care. e. To the extent available, quality and performance indicators for each DBM, PIHP, PAHP and PCCM entity, including enrollee satisfaction.	☐ Provider directory	0.200	1.000	
		☐ Any cost-sharing that will be imposed	0.200		
		☐ Network standards	0.200		
		☐ Coordination of care	0.200		
		☐ Enrollee satisfaction	0.200		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
14. Minimum Requirements for Enrollee Notification *DSC 21.3.1(b)*	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. 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. 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.	☐ Rights and responsibilities of both enrollee and DBM	0.111	1.000	
		☐ Role of primary care dentist	0.111		
		☐ What to do in emergency or urgent medical situation	0.111		
		☐ How to request grievance or appeal, or request independent review	0.111		
		☐ How to report fraud and abuse	0.111		
		☐ Procedures for referrals and prior authorizations	0.111		
		☐ Any additional telephone numbers or contact	0.111		

		information for reaching DBM			
		☐ Eligibility compliance requirements under program, specifically for payment of premiums and renewal	0.111		
		☐ How to access other program services not covered by DBM	0.111		
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
15. Provider Directory Minimum Requirements - 1	Each DBM, PIHP, PAHP, and when appropriate, the PCCM entity, must make available in paper form upon request and electronic form, the following information about its network providers:	☐ Provider name	0.090	1.000	
		☐ Street address	0.090		
		☐ Phone Number	0.090		
		☐ Website	0.090		

42 CFR 438.10(h)(1), DSC 21.3.1(c)	l. The provider's name as well as any group affiliation. m. Street address(es). n. Telephone number(s). o. Web site URL, as appropriate. p. Specialty, as appropriate. q. Whether the provider will accept new enrollees. r. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office. s. Age limitation. t. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment. u. Office Hours. v. Whether the provider has completed cultural competency training.	☐ Specialty	0.090		
		☐ Accepting new patients	0.090		
		☐ Cultural and linguistic capabilities	0.090		
		☐ Accommodations for people with physical disabilities	0.090		
		☐ Age limitations	0.090		
		☐ Office hours	0.090		
		☐ Whether the provider has completed cultural competency training	0.090		
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score

16. Provider Directory Minimum Requirements - 2 *42 CFR 438.10(h)(2), DSC 21.3.1(c)*	The provider directory must include the following provider types covered under the contract: f. Physicians, including specialists g. Hospitals h. Pharmacies i. Behavioral Health Providers j. LTSS provides, as appropriate	☐ Physicians and specialists	0.200	1.000	
		☐ Hospitals	0.200		
		☐ Pharmacies	0.200		
		☐ Behavioral health providers	0.200		
		☐ LTSS providers, as appropriate	0.200		
Findings Strength AON Suggestion					
17. Provider Directory Minimum Requirements - 3 *42 CFR 438.10(h)(3) – (4), DSC 21.3.1(c)*	Information included in: iii. A paper provider directory must be updated at least: c. Monthly, if the DBM, PIHP, PAHP, or PCCM entity does not have a mobile-enabled, electronic directory; or d. Quarterly, if the DBM, PIHP, PAHP, or PCCM entity has a mobile-enabled, electronic provider directory. iv. Information included in an electronic provider directory must be updated no later than 30 calendar days after the DBM, PIHP, PAHP, or PCCM entity receives updated provider information. Provider directories must be made available on the DBM's, PIHP's, PAHP's, or, if applicable, PCCM	☐ Paper directory is updated monthly or quarterly if mobile is enabled	0.333	1.000	
		☐ Electronic directory is updated every 30 days	0.333		
		☐ Directory is available online	0.334		

	entity's web site in in a machine-readable file and format.				
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
18. Provider Termination Notice *42 CFR 438.10(f)(1), DSC 21.3.1(e)*	The DBM 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.	☐ Written notice to enrollee	0.500	1.000	
		☐ Notice provided within 15 calendar days	0.500		
Findings Strength AON Suggestion					
19. Certificates of Creditable Coverage *DSC 21.3.1(f)*	The DBM is responsible for issuing certificates of creditable coverage to enrollees, upon enrollee request.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings					

Strength AON Suggestion					
20. Provider Incentive Plan *42 CFR 438.10(f)(3), DSC 24.10*	The DBM must make available, upon request, any provider incentive plans in place as set forth in 42 CFR 438.3(i).	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
21. Enrollment with a Primary Dental Care Provider *DSC 18.8.1*	The DBM must provide each enrollee the following minimum information within five business days of notification of enrollment: a. Notification of 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.	☐ 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	

	c. A provider directory. d. The procedures for changing providers.	☐ Enrollee's ability to select another provider from DBM's network	0.250		
		☐ Provider directory	0.250		
		☐ Procedures for changing providers	0.250		
Findings Strength AON Suggestion					
22. Enrollee Handbook *42 CFR 438.10(g)(1), DSC 18.8.2*	Within five business days of receipt of an enrollment file, the DBM must provide each enrollee a model enrollee handbook provided by FHKC that complies with any federal or state requirements, uses FHKC-developed definitions for managed care terminology, and serves a similar function as the summary of benefits and coverage described in 45 CFR 147.200(a).	☐ Model enrollee handbook provided by FHKC provided to enrollees within five business days of receipt of enrollment file	0.250	1.000	
		☐ Complies with any federal and state requirements	0.250		

		☐ Uses FHKC-developed managed care terminology definitions	0.250		
		☐ Serves similar function as summary of benefits and coverage described in 45 CFR 147.200(a)	0.250		
Findings Strength AON Suggestion					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
23. Enrollee Handbook Content -1 *42 CFR 438.10(g)(2)(i) - (iv), DSC 21.3.1(b)*	The DBM's enrollee handbook must include, at a minimum: e. Benefits provided by the DBM. f. How and where to access any benefits provided by FHKC, including any cost sharing, and how transportation is provided. g. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits	☐ Benefits provided by DBM	0.250	1.000	
		☐ How and where to access benefits and transportation	0.250		
		☐ Amount, duration, and	0.250		

	to which they are entitled; and 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 dental care provider.	scope of available benefits			
		☐ Procedures for obtaining benefits	0.250		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
24. Enrollee Handbook Content - 2 *42 CFR 438.10(g)(2)(v) - (viii), DSC 21.3.1(b)*	The DBM's enrollee handbook must include, at a minimum: a. The extent to which, and how, after-hours and emergency coverage are provided, including: 1. What constitutes an emergency medical condition and emergency services. 2. The fact that prior authorization is not required for emergency services. 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.	☐ Extent to which, and how, after-hours and emergency coverage are provided	0.250	1.000	
		☐ Restrictions on enrollee's choice among network providers	0.250		
		☐ Extent to which, and how, enrollees may obtain benefits	0.250		

