December 2024

2024 Annual

Quality Review Technical Report

Florida Healthy Kids Children's Health Insurance Program

Review Period: January 1, 2023 – December 31, 2023

Final

HealthyKids™

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Acknowledgements, Acronyms, and Initialisms[1]

AAAHC ..... Accreditation Association for Ambulatory Health Care
AAB-CH ..... Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
ACA ..... Annual Compliance Assessment
ADD-CH .... Improving Care Coordination to Improve Follow-Up Care for Children Prescribed ADHD Medication
ADHD ..... Attention Deficit Hyperactivity Disorder
ADV ..... Annual Dental Visit
Aetna ..... Aetna Better Health of Florida
AHCA ..... Agency for Healthcare Administration
AHRQ ..... Agency for Healthcare Research and Quality
AMB-CH ..... Ambulatory Care: Emergency Department Visits
AMR-CH ..... Asthma Medication Ratio
ANA ..... Annual Network Adequacy
AOD ..... Alcohol and Other Drug Abuse/Dependence
AON ..... Area of Noncompliance
APM-CH ..... Metabolic Monitoring for Children and Adolescents on Antipsychotics
APP-CH ..... 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-CH ..... Contraceptive Care – Postpartum Women Ages 15−20
CCW-CH ..... 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-CH ..... 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
DBM ..... Dental Benefit Manager
DentalTrac™ ..... a registered trademark of MCNA Systems Corporation
DentaQuest ..... DentaQuest of Florida, Inc.
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
EPSDT ..... Early and Periodic Screening, Diagnostic and Treatment
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-CH ..... Follow-up After Emergency Department Visit for Drug Abuse or Dependence
FUH-CH ..... Follow-up After Hospitalization for Mental Illness
FUM-CH ..... 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
IDSS ..... Interactive Data Submission System
IET ..... Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
IMA-CH ..... 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
MCO ..... Managed Care Organization
MPT ..... Mental Health Utilization
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)
OEV-CH ..... Oral Evaluation, Dental Services
OPA ..... Office of Population Affairs
PA ..... Physician's Assistant
P&P ..... Policy and Procedure
PC-02 ..... Cesarean Birth
PCP ..... Primary Care Provider/Physician
PDENT ..... Preventive Dental Services
PDSA ..... Plan-Do-Study-Act
PHP ..... Partial Hospitalization
PIP ..... Performance Improvement Project
PMV ..... Performance Measure Validation
PPC2-CH ..... 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
SDoH ..... Social Determinants of Health
SEA: With Exclusions ..... Enrolled Children Receiving Dental Sealants on Permanent Molars – With Exclusions
SFM-CH ..... Sealant Receipt on Permanent First Molars
Simply Healthcare ..... Simply Healthcare Plans, Inc.
SQL ..... Structured Query Language
SUD ..... Substance Use Disorder
TDENT ..... Enrolled Children Receiving Dental Treatment Services
TFL-CH ..... Topical Fluoride for Children
TJC ..... The Joint Commission
UM ..... Utilization management

URAC® ..... Utilization Review Accreditation Commission
URI ..... Appropriate Treatment for Upper Respiratory Infection
WCC-CH ..... Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
WCV-CH..... Child and Adolescent Well-Care Visits

Overview

In accordance with Title 42 *Code of Federal Regulations* (CFR) § 438.364, Qsource has produced this *2024 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 2024, 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 2024, 436,075 children were enrolled in the Florida Healthy Kids program, according to enrollment data from FHKC's vendor, Maximus. Enrollment numbers for the medical plans were as follows: Aetna totaled 101,226, CCP totaled 17,762, and Simply totaled 100,278. The dental plans total enrollees were as follows: Liberty totaled 37,116, DentaQuest totaled 84,348, and MCNA totaled 95,345. In June 2023, 280,312 children were enrolled in the program. 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 2023, 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 Healthcare), 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 for 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.

Table 1. Quality Strategy Goals and Alignment

FHKC Goals	Primary Area of Focus	CMS Quality Strategy Alignment	FHKC Steps
Satisfaction: Fulfill child health care insurance expectations and the needs of families.		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, 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

Table 1. Quality Strategy Goals and Alignment

FHKC Goals	Primary Area of Focus	CMS Quality Strategy Alignment	FHKC Steps
			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 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

Table 1. Quality Strategy Goals and Alignment			
FHKC Goals	**Primary Area of Focus**	**CMS Quality Strategy Alignment**	**FHKC Steps**
			♦ 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 helped 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 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 2024, in accordance with the CMS *External Quality Review Protocols* (released in 2023).

EQR Mandatory Activities

Following the CMS Protocols published in February 2023, 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 2024

Protocol #	Activity Name	Mandatory or Optional	Measurement Period
1	Validation of Performance Improvement Projects	Mandatory	January 1, 2023 – December 31, 2023
2	Validation of Performance Measures	Mandatory	January 1, 2023 – December 31, 2023
3	Review of Compliance	Mandatory	January 1, 2023 – December 31, 2023
4	Validation of Network Adequacy	Mandatory	January 1, 2023 – December 31, 2023

Technical Report Guidelines

Qsource is responsible for the creation and production of this *2024 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 2023 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. Comparative information and assessments of the degree to which benefit managers have addressed prior year EQRO recommendations for Quality Improvement (QI);
4. Strengths and weaknesses demonstrated by each plan in providing healthcare services to enrollees;
5. 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
6. Comparative information regarding the plans, consistent with CMS EQR Protocol guidance.

The *2024 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 | 2024 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, VP of Operations
- Kristen Gloria, Qsource, EQRO Program Director
- Hira Siddiqui, Qsource, Florida EQRO Program Manager
- Albert Kennedy, Qsource, Technical Writer
- Fidencio Caballero, Qsource, Healthcare Quality Analyst

Performance Improvement Project (PIP) Validation

Objectives

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 plans.

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) (2023). 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 June 2024. The MY for this validation was January 1, 2023, through December 31, 2023.

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 were scored as Met, Not Met, or Not Applicable.

Qsource also provided a validation score and two validation ratings for the PIP. The validation score was calculated by dividing the number of elements met by the number of elements assessed.

The first validation rating was determined by the percentage score of elements met. The rating indicated Qsource's overall confidence (from no confidence to high confidence) that the PIP adhered to acceptable methodology for all phases of design and data collection and included accurate data analysis and interpretation of PIP results.

Qsource also assigned a second validation rating based on its assessment of whether the PIP produced significant evidence of improvement. To determine this rating, Qsource reviewed the PIPs results and processes along with its relative strengths and weaknesses and the extent to which they affected confidence in the generalizability and usefulness of the PIP's findings.

Table 3 presents the validation status criteria for the PIPs.

Table 3. Overall Validation Status and Confidence Statements

Validation Status	
Met	70–100% of all assessed elements are Met.
Not Met	Less than 70% of all assessed elements are Met.
Rating 1 (Confidence Statements)	
High Confidence	90–100% of all assessed elements are Met.
Moderate Confidence	80–89.99% of all assessed elements are Met.
Low Confidence	70–79.99% of all assessed elements are Met.
No Confidence	Less than 70% of all assessed elements are Met.
Rating 2 (Confidence Statements)	
High Confidence	The PIP achieved statistically significant improvement for all performance measures and interventions resulted in demonstrated improvement.
Moderate Confidence	The PIP achieved statistically or non-statistically significant improvement for at least one measure.

Table 3. Overall Validation Status and Confidence Statements	
Low Confidence	The PIP did not demonstrate statistically or non-statistically significant improvement or none of the interventions resulted in demonstrated improvement.
No Confidence	The PIP did not follow approved methodology or processes through the end date.

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 and Description of Data Obtained

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. 2024 PIP Validation Rating and Overall Score

MCO/DBM	PIP Type	PIP Topic	Quality	Timeliness	Access	Validation Rating 1	Validation Rating 2	Overall Score
Aetna	Clinical	*Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH)*	✓	✓		High	High	100%
	Non-clinical	*Timely Follow-up for Patients After They Have Been Hospitalized for Mental Illness–7-Day (FUH 7-Day)*	✓	✓		High	High	100%

Table 5. 2024 PIP Validation Rating and Overall Score

MCO/DBM	PIP Type	PIP Topic	Quality	Timeliness	Access	Validation Rating 1	Validation Rating 2	Overall Score
CCP	Clinical	*Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH)*	✓	✓		High	High	93.18%
	Non-clinical	*Follow-up After Hospitalization for Mental Illness—7 Days*	✓	✓		Moderate	Moderate	85.42%
DentaQuest	Clinical	*Preventative Dental*	✓	✓	✓	High	Low	100%
	Non-clinical	*Increasing After-hours Care*	✓	✓	✓	High	Low	97.50%
Liberty	Clinical	*Increase the Percentage of Enrollees Receiving Preventive Dental Services*	✓	✓	✓	High	Moderate	96.77%
	Non-clinical	*Access to Care in Rural and Urban Counties*		✓	✓	Moderate	Moderate	81.81%
MCNA	Clinical	*Preventive Dental Visit*	✓	✓	✓	High	Low	100%
	Non-clinical	*Annual Dental Visit (ADV)*	✓	✓	✓	High	Moderate	100%
Simply Healthcare	Clinical	*Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH)*	✓	✓		High	High	91.49%
	Non-clinical	*Improving Care Coordination to Improve Follow-up Care for Children Prescribed ADHD Medication (ADD)*	✓	✓		High	High	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	*Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH)*	**Step 8**: Assess the Improvement Strategies—The MCO included a driver diagram with both primary and secondary drivers of its intervention strategy.
	Timely Follow-up for Patients After They Have Been Hospitalized for Mental Illness–7-Day (FUH 7-Day)	**Step 8**: Assess the Improvement Strategies—The MCO provided a detailed explanation of each step of the Plan-Do-Study-Act (PDSA) cycle.
MCNA	*Annual Dental Visit (ADV)*	**Step 8:** Assess the Improvement Strategies—The DBM demonstrated a strength in their barrier analysis, which allowed them to design improvement strategies to address these barriers.

Table 7. PIP Weaknesses (AONs)

MCO/DBM	PIP Title	AONs and Recommendations
CCP	*Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH)*	**Step 5**: Review the Selected PIP Variables and Performance Measures—The MCO should ensure that it has the correct information reflected in the applicable section of the summary form. **Step 7**: Review the Data Analysis and Interpretation of PIP Results—The MCO should include a discussion assessing the statistical significance of any differences between baseline and the current remeasurement year (Remeasurement 3).

Table 7. PIP Weaknesses (AONs)		
MCO/DBM	**PIP Title**	**AONs and Recommendations**
		Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred—The MCO should ensure the correct and current methodology is presented when noting whether the remeasurement methodology is the same as the baseline methodology.
	Follow-up After Hospitalization for Mental Illness—7 Days	**Step 2**: Review the PIP Aim Statement—The MCO should note the PIP time period as the measurement year that is reflected in the PIP. **Step 5**: Review the Selected PIP Variables and Performance Measures—The MCO should ensure that the correct information is reflected in the applicable section of the summary form. **Step 6**: Review the Data Collection Procedures—The MCO should describe the process used to determine the degree of completeness. **Step 6**: Review the Data Collection Procedures—The MCO should clearly specify data sources. **Step 6**: Review the Data Collection Procedures—The MCO should describe qualifications of staff responsible for abstracting data for medical record review. **Step 6**: Review the Data Collection Procedures—The MCO should describe both inter-rater and intra-rater reliability processes in place for medical record review. **Step 6**: Review the Data Collection Procedures—The MCO should include guidelines developed for abstraction staff for medical record review.
DentaQuest	*Increasing After-hours Care*	**Step 8**: Assess the Improvement Strategies—Due to the continued effect of the public health emergency on the comparability of the measurement years to the baseline, DentaQuest should adjust the baseline rate/timeframe moving forward or retire the PIP.

Table 7. PIP Weaknesses (AONs)		
MCO/DBM	**PIP Title**	**AONs and Recommendations**
Liberty	*Increase the Percentage of Enrollees Receiving Preventive Dental Services*	**Step 5**: Review the Selected PIP Variables and Performance Measures—The DBM should ensure that all information in each step is updated and define the baseline rate.
	Access to Care in Rural and Urban Counties	**Step 2**: Review the PIP Aim Statement—The DBM should include all necessary components into one concise PIP aim statement. **Step 2**: Review the PIP Aim Statement—The DBM should include answerable and measurable goals in the PIP aim statement. **Step 3**: Review the Identified PIP Population—The DBM should clearly define the PIP population in the PIP aim statement. **Step 3**: Review the Identified PIP Population—The DBM should also include details (e.g., age, length of enrollment, diagnoses, procedures, and other characteristics) about how they will select eligible enrollees to whom the PIP aim statement applies. **Step 5**: Review the Selected PIP Variables and Performance Measures—The DBM should ensure that all information in each step is updated and define the baseline rate and benchmark.
Simply Healthcare	*Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH)*	**Step 6**: Review the Data Collection Procedures—The MCO should clearly specify data sources. **Step 6**: Review the Data Collection Procedures—The MCO should describe qualifications of staff responsible for abstracting data for medical record review. **Step 6**: Review the Data Collection Procedures—The MCO should describe both inter-rater and intra-rater reliability processes in place for medical record review. **Step 6**: Review the Data Collection Procedures—The MCO should include guidelines developed for abstraction staff for medical record review.

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. 2024 PIP Interventions

MCO/DBM	PIP Title	Interventions
Aetna	*Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH)*	The provider intervention educated FHK providers about the billing codes and reimbursement rates for depression screening on a regular basis to bring them in compliance with the recommended depression screening. The intervention is expected to contribute to the improvement in rate of depression screenings completed (CDF-CH) over time because it is designed to encourage billing of depression screens by providers. This intervention focuses on providers because they would have the greatest impact on increasing the rate of depression screens completed.
	Timely Follow-up for Patients After They Have Been Hospitalized for Mental Illness–7-Day (FUH 7-Day)	BH Liaison Member Outreach—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 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 12-17 (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.—Discontinued CY2023. Staff saw that depression screenings were being completed (during record review for WCC measures) but not coded in claims/encounters. CCP built a depressions screening collection module in its proprietary medical records database (QMR) and implemented data entry to capture depression screenings completed. This was ongoing for all medical records obtained from the start of the year through the end of the non-supplemental collection period. Flat Files from Provider Offices

Table 8. 2024 PIP Interventions		
MCO/DBM	**PIP Title**	**Interventions**
	Follow-up After Hospitalization for Mental Illness—7 Days	Medical Records for members seen from Grant Funded Programs. Provider Assessment Following Behavioral Health (BH) Admission.
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. 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 Preventive Dental Services (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 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. Live calls with scheduling assistance to members aged 6-14 in Broward county. IVR calls and provider recall letters to members overdue for preventive dental visit. Non-compliant membership divided equally with half of group receiving the provider recall letter intervention and half will receive an IVR call with education and reminder to schedule a dental visit. All counties were included. Members receive notification of their assigned a Primary Dental Home provider that includes contact information to facilitate scheduling a visit. IVR calls members overdue for preventive dental visit. Non-compliant membership received an IVR call with education and reminder to schedule a dental visit. All counties were included. Provider Notification—Non-compliant membership roster will be posted to the provider portal with a call to action to schedule members for preventive dental visits. DQ sought to increase the number of preventive visits among these members.

Table 8. 2024 PIP Interventions		
MCO/DBM	**PIP Title**	**Interventions**
		Live calls members overdue for preventive dental visit. Dental Home magnet and printed flyer. Members will receive a magnet and information flyer that includes dental home information for ease of access.
	Increasing After Hours Care	DentaQuest's QI team completed a fishbone diagram to identify the causes contributing to an outcome and to identify areas for improvement which informed the subsequent barrier analysis to plan and execute interventions. The barriers were prioritized according to the Agency for Healthcare Research and Quality (AHRQ) Barrier Identification and Mitigation Tool. The barriers were then prioritized with the most significant having the highest score and the lowest score is representing a barrier that is less impactful on the aim, to increase the percentage of members completing the Social Determinants of Health (SDoH) survey. DentaQuest implemented a digital communication strategy to ensure multiple methods of communicating information, including current digital methods, to increase the number of members who complete a dental visit. Using the cause and effect diagram, the QI team identified barriers. To prioritize the barriers, DentaQuest implemented the scoring criteria according to the AHRQ Barrier Identification and Mitigation Tool. This tool provides a numerical value for likelihood and severity and multiplies the two for the barrier priority score. The barriers are then prioritized from highest to lowest.
Liberty	*Increase the Percentage of Enrollees Receiving Preventive Dental Services*	*Liberty did not report any improvement strategies for this baseline PIP.*
	Access to Care in Rural and Urban Counties	*Liberty did not report any improvement strategies for this baseline PIP.*
MCNA	*Preventive Dental Visit*	Care Gap Alerts – MCNA Member Service Representatives (MSRs) offer assistance with scheduling an appointment when an alert is triggered in the DentalTrac™ system during inbound calls that indicates the member is overdue for a preventive dental

Table 8. 2024 PIP Interventions		
MCO/DBM	**PIP Title**	**Interventions**
		visit. Text Messages – Text messages will be sent once a month to members who have no claims history on file. Members will continue to receive a text message until an encounter is received. Member Outreach Forms – MCNA created a Member Outreach Form which allows providers to communicate with MCNA when a member is non-compliant with their treatment plan, failing appointments, behind on their dental checkup, etc. and upon receipt of the form via mail, email, or fax, an MCNA representative contacts the member and provides the assistance needed. Practice Site Performance Summary (PSPS) Report – Quarterly profiling report that educates offices on their performance and assists clinicians and their staff to eliminate administrative inefficiencies and showcase their utilization rates in comparison with their peers.
	Annual Dental Visit (ADV)	Care Gap Alerts – MCNA Member Service Representatives (MSRs) offer assistance with scheduling an appointment when an alert is triggered in the DentalTrac™ system during inbound calls that indicates the member is overdue for a preventive dental visit. Text Messages – Text messages will be sent once a month to members who have no claims history on file. Members will continue to receive a text message until an encounter is received. Member Outreach Forms – MCNA created a Member Outreach Form which allows providers to communicate with MCNA when a member is non-compliant with their treatment plan, failing appointments, behind on their dental checkup, etc. and upon receipt of the form via mail, email, or fax, an MCNA representative contacts the member and provides the assistance needed. ADV Outbound Call Campaign – Conduct outbound calls to members who have not had a dental visit within the last six months to encourage them to schedule an appointment. ADV Postcard Mailing – Postcard mailing to members who have not a dental visit to

Table 8. 2024 PIP Interventions		
MCO/DBM	**PIP Title**	**Interventions**
		encourage members to schedule an appointment.
Simply Healthcare	*Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH)*	Does medical record review and subsequent provider education improve the percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.
	Improving Care Coordination to Improve Follow-up Care for Children Prescribed ADHD Medication (ADD)	Care Gaps - Developed a system where gaps in care among members recently prescribed ADHD medications (last 90 days) without a follow-up are identified and shared with BH Providers. This was designed to address gaps in communication among PCPs and BH prescribers.

Comparison of PIP Improvements

Table 9 compares PIP scores from MY 2022 to MY 2023. Improvements from the previous measurement year are indicated in green, and notable decreases in performance are indicated in red.

Table 9. PIP Performance Comparison					
MCO/DBM	**PIP Name**	**MY 2022 Validation Rating**	**MY 2023 Validation Rating**	**MY 2022 Overall Score**	**MY 2023 Overall Score**
Aetna	*Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH)*	High Confidence	High Confidence High Confidence	100%	100%
	Timely Follow-up for Patients After They Have Been Hospitalized for Mental Illness–7-Day (FUH 7-Day)	High Confidence	High Confidence High Confidence	100%	100%

Table 9. PIP Performance Comparison

MCO/DBM	PIP Name	MY 2022 Validation Rating	MY 2023 Validation Rating	MY 2022 Overall Score	MY 2023 Overall Score
CCP	*Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH)*	Low Confidence	High Confidence High Confidence	79.10%	93.18%
	Follow-up After Hospitalization for Mental Illness—7 Days	High Confidence	Moderate Confidence Moderate Confidence	94.74%	85.42%
DentaQuest	*Preventative Dental*	High Confidence	High Confidence Low Confidence	93.48%	100%
	Increasing After-hours Care	Moderate Confidence	High Confidence Low Confidence	88.40%	97.50%
Liberty	*Increase the Percentage of Enrollees Receiving Preventive Dental Services*	High Confidence	High Confidence Moderate Confidence	96.77%	96.77%
	Access to Care in Rural and Urban Counties	High Confidence	Moderate Confidence Moderate Confidence	96.55%	81.81%
MCNA	*Preventive Dental Visit*	High Confidence	High Confidence Low Confidence	100%	100%
	Annual Dental Visit (ADV)	High Confidence	High Confidence Moderate Confidence	100%	100%
Simply Healthcare	*Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH)*	High Confidence	High Confidence High Confidence	100%	91.49%
	Improving Care Coordination to Improve Follow-up Care for	High Confidence	High Confidence High Confidence	100%	100%

Table 9. PIP Performance Comparison					
MCO/DBM	**PIP Name**	**MY 2022 Validation Rating**	**MY 2023 Validation Rating**	**MY 2022 Overall Score**	**MY 2023 Overall Score**
	Children Prescribed ADHD Medication (ADD)				

Table 10 displays the degree to which the plan addressed the previous year's recommendations. With a score of high when all recommendations were addressed, medium when they were partially addressed, low when they were not addressed, and not applicable when the was no comparison available.

Table 10. MY 2022 Recommendations Addressed in MY 2023			
Plan	**Recommendation**	**Action Taken**	**Degree to Which Plan Addressed Recommendation(s)**
CCP	**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.	CCP followed through on the recommendations for Step 5 and Step 8, improving its score from 79.10% in 2023 to 93.18% in 2024.	High
	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	Although CCP followed through with recommendations for Step 7 in the *Follow-up After Hospitalization for Mental Illness—7 Days* PIP, its score decreased from 94.74% in 2023 to 85.42% in 2024.	Medium

Table 10. MY 2022 Recommendations Addressed in MY 2023			
Plan	**Recommendation**	**Action Taken**	**Degree to Which Plan Addressed Recommendation(s)**
	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.		
DentaQuest	**Step 9**. The DBM should ensure improvement strategies are modified to achieve improvement.	DentaQuest followed through on the recommendations for Step 9 in the *Preventative Dental* PIP, improving its score from 93.48% in 2023 to 100% in 2024.	High

Table 10. MY 2022 Recommendations Addressed in MY 2023			
Plan	**Recommendation**	**Action Taken**	**Degree to Which Plan Addressed Recommendation(s)**
	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. Step 9. The DBM should ensure improvement strategies are modified to achieve improvement.	In 2023, Qsource made recommendations for Steps 8 and 9 in the *Increasing After Hours Care* PIP. DentaQuest followed through on recommendations in Step 9 and improved its score from 88.40% in 2023 to 97.50% in 2024.	High
Liberty	**Step 5**. The DBM should provide baseline, benchmark, and goal rates for the PIP.	Liberty's *Increase the Percentage of Enrollees Receiving Preventive Dental Services PIP* was in its planning phase in MY 2022 and is now in its baseline year. While Liberty addressed part of the recommendation made in Step 5, Qsource made further recommendations for all steps in 2024. However, the overall validation rating stayed the same in MY 2023.	Medium
	Step 5. The DBM should provide baseline, benchmark, and goal rates for the PIP.	Liberty's *Access to Care in Rural and Urban Counties PIP* was in its planning phase in MY 2022 and is now in its baseline year. While Liberty addressed part of the	Medium

Table 10. MY 2022 Recommendations Addressed in MY 2023			
Plan	**Recommendation**	**Action Taken**	**Degree to Which Plan Addressed Recommendation(s)**
		recommendation made in Step 5, Qsource made further recommendations for all steps in 2024. Liberty's overall validation rating decreased from 96.55% (High Confidence) to 81.81% (Moderate Confidence) in the non-clinical PIP.	

Conclusions and Recommendations

Aetna

Aetna received a score of 100% (High Confidence) for its clinical PIP *Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH).* The PIP focused on improving access to care preventive screening for depression for adolescents and was in Remeasurement Year 3.

Aetna's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with instructions. Aetna's score of High Confidence for Validation Rating 2 indicated that the PIP achieved some statistically significant improvement. This PIP topic aligned with the National Quality Strategy goal and CMS priority of improved health, as early identification, and diagnosis of depression through screening for depression at the PCP level is associated with better health outcomes, the CMS priority of better health by initiating appropriate treatment in coordination with behavioral health care providers and preventing the negative outcomes associated with depression, and the CMS initiative of focusing on child quality improvement.

Aetna received a score of 100% (High Confidence) for its nonclinical PIP *Timely Follow-up for Patients After They Have Been Hospitalized for Mental Illness–7-Day (FUH 7-Day).* The PIP focused on improving access to care and quality by ensuring follow up is conducted after hospitalization and was in Remeasurement Year 5.

Aetna's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with

instructions. Aetna's score of High Confidence for Validation Rating 2 indicated that the PIP achieved some statistically significant improvement. This PIP topic aligned with priority areas identified by the Department of Health and Human Services (HHS) and CMS by addressing improved health outcomes due to timely follow-up care and with the CMS initiative of focusing on child quality improvement. The PIP topic aligned with CMS priority areas of better care for patients and families, improved health for communities and populations, lower cost through improvement, child and adult quality improvement and prevention, and patient safety.

Additional details about each PIP study are located in Appendix A.

CCP

CCP received a score of 93.18% (High Confidence) for its clinical PIP *Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH)*. The PIP focused on improving access to care preventive screening for depression for adolescents and was in Remeasurement Year 3.

CCP's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with instructions. CCP's score of High Confidence for Validation Rating 2 indicated that the PIP achieved some statistically or significant improvement. This PIP topic aligned with the National Quality Strategy goal and CMS priority of improved health, as early identification, and diagnosis of depression through screening for depression at the PCP level is associated with better health outcomes, the CMS priority of better health by initiating appropriate treatment in coordination with behavioral health care providers and preventing the negative outcomes associated with depression, and the CMS initiative of focusing on child quality improvement. The PIP topic aligned with FHKC's Quality Strategy Goal of Quality: Ensure child-centered standards of health care excellence in all Florida Healthy Kids plans.

CCP received a score of 85.42% (Moderate Confidence) for its nonclinical PIP *Timely Follow-up for Patients After They Have Been Hospitalized for Mental Illness–7-Day (FUH 7-Day)*. The PIP focused on improving access to care and quality by ensuring follow up is conducted after hospitalization and was in Remeasurement Year 1.

CCP's score of Moderate Confidence for Validation Rating 1 indicated that the PIP was mostly written in accordance with instructions. CCP's score of Moderate Confidence for Validation Rating 2 indicated that the PIP achieved statistically or non-statistically significant improvement for at least one measure. This PIP topic aligned with priority areas identified by HHS and CMS by addressing improved health outcomes due to timely follow-up care and with the CMS initiative of focusing on child quality improvement. The PIP topic aligned with CMS priority areas of better care for patients and families, improved health for communities and populations, lower cost through

improvement, child and adult quality improvement and prevention, and patient safety.

Additional details about each PIP study are located in Appendix A.

DentaQuest

DentaQuest received a score of 100% (High Confidence) for its clinical PIP *Preventive Dental*. This PIP focused on access to preventive care critical to long term oral health for children and was in Remeasurement Year 5.