	d. Cost sharing if any is imposed under the FHKC plan.	☐ Cost sharing, if applicable	0.250		
Findings Strength AON Suggestion					
25. Enrollee Handbook Content - 3 *42 CFR 438.10(g)(2)(ix) - (xii), DSC 21.3.1(b)*	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. c. Grievance, appeal, and independent review procedures and timeframes in an FHKC-developed or -approved description, to include: i. The right to file grievances and appeals. ii. The requirements and timeframes for filing a grievance or appeal. iii. The availability of assistance in the filing process. iv. The right to request use of an IRO or the federal review process after the DBM has made a determination on an enrollee's appeal that is averse to the enrollee. v. 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 to use an IRO or the federal review process within the timeframes specified for	☐ Enrollee rights and responsibilities	0.333	1.000	
		☐ Process of selecting and changing enrollee's primary dental care provider	0.333		
		☐ FHKC-developed or -approved grievance, appeal, and independent review procedures and timeframes	0.334		

	filing, and that the enrollee may, consistent with FHKC policy, be required to pay the cost of services furnished while the appeal or IRO/federal review process is pending if the final decision is adverse to the enrollee.				
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
26. Enrollee Handbook Content - 4 *42 CFR 438.10(g) (2) (xiii) -(xvi), DSC 21.3.1(b)*	The DBM's enrollee handbook must include, at a minimum: a. How to access auxiliary aids and services, including additional information in alternative formats or languages. b. The toll-free telephone number for enrollee services, medical management, and any other unit providing services directly to enrollees. c. Information on how to report suspected fraud or abuse. d. Other content required by FHKC in its Plan Model Enrollee Handbook.	☐ How to access auxiliary aids and services	0.250	1.000	
		☐ Toll-free numbers	0.250		
		☐ How to report suspected fraud or abuse	0.250		
		☐ Other FHKC-required content in Plan Model Enrollee Handbook	0.250		

Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
27. 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. d. Provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
28. Notice of Changes *42 CFR 438.10(g)(4)*	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	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					
29. Provider Directory Availability *42 CFR 438.10(h)(4), DSC 3.19.2*	As specified by the Secretary of Health and Human Services, provider directories must be made available on the DBM's website in a machine-readable file and format as well as in paper form.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					
30. Provider Directory Content *42 CFR 438.10(h)(1), DSC*	The DBM must make available in paper form upon request, and electronic form, the following information for each primary dental care provider and specialist in its network:	☐ Provider's name and group affiliation	0.090	1.000	
		☐ Street address(es)	0.090		

3.11.C, DSC 21.3.1	a. The provider's name as well as any group affiliation. b. Street address(es) c. Telephone number(s) d. Website URL, if any e. Specialty, as appropriate f. Office hours g. Age limitations if any h. Whether the provider is accepting new patients i. The provider's cultural and linguistic capabilities, including non-English languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office. j. Whether the provider has completed cultural competency training. k. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment.	☐ Telephone number(s)	0.090		
		☐ Website URL, if any	0.090		
		☐ Specialty, as appropriate	0.090		
		☐ Office hours	0.090		
		☐ Age limitations if any	0.090		
		☐ Accepting new patients or not	0.090		
		☐ Cultural and linguistic capabilities	0.090		
		☐ Whether provider has completed cultural competency training	0.090		
		☐ Accommodations for people with physical disabilities	0.090		

Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
31. Provider Directory Updates *42 CFR 438.10(h)(3), DSC 21.3.1(c)*	Information included in a paper provider directory, or a printable electronic provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 calendar days after the DBM receives updated provider information.	☐ Paper directory updated monthly	0.500	1.000	
		☐ Electronic directory updated no later than 30 calendar days after receipt of updated provider information	0.500		
Findings Strength AON Suggestion					
32. Provider Directory Availability *42 CFR 438.10(h)(4), DSC 21.3.1(c)*	As specified by the Secretary of Health and Human Services, provider directories must be made available on the DBM's website in a machine-readable file and format as well as in paper form.	☐ Yes	1.000	1.000	
		☐ No	0.000		

Findings Strength AON Suggestion			
Enrollee Information Total	***XX***	***32.000***	***XX***

2023 Annual Compliance Assessment: <DBM>					
Enrollee Rights and Protections					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
1. Enrollee Rights *42 CFR 438.100(b)(1)-(3), DSC 19*	An enrollee of the DBM has the right to: a. Receive information per 42 CFR 438.10. b. Be treated with respect and with due consideration for their dignity and privacy. c. Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. d. Participate in decisions regarding their healthcare, including the right to refuse treatment. e. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.	☐ Information per 42 CFR 438.10	0.142	1.000	
		☐ Treated with respect and consideration for dignity and privacy	0.142		
		☐ Information on available treatment options and alternatives in manner appropriate to enrollee's condition and ability to understand	0.142		

	f. Request and receive a copy of their medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526, if the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies. g. Be furnished healthcare services in accordance with 42 CFR 438.206 through 438.210.	☐ Participation in healthcare-related decisions, including refusal of treatment	0.142		
		☐ Free from any form of restraint or seclusion	0.142		
		☐ Copy of medical records and right to request amendments or corrections	0.142		
		☐ Healthcare services per 42 CFR 438.206 through 438.210	0.142		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
2. Freedom to Exercise Rights *42 CFR 438.100(c), DSC 19*	An enrollee of the DBM has the freedom to exercise their rights without being adversely treated by the DBM.	☐ Yes	1.000	1.000	
		☐ No	0.000		

Findings Strength AON Suggestion					
3. Compliance with Federal and State Laws *42 CFR 438.100(d), DSC 19*	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 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.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
		☐ Yes	1.000	1.000	

4. Staff Education and Training *DSC 19*	The DBM must provide education and training to its staff, as appropriate and applicable to the staff members' duties, including but not limited to enrollee rights.	☐ No	0.000		
Findings Strength AON Suggestion					
5. Provider–Enrollee Communication *42 CFR 438.102(a)(1)(i) - (iv), DSC 24.11*	The DBM must not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice from advising or advocating on behalf of an enrollee who is their patient, for: a. The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. b. Any information the enrollee needs to decide among all relevant treatment options. c. The risks, benefits, and consequences of treatment or non-treatment. d. The enrollee's right to participate in decisions regarding their healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.	☐ Enrollee's health status, medical care, or treatment options	0.250	1.000	
		☐ Information needed to decide on treatment option	0.250		
		☐ Risks, benefits, and consequences of treatment and non-treatment	0.250		
		☐ Participation in healthcare-related decisions, including refusal of treatment	0.250		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
6. DBM Non-Refusal to Cover Benefits or Services *DSC 21.3.1(b)*	The DBM must not object or otherwise refuse to provide a benefit or service covered under its contract with FHKC on moral or religious grounds.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					
7. Marketing Materials Requirements *42 CFR 438.10(d)(2)-(4), DSC 31.9*	The DBM must: a. Distribute the materials to its entire service area as indicated in its contract with FHKC. b. Comply with the information requirements of 42 CFR 438.10 to ensure that, before enrolling, the beneficiary receives, from FHKC, the accurate oral and written information the enrollee needs to make an informed decision on whether to enroll. c. Avoid seeking to influence enrollment in conjunction with the sale or offering of any private insurance. d. Avoid engaging directly or indirectly in door-to-door, telephone, email, texting, or other cold-call marketing activities.	☐ Materials to entire service area	0.250	1.000	
		☐ Ensure potential enrollee receives oral and written information to make decision about enrolling	0.250		
		☐ No offering of private insurance	0.250		
		☐ No engaging in marketing activities	0.250		

Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
8. Marketing Material Requirements – Prohibited Statements *DSC 17.1, DSC 17.2*	The DBM must: d. Avoid using absolute superlatives in marketing materials unless such use is substantiated with supporting data provided to FHKC as a part of the marketing activities review process. e. Avoid using superlatives in its logos or product tag lines. f. Avoid comparing itself to another DBM unless: i. such comparison is contained in an independent study, a copy of which has been provided for prior review to FHKC, and ii. the DBM has received written concurrence from all other DBMs being compared. The DBM must provide this documentation to FHKC for prior review.	☐ No use of absolute superlatives in marketing materials unless such use is substantiated with supporting data provided to FHKC	0.333	1.000	
		☐ No use of superlatives in DBM's logos or product tag lines	0.333		
		☐ No comparison of DBM to other DBMs	0.334		
Findings Strength AON Suggestion					
9. Marketing Materials –	The DBM must ensure FHKC that marketing, including plans and materials, is accurate and does	☐ Yes	1.000	1.000	

Professional Integrity *42 CFR 438.104(b)(2)(i) - (ii), DSC 17.2*	not mislead, confuse, or defraud enrollees or FHKC. Inaccurate, false, or misleading information includes, but is not limited to, suggesting that enrollees must enroll in the DBM to obtain or retain benefits or that the DBM is endorsed by the Centers for Medicare & Medicaid Services (CMS), the federal or state government, FHKC, or a similar entity.	☐ No	0.000		
Findings Strength AON Suggestion					
10. Liability for Payment *42 CFR 438.106(a)-(c), DSC 3.10*	The DBM must provide that its Florida Healthy Kids enrollees are not held liable for any of the following: a. The DBM's debts, in the event of the DBM's insolvency. b. Covered services provided to the enrollee, for which: 1. FHKC does not pay the DBM, or 2. FHKC or the DBM does not pay the individual or healthcare provider that furnished the services under a contractual, referral, or other arrangement. c. Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the DBM covered the services directly.	☐ DBM's debts	0.333	1.000	
		☐ Covered services provided to enrollee	0.333		
		☐ Payments for covered services	0.334		

Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
11. Protections from Collection *DSC 3.10*	The DBM and any representative of the DBM must not collect or attempt to collect from an enrollee any money for services covered by the Florida Healthy Kids program or any monies owed by FHKC to the DBM: a. If the enrollee receives a covered service from a provider under the DBM's contract with FHKC in accordance with the Covered Benefits under Attachment D, but the provider is not paid by the DBM, the enrollee must not be held liable for monies owed to the provider by the DBM. b. If the provider is paid less than billed charges, neither the provider nor the DBM may hold the enrollee liable for the rest of the fee except for any co-payment as specified in Attachment D of the DBM's contract with FHKC. c. The DBM must include such a prohibition in all provider contracts serving FHKC enrollees.	☐ If enrollee receives covered service from provider but provider is not paid by DBM, enrollee not held liable for monies owed to provider by DBM	0.333	1.000	
		☐ If provider is paid less than billed charges, neither provider nor DBM may hold enrollee liable for remaining fee except any applicable co-payment	0.333		
		☐ Prohibition included in all provider contracts	0.334		

		serving FHKC enrollees			
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
12. Emergency and Post-Stabilization Services *42 CFR 438.114(c)(1)(i), 42 CFR 438.114(d)(1)(i)-(ii)*	The DBM must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the DBM.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element

				Value	Score
13. Emergency and Post-Stabilization Services – Denial of Payment *42 CFR 438.114(c)(1)(ii)(A)-(B)*	The DBM may not deny payment for treatment obtained under either of the following circumstances: a. An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have placed the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; resulted in serious impairment to bodily functions; or caused serious dysfunction of any bodily organ or part. b. A representative of the DBM instructs the enrollee to seek emergency services.	☐ Emergency medical condition	0.500	1.000	
		☐ Enrollee instructed to seek emergency services	0.500		
Findings Strength AON Suggestion					
14. Emergency Service Limitations *42 CFR 438.114(d)(1)(i)-(ii)*	The DBM must not: a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. b. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's dentist, the DBM, or FHKC of the enrollee's screening and	☐ Did not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms	0.500		

	treatment within 10 calendar days of presentation for emergency services.	☐ Did not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's Dentist, the DBM, or FHKC of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services	0.500	1.000	
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
15. Responsibility for Emergency Coverage and Payment *42 CFR*	The DBM must be bound as responsible for coverage and payment of the determination of when the enrollee is sufficiently stabilized for transfer or discharge, whether the determination is made by the attending emergency physician or the provider actually treating the enrollee.	☐ Yes	1.000	1.000	
		☐ No	0.000		

438.114(d)(3), DSC Attachment A					
Findings Strength AON Suggestion					
16. Post-Stabilization Care Services Coverage and Payment *42 CFR 438.114(e), DSC Attachment A*	The DBM must provide coverage and payment for post-stabilization care services in accordance with provisions set forth in 42 CFR 422.113(c).	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
17. Emergency Medical Condition Screening and Treatment *42 CFR 438.114(d)(2)*	The DBM must 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	1.000	1.000	
		☐ No	0.000		

Findings Strength AON Suggestion					
18. Responsibility for Emergency Coverage and Payment *42 CFR 438.114(d)(3)*	The DBM must be bound as responsible for coverage and payment of the determination of when the enrollee is sufficiently stabilized for transfer or discharge, whether the determination is made by the attending emergency physician or the provider actually treating the enrollee.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					
19. Post-Stabilization Care Services Coverage and Payment *42 CFR 438.114(e)*	The DBM must provide coverage and payment for post-stabilization care services in accordance with provisions set forth in 42 CFR 422.113(c).	☐ Yes	1.000	1.000	
		☐ No	0.000		
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	

				Value	Score
20. Enrollee Confidentiality *42 CFR 438.224, DSC 6.1*	The DBM must: a. Use and disclose medical records and any other health and enrollment information that identifies a particular enrollee in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable. b. Treat all information obtained through its performance under its contract with FHKC as confidential to the extent such information is protected under Florida and federal law. c. Not use any information except as necessary for the proper discharge of its obligations under its contract with FHKC. d. Not use or disclose any protected health information (PHI), personally identifiable information (PII), or other identified information obtained through its performance under its contract with FHKC, except as allowed under the contract and Florida and federal laws, including HIPAA, Florida Statutes sections 624.91 and 409.821, and Florida Statutes Chapter 119. e. Not disclose such information without the written consent of FHKC, the applicant, or the enrollee, except as otherwise required under Florida or federal law.	☐ Use and disclose medical records and any other health and enrollment information that identifies particular enrollee in accordance with privacy requirements in 45 CFR parts 160 and 164, subparts A and E	0.200	1.000	
		☐ Treat all information obtained through performance under contract with FHKC as confidential to extent such information is protected under Florida and federal law	0.200		
		☐ No use of any information except as necessary for proper discharge of	0.200		

		obligations under contract with FHKC			
		☐ No use or disclosure of any PHI, PII, or other identified information obtained through performance under contract with FHKC, except as allowed under contract and Florida and federal laws, including HIPAA, Florida Statutes sections 624.91 and 409.821, and Florida Statutes Chapter 119	0.200		
		☐ No disclosure of such information without written consent of FHKC, applicant, or enrollee, except as otherwise required under Florida or federal law	0.200		