DentaQuest's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with instructions. DentaQuest's score of Low Confidence for Validation Rating 2 indicated that the PIP did not demonstrate statistically or non-statistically significant improvement and/or none of the interventions resulted in demonstrated improvement. This PIP topic aligned with CMS priorities around child quality improvement and better health. The PIP focused on the CMS 416 12b measure, PDENT, and was used to assess the effectiveness of the state Early and Periodic Screening, Diagnostic and Treatment (EPSDT) programs.

DentaQuest received a score of 97.50% (High Confidence) for its nonclinical PIP *Increasing After-hours Care*. The PIP focused on improving access to afterhours care and to ultimately improve oral health in FHKC enrollees aged 5-18 and was in Remeasurement Year 5.

DentaQuest's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with instructions. DentaQuest's score of Low Confidence for Validation Rating 2 indicated that the PIP did not demonstrate statistically or non-statistically significant improvement and/or none of the interventions resulted in demonstrated improvement. This PIP topic aligned with CMS's initiative to improve health for children and priorities of better health.

Additional details about each PIP study are located in Appendix A.

Liberty

Liberty received a score of 96.77% (High Confidence) for its clinical PIP *Increase the Percentage of Enrollees Receiving Preventive Dental Services*. This PIP focused on access to preventive care critical to long term oral health for children and was in its Baseline Measurement Year.

Liberty's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with instructions. Liberty's score of Moderate Confidence for Validation Rating 2 indicated that the PIP achieved statistically or non-statistically significant improvement for at least one measure. This PIP topic aligned with CMS priorities around child quality improvement and better health. The PIP focused on the CMS 416 12b measure Preventive Dental Services (PDENT) and was used to assess the effectiveness of the state EPSDT programs.

Liberty received a score of 81.81% (Moderate Confidence) for its nonclinical PIP *Increasing After-hours Care*. The PIP focused on improving access to care in both rural and urban counties and was in its Baseline Measurement Year.

Liberty's score of Moderate Confidence for Validation Rating 1 indicated that the PIP was mostly written in accordance with instructions. Liberty's score of Moderate Confidence for Validation Rating 2 indicated that the PIP achieved statistically or non-statistically significant improvement for at least one measure. This PIP topic aligned with the National Quality Strategy to improve health for communities, CMS's priority of better health and CMS's initiative to improve health oral health.

Additional details about each PIP study are located in Appendix A.

MCNA

MCNA received a score of 100% (High Confidence) for its clinical PIP *Preventive Dental*. This PIP focused on access to preventive care critical to long term oral health for children and was in Remeasurement Year 5.

MCNA's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with instructions. MCNA's score of Low Confidence for Validation Rating 2 indicated that the PIP did not demonstrate statistically or non-statistically significant improvement and/or none of the interventions resulted in demonstrated improvement. This PIP topic aligned with CMS priorities around child quality improvement and better health. The PIP focused on the CMS 416 12b measure Preventive Dental Services (PDENT) and was used to assess the effectiveness of the state Early and Periodic Screening, Diagnostic and Treatment (EPSDT) programs.

MCNA received a score of 100% (High Confidence) for its nonclinical PIP *Annual Dental Visit (ADV).* The PIP focused on improving utilization of annual dental visits to potentially reduce preventable oral disease. and was in Remeasurement Year 5.

MCNA's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with instructions. MCNA's score of Moderate Confidence for Validation Rating 2 indicated that the PIP achieved statistically or non-statistically significant improvement for at least one measure. The PIP topic aligned with the three aims of the National Quality Strategy to improve health and CMS's initiatives of prevention and to improve oral health.

Additional details about each PIP study are located in Appendix A.

Simply Healthcare

Simply Healthcare received a score of 100% (High Confidence) for its clinical PIP *Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH).* The PIP focused on improving access to care preventive screening for depression for adolescents and was in Remeasurement Year 4.

Simply Healthcare's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with instructions. Simply Healthcare's score of High Confidence for Validation Rating 2 indicated that the PIP achieved some statistically or significant improvement. This PIP topic aligned with the National Quality Strategy goal and CMS priority of improved health, as early identification, and diagnosis of depression through screening for depression at the PCP level is associated with better health outcomes, the CMS priority of better health by initiating appropriate treatment in coordination with behavioral health care providers and preventing the negative outcomes associated with depression, and the CMS initiative of focusing on child quality improvement.

Simply Healthcare received a score of 100% (High Confidence) for its nonclinical PIP *Improving Care Coordination to Improve Follow-up Care for Children Prescribed ADHD Medication (ADD).* The PIP focused on improving coordination of care for children prescribed ADHD medication and access to follow up care and quality by ensuring follow up is conducted after hospitalization and was in Remeasurement Year 5.

Simply Healthcare's score of High Confidence for Validation Rating 1 indicated that the PIP was written in accordance with instructions. Simply Healthcare's score of High Confidence for Validation Rating 2 indicated that the PIP achieved some statistically significant improvement. This PIP topic aligned with priority areas identified by HHS and CMS by addressing improved health outcomes due to timely follow-up care and with the CMS initiative of focusing on child quality improvement. The PIP topic aligned with high priority areas identified by HHS and CMS by addressing child quality improvement and better care for patients and families.

Additional details about each PIP study are located in Appendix A.

Performance Measure Validation (PMV)

Objectives

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, 2023, through December 31, 2023 (MY 2023).

The 2024 PMV, which validates performance measures for MY 2023, 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 (February 2023)*. 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 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 2024 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 2024 were all included under the scope of the formal HEDIS audit. CMS's *Protocol 2: Validation of Performance Measures* (2023) 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 2024 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 nine dental performance measures to be calculated and reported by the contracted DBMs. Six of these were CMS-416 dental service measures, three were CMS Core Set Measures, and the last was a measure that has been retired from HEDIS. 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 2023, CMS does not require another one to be completed for 2 years unless significant system changes occur during the review year. Completed ISCATs from 2023 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. 2024 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-CH)
✓	✓		Chlamydia Screening in Women Ages 16–20 (CHL-CH)
✓	✓		Immunizations for Adolescents (IMA-CH)
✓	✓	✓	Child and Adolescent Well-Care Visits (WCV-CH)
Maternal and Perinatal Health			

Table 11. 2024 PMV: MCO Performance Measures			
Quality	**Timeliness**	**Access**	**Measure**
✓	✓	✓	Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)
✓			Cesarean Birth (PC-02)
✓	✓	✓	Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)
✓	✓	✓	Prenatal and Postpartum Care: Under Age 21 (PPC2-CH)
Care of Acute and Chronic Conditions			
✓	✓		Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years (AAB-CH)
✓			Asthma Medication Ratio: Ages 5–18 (AMR-CH)
✓	✓		Appropriate Testing for Children with Pharyngitis (CWP)
✓			Appropriate Treatment for Children with Upper Respiratory Infection (URI)
✓	✓		Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)
Behavioral Healthcare			
✓	✓		Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)
✓	✓		Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)
✓	✓		Follow-up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)
✓	✓		Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH)
✓	✓		Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17 (FUA-CH)
✓		✓	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)

Table 11. 2024 PMV: MCO Performance Measures			
Quality	**Timeliness**	**Access**	**Measure**
✓	✓		Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)
✓	✓	✓	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
✓			Diagnosed Substance-Related Disorders (DSU)
✓			Mental Health Utilization (MPT)
Experience of Care			
✓			CAHPS® Health Plan Survey 5.1H, Child Version (CPC)

Table 12. 2024 PMV: DBM Performance Measures			
Quality	**Timeliness**	**Access**	**Measure**
✓	✓	✓	Enrolled Children Receiving Dental Sealants on Permanent Molars – With Exclusions (SEA: With Exclusions)
✓	✓	✓	Enrolled Children Receiving Preventive Dental Services (PDENT)
✓	✓	✓	Enrolled Children Receiving Any Dental Services
✓	✓	✓	Enrolled Children Receiving Dental Treatment Services (TDENT)
✓	✓	✓	Enrolled Children Receiving Diagnostic Dental Services
✓	✓	✓	Enrolled Children Receiving Any Preventive Dental or Oral Health Service

Table 12. 2024 PMV: DBM Performance Measures			
Quality	Timeliness	Access	Measure
✓	✓	✓	Annual Dental Visit (ADV)
✓	✓	✓	Oral Evaluation, Dental Services (OEV-CH)*
✓	✓	✓	Topical Fluoride for Children (TFL-CH)*
✓	✓	✓	Sealant Receipt on Permanent First Molars (SFM-CH)*

** This measure is a new measure added for 2024.*

Comparative Findings

Trending analysis is included where possible from the 2023 PMV to the 2024 PMV. To better identify trends for these measures, the use of green and red is used to indicate this year's result for each measure as compared to results from 2023. **Table 13** and **Table 17** indicate an increase (green), decrease (red), or no change from the previous year's rate.

Compared to 2023, all MCOs and DBMs saw an increase in the total measures being reported. For the MCOs, Aetna was noted to have the most improvements with 38 measures trending positively in 2023. CCP had 16 measures trend positively in 2023, and Simply Healthcare had 19 measures trend positively.

CCP was also noted to have six measures with significant (>10.00%) improvement between MY 2022 to MY 2023, the most among the MCOs, with Aetna having three measurements improve significantly and Simply Healthcare having four. CCP showed less measures trending down (14) compared to Aetna and Simply Healthcare during the same time. Aetna reported 20 measures trending down while Simply Healthcare reported 33 measures trending down for 2023.

For the DBMs, DentaQuest had the most improvements for MY 2023 with a total of 88 measures improving from MY 2022, while 29 measures declined. Liberty improved performance in 26 measures while none declined. MCNA improved performance in 35 measures, while declining in 82.

Table 13. 2023 and 2024 PMV Measure Results: MCOs						
Measure	**Aetna**		**CCP**		**Simply Healthcare**	
	2023	**2024**	**2023**	**2024**	**2023**	**2024**
Primary Care Access and Preventive Care						
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)						
Body Mass Index (BMI) Percentile: 3–11 Years	93.78%	85.86%	90.00%	84.91%	87.62%	86.96%
BMI Percentile: 12–17 Years	89.11%	89.67%	88.56%	84.42%	88.04%	89.87%
BMI Percentile: Total	91.48%	87.83%	89.29%	84.67%	87.83%	88.56%
Nutrition Counseling: 3-11 Years	NA	83.84%	NA	76.42%	NA	84.24%
Nutrition Counseling: 12-17 Years	NA	84.04%	NA	80.40%	NA	85.46%
Nutrition Counseling: Total	NA	83.94%	NA	78.35%	NA	84.91%
Physical Activity Counseling: 3-11 Years	NA	82.32%	NA	75.94%	NA	83.15%
Physical Activity Counseling: 12-17 Years	NA	84.04%	NA	79.90%	NA	84.14%
Physical Activity Counseling: Total	NA	83.21%	NA	77.86%	NA	83.70%
Chlamydia Screening in Women (CHL-CH)						
16–20 Years	52.67%	54.28%	56.99%	55.56%	52.63%	58.33%
Immunizations for Adolescents (IMA-CH)						
Meningococcal	78.59%	77.01%	83.94%	72.79%	80.78%	76.40%
Tdap	93.19%	92.83%	93.92%	77.57%	91.48%	87.10%
HPV	37.47%	38.80%	38.44%	30.07%	44.04%	38.93%
Combination #1 (Meningococcal and Tdap)	78.59%	76.90%	83.21%	71.12%	80.29%	75.67%
Combination #2 (Meningococcal, Tdap, and HPV)	36.50%	37.21%	36.98%	29.83%	41.85%	38.20%
Child and Adolescent Well-Care Visits (WCV-CH)						
White	NA	62.74%	NA	68.12%	NA	66.72%

Table 13. 2023 and 2024 PMV Measure Results: MCOs						
Measure	**Aetna**		**CCP**		**Simply Healthcare**	
	2023	**2024**	**2023**	**2024**	**2023**	**2024**
Black or African American	NA	70.68%	NA	68.30%	NA	69.97%
American Indian or Alaska Native	NA	61.11%	NA	NA	NA	57.14%
Asian	NA	71.84%	NA	75.41%	NA	NA
Native Hawaiian or Other Pacific Islander	NA	NA	NA	NA	NA	69.43%
Some Other Race	NA	82.28%	NA	75.00%	NA	75.64%
Two or More Races	NA	NA	NA	62.86%	NA	NA
Asked But No Answer	NA	NA	NA	69.98%	NA	71.41%
Unknown	NA	69.72%	NA	NA	NA	71.18%
Maternal and Perinatal Health						
Cesarean Birth (PC-02)						
Cesarean Birth	NR	NA	NR	NA	NR	NA
Contraceptive Care – Postpartum Women Ages 15–20 (CCP-CH)						
Most or moderately effective contraception – 3 days	0.00%	NA	NR	NA	0.00%	NA
Most or moderately effective contraception – 60 days	50.00%	NA	NR	NA	60.00%	NA
Long-acting reversible method of contraception (LARC) – 3 days	0.00%	NA	NR	NA	0.00%	NA
LARC – 60 days	0.00%	NA	NR	NA	20.00%	NA
Contraceptive Care – All Women Ages 15–20 (CCW-CH)						
Most effective or moderately effective method of contraception	15.00%	15.47%	11.46%	10.01%	15.68%	14.38%
LARC	1.00%	1.15%	0.42%	0.77%	1.08%	1.22%
Prenatal and Postpartum Care: Under Age 21 (PPC2-CH)						
Timeliness of Prenatal Care	50.00%	NA	NR	NA	16.67%	NA
Postpartum Care	NR	NA	NR	NA	66.67%	NA

Table 13. 2023 and 2024 PMV Measure Results: MCOs						
Measure	Aetna		CCP		Simply Healthcare	
	2023	2024	2023	2024	2023	2024
Care of Acute and Chronic Conditions						
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB-CH)						
3 months–17 years	42.90%	42.36%	35.94%	41.01%	42.23%	37.86%
Asthma Medication Ratio: Ages 5-18 (AMR-CH)						
5–11 Years	88.34%	75.50%	100%	90.70%	84.74%	73.80%
12–18 Years	75.11%	67.74%	81.25%	NA	77.42%	65.78%
Appropriate Testing for Children with Pharyngitis (CWP)						
3–17 Years	75.58%	85.07%	68.31%	80.13%	74.25%	85.08%
18–64 Years	75.89%	80.65%	40.00%	NA	67.08%	79.05%
Total	75.59%	84.92%	67.74%	80.19%	73.87%	84.94%
Appropriate Treatment for Children with Upper Respiratory Infection (URI)						
3 Months – 17 Years	93.08%	90.91%	90.51%	92.31%	93.20%	91.07%
18–64 Years	83.90%	85.56%	89.19%	83.33%	89.63%	82.09%
Total	92.82%	90.76%	90.47%	92.12%	93.11%	90.88%
Ambulatory Care: Emergency Department Visits (AMB-CH) – Visits / 1,000 Enrollee Months						
1–9 Years	352.58	384.81	NR	334.60	355.53	398.78
10–19 Years	285.34	304.41	NR	230.54	274.19	307.28
Behavioral Healthcare						
Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)						
Screening for Depression and Follow-up on Date of Positive Screen	NA	9.83%	NA	13.30%	NA	0.75%
Follow-Up Care for Children Prescribed ADHD Medication (ADD-CH)						
Initiation Phase	45.38%	48.55%	39.29%	53.06%	48.15%	47.41%
Continuation and Maintenance Phase	49.30%	58.46%	41.67%	NA	64.03%	68.60%
Follow-Up After Hospitalization for Mental Illness (FUH-CH)						
7-Day Follow-Up: 6–17 Years	40.23%	45.58%	42.86%	33.33%	47.34%	29.30%
30-Day Follow-Up: 6–17 Years	61.47%	65.02%	61.90%	66.67%	71.79%	56.04%
Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH)						
7-Day Follow-Up: 6–17 Years	39.29%	38.46%	16.67%	NA	40.38%	20.37%

Table 13. 2023 and 2024 PMV Measure Results: MCOs						
Measure	**Aetna**		**CCP**		**Simply Healthcare**	
	2023	**2024**	**2023**	**2024**	**2023**	**2024**
30-Day Follow-Up: 6–17 Years	60.71%	51.28%	50.00%	NA	57.69%	42.59%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH)						
7-Day Follow-Up: 13–17 Years	22.22%	11.76%	50.00%	NA	26.32%	NA
30-Day Follow-Up: 13–17 Years	33.33%	29.41%	50.00%	NA	47.37%	NA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)						
1–11 Years	23.81%	NA	NR	NA	47.37%	NA
12–17 Years	52.85%	54.88%	33.33%	NA	51.72%	61.90%
Total	48.61%	52.00%	33.33%	NA	50.65%	59.21%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)						
Blood Glucose Testing: 1–11 Years	42.86%	56.67%	75.00%	NA	40.00%	40.00%
Cholesterol Testing: 1–11 Years	42.86%	40.00%	75.00%	NA	30.00%	23.33%
Blood Glucose and Cholesterol Testing: 1–11 Years	39.29%	36.67%	75.00%	NA	26.67%	23.33%
Blood Glucose Testing: 12–17 Years	63.16%	59.69%	71.43%	NA	63.33%	68.66%
Cholesterol Testing: 12–17 Years	37.72%	47.12%	47.62%	NA	44.67%	48.51%
Blood Glucose and Cholesterol Testing: 12–17 Years	36.84%	43.46%	47.62%	NA	42.00%	46.27%
Blood Glucose Testing Total	60.94%	59.28%	72.00%	NA	59.44%	63.41%
Cholesterol Testing Total	38.28%	46.15%	52.00%	NA	42.22%	43.90%
Blood Glucose and Cholesterol Testing Total	37.11%	42.53%	52.00%	NA	39.44%	42.07%
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)						
Alcohol Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	30.77%	NA	NR	NA	41.67%	NA
Alcohol Abuse or Dependence: Engagement of AOD Treatment: 13–17 Years	0.00%	NA	NR	NA	16.67%	NA

Table 13. 2023 and 2024 PMV Measure Results: MCOs						
Measure	Aetna		CCP		Simply Healthcare	
	2023	2024	2023	2024	2023	2024
Opioid Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	50.00%	NA	NR	NA	50.00%	NA
Opioid Abuse or Dependence: Engagement of AOD Treatment: 13–17 Years	50.00%	NA	NR	NA	0.00%	NA
Other Drug Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	40.45%	48.53%	100%	NA	62.82%	45.45%
Other Drug Abuse or Dependence: Engagement of AOD Treatment: 13–17 Years	5.62%	10.29%	25.00%	NA	20.51%	7.27%
Initiation of AOD Treatment: 13–17 Years Total	38.46%	48.72%	80.00%	NA	57.69%	43.94%
Engagement of AOD Treatment: 13–17 Years Total	5.13%	10.26%	20.00%	NA	19.23%	6.06%
Alcohol Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	28.57%	NA	NR	NA	20.00%	NA
Alcohol Abuse or Dependence: Engagement of AOD Treatment: 18+ Years	0.00%	NA	NR	NA	0.00%	NA
Opioid Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	0.00%	NA	NR	NA	0.00%	NA
Opioid Abuse or Dependence: Engagement of AOD Treatment: 18+ Years	0.00%	NA	NR	NA	0.00%	NA
Other Drug Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	36.84%	NA	NR	NA	45.00%	NA
Other Drug Abuse or Dependence: Engagement of AOD Treatment: 18+ Years	10.53%	NA	NR	NA	10.00%	NA
Initiation of AOD Treatment: 18+ Years Total	33.33%	NA	NR	NA	40.00%	NA

Table 13. 2023 and 2024 PMV Measure Results: MCOs						
Measure	**Aetna**		**CCP**		**Simply Healthcare**	
	2023	**2024**	**2023**	**2024**	**2023**	**2024**
Engagement of AOD Treatment: 18+ Years Total	7.41%	NA	NR	NA	8.00%	NA
Alcohol Abuse or Dependence: Initiation of AOD Treatment Total	30.30%	NA	0.00%	NA	37.93%	NA
Alcohol Abuse or Dependence: Engagement of AOD Treatment Total	0.00%	NA	0.00%	NA	13.79%	NA
Opioid Abuse or Dependence: Initiation of AOD Treatment Total	33.33%	NA	NR	NA	50.00%	NA
Opioid Abuse or Dependence: Engagement of AOD Treatment Total	33.33%	NA	NR	NA	0.00%	NA
Other Drug Abuse or Dependence: Initiation of AOD Treatment Total	39.81%	48.75%	100.00%	NA	59.18%	44.26%
Other Drug Abuse or Dependence: Engagement of AOD Treatment Total	6.48%	11.25%	25.00%	NA	18.37%	6.56%
Initiation of AOD Treatment Total	37.50%	47.87%	80.00%	NA	54.26%	42.47%
Engagement of AOD Treatment Total	5.56%	11.70%	20.00%	NA	17.05%	5.48%
Diagnosed Substance-Related Disorders (DSU)						
Diagnosed Substance Use Disorders: Alcohol: 13–17 Years	NA	0.13%	NA	0.14%	NA	0.07%
Diagnosed Substance Use Disorders: Alcohol: 18–64 Years	NA	0.07%	NA	0.26%	NA	0.23%
Diagnosed Substance Use Disorders: Alcohol: Total	NA	0.12%	NA	0.16%	NA	NA
Diagnosed Substance Use Disorders: Opioid: 13–17 Years	NA	0.01%	NA	0.00%	NA	0.09%
Diagnosed Substance Use Disorders: Opioid: 18–64 Years	NA	0.07%	NA	0.00%	NA	0.01%
Diagnosed Substance Use Disorders: Opioid: Total	NA	0.02%	NA	0.00%	NA	0.00%

Table 13. 2023 and 2024 PMV Measure Results: MCOs						
Measure	**Aetna**		**CCP**		**Simply Healthcare**	
	2023	**2024**	**2023**	**2024**	**2023**	**2024**
Diagnosed Substance Use Disorders: Other: 13–17 Years	NA	0.52%	NA	0.23%	NA	NA
Diagnosed Substance Use Disorders: Other: 18–64 Years	NA	0.77%	NA	0.26%	NA	0.01%
Diagnosed Substance Use Disorders: Other: Total	NA	0.56%	NA	0.24%	NA	0.50%
Diagnosed Substance Use Disorders: Any: 13–17 Years	NA	0.55%	NA	0.32%	NA	1.12%
Diagnosed Substance Use Disorders: Any: 18–64 Years	NA	0.84%	NA	0.52%	NA	NA
Diagnosed Substance Use Disorders: Any: Total	NA	0.60%	NA	0.35%	NA	0.61%
Experience of Care: CAHPS® Health Plan Survey 5.1H, Child Version (General Population)						
Rating of All Healthcare (9+10)	69.01%	67.37%	67.38%	77.60%	70.79%	68.94%
Rating of Personal Doctor (9+10)	74.35%	76.95%	75.93%	84.10%	75.88%	73.04%
Rating of Specialist Seen Most Often (9+10)	75.33%	79.09%	66.67%	80.00%	71.21%	NA
Rating of MCO (9+10)	65.32%	66.14%	58.92%	65.80%	62.25%	64.52%
Getting Needed Care (Always + Usually)	83.60%	81.31%	77.70%	84.30%	87.06%	85.96%
Getting Care Quickly (Always + Usually)	87.01%	88.37%	82.00%	92.00%	91.57%	89.93%
How Well Doctors Communicate (Always + Usually)	96.09%	97.21%	92.00%	96.50%	93.84%	92.57%
Customer Service (Always + Usually)	86.42%	87.89%	91.70%	85.10%	NA	NA
Coordination of Care (Always + Usually)	82.79%	85.78%	80.00%	86.30%	79.34%	NA
Experience of Care: CAHPS® Health Plan Survey 5.1H, Child Version (Children with Chronic Conditions)						
Rating of All Healthcare (9+10)	NR	NR	NR	NR	NR	70.47%
Rating of Personal Doctor (9+10)	NR	NR	NR	NR	NR	73.53%
Rating of Specialist Seen Most Often (9+10)	NR	NR	NR	NR	NR	NA

Table 13. 2023 and 2024 PMV Measure Results: MCOs

Measure	Aetna		CCP		Simply Healthcare	
	2023	2024	2023	2024	2023	2024
Rating of MCO (9+10)	NR	NR	NR	NR	NR	60.73%
Getting Needed Care (Always + Usually)	NR	NR	NR	NR	NR	86.94%
Getting Care Quickly (Always + Usually)	NR	NR	NR	NR	NR	89.04%
How Well Doctors Communicate (Always + Usually)	NR	NR	NR	NR	NR	93.52%
Customer Service (Always + Usually)	NR	NR	NR	NR	NR	NA
Coordination of Care (Always + Usually)	NR	NR	NR	NR	NR	NA

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

Table 14. 2024 PMV: Audited Mental Health Utilization (MPT) Performance Measure: Aetna

Age	Sex	Any Services		Inpatient		Intensive Outpatient/ Partial Hospitalization		Outpatient		Emergency Department		Telehealth	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
0–12 Years	M*	1,010	7.50%	11	0.08%	1	0.01%	750	5.57%	1	0.01%	466	3.46%
	F*	818	6.35%	31	0.24%	7	0.05%	615	4.77%	6	0.05%	374	2.90%
	Total	1,828	6.94%	42	16.00%	8	0.03%	1,365	5.18%	7	0.03%	840	3.19%
13–17 Years	M	794	7.78%	57	0.56%	2	0.02%	546	5.35%	6	0.06%	411	4.03%
	F	1,417	14.17%	145	1.45%	45	0.45%	945	9.45%	13	0.13%	817	8.17%
	Total	2,211	10.94%	202	1.00%	47	0.23%	1,491	7.38%	19	0.09%	1,228	6.08%

18–64 Years	M	76	4.43%	1	0.06%	1	0.06%	37	2.16%	1	0.06%	49	2.86%
	F	146	8.95%	8	0.49%	4	0.25%	81	4.97%	1	0.06%	101	6.19%
	Total	222	6.64%	9	0.27%	5	0.15%	118	3.53%	2	0.06%	150	4.48%

Table 15. 2024 PMV: Audited Mental Health Utilization (MPT) Performance Measure: CCP

Age	Sex	Any Services		Inpatient		Intensive Outpatient/ Partial Hospitalization		Emergency Department		Outpatient		Telehealth	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
0–12 Years	M*	127	5.17%	NA	NA	NA	NA	NA	NA	117	4.76%	NA	NA
	F*	102	4.12%	NA	NA	NA	NA	NA	NA	94	3.80%	NA	NA
	Total	229	4.64%	NA	NA	NA	NA	NA	NA	211	4.28%	35	0.71%
13–17 Years	M	80	5.05%	NA	NA	NA	NA	NA	NA	77	4.86%	NA	NA
	F	153	10.51%	NA	NA	NA	NA	NA	NA	129	8.86%	41	2.82%
	Total	233	7.66%	NA	NA	NA	NA	NA	NA	206	6.78%	55	1.81%
18–64 Years	M	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	F	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	Total	32	6.68%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Table 16. 2024 PMV: Audited Mental Health Utilization (MPT) Performance Measure: Simply													
Age	Sex	Any Services		Inpatient		Intensive Outpatient/ Partial Hospitalization		Outpatient		Emergency Department		Telehealth	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
0–12 Years	M*	1,275	6.95%	33	0.17%	NA	NA	872	4.50%	NA	NA	558	3.50%
	F*	857	7.22%	51	0.19%	NA	NA	543	3.78%	NA	NA	433	3.10%
	Total	2,132	5.92%	84	0.23%	NA	NA	1,415	4.75%	NA	NA	991	3.25%
13–17 Years	M	999	8.00%	104	0.27%	NA	NA	590	4.75%	NA	NA	540	3.95%
	F	1,520	12.25%	197	0.52%	NA	NA	839	7.63%	NA	NA	935	7.00%
	Total	2,519	10.13%	301	0.79%	NA	NA	1,429	6.19%	NA	NA	1,475	5.48%
18–64 Years	M	130	7.00%	NA	NA	NA	NA	78	3.25%	NA	NA	71	3.00%
	F	241	4.65%	NA	NA	NA	NA	123	5.15%	NA	NA	140	5.15%
	Total	371	6.55%	NA	NA	NA	NA	201	4.20%	NA	NA	211	4.01%

DBM-specific PMV results appear in Table 17. The green and red shading indicates an increase, decrease, or no change from the previous year's rate.