Findings Strength AON Suggestion			
Enrollee Rights and Protections Total	***XX***	***20.00***	***XX***

2023 Annual Compliance Assessment: <DBM>					
Credentialing					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
1. Delivery Network – Provider Credentialing *42 CFR 438.206(b)(6),DSC 3.2.2. A*	The DBM must demonstrate that its network providers are credentialed as required by 42 CFR 438.214. The DBM's primary dental care provider network must include only those licensed dentists and specialists practicing within the scope of their professional license to serve as providers under the DBM's contract with FHKC.	☐ Credentialed as required by 42 CFR 438.214	0.500	1.000	
		☐ Licensed dentists and specialists practicing within scope of their professional license	0.500		
Findings Strength AON Suggestion					
2. Facility Standards *DSC 24.6, Florida Healthy Kids Uniform Credentialing and Recredentialing Policy (UCRP)*	Facilities used for enrollees must meet applicable accreditation and licensure requirements and meet facility regulations specified by the Agency for Health Care Administration (AHCA).	☐ Yes	1.000	1.000	
		☐ No	0.000		

Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
3. License *42 CFR 438.214(b)(2), DSC 24.2, UCRP*	The DBM must maintain written policies and procedures (P&Ps) for credentialing and recredentialing of network providers. At a minimum, the DBM's credentialing and recredentialing P&Ps must verify provider licenses, including licenses issued in states other than Florida. Verification must confirm that: a. The license is not expired. b. There are no current limitations on the provider's license.	☐ Confirmation that provider license is not expired	0.500	1.000	
		☐ Confirmation that there are no current limitations on provider's license	0.500		
Findings Strength AON Suggestion					

4. At-Risk Providers -1 *UCRP*	The DBM's credentialing and recredentialing P&Ps must establish categorical risk levels for providers and provider categories who pose an increased financial risk of fraud, waste, and abuse: a. Criminal background checks, including fingerprints, must be conducted for providers, and any person with at least five percent direct or indirect ownership interest in the provider, when such person meets the criteria for a "high" risk. b. Risk levels must be adjusted from "limited" or "moderate" to "high" when any of the following occurs: 1. A provider has a payment suspension imposed based on a credible allegation of fraud, waste, or abuse. 2. The provider has an existing Medicaid or Children's Health Insurance Program (CHIP) overpayment. 3. The provider has been excluded by the Department of Health and Human Services (HHS) or a state Medicaid or CHIP program within the previous 10 years. 4. A temporary moratorium has been lifted in the previous six months for a particular provider type or provider.	☐ Criminal background checks, including fingerprints, conducted for providers and any person with at least five percent direct or indirect ownership interest in provider, when such person meets criteria for "high" risk	0.500	1.000	
		☐ Risk levels adjusted from "limited" or "moderate" to "high" when warranted	0.500		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
5. At-Risk Providers -2 *UCRP*	The DBM's credentialing and recredentialing P&Ps must include pre- and post-enrollment site visits to verify the accuracy of information submitted by providers who are designated as moderate or high categorical risks to the Florida Healthy Kids program and to determine compliance with state and federal enrollment requirements: c. the DBM must require providers to allow CMS, FHKC, their agents, and their designated contractors to conduct unannounced onsite inspections of any and all provider locations. d. providers must be denied enrollment in the network or terminated from the network if the provider fails to permit access to provider locations for any site visits, unless FHKC determines that denial or termination of the provider is not in the best interests of the program and documents such determinations in writing.	☐ DBM requires providers to allow CMS, FHKC, their agents, and their designated contractors to conduct unannounced onsite inspections of any and all provider locations	0.500	1.000	
		☐ Providers denied enrollment in network or terminated from network if provider fails to permit access to provider locations for any site visits, unless FHKC determines that denial or termination of provider is not in program's best interests and documents such determinations in writing.	0.500		

Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
6. Exclusions *UCRP*	The DBM's credentialing and recredentialing P&Ps must confirm the identify and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through checks of the following federal databases upon enrollment and recredentialing: • Social Security Agency's death master file • National Plan and Provider Enumeration System (NPPES) • List of Excluded Individuals/Entities (LEIE) • Excluded Parties List System (EPLS)	☐ Confirm identity of provider or any person with ownership or control interest or who is agent of managing employee of provider	0.500	1.000	
		☐ Determine exclusion status of provider or any person with ownership or control interest or who is agent of managing employee of provider	0.500		
Findings Strength AON Suggestion					
		☐ Yes	1.000	1.000	

7. Exclusions – Ongoing Monitoring *UCRP*	The DBM's credentialing and recredentialing P&Ps must confirm the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through checks of the LEIE and EPLS databases on a monthly basis.	☐ No	0.000		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
8. Provider Contract Compliance *UCRP*	The DBM's credentialing and recredentialing P&Ps must monitor providers for compliance with the provider contract, including: a. Appointment timeliness standards b. Maintenance of accurate directory information, including: 1. Office hours 2. Street address 3. Phone number 4. Acceptance of new patients c. Taking appropriate corrective action with providers.	☐ Monitor provider compliance with appointment timeliness standards	0.333	1.000	
		☐ Monitor provider maintenance of accurate directory information	0.333		
		☐ Take appropriate corrective action with providers	0.334		
Findings Strength					

AON Suggestion					
9. Quality Monitoring *UCRP*	The DBM's credentialing and recredentialing P&Ps must develop a process to identify quality deficiencies, including: a. Monitoring and evaluating claims and encounter data for patterns of care by individual providers. b. Conducting ongoing reviews of providers. c. Taking appropriate corrective action with providers.	☐ Monitoring and evaluating claims and encounter data for patterns of care by individual providers	0.333	1.000	
		☐ Conducting ongoing reviews of providers	0.333		
		☐ Taking appropriate corrective action with providers	0.334		
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
10. Appropriate Actions *UCRP*	The DBM's credentialing and recredentialing P&Ps must impose appropriate sanctions, suspension, restriction, and termination of providers, including terminating or denying enrollment because of inability to verify the identity of the provider applicant or upon determination that the provider has	☐ Yes	1.000	1.000	
		☐ No	0.000		

	falsified any information provided on the application.				
Findings Strength AON Suggestion					
11. Board Certification Exemption *UCRP*	The DBM's credentialing and recredentialing P&Ps must ensure primary dental care providers without board certification are removed from the network or receive an exemption timely.	☐ Yes ☐ No	1.000 0.000	1.000	
Findings Strength AON Suggestion					
12. Board Certification Exemption Requests *UCRP*	Insurer must submit an exemption request to FHKC for a Provider even if that Provider has an active exemption with another Florida Healthy Kids insurer. Exemptions expire after two (2) years unless a Renewal is approved by FHKC.	☐ Yes ☐ No	1.000 0.000	1.000	
Findings Strength AON Suggestion					

Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
13. Recredentialing *UCRP*	The DBM's credentialing and recredentialing P&Ps must: a. Recredential providers at least every three years. b. Repeat criminal background checks at least every five years. c. Recredential providers, including screening activities, prior to allowing providers who were removed from the network to re-enroll in the network.	☐ Recredential providers at least every three years	0.333	1.000	
		☐ Repeat criminal background checks at least every five years	0.333		
		☐ Recredential providers, including screening activities, prior to allowing providers who were removed from network to re-enroll in network	0.334		
Findings Strength AON Suggestion					
14. Verifications *UCRP*	To be eligible to participate in the DBM's Florida Healthy Kids network, providers must:	☐ Have current state license or authority to do business in state in which they practice	0.142	1.000	

	a. Have a current state dental license or authority to do business in the state in which they practice. b. Have no revocation, moratorium, or suspension of their license imposed in Florida or any other state. c. Have no sanctions imposed by Medicare or Medicaid unless there is proof of reinstatement or other documentation showing that all obligations under the sanction have been met. d. Provide evidence of professional liability claims history. e. Not be on the state or federal exclusions lists. f. Not have had Medicaid prescribing rights suspended by AHCA. g. Not had enrollment terminated under Title XVIII of the Act or under the Medicaid program or CHIP of any other state. This provision applies only to providers terminated on or after January 1, 2011, from such programs.	☐ Have no revocation, moratorium, or suspension of license imposed in Florida or any other state	0.142		
		☐ Have no sanctions imposed by Medicare or Medicaid unless there is proof of reinstatement or other documentation showing that all obligations under sanction have been met	0.142		
		☐ Provide evidence of professional liability claims history	0.142		
		☐ Not on state or federal exclusions lists	0.142		
		☐ Not have had Medicaid prescribing rights suspended by AHCA	0.142		

		☐ Not had enrollment terminated under Title XVIII of the Act or under Medicaid program or CHIP of any other state	0.142		
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
15. Disclosures *UCRP*	To be eligible to participate in the DBM's Florida Healthy Kids network, providers must provide disclosures related to ownership and management, business transactions, and conviction of crimes to the DBM. a. Ownership and management disclosures include the information required by 42 CFR 455.104(b): 5. Providers must provide this information upon submission of an application, execution of a provider agreement, upon FHKC's request, during recredentialing, and within 35 days after any change in ownership. 6. DBMs must deny providers enrollment in the network or terminate them from the network when any person with a five	☐ Ownership and management disclosures include information required by 42 CFR 455.104(b)	0.333	1.000	
		☐ Business transaction disclosures include information about ownership of any subcontractor with whom provider has had business transactions totaling more than $25,000 during 12-month	0.333		

	percent or greater direct or indirect ownership interest in the provider, or who is an agent or managing employee of the provider, does not submit timely and accurate information, unless FHKC determines that denial or termination of the provider is not in the best interests of the program and documents such determinations in writing. 7. DBMs must deny providers enrollment in the network or terminate them from the network when any person with a five percent or greater direct or indirect ownership interest in the provider, or who is an agent or managing employee of the provider, fails to cooperate with any required screening methods, including failing to submit sets of fingerprints in the form and manner required within 30 days of request, unless FHKC determines that denial or termination of the provider is not in the best interests of the program and documents such determinations in writing. 8. DBMs must deny providers enrollment in the network or terminate them from the network when any person with a five percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or Title XXI program in the last 10 years, unless FHKC determines that denial or termination of the	period and any significant business transactions between provider and any wholly owned supplier, or between provider and any subcontractor during the previous five-year period.			
		☐ Disclosures related to the conviction of crimes include identity of any person who has ownership or control interest, as defined in 42 CFR 455.101 and 42 CFR 455.102, in provider, or is agent or managing employee of provider, and has been convicted of criminal offense related to person's involvement in any program under Medicare, Medicaid,	0.334		

	provider is not in the best interests of the program and documents such determinations in writing. b. Business transaction disclosures include information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period and any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor during the previous five-year period: 3. The provider must provide such disclosures within 35 days of the date of request by CMS, AHCA, or FHKC. 4. DBMs must include a provision to provide this information within the required timeframe in the provider agreement. Disclosures related to the conviction of crimes include the identity of any person who has ownership or control interest, as defined in 42 CFR 455.101 and 42 CFR 455.102, in the provider, or is an agent or managing employee of the provider and has been convicted of a criminal offense related to the person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs. Providers must provide this information upon entering into a new provider agreement, renewing an	or Title XX services program since inception of those programs			

	existing provider agreement, or upon request by FHKC.				
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
16. Criminal Background Checks *UCRP*	To be eligible to participate in the DBM's Florida Healthy Kids network, providers must consent to criminal background checks, including fingerprinting. Providers and any person with a five percent or more direct or indirect ownership interest in the provider are required to submit a set of fingerprints in the requested form and manner within 30 days upon request.	☐ Consent to criminal background checks, including fingerprinting	0.500	1.000	
		☐ Providers and any person with five percent or more direct or indirect ownership interest in provider required to submit set of fingerprints in requested form and manner within 30 days upon request	0.500		
Findings Strength AON Suggestion					

17. Verifications and Attestations *UCRP*	To be eligible to participate in the DBM's Florida Healthy Kids network, providers must meet the following requirements when the provider is a dentist: a. Facilities that meet the DBM's standards, including that adequate space, supplies, proper sanitation, smoke-free facilities, and proper fire and safety procedures are in place; evidence that the provider's office meets criteria for access for persons with disabilities; and acceptable medical recordkeeping practices. b. Provide a statement regarding any physical or behavioral health problems that may affect the provider's ability to provide healthcare, any history of chemical dependency/substance use disorder, any history of loss of license and/or felony or misdemeanor convictions, and eligibility to become a Medicaid or CHIP provider.	☐ Facilities that meet DBM's standards, evidence that provider's office meets criteria for access for persons with disabilities, and acceptable medical recordkeeping practices	0.500	1.000	
		☐ Statement regarding any physical or behavioral health problems that may affect provider's ability to provide healthcare, any history of chemical dependency/substance use disorder, any history of loss of license and/or felony or misdemeanor convictions, and eligibility to become Medicaid or CHIP provider	0.500		

Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
18. Education and Training *UCRP*	The DBM must have a system for the verification and examination of each provider's credentials. This system must maintain documentation (including copies of provider licenses) of all provider requirements listed in the UCRP, as well as each provider's: • education • experience • prior training • ongoing service training • National Provider Identifier (NPI) and taxonomy.	☐ System for verification and examination of each provider's credentials	0.333	1.000	
		☐ Documentation of all provider requirements listed in UCRP	0.333		
		☐ Documentation of each provider's education, experience, prior training, ongoing service training, and NPI and taxonomy	0.334		
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score