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Annual Dental Visit (ADV)									
All Enrollees	28,120	17,259	61.38%	2,476	1,469	59.33%	22,577	12,952	57.37%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrollees Aged 5 to 6†	1,302	831	63.82%	235	145	61.70%	1,399	807	57.68%
Enrollees Aged 7 to 10	7,452	5,243	70.36%	992	643	64.82%	5,928	3,931	66.31%
Enrollees Aged 11 to 14	9,213	5,906	64.11%	719	433	60.22%	6,979	4,202	60.21%
Enrollees Aged 15 to 18	9,833	5,151	52.38%	530	248	46.79%	8,271	4,012	46.62%
Dental Sealants – With Exclusions*									
Enrolled at Least 1 Month: All Enrollees	41,064	35,510	86.47%	NR**	NR	NR	35,508	2,716	7.65%
Enrolled at Least 1 Month: Enrollees aged 6 to 9	16,301	12,764	78.30%	NR	NR	NR	14,454	1,510	10.45%
Enrolled at Least 1 Month: Enrollees aged 10 to 14	24,763	22,746	91.85%	NR	NR	NR	21,054	1,206	5.73%
Enrolled at Least 3 Months Continuously: All Enrollees	32,025	26,738	83.49%	4,968	543	10.93%	25,004	2,571	10.28%

Table 17. 2024 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	12,343	8,972	72.69%	219	NR	0.00%	9,582	1,424	14.86%
Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	19,682	17,766	90.27%	1,924	292	15.18%	15,422	1,147	7.44%
Enrolled at Least 6 Months Continuously: All Enrollees	25,106	20,276	80.76%	1,780	251	14.10%	18,267	2,234	12.23%
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	9,434	6,353	67.34%	1,045	NR	0.00%	6,656	1,224	18.39%
Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	15,672	13,923	88.84%	NR	NR	NR	11,611	1,010	8.70%

Table 17. 2024 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	27,476	13,985	50.90%	NR	NR	NR	12,480	1,666	13.35%
Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	6,690	4,291	64.14%	NR	NR	NR	4,414	909	20.59%
Enrolled at Least 11 Months Continuously: Enrollees aged 10 to 14	11,063	9,694	87.63%	NR	NR	NR	8,066	757	9.39%
Preventative Dental (PDENT)									
Enrolled at Least 1 Month: All Enrollees	63,786	25,259	39.60%	NR	NR	NR	59,765	20,092	33.62%
Enrolled at Least 1 Month: Enrollees aged 5†	2,081	561	26.96%	NR	NR	NR	3,112	642	20.63%
Enrolled at Least 1 Month:	16,301	7,095	43.52%	NR	NR	NR	16,073	5,934	36.92%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrollees aged 6 to 9									
Enrolled at Least 1 Month: Enrollees aged 10 to 14	24,763	10,630	42.93%	NR	NR	NR	21,916	8,128	37.09%
Enrolled at Least 1 Month: Enrollees aged 15 to 18	20,640	6,973	33.78%	NR	NR	NR	18,664	5,388	28.87%
Enrolled at Least 3 Months Continuously: All Enrollees	50,339	24,072	47.82%	4,968	2,180	43.88%	43,769	18,931	43.25%
Enrolled at Least 3 Months Continuously: Enrollees aged 5†	1,213	483	39.82%	219	98	44.75%	1,712	549	32.07%
Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	12,343	6,681	54.13%	1,924	944	49.06%	11,020	5,488	49.80%

Table 17. 2024 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	19,682	10,172	51.68%	1,780	811	45.56%	16,210	7,695	47.47%
Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	17,101	6,736	39.39%	1,045	327	31.29%	14,827	5,199	35.06%
Enrolled at Least 6 Months Continuously: All Enrollees	39,531	21,519	54.44%	NR	NR	NR	32,756	16,392	50.04%
Enrolled at Least 6 Months Continuously: Enrollees aged 5†	694	347	50.00%	NR	NR	NR	877	387	44.13%
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	9,434	5,901	62.55%	NR	NR	NR	7,898	4,619	58.48%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	15,672	9,132	58.27%	NR	NR	NR	12,305	6,715	54.57%
Enrolled at Least 6 Months Continuously: Enrollees aged 15 to 18	13,731	6,139	44.71%	NR	NR	NR	11,676	4,671	40.01%
Enrolled at Least 11 Months Continuously: All Enrollees	27,479	16,295	59.30%	NR	NR	NR	22,491	12,271	54.56%
Enrolled at Least 11 Months Continuously: Enrollees aged 5†	3	3	100.00%	NR	NR	NR	120	72	60.00%
Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	6,690	4,482	67.00%	NR	NR	NR	5,424	3,462	63.83%

Table 17. 2024 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	11,063	6,972	63.02%	NR	NR	NR	8,619	5,082	58.96%
Enrolled at Least 11 Months Continuously: Enrollees aged 15 to 18	9,723	4,838	49.76%	NR	NR	NR	8,328	3,655	43.89%
Any Dental Services									
Enrolled at Least 1 Month: All Enrollees	63,785	26,798	42.01%	NR	NR	NR	59,765	21,494	35.96%
Enrolled at Least 1 Month: Enrollees aged 5†	2,081	607	29.17%	NR	NR	NR	3,112	706	22.69%
Enrolled at Least 1 Month: Enrollees aged 6 to 9	16,301	7,408	45.45%	NR	NR	NR	16,073	6,182	38.46%
Enrolled at Least 1 Month:	24,763	11,161	45.07%	NR	NR	NR	21,916	8,556	39.04%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrollees aged 10 to 14									
Enrolled at Least 1 Month: Enrollees aged 15 to 18	20,640	7,622	36.93%	NR	NR	NR	18,664	6,050	32.42%
Enrolled at Least 3 Months Continuously: All Enrollees	50,339	24,687	49.04%	4,968	2,341	47.12%	43,769	20,103	45.93%
Enrolled at Least 3 Months Continuously: Enrollees aged 5†	1,213	509	41.96%	219	99	45.21%	1,712	594	34.70%
Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	12,343	6,914	56.02%	1,924	984	51.14%	11,020	5,666	51.42%
Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	19,682	10,609	53.90%	1,780	872	48.99%	16,210	8,054	49.69%

Table 17. 2024 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	17,101	6,655	38.92%	1,045	386	36.94%	14,827	5,789	39.04%
Enrolled at Least 6 Months Continuously: All Enrollees	39,531	22,441	56.77%	NR	NR	NR	32,756	17,255	52.68%
Enrolled at Least 6 Months Continuously: Enrollees aged 5†	694	363	52.31%	NR	NR	NR	877	410	46.75%
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	9,434	6,045	64.08%	NR	NR	NR	7,898	4,730	59.89%
Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	15,672	9,429	60.16%	NR	NR	NR	12,305	6,975	56.68%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 6 Months Continuously: Enrollees aged 15-18	13,731	6,604	48.10%	NR	NR	NR	11,676	5,140	44.02%
Enrolled at Least 11 Months Continuously: All Enrollees	27,479	16,914	61.55%	NR	NR	NR	22,491	12,860	57.18%
Enrolled at Least 11 Months Continuously: Enrollees aged 5†	3	3	100%	NR	NR	NR	120	73	60.83%
Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	6,690	4,584	68.52%	NR	NR	NR	5,424	3,536	65.19%
Enrolled at Least 11 Months Continuously: Enrollees aged 10 to 14	11,063	7,164	64.76%	NR	NR	NR	8,619	5,258	61.00%

Table 17. 2024 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	9,723	5,163	53.10%	NR	NR	NR	8,328	3,993	47.95%
Dental Treatment Services (TDENT)									
Enrolled at Least 1 Month: All Enrollees	63,785	9,456	14.82%	NR	NR	NR	59,765	7,468	12.50%
Enrolled at Least 1 Month: Enrollees aged 5†	2,081	173	8.31%	NR	NR	NR	3,112	167	5.37%
Enrolled at Least 1 Month: Enrollees aged 6 to 9	16,301	2,772	17.01%	NR	NR	NR	16,073	2,247	13.98%
Enrolled at Least 1 Month: Enrollees aged 10 to 14	24,763	3,774	15.24%	NR	NR	NR	21,916	2,792	12.74%
Enrolled at Least 1 Month:	20,640	2,737	13.26%	NR	NR	NR	18,664	2,262	12.12%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrollees aged 15 to 18									
Enrolled at Least 3 Months Continuously: All Enrollees	50,339	14,088	27.99%	4,968	918	18.48%	43,769	7,111	16.25%
Enrolled at Least 3 Months Continuously: Enrollees aged 5†	1,213	353	29.10%	219	27	12.33%	1,712	144	8.41%
Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	12,343	2,832	22.94%	1,924	379	19.70%	11,020	2,107	19.12%
Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	19,682	3,581	18.19%	1,780	343	19.27%	16,210	2,677	16.51%
Enrolled at Least 3 Months Continuously:	17,101	7,322	42.82%	1,045	169	16.17%	14,827	2,183	14.72%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrollees aged 15 to 18									
Enrolled at Least 6 Months Continuously: All Enrollees	39,531	8,126	20.56%	NR	NR	NR	32,756	6,263	19.12%
Enrolled at Least 6 Months Continuously: Enrollees aged 5†	694	110	15.85%	NR	NR	NR	877	102	11.63%
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	9,434	2,326	24.66%	NR	NR	NR	7,898	1,815	22.98%
Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	15,672	3,273	20.88%	NR	NR	NR	12,305	2,376	19.31%
Enrolled at Least 6 Months Continuously:	13,731	2,417	17.60%	NR	NR	NR	11,676	1,970	16.87%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrollees aged 15 to 18									
Enrolled at Least 11 Months Continuously: All Enrollees	27,479	6,074	22.10%	NR	NR	NR	22,491	4,756	21.15%
Enrolled at Least 11 Months Continuously: Enrollees aged 5†	3	2	66.67%	NR	NR	NR	120	25	20.83%
Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	6,690	1,728	25.83%	NR	NR	NR	5,424	1,362	25.11%
Enrolled at Least 11 Months Continuously: Enrollees aged 10 to 14	11,063	2,504	22.63%	NR	NR	NR	8,619	1,818	21.09%
Enrolled at Least 11 Months Continuously:	9,723	1,840	18.92%	NR	NR	NR	8,328	1,551	18.62%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrollees aged 15 to 18									
Dental Diagnostic Services									
Enrolled at Least 1 Month: All Enrollees	63,785	26,173	41.03%	NR	NR	NR	59,765	20,455	34.23%
Enrolled at Least 1 Month: Enrollees aged 5†	2,081	588	28.26%	NR	NR	NR	3,112	672	21.59%
Enrolled at Least 1 Month: Enrollees aged 6 to 9	16,301	7,272	44.61%	NR	NR	NR	16,073	5,989	37.26%
Enrolled at Least 1 Month: Enrollees aged 10 to 14	24,763	10,917	44.09%	NR	NR	NR	21,916	8,177	37.31%
Enrolled at Least 1 Month: Enrollees aged 15 to 18	20,640	7,396	35.83%	NR	NR	NR	18,664	5,617	30.10%
Enrolled at Least 3 Months	50,339	24,861	49.39%	4,968	2,242	45.13%	43,769	19,228	43.93%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Continuously: All Enrollees									
Enrolled at Least 3 Months Continuously: Enrollees aged 5†	1,213	502	41.38%	219	98	44.75%	1,712	570	33.29%
Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	12,343	6,822	55.27%	1,924	958	49.79%	11,020	5,529	50.17%
Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	19,682	10,417	52.93%	1,780	832	46.74%	16,210	7,726	47.66%
Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	17,101	7,120	41.63%	1,045	354	33.88%	14,827	5,403	36.44%
Enrolled at Least 6 Months	39,531	21,751	55.02%	NR	NR	NR	32,756	16,629	50.77%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Continuously: All Enrollees									
Enrolled at Least 6 Months Continuously: Enrollees aged 5†	694	359	51.73%	NR	NR	NR	877	400	45.61%
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	9,434	5,997	63.57%	NR	NR	NR	7,898	4,647	58.84%
Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	15,672	9,301	59.35%	NR	NR	NR	12,305	6,745	54.82%
Enrolled at Least 6 Months Continuously: Enrollees aged 15 to 18	13,731	6,453	47.00%	NR	NR	NR	11,676	4,837	41.43%
Enrolled at Least 11 Months	27,479	16,688	60.73%	NR	NR	NR	22,491	12,418	55.21%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Continuously: All Enrollees									
Enrolled at Least 11 Months Continuously: Enrollees aged 5†	3	3	100%	NR	NR	NR	120	73	60.83%
Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	6,690	4,546	67.95%	NR	NR	NR	5,424	3,478	64.12%
Enrolled at Least 11 Months Continuously: Enrollees aged 10 to 14	11,063	7,082	64.02%	NR	NR	NR	8,619	5,107	59.25%
Enrolled at Least 11 Months Continuously: Enrollees aged 15 to 18	9,723	5,057	52.01%	NR	NR	NR	8,328	3,760	45.15%
Any Dental or Oral Health Services									
Enrolled at Least 1	63,785	25,259	39.60%	NR	NR	NR	59,765	20,092	33.62%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Month: All Enrollees									
Enrolled at Least 1 Month: Enrollees aged 5†	2,081	561	26.96%	NR	NR	NR	3,112	642	20.63%
Enrolled at Least 1 Month: Enrollees aged 6 to 9	16,301	7,095	43.52%	NR	NR	NR	16,073	5,934	36.92%
Enrolled at Least 1 Month: Enrollees aged 10 to 14	24,763	10,630	42.93%	NR	NR	NR	21,916	8,128	37.09%
Enrolled at Least 1 Month: Enrollees aged 15 to 18	20,640	6,973	33.78%	NR	NR	NR	18,664	5,388	28.87%
Enrolled at Least 3 Months Continuously: All Enrollees	50,339	24,072	47.82%	4,968	2,180	43.88%	43,769	18,931	43.25%
Enrolled at Least 3	1,213	483	39.82%	219	98	44.75%	1,712	549	32.07%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Months Continuously: Enrollees aged 5†									
Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	12,343	6,681	54.13%	1,924	944	49.06%	11,020	5,488	49.80%
Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	19,682	10,172	51.68%	1,780	811	45.56%	16,210	7,695	47.47%
Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	17,101	6,736	39.39%	1,045	327	31.29%	14,827	5,199	35.06%
Enrolled at Least 6 Months Continuously: All enrollees	39,531	21,519	54.44%	NR	NR	NR	32,756	16,392	50.04%
Enrolled at Least 6 Months	694	347	50.00%	NR	NR	NR	877	387	44.13%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Continuously: Enrollees aged 5†									
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	9,434	5,901	62.55%	NR	NR	NR	7,898	4,619	58.48%
Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	15,672	9,132	58.27%	NR	NR	NR	12,305	6,715	54.57%
Enrolled at Least 6 Months Continuously: Enrollees aged 15 to 18	13,731	6,139	44.71%	NR	NR	NR	11,676	4,671	40.01%
Enrolled at Least 11 Months Continuously: All Enrollees	27,479	16,295	59.30%	NR	NR	NR	22,491	12,271	54.56%
Enrolled at Least 11 Months Continuously:	3	3	100%	NR	NR	NR	120	72	60.00%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrollees aged 5†									
Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	6,690	4,482	67.00%	NR	NR	NR	5,424	3,462	63.83%
Enrolled at Least 11 Months Continuously: Enrollees aged 10 to 14	11,063	6,972	63.02%	NR	NR	NR	8,619	5,082	58.96%
Enrolled at Least 11 Months Continuously: Enrollees aged 15 to 18	9,723	4,838	49.76%	NR	NR	NR	8,328	3,655	43.89%
Oral Evaluation, Dental Services (OEV-CH)									
Enrolled at Least 1 Month: All enrollees	NR	NR	NR	NR	NR	NR	75,364	23,228	30.82%
Enrolled at Least 1 Month: Enrollees aged 3 to 5	NA	NA	NA	NA	NA	NA	3,644	782	21.46%

Table 17. 2024 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 5†	NR	NR	NR	NR	NR	NR	NA	NA	NA
Enrolled at Least 1 Month: Enrollees aged 6 to 7	NA	NA	NA	NA	NA	NA	10,454	3,278	31.36%
Enrolled at Least 1 Month: Enrollees aged 6 to 9	NR	NR	NR	NR	NR	NR	NA	NA	NA
Enrolled at Least 1 Month: Enrollees aged 8 to 9	NA	NA	NA	NA	NA	NA	10,919	3,799	34.79%
Enrolled at Least 1 Month: Enrollees aged 10 to 11	NA	NA	NA	NA	NA	NA	10,928	3,885	35.55%
Enrolled at Least 1 Month:	NR	NR	NR	NR	NR	NR	NA	NA	NA

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrollees aged 10 to 14									
Enrolled at Least 1 Month: Enrollees aged 12 to 14	NA	NA	NA	NA	NA	NA	16,594	5,413	32.62%
Enrolled at Least 1 Month: Enrollees aged 15 to 18	NR	NR	NR	NR	NR	NR	22,825	6,071	26.60%
Enrolled at Least 3 Months Continuously: All enrollees	NR	NR	NR	3,734	1,970	52.76%	54,889	21,722	39.57%
Enrolled at Least 3 Months: Enrollees aged 3 to 5	NA	NA	NA	NA	NA	NA	2,100	659	31.38%
Enrolled at Least 3 Months Continuously: Enrollees aged 5†	NR	NR	NR	120	65	54.17%	NA	NA	NA

Table 17. 2024 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 7	NA	NA	NA	NA	NA	NA	7,216	3,015	41.78%
Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	NR	NR	NR	711	394	55.41%	NA	NA	NA
Enrolled at Least 3 Months Continuously: Enrollees aged 8 to 9	NA	NA	NA	NA	NA	NA	7,781	3,524	45.29%
Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 11	NA	NA	NA	NA	NA	NA	7,928	3,615	45.60%
Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	NR	NR	NR	725	432	59.59%	NA	NA	NA

Table 17. 2024 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 12 to 14	NA	NA	NA	NA	NA	NA	12,391	5,118	41.30%
Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	NR	NR	NR	596	352	59.06%	17,473	5,791	33.14%
Enrolled at Least 6 Months Continuously: All enrollees	33,164	18,639	56.20%	NR	NR	NR	35,262	17,153	48.64%
Enrolled at Least 6 Months Continuously: Enrollees aged 3 to 5	NA	NA	NA	NA	NA	NA	853	363	42.56%
Enrolled at Least 6 Months Continuously: Enrollees aged 5†	NR	NR	NR	NR	NR	NR	NA	NA	NA

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 7	NA	NA	NA	NA	NA	NA	4,299	2,296	53.41%
Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	6,690	4,009	59.93%	NR	NR	NR	NA	NA	NA
Enrolled at Least 6 Months Continuously: Enrollees aged 8 to 9	NA	NA	NA	NA	NA	NA	4,681	2,664	56.91%
Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 11	NA	NA	NA	NA	NA	NA	5,085	2,853	56.11%
Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	13,867	8,510	61.37%	NR	NR	NR	NA	NA	NA

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 6 Months Continuously: Enrollees aged 12 to 14	NA	NA	NA	NA	NA	NA	8,124	4,090	50.34%
Enrolled at Least 6 Months Continuously: Enrollees aged 15 to 18	12,607	6,120	48.54%	NR	NR	NR	12,220	4,887	39.99%
Enrolled at Least 11 Months Continuously: All enrollees	NR	NR	NR	NR	NR	NR	NA	NA	NA
Enrolled at Least 11 Months Continuously: Enrollees aged 5†	NR	NR	NR	NR	NR	NR	NA	NA	NA
Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	NR	NR	NR	NR	NR	NR	NA	NA	NA

Table 17. 2024 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	NR	NR	NR	NR	NR	NR	NA	NA	NA
Enrolled at Least 11 Months Continuously: Enrollees aged 15 to 18	NR	NR	NR	NR	NR	NR	NA	NA	NA
Enrolled at Least 12 Months Continuously: All Enrollees	NA	NA	NA	NA	NA	NA	23,283	12,532	53.82%
Enrolled at Least 12 Months Continuously: Enrollees aged 5†	NA	NA	NA	NA	NA	NA	23,283	5,592	24.02%
Enrolled at Least 12 Months Continuously: Enrollees aged 6 to 7	NA	NA	NA	NA	NA	NA	116	18	15.52%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 12 Months Continuously: Enrollees aged 8 to 9	NA	NA	NA	NA	NA	NA	2,712	751	27.69%
Enrolled at Least 12 Months Continuously: Enrollees aged 10 to 11	NA	NA	NA	NA	NA	NA	3,022	929	30.74%
Enrolled at Least 12 Months Continuously: Enrollees aged 12 to 14	NA	NA	NA	NA	NA	NA	3,397	1,044	30.73%
Enrolled at Least 12 Months Continuously: Enrollees aged 15 to 18	NA	NA	NA	NA	NA	NA	5,481	1,390	25.36%
Topical Fluoride for Children (TFL-CH)									
Enrolled at Least 12 Months Continuously (Numerator	47,637	7,843	16.46%	13,955	3,161	22.65%	23,283	5,592	24.02%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
1): All enrollees									
Enrolled at Least 12 Months Continuously (Numerator 1): Enrollees aged 5†	1,160	37	3.19%	41	10	24.39%	116	18	15.52%
Enrolled at Least 12 Months Continuously (Numerator 1): Enrollees aged 6 to 7	NA	NA	NA	NA	NA	NA	2,712	751	27.69%
Enrolled at Least 12 Months Continuously (Numerator 1): Enrollees aged 6 to 9	5,263	960	18.24%	1,784	491	27.52%	NA	NA	NA
Enrolled at Least 12 Months Continuously (Numerator 1): Enrollees aged 8 to 9	NA	NA	NA	NA	NA	NA	3,022	929	30.74%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 12 Months Continuously (Numerator 1): Enrollees aged 10 to 11	NA	NA	NA	NA	NA	NA	3,397	1,044	30.73%
Enrolled at Least 12 Months Continuously (Numerator 1): Enrollees aged 10 to 14	6,755	1,349	19.97%	2,096	567	27.05%	NA	NA	NA
Enrolled at Least 12 Months Continuously (Numerator 1): Enrollees aged 12 to 14	NA	NA	NA	NA	NA	NA	5,481	1,390	25.36%
Enrolled at Least 12 Months Continuously (Numerator 1): Enrollees aged 15 to 18	7,407	1,472	19.87%	2,336	608	26.03%	8,555	1,460	17.07%
Enrolled at Least 12	47,637	7,843	16.46%	13,955	3,161	22.65%	23,283	5,592	24.02%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Months Continuously (Numerator 2): All enrollees									
Enrolled at Least 12 Months Continuously (Numerator 2): Enrollees aged 5†	1,160	37	3.19%	41	10	24.39%	116	18	15.52%
Enrolled at Least 12 Months Continuously (Numerator 2): Enrollees aged 6 to 7	NA	NA	NA	NA	NA	NA	2,712	751	27.69%
Enrolled at Least 12 Months Continuously (Numerator 2): Enrollees aged 6 to 9	5,263	960	18.24%	1,784	491	27.52%	NA	NA	NA
Enrolled at Least 12 Months Continuously	NA	NA	NA	NA	NA	NA	3,022	929	30.74%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
(Numerator 2): Enrollees aged 8 to 9									
Enrolled at Least 12 Months Continuously (Numerator 2): Enrollees aged 10 to 11	NA	NA	NA	NA	NA	NA	3,397	1,044	30.73%
Enrolled at Least 12 Months Continuously (Numerator 2): Enrollees aged 10 to 14	6,755	1,349	19.97%	2,096	567	27.05%	NA	NA	NA
Enrolled at Least 12 Months Continuously (Numerator 2): Enrollees aged 12 to 14	NA	NA	NA	NA	NA	NA	5,481	1,390	25.36%
Enrolled at Least 12 Months Continuously (Numerator	7,407	1,472	19.87%	2,336	608	26.03%	8,555	1,460	17.07%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
2): Enrollees aged 15 to 18									
Enrolled at Least 12 Months Continuously (Numerator 3): All enrollees	NA	NA	NA	13,955	0	0.00%	23,283	0	0.00%
Enrolled at Least 12 Months Continuously (Numerator 3): Enrollees aged 5†	NA	NA	NA	41	0	0.00%	116	0	0.00%
Enrolled at Least 12 Months Continuously (Numerator 3): Enrollees aged 6 to 7	NA	NA	NA	NA	NA	NA	2,712	0	0.00%
Enrolled at Least 12 Months Continuously (Numerator 3): Enrollees aged 6 to 9	NA	NA	NA	1,784	0	0.00%	NA	NA	NA

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Enrolled at Least 12 Months Continuously (Numerator 3): Enrollees aged 8 to 9	NA	NA	NA	NA	NA	NA	3,022	0	0.00%
Enrolled at Least 12 Months Continuously (Numerator 3): Enrollees aged 10 to 11	NA	NA	NA	NA	NA	NA	3,397	0	0.00%
Enrolled at Least 12 Months Continuously (Numerator 3): Enrollees aged 10 to 14	NA	NA	NA	2,096	0	0.00%	NA	NA	NA
Enrolled at Least 12 Months Continuously (Numerator 3): Enrollees aged 12 to 14	NA	NA	NA	NA	NA	NA	5,481	0	0.00%
Enrolled at Least 12	NA	NA	NA	2,336	0	0.00%	8,555	0	0.00%

Table 17. 2024 PMV Measure Results: DBMs									
Measure Name	DentaQuest			Liberty			MCNA		
	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)	Denom.	Num.	Rate (%)
Months Continuously (Numerator 3): Enrollees aged 15 to 18									
Sealant Receipt on Permanent First Molars (SFM-CH)									
Enrolled at Least 12 Months Continuously (Numerator 1): Enrollees aged 10	953	570	59.81%	800	156	19.50%	1,705	953	55.89%
Enrolled at Least 12 Months Continuously (Numerator 2): Enrollees aged 10	953	434	45.54%	800	107	13.38%	1,705	766	44.94%

** 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.
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.

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 staff, who were well prepared for the review, as evidenced by their identifying subject matter experts for each of the various areas contributing to performance measure data reporting. DentaQuest had a rigorous data validation and monitoring process, managed in Microsoft Structured Query Language (SQL), which ensured the data elements in the warehouse were correctly transferred into their Windward System. DentaQuest also had a weekly audit process in place to ensure accurate data transfer and to identify any gaps in the data. The Windward system further supported successful measure production and reporting. Outside of measure production, the system was used across multiple departments to support various activities.

Likewise, Liberty was lauded for its 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. Moreover, Liberty demonstrated 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 being well prepared for the review, as evidenced by the DBM identifying subject matter experts for each of the various areas contributing to performance measure data reporting. MCNA demonstrated strengths with its internally developed system, DentalTrac. The comprehensive system captured all data required for performance measure reporting, including claims, enrollment, and provider data. The unique system supported seamless data integration and inherently maintained the necessary controls to support data completeness and accurately produce the measures under the scope of the validation. Furthermore, MCNA maintains NCQA certification for applicable HEDIS reporting.