19. Provider Nondiscrimination *42 CFR 438.214(c), DSC 24.1*	The DBM's network provider selection policies and procedures, consistent with 42 CFR 438.12, must not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of their license or certification under applicable state law, solely on the basis of that license or certification, including providers that serve high-risk populations or specialize in conditions that require costly treatment. The DBM must provide affected providers with written notice of the reason for its decision to decline to include individual providers or groups of providers in its provider network.	☐ No discrimination against providers acting within scope of license or certification solely on basis of that license or certification, including providers serving high-risk populations or specializing in conditions that require costly treatment	0.500	1.000	
		☐ Written notice of DBM's decision to decline to include providers or groups of providers in DBM's network	0.500		
Findings Strength AON Suggestion					
20. Excluded Providers *42 CFR*	The DBM must not employ or contract with providers excluded from participation in federal healthcare programs under either section 1128 or section 1128A of the Social Security Act.	☐ Yes	1.000	1.000	
		☐ No	0.000		

438.214(d), DSC 24.3					
Findings Strength AON Suggestion					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
21. Board Certification Exemption Requests *UCRP*	Insurer must submit an exemption request to FHKC for a Provider even if that Provider has an active exemption with another Florida Healthy Kids insurer. Exemptions expire after two (2) years unless a Renewal is approved by FHKC.	☐ Yes	1.000	1.000	
		☐ No	0.000		
Credentialing Totals			***XX***	***21.000***	***XX***

ACA MCO and DBM File Review Tools

Florida Healthy Kids 2023 MCO/DBM Credentialing File Review Tool																															
MCO: <MCO>		**Date: <D/M/YY>**																													
		File Number																													
		1 -			**2 -**			**3 -**			**4 -**			**5 -**			**6 -**			**7 -**			**8 -**			**9 -**			**10 -**		
#	**Review Element**	**Y**	**N**	**N/A**	**Y**	**N**	**N/A**	**Y**	**N**	**N/A**	**Y**	**N**	**N/A**	**Y**	**N**	**N/A**	**Y**	**N**	**N/A**	**Y**	**N**	**N/A**	**Y**	**N**	**N/A**	**Y**	**N**	**N/A**	**Y**	**N**	**N/A**
1	Medicaid ID																														
2	Current license, no limitations, AHCA HQA license for facilities (must be in file)																														
3	PCP board certification (certified, eligible, waived)																														
4	Valid DEA																														
5	Education and training (education, experience, prior training, NPI, taxonomy)																														
6	Professional Liability Claims History																														
7	Exclusion status (SSA death master file,																														

	NPPES, OIG [LEIE], SAM [EPLS])																												
8	Sanctions (Medicare, Medicaid)																												
9	Title XVIII, Medicaid, CHIP enrollment not terminated																												
10	Medicaid prescribing rights not suspended by AHCA																												
11	Hospital privileges or covering provider in good standing																												
12	Immunization Registry (PCP providers registered in SHOTS program)																												
13	Attestation: Physical or behavioral health problems affecting ability to provide healthcare																												
14	Attestation: History of chemical dependency or substance use disorder																												

15	Attestation: Loss of licensure																												
16	Attestation: Felony or misdemeanor convictions																												
17	Attestation: Patient load no more than 3,000 active patients																												
18	Disclosures: Ownership and management, business transactions, criminal convictions																												
19	Criminal background check and fingerprints required**																												
20	Risk Level**																												
21	Site visit for moderate or high risk**																												
	Totals																												

Raw Score	
Y	
N	
N/A	
Compliance Score	
Y/(Y+N)	**%**

ACA MCO and DBM File Review Instructions

Credentialing/Recredentialing File Review Tool Instructions

Authority: 42 Code of Federal Regulations *(CFR) § 438.206, 214, FHKC Uniform Credentialing and Recredentialing Policy, Medical Services Contract/Dental Services Contract.*

Tool Components

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

Tool Items for Scoring

Applicable items noted in columns 1–4 below: C=credentialing, R=recredentialing, M=medical, D=dental.

Applicable items noted in column 5: Y=yes, N=no, N/A=not applicable.

Credentialing and Recredentialing File Review Tool Instructions for MCOs and DBMs				
C	R	M	D	Item
x	x	x	x	File #: This column is prepopulated (1–10) to identify the total number of files required to be reviewed. Enter the initials of the provider being reviewed next to the file #.
	x	x	x	Recredentialed within 3 years: Enter the last credentialing date and the current recredentialing date. Mark "Y" if recredentialing occurred within 3 years (to the month) from the last credentialing date.
x	x	x	x	Current license: Mark "Y" if there is evidence of primary source verification of an appropriate license with no limitations. For institutional providers, mark "Y" if the Department of Health/Agency for Health Care Administration (AHCA) licenses are verified. Otherwise, mark "N."
x	x	x	x	Medicaid ID: Mark "Y" if there is evidence of verification of the AHCA Medicaid ID and any limitations/restrictions. Otherwise, mark "N."
x	x	x		PCP [primary care provider] board certification: For PCPs, mark "Y" if there is evidence of primary source verification of board certification status (certified or eligible). If the PCP is not board eligible or certified, look for evidence of certification waiver by FHKC. If no waiver is found, mark "N." For non-PCP providers, mark "N/A."

Credentialing and Recredentialing File Review Tool Instructions for MCOs and DBMs				
C	R	M	D	Item
x	x	x	x	Valid DEA: Mark "Y" if there is evidence of primary source verification of a valid DEA number. If there is no evidence of DEA, look for evidence of covering prescribing provider and a valid DEA for the covering prescribing provider. If the provider is non-prescribing (e.g., facility or ancillary provider), mark "N/A."
x		x	x	Education and training: Mark "Y" if there is evidence of verification of education, training, National Provider Identifier (NPI), and taxonomy. For institutional providers, mark "N/A." Otherwise, mark "N."
	x	x	x	Ongoing service training: Mark "Y" if there is evidence of ongoing service training since the last credentialing date. For institutional providers, mark "N/A." Otherwise, mark "N."
x	x	x	x	Professional liability claims history: Mark "Y" if there is evidence of a search of the National Practitioner Data Bank (NPDB) for practitioners. For institutional providers, mark "N/A." Otherwise, mark "N."
x	x	x	x	Exclusion status: Mark "Y" if there is evidence of a search of all of the following: Social Security Administration (SSA) Death Master File, National Plan and Provider Enumeration System (NPPES) for an NPI, Office of the Inspector General (OIG) Exclusion List, and System for Award Management (SAM) Exclusion List. Otherwise, mark "N."
x	x	x	x	Sanctions: Mark "Y" if there is evidence of verification of Medicare and/or Medicaid sanctions through the OIG exclusions list. Otherwise, mark "N."
x	x	x	x	Title XVIII, Medicaid, CHIP enrollment not terminated: Mark "Y" if there is evidence that Medicare, Medicaid, and CHIP enrollments (as applicable) are not terminated. Otherwise, mark "N."
x	x	x	x	Medicaid prescribing rights not terminated by ACHA: Mark "Y" if there is evidence from AHCA that the Medicaid number for the provider is active (not termed, denied, or pending). For institutional providers, mark "N/A." Otherwise, mark "N."
x	x	x		Hospital or covering provider in good standing: For medical practitioners, mark "Y" if there is evidence that hospital privileges (or those of a covering provider) have been verified. Mark "N/A" for institutional providers or providers who do not admit to the hospital. Otherwise, mark "N."
x	x	x		Immunization registry (PCPs registered in SHOTS program): Mark "Y" if there is evidence that the PCP is currently enrolled in the SHOTS program. Mark "N/A" for non-PCPs. Otherwise, mark "N."
x	x	x	x	Attestation – Physical or behavioral health problems affecting ability to provide healthcare: Mark "Y" if there is a completed attestation question on the application. Mark "N/A" for institutional providers. Otherwise, mark "N."
x	x	x	x	Attestation – History of chemical dependency or substance use disorder/treatment: Mark "Y" if there is a completed attestation question on the application. Mark "N/A" for institutional providers. Otherwise, mark "N."