Each of the MCOs was also recognized as having undergone an NCQA HEDIS Compliance Audit, and the final opinion indicated that all performance measures were prepared in accordance with the appropriate technical specifications—HEDIS or CMS Child Core Set, indicating no areas for improvement. 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 2024 PMV, as with the 2023 and 2022 PMV activities.

Improvements

Table 18 includes the MCOs' and DBMs' improvements which were greater than 10.00% vs. the previous year's PMV.

Among MCOs, Aetna had the most improvements since the 2023 PMV, with 38 measures trending up. Of those measures

with a positive trend, a total of 3 measures improved at a rate of 10% or greater. CCP showed improvement across its aspects of care with 16 measures trending positively, 6 improving by 10% or greater. Finally, Simply Healthcare had 4 measures with significant (>10%) improvement from its total of 18 measures with positive trends.

Among DBMs, DentaQuest had the most improvements since the 2023 PMV, with 88 measures trending up. Of those measures with a positive trend, a total of 38 measures improved at a rate of 10% or greater. Liberty showed improvement across its aspects of care with 26 measures trending positively, 24 improving by 10% or greater. Finally, MCNA had 4 measures with significant (>10%) improvement from its total of 35 measures with positive trends.

Table 18. Improvements Since 2023 PMV by MCO/DBM

MCO/DBM	Measure	Quality	Timeliness	Access	2023 Measure Result	2024 Measure Result
Aetna	Appropriate Testing for Children with Pharyngitis (CWP): 3–17 Years	✓	✓		75.58%	85.07%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH): Blood Glucose Testing: 1–11 Years	✓	✓		42.86%	56.67%
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): Initiation of AOD Treatment Total	✓	✓	✓	37.50%	47.87%
CCP	Appropriate Testing for Children with Pharyngitis (CWP): 3–17 Years	✓	✓		68.31%	80.13%
	Appropriate Testing for Children with Pharyngitis (CWP): Total	✓	✓		67.74%	80.19%
	Follow-Up Care for Children Prescribed ADHD Medication (ADD-CH): Initiation Phase	✓	✓		39.29%	53.06%

Table 18. Improvements Since 2023 PMV by MCO/DBM

MCO/DBM	Measure	Quality	Timeliness	Access	2023 Measure Result	2024 Measure Result
	Experience of Care: CAHPS® Health Plan Survey 5.1H, Child Version (General Population): Rating of All Healthcare (9+10)	✓			67.38%	77.60%
	Experience of Care: CAHPS® Health Plan Survey 5.1H, Child Version (General Population): Rating of Specialist Seen Most Often (9+10)	✓			66.67%	80.00%
	Experience of Care: CAHPS® Health Plan Survey 5.1H, Child Version (General Population): Getting Care Quickly (Always + Usually)	✓			82.00%	92.00 %
Simply Healthcare	Appropriate Testing for Children with Pharyngitis (CWP): 3–17 Years	✓	✓		74.25%	85.08%
	Appropriate Testing for Children with Pharyngitis (CWP): 18–64 Years	✓	✓		67.08%	79.05%
	Appropriate Testing for Children with Pharyngitis (CWP): Total	✓	✓		73.87%	84.94%
	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH): 12–17 Years	✓		✓	51.72	61.90%
DentaQuest	Annual Dental Visit (ADV): Enrollees Aged 5 to 6	✓	✓	✓	42.01%	63.82%
	Annual Dental Visit (ADV): Enrollees Aged 7 to 10	✓	✓	✓	54.23%	70.36%
	Annual Dental Visit (ADV): Enrollees Aged 11 to 14	✓	✓	✓	48.99%	64.11%
	Annual Dental Visit (ADV): Enrollees Aged 15 to 18	✓	✓	✓	40.75%	52.38%
	Dental Sealants – With Exclusions: Enrolled at Least 1 Month: All Enrollees	✓	✓	✓	12.08%	86.47%

Table 18. Improvements Since 2023 PMV by MCO/DBM						
MCO/DBM	**Measure**	**Quality**	**Timeliness**	**Access**	**2023 Measure Result**	**2024 Measure Result**
	Dental Sealants – With Exclusions: Enrolled at Least 1 Month: Enrollees aged 6 to 9	✓	✓	✓	13.47%	78.30%
	Dental Sealants – With Exclusions: Enrolled at Least 1 Month: Enrollees aged 10 to 14	✓	✓	✓	11.18%	91.85%
	Dental Sealants – With Exclusions: Enrolled at Least 3 Months Continuously: All Enrollees	✓	✓	✓	13.14%	83.49%
	Dental Sealants – With Exclusions: Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	✓	✓	✓	14.73%	72.69%
	Dental Sealants – With Exclusions: Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	✓	✓	✓	12.13%	90.27%
	Dental Sealants – With Exclusions: Enrolled at Least 6 Months Continuously: All Enrollees	✓	✓	✓	14.31%	80.76%
	Dental Sealants – With Exclusions: Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	✓	✓	✓	16.17%	67.34%
	Dental Sealants – With Exclusions: Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	✓	✓	✓	13.13%	88.84%
	Dental Sealants – With Exclusions: Enrolled at Least 11 Months Continuously: All Enrollees	✓	✓	✓	15.42%	50.90%
	Dental Sealants – With Exclusions: Enrolled at Least 11 Months Continuously: Enrollees aged 6 to 9	✓	✓	✓	17.39%	64.14%
	Dental Sealants – With Exclusions: Enrolled at Least 11 Months Continuously: Enrollees aged 10 to 14	✓	✓	✓	14.19%	87.63%

Table 18. Improvements Since 2023 PMV by MCO/DBM

MCO/DBM	Measure	Quality	Timeliness	Access	2023 Measure Result	2024 Measure Result
	Preventive Dental: Enrolled at Least 11 Months Continuously: Enrollees aged 5†	✓	✓	✓	55.15%	100.00%
	Any Dental Services: Enrolled at Least 1 Month: All enrollees	✓	✓	✓	16.88%	42.01%
	Any Dental Services: Enrolled at Least 1 Month: Enrollees aged 5†	✓	✓	✓	9.05%	29.17%
	Any Dental Services: Enrolled at Least 1 Month: Enrollees aged 6 to 9	✓	✓	✓	20.56%	45.45%
	Any Dental Services: Enrolled at Least 1 Month: Enrollees aged 10 to 14	✓	✓	✓	16.98%	45.07%
	Any Dental Services: Enrolled at Least 1 Month: Enrollees aged 15 to 18	✓	✓	✓	14.83%	36.93%
	Any Dental Services: Enrolled at Least 3 Months Continuously: All enrollees	✓	✓	✓	18.28%	49.04%
	Any Dental Services: Enrolled at Least 3 Months Continuously: Enrollees aged 5†	✓	✓	✓	11.32%	41.96%
	Any Dental Services: Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	✓	✓	✓	22.32%	56.02%
	Any Dental Services: Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	✓	✓	✓	18.27%	53.90%
	Any Dental Services: Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	✓	✓	✓	15.87%	38.92%

Table 18. Improvements Since 2023 PMV by MCO/DBM						
MCO/DBM	**Measure**	**Quality**	**Timeliness**	**Access**	**2023 Measure Result**	**2024 Measure Result**
	Any Dental Services: Enrolled at Least 6 Months Continuously: All enrollees	✓	✓	✓	19.95%	56.77%
	Any Dental Services: Enrolled at Least 6 Months Continuously: Enrollees aged 5†	✓	✓	✓	15.07%	52.31%
	Any Dental Services: Enrolled at Least 6 Months Continuously: Enrollees aged 6 to 9	✓	✓	✓	24.58%	64.08%
	Any Dental Services: Enrolled at Least 6 Months Continuously: Enrollees aged 10 to 14	✓	✓	✓	19.68%	60.16%
	Any Dental Services: Enrolled at Least 6 Months Continuously: Enrollees aged 15 to 18	✓	✓	✓	17.13%	48.10%
	Any Dental Services: Enrolled at Least 11 Months Continuously: Enrollees aged 5†	✓	✓	✓	55.88%	100%
	Dental Treatment Services: Enrolled at Least 3 Months Continuously: Enrollees aged 5	✓	✓	✓	11.32%	29.10%
	Dental Treatment Services: Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	✓	✓	✓	15.87%	42.82%
	Dental Treatment Services: Enrolled at Least 11 Months Continuously: Enrollees aged 5	✓	✓	✓	15.44%	66.67%
	Dental Diagnostic Services: Enrolled at Least 11 Months Continuously: Enrollees aged 5	✓	✓	✓	55.15%	100%
	Any Dental or Oral Health Services: Enrolled at Least 11 Months Continuously: Enrollees aged 5	✓	✓	✓	55.15%	100%

Table 18. Improvements Since 2023 PMV by MCO/DBM						
MCO/DBM	**Measure**	**Quality**	**Timeliness**	**Access**	**2023 Measure Result**	**2024 Measure Result**
Liberty	Preventive Dental: Enrolled at Least 3 Months Continuously: All enrollees	✓	✓	✓	16.42%	43.88%
	Preventive Dental: Enrolled at Least 3 Months Continuously: Enrollees aged 5	✓	✓	✓	17.98%	44.75%
	Preventive Dental: Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	✓	✓	✓	19.88%	49.06%
	Preventive Dental: Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	✓	✓	✓	17.11%	45.56%
	Preventive Dental: Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	✓	✓	✓	11.00%	31.29%
	Any Dental Services: Enrolled at Least 3 Months Continuously: All enrollees	✓	✓	✓	19.79%	47.12%
	Any Dental Services: Enrolled at Least 3 Months Continuously: Enrollees aged 5†	✓	✓	✓	20.18%	45.21%
	Any Dental Services: Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	✓	✓	✓	22.63%	51.14%
	Any Dental Services: Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	✓	✓	✓	20.55%	48.99%
	Any Dental Services: Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	✓	✓	✓	15.22%	36.94%
	Dental Treatment Services: Enrolled at Least 3 Months Continuously: All enrollees	✓	✓	✓	6.12%	18.48%

Table 18. Improvements Since 2023 PMV by MCO/DBM						
MCO/DBM	**Measure**	**Quality**	**Timeliness**	**Access**	**2023 Measure Result**	**2024 Measure Result**
	Dental Treatment Services: Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	✓	✓	✓	6.56%	19.70%
	Dental Treatment Services: Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	✓	✓	✓	6.43%	19.27%
	Dental Treatment Services: Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	✓	✓	✓	5.42%	16.17%
	Dental Diagnostic Services: Enrolled at Least 3 Months Continuously: All enrollees	✓	✓	✓	17.09%	45.13%
	Dental Diagnostic Services: Enrolled at Least 3 Months Continuously: Enrollees aged 5	✓	✓	✓	18.99%	44.75%
	Dental Diagnostic Services: Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	✓	✓	✓	20.45%	49.79%
	Dental Diagnostic Services: Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	✓	✓	✓	17.31%	46.74%
	Dental Diagnostic Services: Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	✓	✓	✓	12.44%	33.88%
	Any Dental or Oral Health Services: Enrolled at Least 3 Months Continuously: All enrollees	✓	✓	✓	14.93%	43.88%
	Any Dental or Oral Health Services: Enrolled at Least 3 Months Continuously: Enrollees aged 5	✓	✓	✓	20.18%	44.75%
	Any Dental or Oral Health Services: Enrolled at Least 3 Months Continuously: Enrollees aged 6 to 9	✓	✓	✓	22.63%	49.06%

Table 18. Improvements Since 2023 PMV by MCO/DBM						
MCO/DBM	**Measure**	**Quality**	**Timeliness**	**Access**	**2023 Measure Result**	**2024 Measure Result**
	Any Dental or Oral Health Services: Enrolled at Least 3 Months Continuously: Enrollees aged 10 to 14	✓	✓	✓	20.55%	45.56%
	Any Dental or Oral Health Services: Enrolled at Least 3 Months Continuously: Enrollees aged 15 to 18	✓	✓	✓	15.22%	31.29%
MCNA	Preventive Dental: Enrolled at Least 3 Months Continuously: Enrollees aged 5	✓	✓	✓	45.45%	60.00%
	Any Dental or Oral Health Services: Enrolled at Least 11 Months Continuously: Enrollees aged 5	✓	✓	✓	45.45%	60.83%
	Dental Diagnostic Services: Enrolled at Least 11 Months Continuously: Enrollees aged 5	✓	✓	✓	45.45%	60.83%
	Any Dental or Oral Health Services: Enrolled at Least 11 Months Continuously: Enrollees aged 5	✓	✓	✓	45.45%	60.00%

Conclusions

Aetna

Aetna underwent an NCQA HEDIS Compliance Audit by a NCQA-Certified HEDIS Compliance Auditor for their performance measures. Qsource reviewed all related documentation, which included Aetna's completed ISCAT. Sufficient and complete documentation was available to support the performance measure validation activities. 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 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. Qsource reviewed all related documentation, which included CCP's completed ISCAT. Sufficient and complete documentation was available to support the performance measure validation activities. 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 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 Healthcare

Simply Healthcare underwent a NCQA HEDIS Compliance Audit by a NCQA-Certified HEDIS Compliance Auditor for their performance measures. Qsource reviewed all related documentation, which included Simply Healthcare's completed ISCAT. Sufficient and complete documentation was available to support the performance measure validation activities. It was determined that all performance measures conformed to the appropriate technical specifications, and they received a Reportable designation. Subsequently, Simply Healthcare has passed the PMV.

The final opinion 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 Healthcare'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 enrollees with an oversample of 5 for each of the selected CMS Core Set measures, specifically, Sealant Receipt on Permanent First Molars (SFM-CH), Oral Evaluation, Dental Services (OEV-CH), and Prevention: Topical Fluoride for Children (TFL-CH). All data attributes required for measure reporting, including enrollee age, date of service, procedure code, taxonomy, continuous enrollment, and tooth number, were verified. The validated processes used to develop these measures were aggregated into 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 enrollees with an oversample of 5 for each of the selected CMS Core Set measures, specifically, Sealant Receipt on Permanent First Molars (SFM-CH), Oral Evaluation, Dental Services (OEV-CH), and Prevention: Topical Fluoride for Children (TFL-CH). All data attributes required for measure reporting, including enrollee age, date of service, procedure code, taxonomy, continuous enrollment, 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 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. 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 5 for each of the selected CMS-416 measures, specifically Sealant Receipt on Permanent First Molars (SFM-CH), Oral Evaluation, Dental Services (OEV-CH), and Prevention: Topical Fluoride for Children (TFL-CH). 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)

Objectives

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 19**. Coordination and Continuity of Care, Coverage and Authorization of Services, and Subcontractual Relationships and Delegation were the standards reviewed and included in this report.

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

Table 19. Compliance Assessment Standards

Standard	CFR Citations	Quality	Timeliness	Access	Review Year
Availability of Services (AOS)	42 CFR § 438.206		✓	✓	2024
Assurances of Adequate Capacity and Services (AACS)	42 CFR § 438.207	✓	✓	✓	2024

Table 19. Compliance Assessment Standards

Standard	CFR Citations	Quality	Timeliness	Access	Review Year
Grievances and Appeals (GA)	42 CFR § 438.228			✓	2024
Practice Guidelines (PG)	42 CFR § 438.236	✓			2024
Health Information Systems (HIS)	42 CFR § 438.242	✓	✓	✓	2024
Quality Assessment and Performance Improvement (QAPI)	42 CFR § 438.330	✓	✓	✓	2024
Coordination and Continuity of Care	42 CFR § 438.208	✓	✓	✓	2025
Coverage and Authorization of Services	42 CFR § 438.210		✓	✓	2025
Subcontractual Relationships and Delegation	42 CFR § 438.230	✓	✓	✓	2025
Enrollee Information*	42 CFR § 438.224	✓		✓	2026
Enrollee Rights and Protections*	42 CFR § 438.100	✓	✓	✓	2026
Provider Selection (Credentialing/ Recredentialing)	42 CFR § 438.214	✓	✓		2026

**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 2024 ACA review were guided by CMS's EQR Protocol 3 (February 2023). 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 from May through June 2024. 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 20 presents the rating criteria used in the CA validation.

Table 2021. 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 Grievance, Appeal, and Utilization Management (UM) Denial files to evaluate how the MCO applies the processes and procedures required in 42 CFR § 457.1250 and 42 CFR § 438.358 in its operational practice. Qsource asked each plan to provide the universe of 2023 Grievance, Appeal, and Utilization Management (UM) Denial 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 policies and procedures (P&Ps), quality studies, reports, medical records/files, and other related plan 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 21 includes overall compliance scores for all standards evaluated in 2024 for the ACA. Table 22 includes the file review scores.

Table 21. 2024 Compliance Scores and Ratings

Standards	Score	Compliance Rating
Aetna		
Availability of Services (AOS)	100%	High Compliance
Assurances of Adequate Capacity and Services (AACS)	100%	High Compliance
Grievances and Appeals (GA)	100%	High Compliance
Practice Guidelines (PG)	100%	High Compliance
Health Information Systems (HIS)	100%	High Compliance
Quality Assessment and Performance Improvement (QAPI)	100%	High Compliance

Table 21. 2024 Compliance Scores and Ratings		
Standards	**Score**	**Compliance Rating**
Aetna Overall Compliance Standard Score	**100%**	**High Compliance**
CCP		
Availability of Services (AOS)	100%	High Compliance
Assurances of Adequate Capacity and Services (AACS)	100%	High Compliance
Grievances and Appeals (GA)	95.71%	High Compliance
Practice Guidelines (PG)	100%	High Compliance
Health Information Systems (HIS)	100%	High Compliance
Quality Assessment and Performance Improvement (QAPI)	100%	High Compliance
CCP Overall Compliance Standard Score	**99.29%**	**High Compliance**
DentaQuest		
Availability of Services (AOS)	100%	High Compliance
Assurances of Adequate Capacity and Services (AACS)	100%	High Compliance
Grievances and Appeals (GA)	98.57%	High Compliance
Practice Guidelines (PG)	100%	High Compliance
Health Information Systems (HIS)	80.00%	Moderate Compliance
Quality Assessment and Performance Improvement (QAPI)	80.00%	Moderate Compliance
DentaQuest Overall Compliance Standard Score	**93.10%**	**High Compliance**
Liberty		
Availability of Services (AOS)	92.31%	High Compliance
Assurances of Adequate Capacity and Services (AACS)	100%	High Compliance
Grievances and Appeals (GA)	100%	High Compliance
Practice Guidelines (PG)	100%	High Compliance
Health Information Systems (HIS)	100%	High Compliance

Table 21. 2024 Compliance Scores and Ratings		
Standards	**Score**	**Compliance Rating**
Quality Assessment and Performance Improvement (QAPI)	100%	High Compliance
Liberty Overall Compliance Standard Score	**98.72%**	**High Compliance**
MCNA		
Availability of Services (AOS)	100%	High Compliance
Assurances of Adequate Capacity and Services (AACS)	100%	High Compliance
Grievances and Appeals (GA)	100%	High Compliance
Practice Guidelines (PG)	100%	High Compliance
Health Information Systems (HIS)	100%	High Compliance
Quality Assessment and Performance Improvement (QAPI)	100%	High Compliance
MCNA Overall Compliance Standard Score	**100%**	**High Compliance**
Simply Healthcare		
Availability of Services (AOS)	100%	High Compliance
Assurances of Adequate Capacity and Services (AACS)	100%	High Compliance
Grievances and Appeals (GA)	97.14%	High Compliance
Practice Guidelines (PG)	100%	High Compliance
Health Information Systems (HIS)	100%	High Compliance
Quality Assessment and Performance Improvement (QAPI)	100%	High Compliance
Simply Healthcare Overall Compliance Standard Score	**99.52%**	**High Compliance**

Table 22. 2024 File Review Scores		
File	**Score**	**Compliance Rating**
Aetna		

Table 22. 2024 File Review Scores		
File	**Score**	**Compliance Rating**
Appeals File Review	97.50%	High Compliance
Grievances File Review	100%	High Compliance
UM Denials File Review	100%	High Compliance
Aetna Overall Compliance Standard Score	**99.17%**	**High Compliance**
CCP		
Appeals File Review	100%	High Compliance
Grievances File Review	100%	High Compliance
UM Denials File Review	100%	High Compliance
CCP Overall Compliance Standard Score	**100%**	**High Compliance**
DentaQuest		
Appeals File Review	100%	High Compliance
Grievances File Review	87.50%	Moderate Compliance
UM Denials File Review	100%	High Compliance
DentaQuest Overall Compliance Standard Score	**95.83%**	**High Compliance**
Liberty		
Appeals File Review	100%	High Compliance
Grievances File Review	100%	High Compliance
UM Denials File Review	100%	High Compliance
Liberty Overall Compliance Standard Score	**100%**	**High Compliance**
MCNA		
Appeals File Review	100%	High Compliance
Grievances File Review	100%	High Compliance
UM Denials File Review	95.00%	High Compliance

Table 22. 2024 File Review Scores		
File	**Score**	**Compliance Rating**
MCNA Overall Compliance Standard Score	**98.33%**	**High Compliance**
Simply Healthcare		
Appeals File Review	100%	High Compliance
Grievances File Review	100%	High Compliance
UM Denials File Review	100%	High Compliance
Simply Healthcare Overall Compliance Standard Score	**100%**	**High Compliance**

Table 23. 2024 ACA Overall Compliance Scores	
Standard	**Plan Overall Compliance 2024**
Availability of Services (AOS)	98.72%
Assurances of Adequate Capacity and Services (AACS)	100.00%
Grievances and Appeals (GA)	98.57%
Practice Guidelines (PG)	100.00%
Health Information Systems (HIS)	96.67%
Quality Assessment and Performance Improvement (QAPI)	96.67%
Appeals File Review	99.58%
Grievances File Review	97.92%
UM Denials File Review	99.17%
Total Overall Score	98.66%

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 24. 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 2425. ACA Strengths and Weaknesses by Standard

MCO/DBM	Standard Title	Strength/AON
Strengths		
Aetna	Availability of Services	**Element 4: Behavioral Health; Substance Use Disorder Benefits:** The MCO provided extensive and varied evidence of ensuring delivery of services and support to enrollees with BH care needs, including substance use disorder services.
	Assurances of Adequate Capacity and Services	**Element 6: Social Determinants of Health:** The MCO's Resource and Services for Members website offered excellent and varied information regarding community resources for its enrollees.
DentaQuest	Availability of Services	**Element 10: Publicly Available Website:** The DBM performed a live demonstration of enrollee-facing materials and resources on its website.
	Grievances and Appeals	**Element 26: Format of Grievance Notice:** The DBM could include clear guidelines on their notice regarding auxiliary aids and service.

Table 2425. ACA Strengths and Weaknesses by Standard		
MCO/DBM	**Standard Title**	**Strength/AON**
		Element 27: Format of Appeal Notice: The DBM could include clear guidelines on their notice regarding alternative formats, auxiliary aids, and services.
Liberty	Availability of Services	**Element 10: Publicly Available Website:** The DBM provided a live demonstration of its website during the review.
	Grievances and Appeals	**Element 15: Notice in Cases of Possible Fraud:** The DBM has a robust process in place to handle cases of possible fraud. The DBM thoroughly investigates and takes prompt action if there are any attempts of fraud.
	Practice Guidelines	**Element 3: Application of Guidelines:** The DBM provided a live demonstration of its website including the location of educational materials and resources for enrollees.
MCNA	Availability of Services	**Element 10: Publicly Available Website:** The DBM performed a walkthrough of their website during the review to provide a real time demonstration of compliance with the criteria.
	Practice Guidelines	**Element 3: Application of Guidelines:** The DBM demonstrated its website including extensive enrollee education based on clinical guidelines.
AONs		
Aetna	File Review	**Appeals:** The MCO should ensure appeals are resolved timely.
CCP	Grievances and Appeals	**Element 1: Grievance and Appeal System:** While the MCO provided evidence that they will update their policy to reflect the submission requirement, the amended policy was not in place for the 2023 review period. The MCO should ensure that it provides its Grievance and Appeal policies and procedures to FHKC by the date established in the approved implementation plan and at least 60 Calendar Days prior to any proposed changes.

Table 2425. ACA Strengths and Weaknesses by Standard		
MCO/DBM	**Standard Title**	**Strength/AON**
		Element 4: Timing to File Grievance and Appeal: The MCO should revise its policy and procedure to ensure that enrollees may file a grievance with the MCO at any time.
DentaQuest	Grievances and Appeals	**Element 8: Timing of Notice:** The DBM should update its policies and procedures to ensure that, for denial of payment, a NABD is mailed at the time of any action affecting the claim.
	Health Information Systems	**Element 4: Electronic Health Records for Providers Throughout the Contract Term:** The DBM should have a policy or procedure which reflects the requirement to report to FHKC annually.
	Quality Assessment and Performance Improvement (QAPI)	**Element 2: Fraud, Waste, and Abuse:** The DBM should have a method to verify services that were represented to have been delivered by network Providers were received by Enrollees. The DBM should include in its policy or procedure that it would provide its Fraud, Waste, and Abuse policies to FHKC for approval prior to any changes.
		Element 3: Accreditation: The DBM should ensure that it informs FHKC of any change in accreditation status within thirty (30) Calendar Days of such change.
	File Reviews	**Grievances:** The DBM should ensure that the investigation into each grievance is thoroughly documented. During the Grievance file review, it was determined that some files were missing proper documentation and investigation notes.
Liberty	Availability of Services	**Element 2: Delivery Network:** While the DBM's policy stated that it would notify FHKC within seven days of an adverse change, the policy should address the requirement that it give advance notice within 60 calendar days of an anticipated termination of any provider with at least 50 enrollees on its patient panel.
MCNA	File Reviews	**UM Denials:** The DBM should ensure timeliness of UM denial decisions and notifications.

Table 2425. ACA Strengths and Weaknesses by Standard		
MCO/DBM	**Standard Title**	**Strength/AON**
Simply Healthcare	Grievances and Appeals	**Element 1: Grievance and Appeal System:** The MCO should have a policy or procedure which ensures that it provides its Grievance and Appeal P&Ps to FHKC by the date established in the approved implementation plan and at least 60 calendar days prior to any proposed changes.

Improvements Since the 2023 ACA

Corrective action plans (CAPs) are designed to improve performance and give plans the opportunity to receive help with quality improvement. 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 2023 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 25.

Table 25. Improvements Since the 2023 ACA	
2023 AON	**Improvements**
CCP	
Standard Provider 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.	The MCO addressed the AON. This was discussed in length in the Compliance Assessment and, at the time, CCP agreed, and we discussed where in the P&P the criteria needed to be added. The P&P was submitted in draft form as the deliverable was due August 18, 2023, and the CCP Quality Improvement Committee (QIC) does not meet until August 21, 2023. The actions satisfy the CAP.
Credentialing/Recredentialing File Review—The MCO should include the Primary Care Provider (PCP) Board Certification requirement in the policy	Per CCP, File #8 contained a provider credentialed without Board Certification. CCP Provider Operations has this requirement in their P&P for confirming board certification while CCP Credentialing added the requirement

Table 25. Improvements Since the 2023 ACA	
2023 AON	**Improvements**
and procedures for Provider Operations and Credentialing.	to their P&P for validating during the credentialing approval process. The provider was terminated and is no longer active in the CCP network. The Credentialing department will monitor the Board Certification validation process on an ongoing basis via the monthly Committee Log Audit. The P&P was submitted in draft form as the deliverable was due August 18, 2023, and the CCP QIC does not meet until August 21, 2023. The actions satisfy the CAP.
DentaQuest	
Enrollee Information, Element 11: Minimum Requirements for Potential Enrollees—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.	DentaQuest will add 18.9 Disenrollment contract language to page 6 of the member handbook under section: "Can DentaQuest Disenroll my child?" Qsource is satisfied with the CAP response. DentaQuest made the requested changes to the handbook and had it approved by FHKC on 9/14/2023.
Enrollee Information, Element 22: Enrollee Handbook—The DBM should demonstrate compliance with the sub-element regarding FHKC terminology.	DentaQuest will update MKT03-INS Page 6 Enrollee Materials to include all of the language found in section 18.8 and also include language that the member handbook serves as a summary of benefits. Language will be added to the member handbook on approval from FHKC. Qsource is satisfied with the CAP response. DentaQuest made the requested changes to the handbook and had it approved by FHKC on 9/14/2023.

Table 25. Improvements Since the 2023 ACA	
2023 AON	**Improvements**
Enrollee Rights and Protections, Element 11: 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.	DentaQuest will update the member handbook with language that the member is not responsible for any covered services should the plan not pay due to insolvency. Adding it to page 7 new paragraph Liability of Payment. Policy PP FIN09-ENT will be updated to include the CAP language in Enrollee Rights and Protections Element 10 Liability of payment as an exhibit to the existing PP. DentaQuest submitted the member handbook and the PP FIN09-ENT policy for review. The draft changes are shown. Qsource is satisfied with the CAP response. DentaQuest made the requested changes to the handbook and had it approved by FHKC on 9/14/2023.
Provider Selection Credentialing/ Recredentialing, 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.	DentaQuest resubmitted PEC01-INS "stating that the policy did have this information listed. I have resubmitted and highlighted where this information is found on Page 14 of PEC01". Qsource reviewed PEC01-INS and found the information regarding providers and any person with five percent or more direct or indirect ownership. However, the 30-day requirement was not listed.
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.	The DBM updated their printed materials policy to reflect five-business day turnaround time related to printed materials for enrollees. The DBM addressed the AON with specific actions that included an update in DBM's policy to include reference to the five-business day turnaround time related to the printed materials for enrollees. A completion date and the responsible parties were identified. The DBM completed the requested changes and submitted an updated policy on April 20, 2023. The actions satisfy the CAP.

Table 25. Improvements Since the 2023 ACA	
2023 AON	**Improvements**
Enrollee 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.	The font requirements in the policy for printed enrollee materials 12-point font and 18-point font for taglines were added to ensure consistency with formatting of enrollee materials requirements. The DBM addressed the AON with specific actions that included an update to the font requirements in the policy for printed enrollee materials was added to ensure consistency with formatting of enrollee materials requirements. A completion date and the responsible parties were identified. The DBM completed the requested changes and submitted an updated policy on April 27, 2023. The actions satisfy the CAP.
Enrollee Information, Element 31: Provider Directory Updates—The DBM should clearly indicate that printed provider directories are updated at least monthly within the content of the Maintaining Provider Directories policy.	The DBM addressed the AON by updating the Maintaining Provider Directories policy to specifically state "updated at least monthly." The policy stated that printed provider directories are updated quarterly, or more frequently as determined by state and federal regulatory entities, with the most recent changes to office profiles. As required in the contract, Liberty updates printed directories monthly. Considering the broad verbiage, the policy has been updated to clearly reflect 30 days. The DBM addressed the AON with specific actions that included an update to the Maintaining Provider Directories policy to specifically state "updated at least monthly." A completion date and the responsible parties were identified. The DBM completed the requested changes and submitted an updated policy on May 15, 2023. The actions satisfy the CAP.
Enrollee Rights and Protections, Element 10: Liability for Payments—The DBM should have policies in place that clearly identify that enrollees of	The DBM addressed the AON by updating policy to clearly identify that enrollees of the DBM are not liable for payments for all of the reasons listed in the element. The DBM addressed the AON with specific actions that clearly identified that enrollees of the DBM are not liable for payments for all of the

Table 25. Improvements Since the 2023 ACA	
2023 AON	**Improvements**
the DBM are not liable for payments for all of the reason listed in the element.	reasons listed in the element. A completion date and the responsible parties were identified. The DBM completed the requested changes and submitted an updated policy on May 3, 2023. The actions satisfy the CAP.
Provider Selection Credentialing/Recredentialing, Element 4: At-Risk Providers—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.	The DBM's CAP addressed the identified AON by updating the current policy to clearly address risk-level assessments of providers that have been found to have payment suspensions as a result of credible allegations of fraud, waste, or abuse. The DBM addressed the AON by updating the current policy to clearly address risk-level assessments of providers that have been found to have payment suspensions as a result of credible allegations of fraud, waste, or abuse. A completion date and the responsible parties were identified. The DBM completed the requested changes and submitted an updated policy on May 5, 2023. The actions satisfy the CAP.

Annual Network Adequacy (ANA)

Objectives

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 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 2024 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 2024 ANA review, Qsource conducted the following:

- analyses of the geographic distribution of the MCO's providers as of March 2024; and,
- review of the MCO's appointment availability and accessibility P&Ps, provider manual, and enrollee handbook in place during 2024.

Information and data for the 2024 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.

Technical Methods of Data Collection and Analysis

The 2024 ANA evaluation included MCO and DBM provider networks as of March 2024. 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 March 2024, supplied by each MCO or DBM, and enrollment/eligibility files as of March 2024,

provided by FHKC. To be included in the analysis, an enrollee had to have the following:

- active eligibility and enrollment in the MCO/DBM as of March 2024;
- 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 March 2024;
- 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.

Description of Data Obtained

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, March 2024. 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 26 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 26. 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
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 27 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 27. 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 28 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 28. MCO Time Analysis by Required Provider Type

Provider Type	% of Enrollees with Access: Aetna		% of Enrollees with Access: CCP		% of Enrollees with Access: Simply Healthcare	
	Urban 2024	Rural 2024	Urban 2024	Rural 2024	Urban 2024	Rural 2024
Primary Care Provider (PCP) – Family Medicine	99.77%	94.48%	100%	100%	99.93%	96.36%
PCP – Pediatrics	99.97%	95.10%	100%	100%	100%	99.89%
Allergy & Immunology	99.99%	86.22%	95.14%	26.44%	100%	77.28%
Dermatology	100%	95.96%	100%	43.73%	99.95%	82.15%
Obstetrics & Gynecology	99.90%	88.57%	100%	100%	99.96%	84.96%

Table 28. MCO Time Analysis by Required Provider Type						
Provider Type	**% of Enrollees with Access: Aetna**		**% of Enrollees with Access: CCP**		**% of Enrollees with Access: Simply Healthcare**	
	Urban 2024	**Rural 2024**	**Urban 2024**	**Rural 2024**	**Urban 2024**	**Rural 2024**
Optometry	100%	100%	100%	95.93%	100%	98.74%
Otolaryngology (ENT)	99.99%	95.46%	100%	45.08%	99.67%	89.25%
Behavioral Health – Pediatric	100%	99.70%	100%	46.44%	100%	100%
Behavioral Health – Other	100%	100%	100%	100%	100%	100%
Specialist – Pediatric	99.99%	100%	100%	20.00%	99.88%	86.91%
Specialist – Other	99.89%	94.45%	99.93%	77.63%	99.91%	96.03%
Hospital	99.42%	88.65%	88.83%	22.03%	99.83%	88.93%
Pharmacy	99.86%	92.72%	99.72%	95.93%	99.88%	92.75%

Table 29 displays the percentage of enrollees in each MCO that had access to care within the required distance standards for each provider type.

Table 29. 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 Healthcare	
	Urban 2024	Rural 2024	Urban 2024	Rural 2024	Urban 2024	Rural 2024
Primary Care Provider (PCP) – Family Medicine	99.89%	95.96%	100%	95.93%	99.96%	97.15%
PCP – Pediatrics	100%	96.61%	100%	100%	100%	99.89%
Allergy & Immunology	99.99%	75.26%	96.07%	25.42%	100%	67.51%
Dermatology	99.99%	93.64%	100%	33.22%	99.82%	78.00%
Obstetrics & Gynecology	99.98%	92.66%	100%	100%	100%	89.29%
Optometry	100%	99.58%	100%	89.15%	100%	95.42%
Otolaryngology (ENT)	99.05%	92.75%	100%	45.08%	99.66%	84.49%
Behavioral Health – Pediatric	100%	97.21%	100%	45.42%	100%	100%
Behavioral Health – Other	100%	99.91%	100%	100%	100%	100%
Specialist – Pediatric	99.98%	98.99%	100%	18.31%	99.62%	80.31%
Specialist – Other	99.94%	96.32%	99.99%	78.64%	99.96%	97.22%
Hospital	99.74%	92.43%	98.21%	32.54%	99.98%	92.57%
Pharmacy	99.34%	84.29%	99.71%	91.19%	99.54%	84.06%

Table 30 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 30. 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 2024	Rural 2024	Urban 2024	Rural 2024	Urban 2024	Rural 2024
Primary Care Dentists*	99.99%	95.87%	99.93%	98.50%	99.99%	99.12%
Pediatric Dentists	99.99%	95.87%	99.90%	98.50%	99.99%	99.09%
General Dentists	96.75%	46.83%	94.43%	27.30%	97.66%	62.70%
Orthodontists*	100%	89.08%	99.99%	86.93%	99.58%	80.49%
Dental Specialists*	99.08%	39.55%	95.60%	40.81%	98.49%	39.86%
Endodontists	94.28%	31.82%	93.73%	22.97%	96.77%	25.17%
Oral Surgeons	93.31%	31.24%	90.10%	27.83%	90.48%	36.56%
Periodontists	83.71%	13.57%	71.83%	8.83%	82.92%	18.06%
Prosthodontists	22.51%	10.56%	25.28%	4.06%	31.28%	19.00%

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

Table 31 displays the percentage of enrollees in each DBM that had access to care within the required distance standards for each provider type.

Table 31. 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 2024	Rural 2024	Urban 2024	Rural 2024	Urban 2024	Rural 2024
Primary Care Dentists*	99.99%	96.99%	99.98%	99.56%	99.99%	99.63%

Table 31. 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 2024	Rural 2024	Urban 2024	Rural 2024	Urban 2024	Rural 2024
Pediatric Dentists	99.99%	96.99%	99.98%	99.56%	99.99%	99.63%
General Dentists	97.55%	54.47%	95.01%	36.31%	98.09%	72.51%
Orthodontists*	100%	79.42%	99.98%	74.47%	99.58%	73.42%
Dental Specialists*	98.56%	26.74%	95.90%	29.24%	98.32%	24.60%
Endodontists	94.38%	20.81%	93.65%	18.73%	96.31%	14.45%
Oral Surgeons	92.79%	17.93%	88.99%	17.93%	89.40%	20.96%
Periodontists	83.35%	4.22%	76.09%	4.42%	83.19%	10.51%
Prosthodontists	31.77%	4.76%	33.29%	3.00%	30.85%	10.44%

**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 2024 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 2024 and consistent with contract standards.

Improvements from 2023 ANA

Based upon the recommendations made by Qsource in the 2023 ANA, the MCOs and DBMs worked to improve their time and distance results for the 2024 ANA. These recommendations and improvements can be seen in **Table 32**.

Table 32. Improvements Since the 2023 ANA by MCO/DBM

MCO/ DBM	Standard and Element	2023 Recommendations for Improvement	MCO/DBM's Action	Quality	Timeliness	Access
Aetna	Network Adequacy: Time and Distance Standards	Qsource recommends that Aetna evaluate its potential and take appropriate actions to improve access for rural enrollees to allergy & immunology and obstetrics and gynecology. Aetna should continue to monitor its provider network and implement corrective action for identified deficiencies. Finally, Qsource recommends continued annual review of Aetna's appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.	♦ In response to the 2023 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: ♦ Acute Care Hospitals- ABH has completed the negotiations with the following acute care hospital in Region 3 and are in the onboarding process (credentialing and/or loading provider record) ♦ UF Health Spanish Plaines Hospital ♦ UF Health Leesburg Hospital ♦ Allergy and Immunology- FHKC has approved waivers for this specialty for regions 2,6, and 8 through December 31, 2023. In addition, ABHFL has requested again waivers for this specialty as of June 2024. 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)		✓	✓

Table 32. Improvements Since the 2023 ANA by MCO/DBM						
MCO/ DBM	**Standard and Element**	**2023 Recommendations for Improvement**	**MCO/DBM's Action**	**Quality**	**Timeliness**	**Access**
			♦ Behavioral Health Pediatric--ABH works with our vendor to monitor network geographic access. Network adequacy reports are shared with vendor to ensure all providers have been reported in the master rosters. Vendor reviews and advises if all recruiting efforts have been exhausted and/or if there are no other available providers to contract. ♦ Dermatology-ABH works with our vendor to monitor network geographic access. Network adequacy reports are shared with vendor to ensure all providers have been reported in the master rosters. Vendor reviews and advises if all recruiting efforts have been exhausted and/or if there are no other available providers to contract. ♦ Obstetrics & Gynecology- ABH is monitoring and evaluating our network consistently and executing our contracting efforts for any available providers. Provider records are reviewed to remediate any data discrepancies affecting network adequacy/gaps. ♦ Otolaryngology (ENT)- FHKC has approved waivers for this specialty for regions 3 and 8 through December 31, 2023. In addition, ABHFL has requested again waivers for this specialty as of June 2024. 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,			

Table 32. Improvements Since the 2023 ANA by MCO/DBM						
MCO/ DBM	**Standard and Element**	**2023 Recommendations for Improvement**	**MCO/DBM's Action**	**Quality**	**Timeliness**	**Access**
			unresponsiveness, unavailable licensed providers with this specialty in this area)			
CCP	Network Adequacy: Time and Distance Standards	Qsource recommends that CCP evaluate the potential and take appropriate actions to improve access to allergy & immunology, behavioral-pediatric and hospitals. CCP should continue to monitor its provider network and implement corrective actions for identified deficiencies.	♦ We appreciate the additional submission CCP was able to provide once we recognized errors in our second submission to Qsource for our Annual Network Adequacy Review. In review of the results, we acknowledge the overall weighted result of 98.29% and the comprehensive access achieved for pediatric PCPs and the challenges identified in rural family medicine PCPs and other specialties. We currently have waivers approved for the specialties not meeting the required standards and appreciate your feedback as we continue to evaluate and enhance access, if available, to Acute Care Hospitals, Allergy & Immunology, Otolaryngology, and pediatric specialists. We will also address any provider data issues to ensure accurate submissions in the future. Additionally, we will continue monitoring our provider network and implementing corrective actions to improve access and compliance with standards. We value your recommendations and will review our network adequacy regularly and our appointment availability survey process annually to ensure the best continued future network adequacy.		✓	✓
Simply Healthcare	Network Adequacy: Time and	Qsource recommends that Simply Healthcare evaluate the potential and take	♦ Following our review of the Qsource's findings within the draft Annual Network Adequacy report, Simply		✓	✓

Table 32. Improvements Since the 2023 ANA by MCO/DBM

MCO/ DBM	Standard and Element	2023 Recommendations for Improvement	MCO/DBM's Action	Quality	Timeliness	Access
	Distance Standards	appropriate actions to improve access to dermatology, pediatric–specialists, acute care hospitals and pharmacy provider types for rural enrollees. Simply Healthcare should continue to monitor its provider network and implement corrective action for identified deficiencies. Qsource also suggests consideration of continued annual review of Simply Healthcare's appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.	Healthcare is providing comments and feedback to address the below recommendations: ♦ Per our latest adequacy network review our member access for the 4 mentioned specialties are: ♦ With waivers submitted: ▪ *Rural – Dermatology – (83% time; 76% distance)* ▪ *Rural – Specialist - Pediatric – (86% time; 76% distance)* ▪ *Rural – Pharmacy – (97% time; 89% distance)* ♦ No waiver submitted as we show as passing internally: ▪ *Rural – Hospital – (93% time; 95%)* ♦ Simply Healthcare has performed analysis and will be taking the below steps to cure the issues identified: ▪ *Simply Healthcare is active Statewide in FL, the new rural counties are: Baker, Bradford, Calhoun, Columbia, Dixie, Franklin, Gadsden, Gilchrist, Glades, Gulf, Hamilton, Hardee, Holmes, Jackson, Jefferson, Lafayette, Levy, Liberty, Madison, Putnam, Suwannee, Taylor, Union, Wakulla, Walton, Washington.* ▪ *The report identified disparities in access between urban and rural enrollees—particularly for; Dermatology, Specialist – Pediatric, Pharmacy and Hospital.* ▪ *Per our internal reports, in the hospital category we are passing for both urban (100% Time; 100%*			

Table 32. Improvements Since the 2023 ANA by MCO/DBM

MCO/ DBM	Standard and Element	2023 Recommendations for Improvement	MCO/DBM's Action	Quality	Timeliness	Access
			Distance) and rural (93% Time; 95% Distance) counties. ▪ *The disparities in access to these provider types are due to lack of the provider types within the rural counties. In most cases Simply Healthcare has secured all available providers in the county.* ▪ *Simply Healthcare has submitted waiver requests to Florida Healthy Kids for all quarters of the year 2020, 2021 and 2022, as well for Q1 in April, Q2 in July of 2023 where there are no additional providers to recruit to meet the access requirements.* ♦ **Dermatology**: ♦ Waiver requests submitted in July Q2 2023 for Region 3 for both time and distance and for Region 7 time only. ♦ Region 3—Network currently has 2 group with 3 providers in region 3 that has is in negotiations. ▪ *Network averages 31.4% with access in miles to the nearest dermatologist in the County and overall of 86.6% with access in miles for the region.* ♦ Region 7—Network currently has 1 group with 2 providers in Brevard counties in region 7 that has been contracted but only treat Medicare members. Network is finalizing negotiations with 1 group that has 5 providers that treat FHKC members.			

Table 32. Improvements Since the 2023 ANA by MCO/DBM						
MCO/ DBM	**Standard and Element**	**2023 Recommendations for Improvement**	**MCO/DBM's Action**	**Quality**	**Timeliness**	**Access**
			▪ *Network averages 31.4% with access in miles to the nearest dermatologist in the County and overall of 86.6% with access in miles for the region.* ♦ Specialist – Pediatric ♦ Waiver requests submitted in July Q2 2023 for Region 2, 3 and 4 for both time and distance ♦ Region 2— ▪ *Since last quarter, the Health Plan Specialists – Pediatrics, with 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, Bay, and Holmes counties provide access to pediatric cardiology, pediatric endocrinology, pediatric gastroenterology, pediatric hematology/oncology, and pediatric pulmonology specialties, as there are limited practitioners in this Region 2 that are available to contract with the plan.* ▪ *DOH search results found no records of pediatric specialist provider types for Calhoun, Liberty, Franklin, Gulf, Gadsden, Jefferson, Madison, Taylor, and Wakulla. The normal pattern of care is for members to travel outside of the Region 2 to*			

Table 32. Improvements Since the 2023 ANA by MCO/DBM						
MCO/ DBM	**Standard and Element**	**2023 Recommendations for Improvement**	**MCO/DBM's Action**	**Quality**	**Timeliness**	**Access**
			Nemours in Jacksonville and UF Shands in Gainesville for certain pediatric specialty services. ♦ Region 3 ▪ *Total of 83 Pediatric specialists found in the Region. Pediatric specialists in this region are found in Alachua, Hernando, Lake, Sumter, and Marion Counties, with deficiencies in Citrus, Dixie, Putnam and Gilchrist, Hamilton, and Lafayette there are no eligible pediatric specialists are found to contract. No Pediatric specialists found in Gilchrist, Dixie, Levy, Citrus.* ♦ Region 4 ▪ *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 are found to contract.* ▪ *Additional waiver requests for Q2 2023 were submitted for Region 6, 8, and 11 in rural counties for distance only* ♦ Region 6 – Health Plan is contracted with 161 Pediatric specialists and members without access is only in Highlands County for distance, 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.			

Table 32. Improvements Since the 2023 ANA by MCO/DBM						
MCO/ DBM	**Standard and Element**	**2023 Recommendations for Improvement**	**MCO/DBM's Action**	**Quality**	**Timeliness**	**Access**
			♦ 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 and 27.9 miles for members without access in Hendry. There are no eligible pediatric specialists in those counties to contract. Due to no specialists available in the Glades and Hendry county, we respectfully request leniency for this performance measure and a waiver of the financial consequences. ♦ 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. Due to no specialists available in the region, we respectfully request leniency for this performance measure and a waiver of the financial consequences. ♦ **Pharmacy:** ♦ Waiver requests submitted in July Q2 2023 for Region 2 for distance only ♦ Network adequacy requirements are met for all counties in Region 2, with exceptions noted in response. ♦ Please note that for region 2, there were 10 counties where we didn't meet the network adequacy requirements. There are no opportunities to contract with additional pharmacies in any of these counties since the pharmacies that exist in these counties are			

Table 32. Improvements Since the 2023 ANA by MCO/DBM						
MCO/ DBM	**Standard and Element**	**2023 Recommendations for Improvement**	**MCO/DBM's Action**	**Quality**	**Timeliness**	**Access**
			already in our network or have declined network participation. ♦ Simply Healthcare 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. ♦ With regards to Appointment Access Surveys, the Plan is currently working with its vendor to explore ways to potentially enhance its process in order to better analyze access to care for rural enrollees. The Plan appreciates the feedback provided and will continue to monitor and evaluate its appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.			
Denta-Quest	Network Adequacy: Time and Distance Standards	Qsource recommends that DentaQuest take appropriate actions to improve access to orthodontists and dental specialists for rural enrollees. DentaQuest should continue to monitor	♦ Rural area access to orthodontists and dental specialists: ♦ DentaQuest is committed to ensure all Florida Healthy Kids enrollees in urban and rural areas receive oral care, including assisting members to access care when a participating provider is either not available or is unable to provide necessary care.		✓	✓

Table 32. Improvements Since the 2023 ANA by MCO/DBM

MCO/ DBM	Standard and Element	2023 Recommendations for Improvement	MCO/DBM's Action	Quality	Timeliness	Access
		its provider network and implement corrective action for identified deficiencies.	♦ If an enrollee has a need to see a specialist, our Member Placement Representatives have a process to place the enrollee with an appropriate provider. During 2022 and 2023, DentaQuest successfully placed all Florida Healthy Kids members with an in-network provider. ♦ DentaQuest has a commitment to constantly monitor network participation. We continually recruit as part of our expansion goals in Florida. Some of the ways we recruit is to use multiple sources like the Florida Board of Dentistry license verification tool, The American Board of Oral and Maxillofacial Surgery tool, The American Board of Orthodontics locator tool, The American Board of Endodontics site, the Provider Master List from The Agency for Health Care Administration, our competitors directories and leads we receive from participating providers, from our own members and from current clients. Also, as part of our ongoing recruiting process, we work with Dental Schools (University of Florida, Lake Erie College of Osteopathic Medicine & Nova Southeastern University) to help recognize new providers entering the system, identify where they will reside and collaborate on how we can partner together to expand the network. ♦ DentaQuest recognizes the importance of network compliance and meeting access goals for targeted areas. The network development team is doing additional research for each deficient area using available tools to			

Table 32. Improvements Since the 2023 ANA by MCO/DBM						
MCO/ DBM	Standard and Element	2023 Recommendations for Improvement	MCO/DBM's Action	Quality	Timeliness	Access
			ensure that all providers have been contacted. In the event, a special financial arrangement is needed for compliance, a non-panel arrangement is initiated. ♦ DentaQuest will negotiate with the provider or group to achieve the most favorable financial arrangement for the plan. Special Fee arrangements are reviewed and approved by DentaQuest management and Underwriting. ♦ DentaQuest has identified two principal barriers while meeting specialist access in rural counties. However, DentaQuest's utilization patterns demonstrate Florida Healthy Kids enrollees are certainly receiving dental care in rural counties. Our review showed 100% of members needing care in 2022 had access to a dental provider and was able to access care with an in-network provider. While most General Dentists and Pediatric Dentists also provide specialty services, we continue to pay close attention to opportunities to increase access in these areas as it is our policy to ensure an appropriate range of services with properly credentialed and licensed dentists are available to all enrolled members. ♦ The two identified barriers are: ♦ Time and Distance Standard; and ♦ Dentist Shortage			

Table 32. Improvements Since the 2023 ANA by MCO/DBM						
MCO/ DBM	**Standard and Element**	**2023 Recommendations for Improvement**	**MCO/DBM's Action**	**Quality**	**Timeliness**	**Access**
Liberty	Network Adequacy: Time and Distance Standards	Qsource recommends that Liberty take appropriate actions to improve access to orthodontists and dental specialists for rural enrollees. Liberty should continue to monitor its provider network and implement corrective action for identified deficiencies. Qsource also suggests continued annual review of Liberty's appointment availability survey process and results to confirm compliance with standards for future network adequacy analyses.	♦ From the Time Standard analysis, Liberty improved its Rural Primary Care Dentists score from 98.48% in 2023 to 98.50% 2024. ♦ From the Distance Standard analysis, Liberty improved both its Urban and Rural Dental Specialists score from 2023 to 2024. Rural Primary Care Dentists also improved from 2023 to 2024.		✓	✓

Table 32. Improvements Since the 2023 ANA by MCO/DBM						
MCO/ DBM	**Standard and Element**	**2023 Recommendations for Improvement**	**MCO/DBM's Action**	**Quality**	**Timeliness**	**Access**
MCNA	Network Adequacy: Time and Distance Standards	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. MCNA should continue to monitor its provider network and implement corrective action for identified deficiencies.	♦ For the Time Standard analysis, MCNA improved its Urban scores for Primary Care Dentists and Orthodontists in 2024. For Rural, Primary Care Dentists, Orthodontists, and Dental Specialists improved. ♦ In the Distance Standard, MCNA improved from 2023 to 2024 in Orthodontists and Dental Specialists. MCNA also improved its scores for Rural Orthodontists in 2024.		✓	✓

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 33**.

Table 33. ANA Conclusions and Recommendations	
	Strengths
Aetna	♦ 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. ♦ Urban access to all required specialties/specialty categories were at least 99.00%.

Table 33. ANA Conclusions and Recommendations	
	♦ Aetna demonstrated a comprehensive access (at least 95.00%) for access for time and distance standards to PCPs for both urban and rural enrollees. This was an increase from 2023 rates (at least 94.00%).
	Recommendations
	♦ Qsource recommends that Aetna evaluate its potential and take appropriate actions to improve access for rural enrollees to Acute Care Hospitals, Allergy & Immunology and Obstetrics & Gynecology, and Pharmacy.
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 pediatric PCPs (100%) for both urban and rural enrollees.
	Recommendations
	♦ Qsource recommends that CCP evaluate the potential and take appropriate actions to improve access to Acute Care Hospitals, Allergy & Immunology, Otolaryngology (ENT), Specialist-Other, and Specialists – Pediatric.
Simply Healthcare	**Strengths**
	♦ Simply Healthcare 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 Healthcare provided comprehensive access (at least 96.00%) for time and distance standards to PCPs for both urban and rural enrollees. ♦ Rural access for time standards increased for the following categories: Optometry (98.74%), PCP – Family Medicine (96.36%), Specialist – Other (96.03%), and Specialist – Pediatric (86.91%).
	Recommendations
	♦ Qsource recommends that Simply Healthcare take appropriate actions to improve access to Acute Care Hospitals, Allergy & Immunology, Dermatology, Obstetrics & Gynecology, Otolaryngology (ENT), Pharmacies, and Specialists – Pediatric for rural enrollees.
DentaQuest	**Strengths**

Table 33. ANA Conclusions and Recommendations	
	♦ 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 95.00%) to Primary Care Dentists for both urban and rural enrollees. ♦ Rural access to all provider types increased for both time and distance standards in 2024.
	Recommendations ♦ 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 access (at least 98.00%) to Primary Care Dentists for both urban and rural enrollees, with urban enrollees having nearly complete access for both time and distance standards (99.93%, time; 99.98%, distance).
	Recommendations ♦ Qsource recommends that Liberty take appropriate actions to improve access to orthodontists and dental specialists for rural enrollees.
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 Primary Care Dentists for both urban and rural enrollees. ♦ Over 99.00% of urban and rural enrollees had access to Primary Care Dentists for both time and distance standards; urban enrollees had over 98.00% access to all provider types for distance standards as well. ♦ Distance standards for urban enrollees increased or remained the same across all provider types in 2024.