Credentialing and Recredentialing File Review Tool Instructions for MCOs and DBMs				
C	R	M	D	Item
x	x	x	x	Attestation – Loss of licensure: Mark "Y" if there is a completed attestation question on the application. Mark "N/A" for institutional providers. Otherwise, mark "N."
x	x	x	x	Attestation – Felony or misdemeanor convictions: Mark "Y" if there is a completed attestation question on the application. Mark "N/A" for institutional providers. Otherwise, mark "N."
x	x	x		Attestation – Patient load no more than 3,000 active patients: Mark "Y" if there is a completed attestation question on the application. Mark "N/A" for non-physician providers. Otherwise, mark "N."
x	x	x	x	Disclosures – Ownership and management, business transactions, criminal convictions: Mark "Y" if there is an appropriate completed disclosure form in the file. Mark "N/A" for institutional providers. Otherwise, mark "N."
x	x	x	x	Criminal background checks and fingerprints required: Mark "Y" if there is evidence from AHCA that the Medicaid number for the provider is active (not termed, denied, or pending). Mark "N/A" for institutional providers. Otherwise, mark "N."
x	x	x	x	Risk level: Mark "Y" if there is evidence from AHCA that the Medicaid number for the provider is active (not termed, denied, or pending). Mark "N/A" for institutional providers. Otherwise, mark "N."
x	x	x	x	Site visit for moderate or high risk: Mark "Y" if there is evidence from AHCA that the Medicaid number for the provider is active (not termed, denied, or pending). Mark "N/A" for institutional providers. Otherwise, mark "N."

Scoring

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

ANA Review Tools

Table B-1 displays the completed tools for review of the MCOs' and DBMs' appointment availability P&Ps, provider manual, and enrollee handbook as evidence of implementation of required standards.

Table B-1. 2023 Appointment Availability Review Tool		
Standard	**Evident in MCO P&Ps**	**Comments**
Emergency care shall be provided immediately.	<Yes/No>	
Urgently needed care shall be provided within 24 hours.	<Yes/No>	
Routine care shall be provided within seven calendar days of the enrollee's request for services.	<Yes/No>	
Well-child visits, as recommended by the American Academy of Pediatrics, shall be provided within four weeks of the enrollee's request.	<Yes/No>	
Follow-up care shall be provided as medically appropriate.	<Yes/No>	

Appendix C | ACA QP Tool with NCQA Crosswalk

Qsource's EQR assessment tools review compliance with the 12 standards of 42 CFR 438, Subparts D and E. Table C-1 provides a crosswalk between the 3 standards and the tools used to conduct the MY 2022 ACA.

Table C-1. QP Standard: Enrollee Information Requirements

Element #	ACA Tool Element Name	42 CFR Reference(s)	2021 NCQA Element(s)	NCQA Equivalency*	Comments
1	Information Requirements – Basic rules	438.10(c)(1)	MED12 A-I; MED13 A- C; MED14 A-D; ME2 A	Met	
2	Beneficiary Support System	42 CFR 438.71(d)	N/A	N/A	State Function
3	Culturally Competent Communication	None	N/A	N/A	
4	Choice Counseling	42 CFR 438.71(c)	N/A	Not Met	
5	Electronic Enrollee Information	42 CFR 438.10(c) (6) (i) -(v), MSC 21-3	MED12 B; ME 1B	Met	
6	Enrollee Assistance	42 CFR 438.10(c)(7), MSC 21	MED8 A; MED12 A-I; MED13 A-C; MED14 A- D; ME2 A; ME3A-C; LTSS1 A	Met	
7	Language Identification	42 CFR 438.10(d)(1)	HEDIS Measure: Language Diversity of Membership - Number and percentage of Medicaid and Medicare members	Met	

Table C-1. QP Standard: Enrollee Information Requirements					
Element #	**ACA Tool Element Name**	**42 CFR Reference(s)**	**2021 NCQA Element(s)**	**NCQA Equivalency***	**Comments**
			enrolled at any time during the measurement year by demand for language interpreter services and spoken language.		
8	Translation Services	42 CFR 438.10(d)(2)-(4), MSC 21-3	MED12 D- H; RR2 A, B; RR3 B; UM3 A	Met	
9	Language and Format	42 CFR 438.10(d)(2)-(4), MSC 21.3	MED12 C- H; MED13 B,C; NET6 J; ME7 A, B; ME2 A, B; UM3 A	Met	
10	Minimum Requirements for Potential Enrollees-1	42 CFR 438.10(d)(2)-(4), MSC 21.3	None	N/A	State Function
11	Minimum Requirements for Potential Enrollees-2	42 CFR 438.10(d)(2)-(4), MSC 21.3	None	N/A	State Function
12	Minimum Requirements for Potential Enrollees-3	42 CFR 438.10(d)(2)-(4), MSC 21.3	None	Not Met	State Function
13	Provider Directory Minimum Requirements-1	42 CFR 438.10(h)(1)-(2), MSC 21.3.1(c)	NET5 A, J; MED14 A-D	Met	

Table C-1. QP Standard: Enrollee Information Requirements					
Element #	**ACA Tool Element Name**	**42 CFR Reference(s)**	**2021 NCQA Element(s)**	**NCQA Equivalency***	**Comments**
14	Provider Directory Minimum Requirements-2	42 CFR 438.10(h)(1)-(2), MSC 21.3.1(c)	NET5 A, F; MED14 A-D	Met	
15	Provider Directory Minimum Requirements-3	42 CFR 438.10(h)(1)-(2), MSC 21.3.1(c)	NET5 B, G, J	Met	
16	Minimum Requirements for Enrollee Notification	42 CFR 438.10	None	N/A	
17	Provider Termination Notice	42 CFR 438.10(f)(1), MSC 3-19-2	MED1 H; NET5A	Met	
18	Advance Directives	438.10	MED1 I	Met	
19	Certificates of Creditable Coverage	None	N/A	Not Met	State function
20	Physician Incentive Plan	42 CFR 438.10(f)(3), MSC 24-5	MED1 J	Met	
21	Enrollee Handbook	42 CFR 438.10(g)(1), MSC 3-11-B, MSC 3-19-2, MSC Attachment C, PG	MED8 A; MED12 C; RR3 A	Partially Met	
22	Enrollee Handbook Content 1	42 CFR 438.10(g) (2) (i) -(iv), MSC 21-3-1(b)	MED8 A; ME2A, MED9 D; ME3 A	Met	

Table C-1. QP Standard: Enrollee Information Requirements					
Element #	**ACA Tool Element Name**	**42 CFR Reference(s)**	**2021 NCQA Element(s)**	**NCQA Equivalency***	**Comments**
23	Enrollee Handbook Content 2	42 CFR 438.10(g) (2) (v) -(viii), MSC 21-1-1(b)	ME2 A; MED9 D; ME3 A; MED1 D; MED8 A; ME2 A	Met	
24	Enrollee Handbook Content 3	42 CFR 438.10(g) (2) (ix) -(xii), MSC 21-3-1(b)	MED12C; ME1 A; ME2A; MED8 C; UM8 A; ME7 A, B; UM9 D; MED1 I	Met	
25	Enrollee Handbook Content 4	42 CFR 438.10(g) (2) (xiii) -(xvi), MSC 21-3-1(b)	MED12 C; NET6 L; RR3 A; UM3 A; MED13 A; RR3 B	Partially Met	
26	Information Delivery Methods	42 CFR 438.10(g) (3) (i) -(iv), MSC 21	RR3 A	Met	
27	Notice of Changes	42 CFR 438.10(g)(4), MSC 21-3-1(e)	MED8 E	Met	
28	Pharmacy Information	42 CFR 438.10(i)(1)-(2), MSC 3-19-2	UM11 B	Partially Met	
29	Pharmacy Drug List	42 CFR 438.10(i)(3), MSC 21-3-1(d)	MED1 K; UM11 B	Met	

Table C-2. QP Standard: Enrollee Rights and Protections					
Element #	**ACA Tool Element Name**	**42 CFR Reference(s)**	**2019 NCQA Element(s)**	**NCQA Equivalency**	**Qsource Notes**
1	Enrollee Rights	42 CFR 438.100(b)(1)-(3), MSC 19	RR1A	Partially Met	
2	Freedom to Exercise Rights	42 CFR 438.100(c), MSC 19	None	Not Met	
3	Compliance with Federal and State Laws	42 CFR 438.100(d), MSC 4.12, MSC 30	None	Not Met	
4	Staff Education and Training	MSC 12, MSC 19	None	Not Met	
5	Provider–Enrollee Communication	42 CFR 438.102(a)(1)(i)-(iv), MSC 24.6	None	Not Met	
6	MCO Non-Refusal to Cover Benefits or Services	MSC 21.3(b), (c), MSC 24.3.10	None	Not Met	
7	Marketing Material Requirements	42 CFR 438.104(b) (1) (i) -(v), MSC 17.3, MSC 17.4	MED12 A, B, C, D, E, F, G, H, I; MED13 A, B, C; MED14 A, B, C, D; RR3 A, RR4, B, C; QI 2 B	Partially Met	
8	Marketing Material Requirements – Prohibited Statements	MSC 17.1, MSC 17.2	None	Partially Met	

Table C-2. QP Standard: Enrollee Rights and Protections					
Element #	**ACA Tool Element Name**	**42 CFR Reference(s)**	**2019 NCQA Element(s)**	**NCQA Equivalency**	**Qsource Notes**
9	Marketing Material – Professional Integrity	42 CFR 438.104(b)(2) (i) -(ii), MSC 17.2	None	Not Met	
10	Liability for Payment	42 CFR 438.106(a)-(c), MSC 9.1	MED9 C	Not met	
11	Protections from Collection	MSC 9.3	None	Not Met	
12	Emergency and Post-Stabilization Services	42 CFR 422.113 (2)(i), 438.114(c)(1)(i), MSC Attachment A	MED9 C	Partially Met	
13	Emergency and Post-Stabilization Services – Denial of Payment	42 CFR 438.114(c)(1)(ii) (A)-(B)	MED9 C	Partially Met	
14	Emergency Service Limitations	42 CFR 438.114(d)(1)(i)-(ii), MSC Attachment A	MED9 D	Met	
15	Emergency Medical Condition Screening and Treatment	42 CFR 438.114(d)(2), MSC Attachment A	MED9 D	Met	
16	Responsibility for Emergency Coverage and Payment	42 CFR 438.114(d)(3), MSC Attachment A	MED9 D	Met	

Table C-2. QP Standard: Enrollee Rights and Protections					
Element #	**ACA Tool Element Name**	**42 CFR Reference(s)**	**2019 NCQA Element(s)**	**NCQA Equivalency**	**Qsource Notes**
17	Post-Stabilization Care Services Coverage and Payment	42 CFR 438.114(e), MSC Attachment A	None	N/A	
18	Enrollee Confidentiality	42 CFR 438.224, MSC 7.1	MED4 A	Partially Met	

Table C-3. QP Standard: Credentialing/Recredentialing					
Element #	**ACA Tool Element Name**	**42 CFR Reference(s)**	**2019 NCQA Element(s)**	**NCQA Equivalency***	**Qsource Notes**
1	Delivery Network – Provider Credentialing	42 CFR 438.206(b)(6), Florida Healthy Kids Uniform Credentialing and Recredentialing Policy (UCRP)	None	Not Met	
2	Delivery Network-Provider Credentialing, Mental Health and Substance Abuse	42 CFR 438.203(b)(6), Florida Healthy Kids Uniform Credentialing and Recredentialing Policy (UCRP)	None	Not Met	
3	Facility Standards	UCRP	None	Not Met	
4	Mental Healthcare and Substance Abuse Providers	UCRP	None	Not Met	

Table C-3. QP Standard: Credentialing/Recredentialing					
Element #	**ACA Tool Element Name**	**42 CFR Reference(s)**	**2019 NCQA Element(s)**	**NCQA Equivalency***	**Qsource Notes**
5	Indian Health Care Providers	UCRP	None	Not Met	
6	License	UCRP	None	Not met	
7	At-Risk Providers – 1	UCRP	None	Not Met	
8	At-Risk Providers – 2	UCRP	None	Not Met	
9	Exclusions	UCRP	None	Not Met	
10	Exclusions –Ongoing Monitoring	UCRP	None	Not Met	
11	Provider Contract Compliance	UCRP	None	Not Met	
12	Quality Monitoring	UCRP	None	Not Met	
13	Appropriate Actions	UCRP	None	Not Met	
14	Board Certification Exemption-1	UCRP	None	Not Met	
15	Board Certification Exemption-2	UCRP	None	Not Met	
16	Recredentialing	UCRP	None	Not Met	
17	Verifications	UCRP	None	Not Met	
18	Disclosures	UCRP	None	Not Met	
19	Criminal Background Checks	UCRP	None	Not Met	
20	Verifications and Attestations	UCRP	None	Not Met	
21	Education and Training	UCRP	None	Not Met	

Table C-3. QP Standard: Credentialing/Recredentialing					
Element #	**ACA Tool Element Name**	**42 CFR Reference(s)**	**2019 NCQA Element(s)**	**NCQA Equivalency***	**Qsource Notes**
22	Immunization Registry Enrollment	UCRP	None	Not Met	
23	Provider Nondiscrimination	42 CFR 438.214(c), MSC 24.1	CR1 A	Met	
24	Excluded Providers	42 CFR 438.214(d), MSC 24.3	None	Not Met	