Table 33. ANA Conclusions and Recommendations	
	Recommendations
	♦ 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.

2024 EQR Conclusions and Recommendations

Qsource conducted mandatory EQR activities for FHKC's plans for MY 2023. The results of 2024 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 2024 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

FHKC's 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 2024 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

The 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 25 performance measures for MCOs and 10 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

Availability of Services (AOS), Assurances of Adequate Capacity and Services (AACS), Grievances and Appeals (GA), Practice Guidelines (PG), Health Information Systems (HIS) and Quality Assessment and Performance Improvement (QAPI) were the areas evaluated during the 2024 ACA activities. Except for one standard for one DBM, all MCOs and DBMs achieved a high level of compliance at 95.00% or greater in all 2024 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 MCOs work to improve rural access to acute care hospitals, allergy and immunology, obstetrics and gynecology, dermatology, otolaryngology (ENT), pharmacy and pediatric specialists. Qsource recommends that DBMs work to improve rural access to orthodontists, pediatric dentists and dental specialists. 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 2024 EQR activities demonstrated that the Plans were well-qualified and committed to facilitating timely, accessible, and high-quality healthcare for all enrollees.

Appendix A | 2024 PMV Audited Measures

MCO Performance Measures

The HEDIS measures validated by Qsource for MY 2023 (January 1, 2023 – December 31, 2023) 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. 2024 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-CH)	NCQA: Percentage of children ages 3 to 17 who had an outpatient visit with a primary care practitioner (PCP) or obstetrician/gynecologist (OB/GYN) and who had evidence of the following during the measurement year: ♦ Body mass index (BMI) Percentile documentation* ♦ Counseling for Nutrition ♦ Counseling for Physical Activity * Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed, rather than an absolute BMI value. For WCC-CH, 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

Table A-1. 2024 PMV: MCO Performance Measures	
Measure Name	**Measure Steward and Definition**
Chlamydia Screening in Women Ages 16–20 (CHL-CH)	NCQA: Percentage of women ages 16 to 20 who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
Immunizations for Adolescents (IMA-CH)	NCQA: Percentage of adolescents aged 13 who had 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-CH)	NCQA: Percentage of children ages 3 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement year. The measure was stratified by race: ♦ White ♦ Black or African American ♦ American Indian or Alaska Native ♦ Asian ♦ Native Hawaiian or Other Pacific Islander ♦ Some Other Race ♦ Two or More Races ♦ Asked but No Answer ♦ Unknown
Maternal and Perinatal Health	

Table A-1. 2024 PMV: MCO Performance Measures	
Measure Name	**Measure Steward and Definition**
Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)	OPA: Among women ages 15 to 20 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: ♦ Most or moderately effective contraception: 3 days ♦ Most or moderately effective contraception: 60 days ♦ Long-acting reversible method of contraception (LARC): 3 days ♦ LARC: 60 days
Cesarean Birth (PC-02)	Retired by CMS; FHKC will continue to report on this measure for 2024. 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 to 20 (CCW-CH)	OPA: Among women ages 15 to 20 at risk of unintended pregnancy who were provided contraceptive care. Two rates are reported: ♦ Most effective or moderately effective method of contraception ♦ LARC
Prenatal and Postpartum Care: Under Age 21 (PPC2-CH)*	NCQA: 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 beneficiaries, the measure assesses the following facets of prenatal and postpartum care: ♦ Timeliness of Prenatal Care: Percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment. ♦ Postpartum Care: Percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Table A-1. 2024 PMV: MCO Performance Measures	
Measure Name	**Measure Steward and Definition**
Care of Acute and Chronic Conditions	
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years (AAB-CH)	NCQA: Percentage of episodes for beneficiaries ages 3 months to 17 years with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.
Asthma Medication Ratio: Ages 5–18 (AMR-CH)	NCQA: The percentage of children and adolescents ages 5 to 18 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
Appropriate Testing for Children with Pharyngitis (CWP)	NCQA: The percentage of episodes for members 3 years of age and older with a diagnosis of pharyngitis, dispensed an antibiotic and received a group A streptococcus 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 Children with Upper Respiratory Infection (URI)	NCQA: 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

Table A-1. 2024 PMV: MCO Performance Measures	
Measure Name	**Measure Steward and Definition**
	♦ 18–64 years
Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	NCQA: Rate of emergency department (ED) visits per 1,000 beneficiary months among children up to age 19. A total rate and two age stratifications are reported: ♦ 1–9 years ♦ 10–19 years
Behavioral Healthcare	
Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	NCQA: 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: Percentage of children ages 6 to 12 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 (C&M) Phase: Percentage of children ages 6 to 12 with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)	CMS: Percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the qualifying encounter.

Table A-1. 2024 PMV: MCO Performance Measures	
Measure Name	**Measure Steward and Definition**
Follow-up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)	NCQA: Percentage of discharges for beneficiaries ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: ♦ Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge. ♦ Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge.
Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH)	NCQA: Percentage of emergency department (ED) visits for beneficiaries ages 6 to 17 with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: ♦ Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). ♦ Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).
Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17 (FUA-CH)	NCQA: Percentage of emergency department (ED) visits for beneficiaries ages 13 to 17 years 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: ♦ Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). ♦ Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).

Table A-1. 2024 PMV: MCO Performance Measures	
Measure Name	**Measure Steward and Definition**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	NCQA: Percentage of children and adolescents ages 1 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment. A total rate and two age stratifications are reported: ♦ 1-11 years ♦ 12-17 years
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	NCQA: Percentage of children and adolescents ages 1 to 17 who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: ♦ Percentage of children and adolescents on antipsychotics who received blood glucose testing. ♦ Percentage of children and adolescents on antipsychotics who received cholesterol testing. ♦ Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing. A total rate and two age stratifications are reported: ♦ 1-11 years ♦ 12-17 years
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NCQA: The percentage of new episodes of substance use disorder (SUD) in adults and adolescents 13 years of age and older who received: ♦ Initiation of SUD Treatment: New episodes, after which the individual initiated treatment through an inpatient SUD admission, outpatient visit, telehealth or intensive outpatient encounter or partial hospitalization, or received medication within 14 days of diagnosis. ♦ Engagement of SUD Treatment: New episodes, after which the individual initiated treatment and had two or more additional SUD services or medications within 34 days of the initiation visit.

Table A-1. 2024 PMV: MCO Performance Measures	
Measure Name	**Measure Steward and Definition**
	For IET, a total rate and two age stratifications are reported for each indicator: ♦ 13–17 years ♦ 18–64 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-Related Disorders (DSU)	NCQA: The percentage of members 13 years of age and older who were diagnosed with a substance use disorder (SUD) 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. ♦ 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
Mental Health Utilization (MPT)	Measure retired; however, FHKC will continue to report on this measure for 2024. This measure summarizes the number and percentage of members receiving the following mental health services during the measurement year: ♦ Inpatient ♦ Intensive outpatient or partial hospitalization

Table A-1. 2024 PMV: MCO Performance Measures	
Measure Name	**Measure Steward and Definition**
	♦ Outpatient ♦ Emergency department (ED) ♦ Telehealth ♦ Any service
Experience of Care	
CAHPS® Health Plan Survey 5.1H, Child Version (CPC)	For 2024, FHKC asked that the MCOs add the supplemental question: "How would you rate the number of doctors you had to choose from?" FHKC asked that the MCOs add CAHPS® Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH).

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 2024 PMV activities for the DBMs. These measures are listed and defined in **Table A-2**.

Table A-2. 2024 PMV: DBM Performance Measures

Measure Name	Measure Steward and Definition
Enrolled Children Receiving Dental Sealants on Permanent Molars – With Exclusions (SEA: With Exclusions)	CMS-416: SEA:– 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.
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: Retired by CMS; FHKC will continue to report on this measure for 2024. 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

Table A-2. 2024 PMV: DBM Performance Measures	
Measure Name	**Measure Steward and Definition**
	♦ 7–10 years ♦ 11–14 years 15–18 years
Oral Evaluation, Dental Services (OEV-CH)*	Percentage of enrolled children aged 3 to 18 who received a comprehensive or periodic oral evaluation within the measurement year: children who are aged 3 to 18 as of December 31 of the measurement year.
Topical Fluoride for Children (TFL-CH)*	Percentage of enrolled children aged 3 through 18 who received at least two topical fluoride applications as: ♦ dental or oral health services; ♦ dental services; and oral health services within the measurement year.
Sealant Receipt on Permanent First Molars (SFM-CH)*	Percentage of enrolled children aged 10 who have ever received sealants on permanent first molar teeth: ♦ at least one sealant; and all four molars sealed by the 10th birthdate.

Appendix B | 2024 Sample EQR Assessment Tools

ACA MCO Tools

2024 Annual Compliance Assessment — Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
1. Delivery Network 42 CFR § 438.206(b)(1)	The MCO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
2. Delivery Network 42 CFR § 438.206(b)(1) MCOC 24.1, 84-85	The MCO shall provide FHKC with sixty (60) calendar days advance written notice of any anticipated termination of large provider groups, hospitals, or any independently practicing provider if the independently practicing provider has at least fifty (50) enrollees on its patient panel.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
3. Women's Health Specialists 42 CFR § 438.206(b)(2)	The MCO provides female enrollees with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					

2024 Annual Compliance Assessment — Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
Strength					
AON					
Suggestion					
4. Behavioral Health; Substance Use Disorder Benefits MCOC 22.2, 71-72	The MCO shall adopt Section 394.491 and Chapter 397, Florida Statutes, as guiding principles in the delivery of services and support to enrollees with behavioral health care needs, including substance use disorder services. The MCO shall maintain policies and procedures that support: 1) Early identification of behavioral health care needs through the use of valid assessments; 2) The use of services that enhance the enrollee's likelihood of positive outcomes, improved ability to function at home, school and in the community, and to live drug free; 3) enrollees' ability to receive services in the least restrictive and most normal environment that is clinically appropriate; 4) The use of care or case management and coordination of services; and 5) A smooth transition to adult behavioral health care, for older enrollees. The MCO shall also make educational materials about recognizing child and adolescent behavioral health care needs and how to obtain access to treatment and support services available to enrollees.	☐ Early identification ☐ Use of services ☐ Ability to receive services ☐ Use of care or case management, and coordination of services ☐ Transition to adult care	**0.20** **0.20** **0.20** **0.20** **0.20**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					

2024 Annual Compliance Assessment — Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
5. Second Opinion 42 CFR § 438.206(b)(3)	The MCO provides for a second opinion from a network provider or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
6. Out-of-Network Services 42 CFR § 438.206(b)(4)	If the provider network is unable to provide necessary services covered under the contract to a particular enrollee, the MCO adequately and timely covers these services out-of-network for the enrollee for as long as the MCO provider network is unable to provide them.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
7. Out-of-Network Costs 42 CFR § 438.206(b)(5)	The MCO requires out-of-network providers to coordinate with the MCO for payment and ensures the cost to the enrollee is no greater than it would be if the services were furnished within the network.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2024 Annual Compliance Assessment — Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
8. Family Planning 42 CFR § 438.206 (b)(7)	The MCO demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
9. Timely Access MCOC 24.4.3, 93	The MCO shall provide timely treatment for enrollees in accordance with the following standards: 1) Emergency care shall be provided immediately; 2) Urgently needed care shall be provided within twenty-four (24) hours; 3) Routine care shall be provided within seven (7) calendar days of the enrollee's request for services; Waiting times do not exceed 45 minutes. 4) Well-child visits, as recommended by the American Academy of Pediatrics, shall be provided within four (4) weeks of the enrollee's request; and 5) Follow-up care shall be provided as medically appropriate.	☐ Emergency care provided immediately ☐ Urgently needed care in 24 hours ☐ Routine Care within 7 days of request for services ☐ Well-child visits within 4 weeks of request ☐ Follow-up care as medically appropriate	**0.20** **0.20** **0.20** **0.20** **0.20**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2024 Annual Compliance Assessment — Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
10. Hours of Operation and Access 42 CFR § 438.206(c)(1)(ii)-(iii)	The MCO ensures that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees. The MCO makes services included in the contract available 24 hours a day, seven days a week, when medically necessary.	☐ Comparable to hours of operation for commercial ☐ Services available 24 hours a day, seven days a week, when medically necessary	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
11. Provider Compliance 42 CFR § 438.206(c)(1)(iv)-(vi)	The MCO: 1) Establishes mechanisms to ensure compliance by network providers with appointment and wait times; 2) Monitors network providers regularly to determine compliance; and 3) Takes corrective action if there is a failure to comply by a network provider.	☐ Mechanisms to ensure compliance ☐ Monitoring to determine compliance ☐ Corrective action if failure to comply	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
12. Access and Cultural Considerations 42 CFR § 438.206(c)(2)	The MCO participates in the FHKC's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					

2024 Annual Compliance Assessment — Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
Strength					
AON					
Suggestion					
13. Accessibility Considerations 42 CFR § 438.206(c)(3)	The MCO ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
14. Federally Qualified Health Centers; Rural Health Centers MCOC 24.3.9, 88	The MCO shall reimburse FQHCs and RHCs at or above the reimbursement amounts provided under the Medicaid Prospective Payment System for such entities. No supplemental payments from FHKC will be provided for these payments under any circumstances. The MCO is responsible for the entire amount. The MCO shall provide a quarterly report identifying all network FQHCs and RHCs and attesting to The MCO's compliance with these reimbursement requirements.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
15. Indian Health Care Providers 42 CFR 447.45 MCOC 24.3.10, 89-90	The MCO shall: 1) Maintain sufficient numbers of Indian Health Care Providers (IHCPs) in The MCO's provider network to ensure timely access to services to eligible enrollees.	☐ Maintain sufficient numbers of IHCPs ☐ Provide quarterly attestation and documentation ☐ Allow enrollees to choose IHCP as PCP	**0.17** **0.17** **0.17**	**1.00**	**0.00**

2024 Annual Compliance Assessment — Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
	2) Provide a quarterly attestation and supporting documentation to FHKC demonstrating compliance with this requirement. 3) 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. 4) 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. 5) Allow out-of-network IHCPs to refer enrollees to a network Provider. Should there be too few IHCPs in the State to ensure timely access to Covered Services, enrollees who are eligible to receive such services shall be permitted to access out-of-state IHCPs. 6) Pay for Covered Services provided to eligible enrollees by IHCPs, whether participating in the network or not, at either the rate negotiated between The MCO and the IHCP or at a rate not less than the level and amount of payment The MCO would make for services to a non-IHCP network provider. The MCO shall make all payments to network IHCPs in a timely manner, as required by 42 CFR 447.45 and 447.46.	☐ Allow enrollees to obtain covered services from out-of-network IHCP ☐ Allow out-of-network IHCPs to refer enrollees to network provider ☐ The MCO pays for Covered Services provided to enrollees	**0.17** **0.16** **0.16**		
	Comments **Strength** **AON** **Suggestion**				
16. Cultural Competency Plan MCOC 20; 75	The MCO shall submit its initial cultural competency plan for approval by FHKC by the date established in the approved implementation plan and annually thereafter by July 1st.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments				

2024 Annual Compliance Assessment — Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
Strength					
AON					
Suggestion					
17. Publicly Available Website MCOC 21; 75	The MCO shall provide a publicly available website with access to Florida Healthy Kids information. The publicly available website shall include: 1) The *Enrollee Handbook*, 2) A printable provider directory, 3) A searchable electronic provider directory, 4) A link to FHKC's Florida Healthy Kids website, and 5) Any other information that may be needed by enrollees or potential enrollees. The MCO's publicly available website is subject to FHKC approval.	☐ Handbook ☐ Provider directory ☐ Electronic directory ☐ Link to FHKC site ☐ Additional information	**0.20** **0.20** **0.20** **0.20** **0.20**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
18. Enrollee Customer Service MCOC 21; 75	The MCO shall maintain an enrollee service unit to provide enrollee-related customer service. The enrollee service unit shall have the ability to answer enrollee inquiries by telephone, electronic communication, and written communication. The enrollee service unit shall be accessible by a toll-free telephone number during the hours of 7:30 a.m. to 7:30 p.m. Eastern Time, Monday through Friday, except on FHKC-recognized holidays. The MCO shall also provide a telecommunication device for the deaf (TTY/TDD) and access to interpreter services.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					

2024 Annual Compliance Assessment — Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
AON					
Suggestion					
		Availability of Services Score	**0.00%**	**17.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Assurances of Adequate Capacity and Services					
1. Assurances of Adequate Capacity—Supporting Documentation 42 CFR § 438.207(b)(1)-(2)	The MCO submits documentation to FHKC, in a format specified by FHKC, to demonstrate that it complies with the following requirements: 4) Offers an appropriate range of preventive, primary care, and specialty services, that is adequate for the anticipated number of enrollees for the service area; and 5) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
2. Timing of Documentation	The MCO submits the documentation described in element one as specified by FHKC, but no less frequently than the following:	☐ Time of contract execution ☐ On a monthly basis	**0.33** **0.33**	**1.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>						
Evaluation Elements		**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
					Value	**Score**
Assurances of Adequate Capacity and Services						
	42 CFR § 438.207(c)(1)-(3)	1) At the time it enters into a contract with FHKC; 2) On a monthly basis; and 3) At any time there has been a significant change (as defined by) in the MCO's operations that would affect the adequacy of capacity and services, including: a) Changes in MCO services, benefits, geographic service area, composition of or payments to its provider network; and b) Enrollment of a new population in the MCO.	☐ At time of significant change in operations	**0.34**		
	Comments **Strength** **AON** **Suggestion**					
3.	Geographic Access Exemptions MCOC 24.4.2.1, 92	The MCO may request a service area exemption to waive time and/or distance network adequacy standards for a given geographical area. To request a service area exemption, the MCO must submit a written request for an exemption accompanied by supporting documentation. These requests shall include: 6) Identification of the service area, provider type(s), and specific standard(s) the request for exemption covers; 7) The reason for the request, which may include: i. No providers exist in the area; ii. No providers exist in the area that are able to pass The MCO's credentialing or recredentialing standards; and/or iii. Limited providers exist in the area and all refuse to contract with The MCO despite The MCO's documented good faith efforts to contract; 8) The number of providers in the area; 9) The distance to the nearest network provider; 10) Documentation of The MCO's efforts to find providers in the area as well as proof of existing providers' inability to be credentialed/recredentialed or proof of The MCO's failed good faith efforts to contract, as appropriate. The MCO must	☐ Time of contract execution ☐ Service area, provider type, standards ☐ Reason for request ☐ Number of providers ☐ Nearest provider ☐ Effort to find providers ☐ Certification ☐ Plan to monitor area ☐ Explanation of timely services ☐ Additional information	**0.10** **0.10** **0.10** **0.10** **0.10** **0.10** **0.10** **0.10** **0.10** **0.10**	**1.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>						
Evaluation Elements		**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
					Value	**Score**
Assurances of Adequate Capacity and Services						
		provide the practice address and phone number of any provider refusing to contract; 11) Certification attesting that documentation is complete and accurate; 12) The MCO's plan to monitor the area and take action should any change occur; 13) Explanation of how The MCO will provide timely services to enrollees in the area; and 14) Any other information FHKC deems necessary to make a determination.				
	Comments **Strength** **AON** **Suggestion**					
4.	Coordination; Transition of Care MCOC 22.11, 78.	The MCO shall coordinate, or provide for the coordination of, services between settings of care, including appropriate discharge planning for short and long-term hospital and institutional stays, with services enrollees receive from other health care coverage or liable third parties, and with services enrollees receive from community and social support providers. The MCO shall implement a transition of care policy consistent with the transition of care policy adopted by FHKC. FHKC's transition of care policy shall be made publicly available. The MCO will provide a copy of The MCO's transition of care policy to FHKC during implementation of the Contract, by the date established in the approved implementation plan, and prior to any proposed changes. Changes to The MCO's transition of care policy are subject to FHKC's approval. Summaries of the transition of care policy shall be included in the *Enrollee Handbook* and relevant notices. Notwithstanding any other provision of this Contract, as of the Effective Date of this Contract, The MCO shall be liable for the cost of any previously authorized, ongoing course of treatment provided to an enrollee by any provider, regardless of whether such provider has a contract with The MCO, without any further authorizations, for an additional sixty (60) Calendar Days after termination or expiration of any prior MCO's contract covering such enrollees.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>						
Evaluation Elements		Criteria	Criteria Met	Criteria Value	Element	
					Value	Score
Assurances of Adequate Capacity and Services						
	Comments					
	Strength					
	AON					
	Suggestion					
5.	Disease and Case Management MCOC 22.10, 77	The MCO shall provide disease and case management services. The MCO shall provide FHKC a list of disease and case management programs, to the extent any case management is condition specific, by the date established in the approved implementation plan. The MCO shall inform FHKC of any addition or removal of such programs sixty (60) Calendar Days prior to the change. The MCO shall have policies and procedures in place for identifying and enrolling enrollees likely to benefit from such services. The MCO shall provide a quarterly disease and case management report that includes the number of enrollees identified as eligible for disease or case management, the number of enrollees enrolled in the quarter, the percentage of eligible enrollees engaged in disease or case management, The MCO's definition of "engagement" and a breakdown of such information by program.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments					
	Strength					
	AON					
	Suggestion					
6.	Social Determinants of Health MCOC 22.9, 77	The MCO shall have a mechanism to address social services needs of enrollees through available community-based social service resources. The MCO shall not require enrollees to access community-based social service resources instead of covered benefits.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments					
	Strength					
	AON					
	Suggestion					

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Assurances of Adequate Capacity and Services					
		Assurances of Adequate Capacity and Services Score	**0.00%**	**6.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
1. Grievance and Appeal System 42 CFR § 438.402(a) MCOC 23, 78.	The MCO has a grievance system in place for enrollees. The MCO shall provide its Grievance and Appeal policies and procedures to FHKC by the date established in the approved implementation plan and at least sixty (60) Calendar Days prior to any proposed changes. The initial policy and procedures and/or any subsequent changes are subject to approval by FHKC.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
2. Authority to File 42 CFR § 438.402.(c)(1)(i)	An enrollee may file a grievance and request an appeal with the MCO. An enrollee may request a State fair hearing after receiving notice under § 438.408 that the adverse benefit determination is upheld.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
		☐ Yes	**1.00**	**1.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
3. Provider or Authorized Representative 42 CFR § 438.402.(c)(1)(ii)	With the written consent of the enrollee, a provider or an authorized representative may request an FHKC appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee.	☐ No	**0.00**		
Comments **Strength** **AON** **Suggestion**					
4. Timing to File Grievance and Appeal 42 CFR § 438.402(c)(2)	An enrollee may file a grievance with the MCO at any time. Following receipt of a notice of adverse benefit determination (NABD), an enrollee has 60 calendar days from the date on the NABD notice to file an FHKC appeal with FHKC.	☐ May file a grievance at any time ☐ Has 60 calendar days to file an appeal after receiving NABD	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
5. Procedures 42 CFR § 438.402(c)(3)	An enrollee may file a grievance with the MCO either orally or in writing. An enrollee may file an appeal contesting the MCO's proposed adverse benefit determination either orally or in writing at the FHKC phone number or address listed on the MCO-issued notice of adverse determination.	☐ May file grievance orally or in writing ☐ May file appeal orally or in writing	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength**					

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>						
Evaluation Elements		**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
	AON **Suggestion**					
6.	Availability of Notices 42 CFR § 438.404(a)	The MCO gives enrollees a timely and adequate notice of an adverse benefit determination in writing and makes the NABD available by the following means at no cost to the enrollee: 1) Written translation; 2) Oral interpretation; 3) Alternative formats; and 4) Auxiliary aids and services.	☐ Timely and adequate notice ☐ Available via the listed means	**0.50** **0.50**	**1.00**	**0.00**
	Comments **Strength** **AON** **Suggestion**					
7.	Content of Notice of Adverse Benefit Determination (NABD) 42 CFR § 438.404(b)(1)-(6)	The notice explains the following: 1) The adverse benefit determination the MCO has made or intends to make; 2) The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits; 3) The enrollee's right to file a FHKC appeal of the MCO's adverse benefit determination; 4) The procedures for exercising the rights;	☐ Determination made or intends to make ☐ Reasons for determination ☐ Right to file appeal ☐ Procedures for exercising rights ☐ Circumstances for which an appeal can be expedited ☐ Right to continuing benefits pending appeal resolution	**0.16** **0.16** **0.17** **0.17** **0.17** **0.17**	**1.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
	5) The circumstances under which an appeal process can be expedited and how to request it; and 6) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued.					
Comments **Strength** **AON** **Suggestion**						
8. Adverse Benefit Determinations MCOC 22.6.1, 74-75	For termination, suspension or reduction of previously approved services, the notice must be provided at least ten (10) Calendar Days before the date of action except when: 1) The MCO has information confirming the death of the enrollee; 2) The MCO receives a clear signed written statement from the enrollee stating that the enrollee no longer wishes to receive services, or the enrollee gives information that requires termination or reduction of services and the enrollee indicates understanding that termination or reduction of services must be the outcome of providing such information; 3) The enrollee has been admitted to an institution which causes ineligibility under the plan for further services; 4) The enrollee's whereabouts are unknown and the United States Postal Service returns The MCO's mail to the enrollee with no forwarding address; 5) The MCO establishes that the enrollee is enrolled in Florida Healthy Kids with another MCO; 6) A change in the level of medical care is prescribed by the enrollee's physician;	☐ Death confirmation ☐ Signed statement ☐ Ineligibility ☐ Unknown whereabouts ☐ Enrollment with other MCO ☐ Change in level of care ☐ ABD with screening ☐ In accordance with 42 CFR 431.213(h) ☐ Fraud		**0.12** **0.11** **0.11** **0.11** **0.11** **0.11** **0.11** **0.11** **0.11**	**1.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
	7) The notice involves an Adverse Benefit Determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; 8) In accordance with 42 CFR 431.213(h); and 9) The MCO has facts, verified through secondary sources when possible, indicating that action should be taken because of probable Fraud by the enrollee. In such instances the notice must be provided at least five (5) Calendar Days before the date of action.				
Comments **Strength** **AON** **Suggestion**					
9. Timing of Notice 42 CFR § 438.404(c)(1-2)	The MCO mails the NABD at the following times: 1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least 10 days before the date of action; and 2) For denial of payment, at the time of any action affecting the claim.	☐ At least 10 days before the date of action ☐ At the time of any action affecting the claim	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
10. Timing for Standard Service Authorization 42 CFR § 438.404(c)(3)	For standard service authorization decisions that deny or limit services, the MCO mails the notice within 14 calendar days following the receipt of request for service.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
11. Extension of Standard Service Authorization Decisions 42 CFR § 438.404(c)(4)	If the MCO meets the criteria set forth for extending the timeframe for standard service authorization decisions, compliance requires that it: 1) Gives the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and 2) Issues and carries out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.	☐ Written notice ☐ Makes determination timely	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
12. Non-Enrollee Request Extension 42 CFR § 438.404(c)(4)	If a Grievance timeframe has been extended other than at the request of an enrollee, The MCO shall make reasonable efforts to give the enrollee: 15) Prompt oral notice of the delay; Written notice of the decision to extend the timeframe within two (2) calendar days; and	☐ Prompt notice of delay ☐ Written notice of decision to extend timeframe ☐ Notice of enrollee's right to file Grievance	**0.33** **0.33** **0.33**	**1.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
MCOC 23.1, 90	Notice of the enrollee's right to file a Grievance regarding this decision.				
Comments **Strength** **AON** **Suggestion**					
13. Service Authorizations not Reached Within Timeframe 42 CFR § 438.404(c)(5)	For service authorization decisions not reached within the 14-calendar day timeframe, (which constitutes a denial and is thus an adverse benefit determination) the MCO mails the notice on the date that the timeframes expire.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
14. Timing for Expedited Service Authorizations 42 CFR § 438.404(c)(6)	For expedited service authorization decisions, the MCO mails the notice within 72 hours of receipt of the request for service.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
15. Exceptions from Advance Notice 42 CFR § 431.213	The MCO may send a notice not later than the date of action if – 1) The MCO has factual information confirming the death of an enrollee; 2) The MCO receives a clear written statement signed by an enrollee that – a) The enrollee no longer wishes services; or b) Gives information that requires termination or reduction of services and indicates that this must be the result of supplying that information; 3) The enrollee has been admitted to an institution where the enrollee is ineligible under the plan for further services; 4) The enrollee's whereabouts are unknown, and the post office returns agency mail directed to the enrollee indicating no forwarding address; 5) The MCO establishes the fact that the enrollee has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; 6) A change in the level of medical care is prescribed by the enrollee's physician; or 7) The date of action will occur in less than 10 days.	☐ Death of enrollee ☐ No longer wishes services, or information requires termination or reduction of services ☐ Admitted to institution and ineligible for further services ☐ Whereabouts unknown ☐ Accepted by another Medicaid jurisdiction ☐ Change in level of care prescribed ☐ Date of action will occur in less than ten days	**0.15** **0.15** **0.14** **0.14** **0.14** **0.14** **0.14**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
	The MCO may shorten the period of advance notice to 5	☐ Facts indicating probable fraud	**0.50**	**1.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
16. Notice in Cases of Possible Fraud 42 CFR § 431.214	days before the date of action if – 1) The MCO has facts indicating that action should be taken because of probable fraud by the enrollee; and 2) The facts have been verified, if possible, through secondary sources.	☐ Facts verified	**0.50**		
Comments **Strength** **AON** **Suggestion**					
17. Handling of Grievances and Appeals 42 CFR § 438.406(a)	In handling grievances and appeals, the MCO gives enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
18. Acknowledging Grievances and Forwarding Appeals 42 CFR § 438.406(b)(1)	The MCO's process for handling enrollee grievances and for satisfying FHKC requirements for appeals of adverse benefit determinations includes acknowledging receipt of each grievance and forwarding appeal of adverse benefit determinations to FHKC and informing the enrollee that FHKC will contact them about their appeal.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
19. Reviewer Requirements 42 CFR § 438.406(b)(2)	The MCO's process for handling enrollee grievances and appeals of adverse benefit determinations includes ensuring that the individuals who make decisions on grievances and appeals are individuals – 1) Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual; 2) Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, in treating the enrollee's condition or disease: a) An appeal of a denial that is based on lack of medical necessity; b) A grievance regarding denial of expedited resolution of an appeal; or c) A grievance or appeal that involves clinical issues; 3) Who take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to	☐ Not involved in previous review or subordinate ☐ Appropriate clinical expertise ☐ Take into account all information	**0.33** **0.33** **0.34**	**1.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
	whether such information was submitted or considered in the initial adverse benefit determination.				
Comments **Strength** **AON** **Suggestion**					
20. Oral Inquiries Treated as Appeals 42 CFR § 438.406(b)(3)1	The MCO's process for satisfying FHKC's requirements for appeals of adverse benefit determinations includes providing that oral inquiries seeking to appeal an adverse benefit determination are forwarded to FHKC and treated as appeals (to establish the earliest possible filing date).	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
21. Resolution and Notification 42 CFR § 438.408(a)	The MCO resolves each grievance and appeal process-related obligations, and provides notice, as expeditiously as the enrollee's health condition requires, within FHKC-established timeframes.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
22. Grievance Resolution Timeframe 42 CFR § 438.408(b)(1)	For standard resolution of a grievance and notice to the affected parties, the MCO resolves each grievance within 90 calendar days from the day the MCO receives the grievance.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
23. Standard Appeal Resolution Timeframe 42 CFR § 438.408(b)(2)	For standard resolutions, the MCO resolves each appeal and provides notice within 14 calendar days of receipt.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
24. Expedited Appeal Resolution Timeframe 42 CFR § 438.408(b)(3)	For expedited resolutions, the MCO resolves each appeal and provides notice within 72 hours of receipt.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
Strength **AON** **Suggestion**					
25. Extension of Appeal Timeframes 42 CFR § 438.408(c)(1)	The MCO may extend the timeframes for standard and expedited appeal resolution by up to 14 calendar days if – 1) The enrollee requests the extension; and 2) The MCO shows (to the satisfaction of FHKC, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.	☐ Extension justified ☐ Requirements following extension	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
26. Extension Requirements 42 CFR § 438.408(c)(2)	If the MCO extends the timeframes not at the request of the enrollee, compliance requires that it complete all of the following: 1) Make reasonable efforts to give the enrollee prompt oral notice of the delay; 2) Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and 3) Complete the reconsideration phase of the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.	☐ Prompt oral notice ☐ Written notice ☐ Complete reconsideration phase timely	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
27. Format of Grievance Notice 42 CFR § 438.408(d)(1)	The MCO uses the FHKC-established method to notify an enrollee of the resolution of a grievance and ensures that such methods provide for: 1) Written translation; 2) Oral interpretation; 3) Alternative formats; and 4) Auxiliary aids and services.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
28. Format of Appeal Notice 42 CFR § 438.408(d)(2)	For all appeals, the MCO provides written notice of resolution in a format and language that provider for: 1) Written translation; 2) Oral interpretation; 3) Alternative formats; and 4) Auxiliary aids and services	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
29. Content of Notice of Appeal Resolution – Results and Date	The written notice of the resolution includes the results of the resolution process and the date it was completed.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
42 CFR § 438.408(e)(1)					
Comments **Strength** **AON** **Suggestion**					
30. Expedited Resolution of Appeals 42 CFR § 438.410(a)	The MCO establishes and maintains an expedited review process for appeals when the MCO determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
31. Punitive Action Prohibited 42 CFR § 438.410(b)	The MCO ensures that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
32. Expedited Resolution of Appeals Requirements 42 CFR § 438.410(c)	If the MCO denies a request for expedited resolution of an appeal, it – 1) Transfers the appeal to the timeframe for standard resolution; 2) Makes reasonable efforts to give the enrollee prompt oral notice of the delay; 3) Within two (2) calendar days gives the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if the enrollee disagrees with that decision; and 4) Completes the reconsideration phase of the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.	☐ Transfer to standard timeframe ☐ Give prompt oral notice ☐ Provide written notice ☐ Complete reconsideration no later than the date extension expires	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
33. Provider Information 42 CFR § 438.414	The MCO provides information about the grievance and FHKC appeal procedures and filing timeframes to all providers and subcontractors at the time they enter into a contract.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
		☐ Yes	**1.00**	**1.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
34. Recordkeeping Requirements – Ongoing Monitoring 42 CFR § 438.416(a)	The MCO maintains records of grievances and appeals and reviews the information as part of its ongoing monitoring procedures, as well as for updates and revisions to FHKC's Quality Strategy.	☐ No	**0.00**		
Comments **Strength** **AON** **Suggestion**					
35. Recordkeeping Requirements - Information 42 CFR § 438.416(b)	The record of each grievance or appeal contains, at a minimum, all of the following information: 1) A general description of the reason for the appeal or grievance; 2) The date received; 3) The date of each review or, if applicable, review meeting; 4) Resolution at each level of the appeal or grievance, if applicable; 5) Date of resolution at each level, if applicable; and 6) Name of the enrollee for whom the appeal or grievance was filed.	☐ Reason for appeal or grievance ☐ Date received ☐ Date of each review ☐ Resolution ☐ Date of resolution ☐ Name of enrollee	**0.16** **0.16** **0.17** **0.17** **0.17** **0.17**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
		☐ Yes	**1.00**	**1.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
36. Recordkeeping Requirements -Accuracy and Accessibility 42 CFR § 438.416(c)	The record must be accurately maintained in a manner accessible to FHKC and available upon request to CMS.	☐ No	**0.00**		
Comments **Strength** **AON** **Suggestion**					
37. Continuation of Benefits 42 CFR § 438.420(b)	The MCO continues the enrollee's benefits if all of the following occur: 1) The enrollee files the request for an appeal timely; 2) The appeal involves the termination, suspension, or reduction of previously authorized services; 3) The services were ordered by an authorized provider; 4) The period covered by the original authorization has not expired; and 5) The enrollee timely files for continuation of benefits.	☐ Enrollee files timely request ☐ Appeal involves change in previously authorized service ☐ Services ordered by authorized provider ☐ Period covered by authorization not expired. ☐ Enrollee files timely for continuation of benefits	**0.20** **0.20** **0.20** **0.20** **0.20**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
	If, at the enrollee's request, the MCO continues or	☐ Yes	**1.00**	**1.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
38. Duration of Continued or Reinstated Benefits 42 CFR § 438.420(c)	reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs: 1) The enrollee withdraws the appeal or request for appeal; 2) The enrollee fails to request an appeal and continuation of benefits within 10 calendar days after the MCO sends the notice of an adverse resolution to the enrollee's appeal; or 3) An appeal results in a decision adverse to the enrollee.	☐ No	**0.00**		
Comments **Strength** **AON** **Suggestion**					
39. Effectuation of Reversed Appeal Resolutions – Services not Furnished while Appeal Pending 42 CFR § 438.424(a)	If the FHKC appeal reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO authorizes or provides the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
40. Effectuation of Reversed Appeal Resolutions Services Furnished While Appeal Pending 42 CFR § 438.424(b)	If the FHKC appeal reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO pays for those services.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
		Grievance and Appeal Systems Score	**0.00%**	**40.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Practice Guidelines					
1. Adoption of Practice Guidelines 42 CFR § 438.236(b)	The MCO adopts practice guidelines that meet the following requirements: 1) Are based on valid and reliable clinical evidence or a consensus of providers in the particular field; 2) Consider the needs of the MCO's enrollees;	☐ Based on evidence or a consensus ☐ Consider enrollees' needs ☐ Adopted in consultation with network providers	**0.20** **0.20** **0.20**	**1.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>						
Evaluation Elements		**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
					Value	**Score**
Practice Guidelines						
		3) Are adopted in consultation with network providers; 4) Are reviewed and updated whenever the guidelines change and at least every two years; and 5) Comply fully with FHKC medical necessity rule as applicable.	☐ Reviewed and updated as required ☐ Complied with medical necessity	**0.20** **0.20**		
	Comments **Strength** **AON** **Suggestion**					
2.	Dissemination of Guidelines 42 CFR § 438.236(c)	The MCO disseminates the practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments **Strength** **AON** **Suggestion**					
3.	Application of Guidelines 42 CFR § 438.236(d)	Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	☐ Decisions for utilization management ☐ Enrollee education ☐ Coverage of services ☐ Population health programs	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**
	Comments **Strength** **AON**					

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>						
Evaluation Elements		Criteria	Criteria Met	Criteria Value	Element	
					Value	Score
Practice Guidelines						
	Suggestion					
4.	Application of Guidelines MCOC 26.6.1, 102	The MCO shall report on its value-based payment arrangements, including provider participation, enrollee participation, type of value-based payment and planned contracting activities as required by FHKC. FHKC may require The MCO to implement a value-based payment arrangement development plan. The value-based payment arrangement development plan, including measure indicators and outcome targets, shall be subject to approval by FHKC.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments					
	Strength					
	AON					
	Suggestion					
			Practice Guidelines Score	**0.0%**	**4.00**	**0.00**

2024 Annual Compliance Assessment—Quality Process Standards: <MCO>						
Evaluation Elements		Criteria	Criteria Met	Criteria Value	Element	
					Value	Score
Health Information Systems						
1.	General Rule 42 CFR § 438.242(a)	The MCO maintains a health information system that collects, analyzes, integrates, and reports data. The system provides information on areas including, but not limited to, utilization, claims, grievances, and appeals, and disenrollments for reasons other than loss of FHKC eligibility.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments					
	Strength					
	AON					

2024 Annual Compliance Assessment—Quality Process Standards: <MCO>						
Evaluation Elements		**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
					Value	**Score**
Health Information Systems						
	Suggestion					
2.	Basic Elements 42 CFR § 438.242(b)(2)	The MCO's health information system collects data on enrollee and provider characteristics as specified by FHKC, and on all services furnished to enrollees through an encounter data system or other methods as may be specified by FHKC.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments					
	Strength					
	AON					
	Suggestion					
3.	Data Accuracy and Complete-ness 42 CFR § 438.242(b)(3)	The MCO ensures that data received from providers are accurate and complete by: 1) Verifying the accuracy and timeliness of reported data, including data from network providers the MCO is compensating on the basis of capitation payments; 2) Screening the data for completeness, logic, and consistency; and 3) Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for FHKC quality improvement (QI) and care coordination efforts.	☐ Verify accuracy and timeliness ☐ Screen for completeness, logic, and consistency ☐ Collect data in standardized formats	**0.33** **0.33** **0.34**	**1.00**	**0.00**
	Comments					
	Strength					
	AON					
	Suggestion					

2024 Annual Compliance Assessment—Quality Process Standards: <MCO>						
Evaluation Elements		**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
					Value	**Score**
Health Information Systems						
4.	Electronic Health Records for Providers Throughout the Contract Term MCOC 24.5.2, 95	The MCO shall monitor, promote, and support the use of electronic health records (EHRs) by its network providers. By June 30, 2023, and annually thereafter, The MCO shall report to FHKC results of The MCO's efforts at promoting and monitoring the adoption of EHRs among network providers. In the event use of EHRs by The MCO's network providers does not increase from the previous Contract Year, the report shall include changes The MCO has made to its policies and procedures that support the adoption of EHRs.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments **Strength** **AON** **Suggestion**					
5.	Data Availability 42 CFR § 438.242(b)(4)	The MCO makes all collected data available to FHKC and, upon request, to CMS.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments **Strength** **AON** **Suggestion**					
6.	Electronic Notification System MCOC 24.3.5, 87	The MCO shall participate in the Event Notification System (ENS) of the Florida Health Information Exchange. The MCO shall use the hospital encounter data it receives through the ENS in its case and disease management and care coordination programs to identify, develop, and implement interventions that reduce avoidable emergency department visits, hospital admissions, and hospital readmissions for its enrollees. The MCO shall also implement programs to share its ENS encounter data with its network providers to collaborate on these same goals.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2024 Annual Compliance Assessment—Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Health Information Systems					
Comments					
Strength					
AON					
Suggestion					
		Health Information Systems Score	**0.00%**	**6.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program					
1. QAPI Program 42 CFR § 438.330(b)(1-5)	The MCO establishes and implements an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees. FHKC may implement quality initiatives other than those types of quality activities considered in this Contract and may require The MCO to participate in such initiatives. The MCO shall maintain a quality assessment and performance improvement (QAPI) program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes. At a minimum, the QAPI program shall include: 1. Performance improvement projects (PIPs) focusing on clinical and non-clinical areas; 2. Collection and submission of performance measurement data; 3. Mechanisms to detect underutilization and overutilization of services; 4. Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs;	☐ Clinical and Non-clinical PIPs ☐ PIPs data ☐ Mechanisms to detect under-utilization/over-utilization of services ☐ Quality and appropriateness of care mechanisms ☐ Written policies and procedures ☐ Required PMVs and PIPs by CMS	**0.17** **0.17** **0.17** **0.17** **0.16** **0.16**	**1.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>						
Evaluation Elements		**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
					Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program						
		5. Written policies and procedures that address components of effective health care management including anticipation, identification, monitoring, measurement, evaluation of enrollees' health care needs, and effective action to promote quality of care; and 6. Any performance measures and PIPs that are required by CMS during the term of this Contract.				
	Comments **Strength** **AON** **Suggestion**					
2.	QAPI Program MCOC 26.2, 100	The MCO's QAPI shall incorporate an annual quality improvement plan (QIP). The MCO's QIP shall: 1) Include an executive summary describing the structure of The MCO's QAPI, The MCO's approach to quality improvement and how The MCO evaluates the QIP and QAPI to determine new or improved quality improvement activities; 2) Define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest-level of success; 3) Implement specific interventions to better manage enrollee care and promote improved health outcomes; and 4) Identify performance goals supporting the QAPI program. The MCO shall submit its QIP to FHKC during implementation of the Contract, by the date established in the approved implementation plan, and annually thereafter by July 1st. The MCO's QIP is subject to FHKC approval. The MCO shall use the results of the QIP to assess and report on the overall QAPI program to FHKC annually. The MCO shall have a quality improvement committee that develops and is responsible for the oversight of the QIP. The quality improvement committee	☐ Executive summary ☐ Improvements in processes defined and implemented ☐ Enrollee care interventions ☐ Identify performance goals	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>						
Evaluation Elements		Criteria	Criteria Met	Criteria Value	Element	
					Value	Score
Quality Assessment and Performance Improvement (QAPI) Program						
		shall be chaired or co-chaired by The MCO's medical director, meet at least quarterly and include provider representation.				
	Comments **Strength** **AON** **Suggestion**					
3.	Fraud and Abuse MCOC 97-98	The MCO shall have administrative and management arrangements and procedures to detect and prevent Fraud, Waste, and Abuse that comply with all state and federal laws and regulations, including 42 CFR 457.1285. The MCO's arrangements and procedures shall include: 1) A compliance program that includes: a) Written policies, procedures and standards of conduct detailing The MCO's commitment to comply with all applicable requirements and standards; b) A compliance officer responsible for developing and implementing the policies, procedures, and practices designed to ensure compliance with the Contract. The compliance officer shall have sufficient experience in healthcare and shall report directly to the CEO and The MCO's board of directors; c) A regulatory compliance committee on the board of directors and at the senior management level charged with overseeing The MCO's compliance program and its compliance with the Contract; d) A system for training and educating the compliance officer, senior management and The MCO's employees about state, federal, and contractual requirements;	☐ Compliance Program ☐ Verified Services ☐ Distribution of written policies ☐ Prompt reporting	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program					
	e) Effective lines of communication between the compliance officer and The MCO's employees, as evidenced by some formal policy; f) Enforcement of standards through well-publicized disciplinary guidelines; g) Non-retaliation policies against any individual that reports violations of The MCO's Fraud and Abuse policies and procedures or suspected Fraud and Abuse; and h) A system, and related procedures, with dedicated staff for routine internal monitoring, auditing of compliance risks, prompt response to, investigation of, and correction of compliance issues, actions to reduce the potential for recurrence of compliance issues, and ongoing compliance with the requirements of the Contract; 2) A method used to verify services that were represented to have been delivered by network providers were received by enrollees. Such verification process shall be conducted on a regular basis; 3) The distribution of written policies to The MCO's employees, and of any Subcontractor or agent, that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Act, including information about the rights of employees to be protected as whistleblowers; 4) Prompt reporting to FHKC of information The MCO obtains indicating Fraud or potential Fraud by a provider, subcontractors, applicant, or enrollee; and 5) Suspension of payments to a network provider when FHKC or AHCA determines there is a credible allegation of Fraud in accordance with 42 CFR 455.23; and f. Policies and procedures to maintain adequate staffing and resources to investigate unusual incidents and to develop corrective action plans to assist The MCO with				

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program					
	preventing and detecting potential Fraud and Abuse activities. The MCO shall provide its Fraud, Waste, and Abuse policies to FHKC for approval during implementation of this Contract, by the date established in the approved implementation plan, and prior to any changes. Changes to The MCO's Fraud, Waste, and Abuse policies are subject to FHKC approval. The MCO shall provide FHKC with a quarterly Fraud, Waste, and Abuse report detailing prevention activities conducted by The MCO, potential offenses being investigated and any confirmed instances of Fraud or Abuse. The MCO may report information on violations of law by subcontractors, providers, enrollees, or other relevant individuals to FHKC and/or to CMS, as appropriate. The MCO may only report such information regarding enrollees when the information pertains to enrollment in the plan or Covered Services.				
	Comments **Strength** **AON** **Suggestion**				
4. Accreditation MCOC 26.1, 105	The MCO shall: 1) Inform FHKC of any accreditations received by a private independent accrediting entity. 2) Authorize the private independent accrediting entity to provide FHKC with a copy of its most recent accreditation review. 3) Provide FHKC with a report listing the accrediting entity, accreditation program and accreditation level of all accreditations during implementation of the Contract, by the date established in the approved implementation plan, and annually thereafter by December 15th. The MCO shall inform FHKC of any change in accreditation status within 30 calendar days of such change.	☐ Inform FHKC of accreditations ☐ Authorization of accrediting entity ☐ Provide FHKC accreditation report	**0.33** **0.33** **0.34**	**1.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program					
Comments **Strength** **AON** **Suggestion**					
5. Long Term Services and Supports 42 CFR § 438.330(b)(5)	The comprehensive quality assessment and performance improvement program includes at least the following elements for MCOs providing long-term services and supports: 1) Mechanisms to assess the quality and appropriateness of care furnished to enrollees using long-term services and supports, including assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee's treatment/service plan, if applicable; and 2) Participate in efforts by FHKC to prevent, detect, and remediate critical incidents that are based, at a minimum, on the requirements on FHKC for home and community-based waiver programs.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
6. Managed Care Quality Rating System MCOC, 26.4, 101-102	FHKC may adopt the quality rating system developed by CMS or may adopt an alternative quality rating system as allowed in 42 CFR 457.1240 which incorporates 42 CFR 438.334. FHKC will notify The MCO of any such quality rating system. The MCO shall cooperate with FHKC in the implementation and maintenance, including data submission, of such quality rating system.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>						
Evaluation Elements		Criteria	Criteria Met	Criteria Value	Element	
					Value	Score
Quality Assessment and Performance Improvement (QAPI) Program						
	Comments **Strength** **AON** **Suggestion**					
7.	Performance Measurement 42 CFR § 438.330(c)(2)	The MCO annually: 1) Measures and reports to FHKC on its performance, using the standard measures required by FHKC; and 2) Submits data to FHKC which allow FHKC to calculate the MCO's performance using the standard measures identified by FHKC.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments **Strength** **AON** **Suggestion**					
8.	CAHPS® Survey MCOC 26.5, 102	The MCO shall conduct NCQA's Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, or its successor, annually for the Florida Healthy Kids population. The MCO shall conduct the annual CAHPS® survey in a manner that allows The MCO to report on the Florida Healthy Kids results separately from the results of any other group. FHKC may publish The MCO's Florida Healthy Kids CAHPS® survey results.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments **Strength** **AON** **Suggestion**					
			☐ Yes	**1.00**	**1.00**	**0.00**

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program					
9. Performance Improvement Projects 42 CFR § 438.330(d)(2)	Each performance improvement project must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and must include the following elements: 1) Rationale for selection; 2) Specific population targeted; 3) Relevant clinical practice guidelines; 4) Date of remeasurement; 5) Measurement of performance using objective quality indicators; 6) Implementation of interventions to achieve improvement in the access to and quality of care; 7) Evaluation of the effectiveness of the interventions based on the performance measures; and 8) Planning and initiation of activities for increasing or sustaining improvement.	☐ No	**0.00**		
Comments **Strength** **AON** **Suggestion**					
10. Reporting Results to FHKC 42 CFR § 438.330(d)(3)	The MCO reports the status and results of each project conducted to FHKC as requested, but not less than once per year. The MCO shall comply with all reporting requirements in the manner and timeframes specified in the contract with FHKC.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					

2024 Annual Compliance Assessment —Quality Process Standards: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Quality Assessment and Performance Improvement (QAPI) Program					
	Quality Assessment and Performance Improvement Program (QAPI) Score		**0.00%**	**10.00**	**0.00**

ACA DBM Tools

2024 Annual Compliance Assessment—Quality Process Standards: <DBM>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Availability of Services					
1. Delivery Network 42 CFR § 438.206(b)(1) DBMC 24.1,93-94	The DBM maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
2. Delivery Network 42 CFR § 438.206(b)(1) DBMC 24.1,93-94	The DBM shall provide FHKC with sixty (60) Calendar Days advance written notice of any anticipated termination of large Provider groups, hospitals, or any independently practicing Provider if the independently practicing Provider has at least fifty (50) Enrollees on its patient panel.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON**					

2024 Annual Compliance Assessment—Quality Process Standards: <DBM>						
Evaluation Elements		Criteria	Criteria Met	Criteria Value	Element	
					Value	Score
Availability of Services						
	Suggestion					
3.	Second Opinion 42 CFR § 438.206(b)(3)	The DBM provides for a second opinion from a network provider or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments					
	Strength					
	AON					
	Suggestion					
4.	Out-of-Network Services 42 CFR § 438.206(b)(4)	If the provider network is unable to provide necessary services covered under the contract to a particular enrollee, the DBM adequately and timely covers these services out of network for the enrollee, for as long as the DBM provider network is unable to provide them.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments					
	Strength					
	AON					
	Suggestion					
5.	Out-of-Network Costs 42 CFR § 438.206(b)(5)	The DBM requires out-of-network providers to coordinate with the DBM for payment and ensures the cost to the enrollee is no greater than it would be if the services were furnished within the network.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments					
	Strength					
	AON					
	Suggestion					

2024 Annual Compliance Assessment—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
6. Timely Access 42 CFR § 438.206.c(1)(i)	The DBM meets and requires its network providers to meet FHKC standards for timely access to care and services, taking into account the urgency of the need for services so that appointment waiting times do not exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
7. Hours of Operation and Access 42 CFR § 438.206(c)(1)(ii)	The DBM ensures that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees. The DBM makes services included in the contract available 24 hours a day, seven days a week, when medically necessary.	☐ Comparable hours of operation commercial ☐ Services available 24 hours a day, seven days a week, when medically necessary	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
8. Provider Compliance 42 CFR § 438.206(c)(1)(iv)-(vi) DBMC 24.1,93-94	The DBM: 1) Establishes mechanisms to ensure compliance by network providers; 2) Monitors network providers regularly to determine compliance; 3) Takes corrective action if there is a failure to comply by a network provider; and 4) Handle Provider complaints.	☐ Mechanisms to ensure compliance ☐ Monitoring to determine compliance ☐ Corrective action if failure to comply ☐ Handle provider complaints	**0.25** **0.25** **0.25** **0.25**	**1.00**	**0.00**
Comments **Strength** **AON**					

2024 Annual Compliance Assessment—Quality Process Standards: <DBM>						
Evaluation Elements		**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
					Value	**Score**
Availability of Services						
	Suggestion					
9.	Access and Cultural Considerations 42 CFR § 438.206(c)(2)	The DBM participates in FHKC's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and/or disabilities, and regardless of sex.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments					
	Strength					
	AON					
	Suggestion					
10.	Enrollee Customer Service DBMC 21;75	The DBM shall maintain an enrollee service unit to provide Enrollee-related customer service. The enrollee service unit shall have the ability to answer Enrollee inquiries by telephone, electronic communication, and written communication. The enrollee service unit shall be accessible by a toll-free telephone number during the hours of 7:30 a.m. to 7:30 p.m. Eastern Time, Monday through Friday, except on FHKC-recognized holidays. The DBM shall also provide a telecommunication device for the deaf (TTY/TDD) and access to interpreter services.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments					
	Strength					
	AON					
	Suggestion					
11.	Publicly Available Website DBMC 21;75		☐ Enrollee handbook ☐ Printable Provider Directory ☐ A searchable electronic provider directory ☐ A link to other information that may be needed by enrollees or potential	**0.20** **0.20** **0.20** **0.20**	**1.00**	**0.00**

2024 Annual Compliance Assessment—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
	The DBM shall provide a publicly available website with access to Florida Healthy Kids information. The publicly available website shall include: 1) The *Enrollee Handbook*; 2) A printable provider directory; 3) A searchable electronic provider directory; 4) A link to FHKC's Florida Healthy Kids website; and 5) Any other information that may be needed by Enrollees or potential Enrollees. The DBM's publicly available website is subject to FHKC approval.	enrollees. ☐ Any other information that may be needed by enrollees or potential enrollees.	**0.20**		
Comments **Strength** **AON** **Suggestion**					
12. Accessibility Considerations 42 CFR § 438.206(c)(3)	The DBM ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
13. Cultural Competency Plan FHKC Section 20; 75	The DBM shall submit its initial cultural competency plan for approval by FHKC by the date established in the approved implementation plan and annually thereafter by November 1st.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2024 Annual Compliance Assessment—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
Comments					
Strength					
AON					
Suggestion					
14. Indian Health Care Providers 42 CFR 447.45 DBMC 24.8, 96	The DBM shall: 1) Maintain sufficient numbers of Indian Health Care Providers (IHCPs) in the DBM's Provider network to ensure timely access to services to eligible enrollees; 2) Provide a quarterly attestation and supporting documentation to FHKC demonstrating compliance with this requirement; 3) Allow any Enrollee who is eligible to receive services from a network IHCP to choose the IHCP as his or her Primary Care Physician (PCP) so long as the IHCP has the capacity to provide the services; 4) 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; 5) Allow out-of-network IHCPs to refer Enrollees to a network Provider. Should there be too few IHCPs in the State to ensure timely access to Covered Services, Enrollees who are eligible to receive such services shall be permitted to access out-of-state IHCPs; and 6) Pay for Covered Services provided to eligible Enrollees by IHCPs, whether participating in the network or not, at either the rate negotiated between the DBM and the IHCP or at a rate not less than the level and amount of payment the DBM would make for services to a non-IHCP network Provider. The DBM shall make all payments to network IHCPs in a timely manner, as required by 42 CFR 447.45 and 447.46	☐ Maintain sufficient numbers of IHCPs ☐ Provide quarterly attestation and supporting documentation ☐ Allow eligible Enrollees to choose the IHCP as their PCP ☐ Allow eligible Enrollees to obtain covered services from an out-of-network IHCP ☐ Allow out-of-network IHCPs to refer Enrollees to a network Provider. ☐ The DBM pays for Covered Services provided to eligible Enrollees by IHCPs.	**0.16** **0.16** **0.17** **0.17** **0.17** **0.17**	**1.00**	**0.00**
Comments					
Strength					

2024 Annual Compliance Assessment—Quality Process Standards: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Availability of Services					
AON					
Suggestion					
		Availability of Services Score	**0.00%**	**14.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Assurances of Adequate Capacity and Services					
1. Assurances of Adequate Capacity—Supporting Documentation 42 CFR § 438.207(b)(1)-(2)	The DBM submits documentation to FHKC, in a format specified by FHKC, to demonstrate that it complies with the following requirements: 1) Offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area; and 2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated enrollees in the service area.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
2. Timing of Documentation 42 CFR § 438.207(c)(1)-(3)	The DBM submits the documentation in element one as specified by FHKC, but no less frequently than the following: 1) At the time it enters into a contract with FHKC; 2) On a monthly basis; and 3) At any time there has been a significant change (as defined by FHKC) in the DBM's operations that would affect the adequacy of capacity and services, including:	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Assurances of Adequate Capacity and Services					
	a) Changes in DBM services, benefits, geographic service area, composition of or payments to its provider network; or b) Enrollment of a new population in the DBM.				
Comments					
Strength					
AON					
Suggestion					
		Assurances of Adequate Capacity and Services Score	**0.0%**	**2.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
1. Grievance and Appeal System 42 CFR § 438.402(a)	The DBM has a grievance and appeal system in place for enrollees.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
2. Authority to File 42 CFR § 438.402.(c)(1)(i)	An enrollee may file a grievance and request an appeal with the DBM. An enrollee may request a State fair hearing after receiving notice under § 438.408.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
Comments						
Strength						
AON						
Suggestion						
3. Provider or Authorized Representative 42 CFR § 438.402.(c)(1)(ii)	With the written consent of the enrollee, a provider or an authorized representative may request an FHKC appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
4. Timing to File Grievance and Appeal 42 CFR § 438.402(c)(2)	An enrollee may file a grievance with the DBM at any time. Following receipt of a notice of adverse benefit determination (NABD), an enrollee has 60 calendar days from the date on the NABD notice to file a request for a FHKC appeal with FHKC.	☐ ☐	May file a grievance at any time Has 60 calendar days to request an appeal after receiving NABD	**0.50** **0.50**	**1.00**	**0.00**
Comments						
Strength						
AON						
Suggestion						
5. Procedures 42 CFR § 438.402(c)(3)	An enrollee may file a grievance with the DBM either orally or in writing. An enrollee may file an appeal contesting the DBM's proposed adverse benefit determination either orally or in writing at the FHKC phone number or address listed on the DBM-issued notice of adverse determination.	☐ ☐	May file grievance orally or in writing May request appeal orally or in writing	**0.50** **0.50**	**1.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
	Comments					
	Strength					
	AON					
	Suggestion					
6. Availability of Notices 42 CFR § 438.404(a)	The DBM gives enrollees timely and adequate notice of an adverse benefit determination in writing and makes the NABD available by the following means at no cost to the enrollee: 1. Written translation; 2. Oral interpretation; 3. Alternative formats; and 4. Auxiliary aids and services.	☐ ☐	Timely and adequate notice Available via the listed means	**0.50** **0.50**	**1.00**	**0.00**
	Comments					
	Strength					
	AON					
	Suggestion					
7. Content of Notice of Adverse Benefit Determination (NABD) 42 CFR § 438.404(b)(1)-(6)	The notice explains the following: 1. The adverse benefit determination the DBM has made or intends to make; 2. The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits; 3. The enrollee's right to request a FHKC appeal of the DBM's adverse benefit determination; 4. The procedures for exercising the rights;	☐ ☐ ☐ ☐ ☐ ☐	Determination made or intends to make Reasons for determination Right to request appeal Procedures for exercising rights Circumstances for which an appeal can be expedited Right to continuing benefits pending appeal resolution	**0.16** **0.16** **0.17** **0.17** **0.17** **0.17**	**1.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM						
Evaluation Elements	**Criteria**	**Criteria Met**		**Criteria Value**	**Element**	
					Value	**Score**
Grievance and Appeal Systems						
	5. The circumstances under which an appeal process can be expedited and how to request it; and 6. The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued.					
	Comments **Strength** **AON** **Suggestion**					
8. Timing of Notice 42 CFR § 438.404(c)(1) (2)	The DBM mails the NABD at the following times: 1. For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least 10 days before the date of action; and 2. For denial of payment, at the time of any action affecting the claim.	☐ ☐	At least 10 days before the date of action At the time of any action affecting the claim	**0.50** **0.50**	**1.00**	**0.00**
	Comments **Strength** **AON** **Suggestion**					
9. Timing for Standard Service Authorization 42 CFR § 438.404(c)(3)	For standard service authorization decisions that deny or limit services, the DBM mails the notice within 14-calendar days following the receipt of request for service.	☐ ☐	Yes No	**1.00** **0.00**	**1.00**	**0.00**
	Comments **Strength** **AON** **Suggestion**					

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
10. Extension of Standard Service Authorization Decisions 42 CFR § 438.404(c)(4) DBMC 23.1, 90	If the DBM meets the criteria set forth for extending the timeframe for standard service authorization decisions it: 1. Gives the enrollee written notice of the reason for the decision to extend the timeframe and informs the enrollee of the right to file a grievance if he or she disagrees with that decision; and 2. Issues and carries out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.	☐ Written notice ☐ Makes determination timely	**0.50** **0.50**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
11. Non-Enrollee Request Extension 42 CFR § 438.404(c)(4) DBMC 23.1, 90	If a Grievance timeframe has been extended other than at the request of an Enrollee, the DBM shall make reasonable efforts to give the Enrollee: 1. Prompt oral notice of the delay; 2. Written notice of the decision to extend the timeframe within two (2) calendar days; and 3. Notice of the Enrollee's right to file a Grievance regarding this decision.	☐ Prompt oral notice of delay ☐ Written notice of the decision to extend the timeframe within two (2) calendar days; and ☐ Notice of the Enrollee's right to file a Grievance regarding this decision.	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
12. Service Authorizations not Reached	For service authorization decisions not reached within the 14 calendar day timeframe, (which constitutes a denial and is thus an adverse benefit determination) the DBM mails the notice on the date that the timeframes expire.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
Within Timeframe 42 CFR § 438.404(c)(5)					
Comments **Strength** **AON** **Suggestion**					
13. Timing for Expedited Service Authorizations 42 CFR § 438.404(c)(6)	For expedited service authorization decisions, the DBM mails the notice within 72 hours of receipt of the request for service.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
14. Exceptions from Advance Notice 42 CFR § 431.213	The DBM may send a notice not later than the date of action if– 1. The DBM has factual information confirming the death of an enrollee; 2. The DBM receives a clear written statement signed by an enrollee that – 1. The enrollee no longer wishes services; or 2. Gives information that requires termination or reduction of services and indicates that the	☐ Death of enrollee ☐ No longer wishes services, or information requires termination or reduction of services ☐ Admitted to institution and ineligible for further services ☐ Whereabouts unknown ☐ Accepted by another Medicaid jurisdiction ☐ Change in level of care prescribed	**0.15** **0.15** **0.14** **0.14** **0.14** **0.14**	**1.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
	enrollee understands that this must be the result of supplying that information; 3. The enrollee has been admitted to an institution where the enrollee is ineligible under the plan for further services; 4. The enrollee's whereabouts are unknown, and the post office returns agency mail directed to the enrollee indicating no forwarding address; 5. The DBM establishes the fact that the enrollee has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; 6. A change in the level of medical care is prescribed by the enrollee's physician; and/or 7. The date of action will occur in less than 10 days.	☐ Date of action will occur in less than ten days	**0.14**		
	Comments **Strength** **AON** **Suggestion**				
15. Notice in Cases of Possible Fraud 42 CFR § 431.214	The DBM may shorten the period of advance notice to 5 days before the date of action if – 1. The DBM has facts indicating that action should be taken because of probable fraud by the enrollee; and **2.** The facts have been verified, if possible, through secondary sources.	☐ Facts indicating probable fraud ☐ Facts verified	**0.50** **0.50**	**1.00**	**0.00**
	Comments **Strength** **AON** **Suggestion**				
	In handling grievances and appeals, the DBM gives	☐ Yes	**1.00**	**1.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
16. Handling of Grievances and Appeals 42 CFR § 438.406(a)	enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	☐ No	**0.00**		
Comments **Strength** **AON** **Suggestion**					
17. Acknowledging Grievances and Forwarding Appeals 42 CFR § 438.406(b)(1)	The DBM's process for handling enrollee grievances and for satisfying FHKC requirements for appeals of adverse benefit determinations includes acknowledging receipt of each grievance and forwarding appeal of adverse benefit determinations to FHKC and informing the enrollee that FHKC will contact them about their appeal.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
18. Reviewer Requirements 42 CFR § 438.406(b)(2)	The DBM's process for handling enrollee grievances and appeals of adverse benefit determinations includes ensuring that the individuals who make decisions on grievances and appeals are individuals – 1. Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual; 2. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease:	☐ Not involved in previous review or subordinate ☐ Appropriate clinical expertise ☐ Take into account all information	**0.33** **0.33** **0.34**	**1.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
	1. An appeal of a denial that is based on lack of medical necessity; 2. A grievance regarding denial of expedited resolution of an appeal; or 3. A grievance or appeal that involves clinical issues; 3. Who take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.				
	Comments **Strength** **AON** **Suggestion**				
19. Oral Inquiries Treated as Appeals 42 CFR § 438.406(b)(4)	The DBM's process for and for satisfying FHKC's requirements for appeals of adverse benefit determinations includes providing that oral inquiries seeking to appeal an adverse benefit determination are forwarded to FHKC and treated as appeals (to establish the earliest possible filing date).	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments **Strength** **AON** **Suggestion**				
20. Resolution and Notification 42 CFR § 438.408(a)	The DBM resolves each grievance and appeal process-related obligations and provides notice as expeditiously as the enrollee's health condition requires, within FHKC-established timeframes.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments				

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
Strength					
AON					
Suggestion					
21. Grievance Resolution Timeframe 42 CFR § 438.408(b)(1)	For standard resolution of a grievance and notice to the affected parties, the DBM resolves each grievance within 90 calendar days from the day the DBM receives the grievance.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
22. Standard Appeal Resolution Timeframe 42 CFR § 438.408(b)(2)	For standard resolution of an appeal, the DBM resolves each appeal and provides notice within 14 calendar days of receipt.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
23. Expedited Appeal Resolution Timeframe 42 CFR § 438.408(b)(3)	For expedited resolutions, the DBM resolves each appeal and provides notice within 72 hours of receipt.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
AON					
Suggestion					
24. Extension of Appeal Timeframes 42 CFR § 438.408(c)(1)	The DBM may extend the appeal timeframes by up to 14 calendar days if – 1. The enrollee requests the extension; or **2.** The DBM shows (to the satisfaction of FHKC, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.	☐ Enrollee requests extension ☐ DBM shows need for additional information	**0.50** **0.50**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
25. Extension – Requirements 42 CFR § 438.408(c)(2)	If the DBM extends the appeal timeframes not at the request of the enrollee, it must complete all of the following: 1. Make reasonable efforts to give the enrollee prompt oral notice of the delay; 2. Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and **3.** Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.	☐ Prompt oral notice ☐ Written notice ☐ Resolve appeal timely	**0.33** **0.33** **0.34**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
26. Format of Grievance Notice 42 CFR §	The DBM uses the FHKC established method to notify an enrollee of the resolution of a grievance and ensures that	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
438.408(d)(1)	such methods provide for: 1. Written translation; 2. Oral interpretation; 3. Alternative formats; and 4. Auxiliary aids and services.				
Comments **Strength** **AON** **Suggestion**					
27. Format of Appeal Notice 42 CFR § 438.408(d)(2)	For all appeals, the DBM provides written notice of resolution in a format and language that provides for: 1. Written translation; 2. Oral interpretation; 3. Alternative formats; and 4. Auxiliary aids and services.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
28. Content of Notice of Appeal Resolution – Results and Date 42 CFR § 438.408(e)(1)	The written notice of the resolution must include the results of the resolution process and the date it was completed.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
Strength					
AON					
Suggestion					
29. Expedited Resolution of Appeals 42 CFR § 438.410(a)	The DBM establishes and maintains an expedited review process for appeals, when the DBM determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
30. Punitive Action Prohibited 42 CFR § 438.410(b)	The DBM ensures that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
31. Expedited Resolution of Appeals Requirements 42 CFR §	If the DBM denies a request for expedited resolution of an appeal, it– 1. Transfers the appeal to the timeframe for standard resolution; 2. Makes reasonable efforts to give the enrollee prompt	☐ Transfer to standard timeframe ☐ Give prompt oral notice ☐ Provide written notice	**0.25** **0.25** **0.25**	**1.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
438.410(c)	oral notice of the delay; 3. Within two (2) calendar days gives the enrollee written notice of the reason for the decision to extend the timeframe and informs the enrollee of the right to file a grievance if he or she disagrees with that decision; and 4. Completes the reconsideration phase of the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.	☐ Complete reconsideration no later than the date extension expires	**0.25**		
Comments **Strength** **AON** **Suggestion**					
32. Provider Information 42 CFR § 438.414	The DBM provides information about the grievance and FHKC appeal procedures and filing timeframes to all providers and subcontractors at the time they enter into a contract.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
33. Record-Keeping Requirements – Ongoing Monitoring 42 CFR § 438.416(a)	The DBM maintains records of grievances and appeals and reviews the information as part of its ongoing monitoring procedures, as well as for updates and revisions to FHKC's Quality Strategy.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
Comments **Strength** **AON** **Suggestion**					
34. Record-Keeping Requirements – Information 42 CFR § 438.416(b)	The record of each grievance or appeal contains, at a minimum, all of the following information: 1. A general description of the reason for the appeal or grievance; 2. The date received; 3. The date of each review or, if applicable, review meeting; 4. Resolution at each level of the appeal or grievance, if applicable; 5. Date of resolution at each level, if applicable; and 6. Name of the enrollee for whom the appeal or grievance was filed.	☐ Reason for appeal or grievance ☐ Date received ☐ Date of each review ☐ Resolution ☐ Date of resolution ☐ Name of enrollee	**0.16** **0.16** **0.17** **0.17** **0.17** **0.17**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
35. Record-keeping Requirements – Accuracy and Accessibility 42 CFR § 438.416(c)	The record must be accurately maintained in a manner accessible to FHKC and available upon request to CMS.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
Comments					
Strength					
AON					
Suggestion					
36. Continuation of Benefits 42 CFR § 438.420(b)	The DBM continues the enrollee's benefits if all of the following occur: 1. The enrollee files the request for an appeal timely; 2. The appeal involves the termination, suspension, or reduction of previously authorized services; 3. The services were ordered by an authorized provider; 4. The period covered by the original authorization has not expired; and **5.** The enrollee timely files for continuation of benefits.	☐ Enrollee files timely request ☐ Appeal involves change in previously authorized service ☐ Services ordered by authorized provider ☐ Period covered by authorization not expired. ☐ Enrollee files timely for continuation of benefits	**0.20** **0.20** **0.20** **0.20** **0.20**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
37. Duration of Continued or Reinstated Benefits 42 CFR § 438.420(c)	If, at the enrollee's request, the DBM continues or reinstates the enrollee's benefits while the appeal is pending, the DBM continues benefits until one of following occurs: 1. The enrollee withdraws the appeal; 2. The enrollee fails to request an appeal and continuation of benefits within 10 calendar days after the DBM sends the notice of an adverse resolution to the enrollee's appeal; or 3. An appeal results in a decision adverse to the enrollee.	☐ Enrollee withdraws appeal request ☐ Enrollee fails to request appeal and continuation of benefits timely ☐ Appeal decision adverse to the enrollee	**0.33** **0.33** **0.34**	**1.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
Comments **Strength** **AON** **Suggestion**					
38. Effectuation of Reversed Appeal Resolutions Services Not Furnished While Appeal Pending 42 CFR § 438.424(a)	If the FHKC appeal reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the DBM authorizes or provides the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments **Strength** **AON** **Suggestion**					
39. Effectuation of Reversed Appeal Resolutions Services Not Furnished While Appeal Pending 42 CFR § 438.408 42 CFR § 438.1260 DBMC 23.3	Enrollees may request an independent external review within one hundred and twenty (120) calendar days of notification that an appealed Adverse Benefit Determination has been upheld or when the Appeal process has been deemed exhausted by way of the DBM's failure to adhere to the notification and timing requirements of 42 CFR 457.1260 which incorporates 42 CFR 438.408.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Grievance and Appeal Systems					
Comments					
Strength					
AON					
Suggestion					
40. Effectuation of Reversed Appeal Resolutions – Services Furnished While Appeal Pending 42 CFR § 438.424(b)	If the FHKC appeal reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the DBM pays for those services.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
		Grievance and Appeal Systems Score	**0.00%**	**40.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Practice Guidelines					
1. Adoption of Practice Guidelines 42 CFR §		☐ Based on evidence or a consensus ☐ Consider enrollees' needs ☐ Adopted in consultation with network	**0.16** **0.16** **0.17**	**1.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM						
Evaluation Elements		**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
					Value	**Score**
Practice Guidelines						
	438.236(b)	The DBM adopts practice guidelines that meet the following requirements: 1) Are based on valid and reliable clinical evidence or a consensus of providers in the particular field; 2) Consider the needs of the DBM's enrollees; 3) Are adopted in consultation with network providers; 4) Are reviewed and updated periodically as appropriate; 5) Include guidelines specific to oral health and dental needs of individuals with intellectual and developmental disabilities, including appropriate use of intravenous (IV) sedation or other anesthesia; and 6) Comply fully with FHKC medical necessity rule as applicable	providers ☐ Reviewed and updated periodically ☐ Guidelines specific to individuals with intellectual and developmental disabilities ☐ Comply with medical necessity rule	**0.17** **0.17** **0.17**		
	Comments **Strength** **AON** **Suggestion**					
2.	Dissemination of Guidelines 42 CFR § 438.236(c)	The DBM disseminates the practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments **Strength** **AON** **Suggestion**					
3.	Application of Guidelines 42 CFR § 438.236(d)	Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Practice Guidelines					
Comments					
Strength					
AON					
Suggestion					
		Practice Guidelines Score	**0.00%**	**3.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Health Information Systems					
1. General Rule 42 CFR § 438.242(a)	The DBM maintains a health information system that collects, analyzes, integrates, and reports data. The system provides information on areas including, but not limited to, utilization, claims, grievances, and appeals, and disenrollments for reasons other than loss of FHKC eligibility.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					
Suggestion					
2. Basic Elements 42 CFR § 438.242(b)(2)	The DBM's health information system collects data on enrollee and provider characteristics as specified by FHKC, and on all services furnished to enrollees through an encounter data system or other methods as may be specified by FHKC.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
Comments					
Strength					
AON					

2024 Annual Quality Survey—Quality Process Standards: DBM						
Evaluation Elements		**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
					Value	**Score**
Health Information Systems						
	Suggestion					
3.	Data Accuracy and Completeness 42 CFR § 438.242(b)(3)	The DBM ensures that data received from providers are accurate and complete by: 1) Verifying the accuracy and timeliness of reported data, including data from network providers the DBM is compensating on the basis of capitation payments; 2) Screening the data for completeness, logic, and consistency; and 3) Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for FHKC quality improvement (QI) and care coordination efforts.	☐ Verify accuracy and timeliness ☐ Screen for completeness, logic, and consistency ☐ Collect data in standardized formats	**0.33** **0.33** **0.34**	**1.00**	**0.00**
	Comments					
	Strength					
	AON					
	Suggestion					
4.	Electronic Health Records for Providers Throughout the Contract Term DBMC 24.5.2, 95	The DBM shall monitor, promote, and support the use of electronic health records (EHRs) by its network Providers. By June 30, 2023, and annually thereafter, The DBM shall report to FHKC results of the DBM's efforts at promoting and monitoring the adoption of EHRs among network Providers. In the event use of EHRs by the DBM's network Providers does not increase from the previous Contract Year, the report shall include changes the DBM has made to its policies and procedures that support the adoption of EHRs.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments					
	Strength					
	AON					
	Suggestion					
			☐ Yes	**1.00**	**1.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Health Information Systems					
5. Data Availability 42 CFR § 438.242(b)(4)	The DBM makes all collected data available to FHKC and, upon request to CMS.	☐ No	**0.00**		
Comments					
Strength					
AON					
Suggestion					
		Health Information Systems Score	**0.00%**	**5.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program					
1. QAPI Program 42 CFR § 438.330(b)(1-5) DBMC 26.2, 109	The DBM establishes and implements an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees. FHKC may implement quality initiatives other than those types of quality activities considered in this Contract and may require The MCO to participate in such initiatives. The MCO shall maintain a quality assessment and performance improvement (QAPI) program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes. At a minimum, the QAPI program shall include: 5) Performance improvement projects (PIPs) focusing on clinical and non-clinical areas; 6) Collection and submission of performance measurement data;	☐ Clinical and Non-clinical PIPs ☐ PIPs data ☐ Mechanisms to detect under- or over-utilization of services ☐ Quality and appropriateness of care mechanisms ☐ Written policies and procedures ☐ Required PMVs and PIPs by CMS	**0.17** **0.17** **0.17** **0.17** **0.16** **0.16**	**1.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program					
	7) Mechanisms to detect underutilization and overutilization of services; 8) Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs; 9) Written policies and procedures that address components of effective health care management including anticipation, identification, monitoring, measurement, evaluation of enrollees' health care needs, and effective action to promote quality of care; and 10) Any performance measures and PIPs that are required by CMS during the term of this Contract.				
	Comments **Strength** **AON** **Suggestion**				
2. Fraud and Abuse DBMC 26.2, 109	The DBM shall have administrative and management arrangements and procedures to detect and prevent Fraud, Waste, and Abuse that comply with all state and federal laws and regulations, including 42 CFR 457.1285 and DBMC 25, 104. The DBM's arrangements and procedures shall include: 1) A compliance program that includes: 1) Written policies, procedures and standards of conduct detailing the DBM's commitment to comply with all applicable requirements and standards; 2) A compliance officer responsible for developing and implementing the policies, procedures, and practices designed to ensure compliance with the Contract. The compliance officer shall have sufficient experience in healthcare and shall	☐ Compliance Program ☐ Verified Services ☐ Distribution of written policies ☐ Prompt reporting ☐ Suspension of payments due to fraud	**0.20** **0.20** **0.20** **0.20** **0.20**	**1.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program					
	report directly to the CEO and the DBM's board of directors; 3) A regulatory compliance committee on the board of directors and at the senior management level charged with overseeing the DBM's compliance program and its compliance with the Contract; 4) A system for training and educating the compliance officer, senior management and the DBM's employees about state, federal, and contractual requirements; 5) Effective lines of communication between the compliance officer and the DBM's employees, as evidenced by some formal policy; 6) Enforcement of standards through well-publicized disciplinary guidelines; vii. Non-retaliation policies against any individual that reports violations of the DBM's Fraud and Abuse policies and procedures or suspected Fraud and Abuse; and 7) A system, and related procedures, with dedicated staff for routine internal monitoring, auditing of compliance risks, prompt response to, investigation of, and correction of compliance issues, actions to reduce the potential for recurrence of compliance issues, and ongoing compliance with the requirements of the Contract; 2) A method used to verify services that were represented to have been delivered by network Providers were received by Enrollees. Such verification process shall be conducted on a regular basis; 3) The distribution of written policies to the DBM's employees, and of any Subcontractor or agent, that provide detailed information about the False Claims Act and other federal and state laws described in				

2024 Annual Quality Survey—Quality Process Standards: DBM					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program					
	section 1902(a)(68) of the Act, including information about the rights of employees to be protected as whistleblowers; 4) Prompt reporting to FHKC of information the DBM obtains indicating Fraud or potential Fraud by a Provider, Subcontractors, Applicant, or Enrollee; 5) Suspension of payments to a network Provider when FHKC or AHCA determines there is a credible allegation of Fraud in accordance with 42 CFR 455.23; and 6) Policies and procedures to maintain adequate staffing and resources to investigate unusual incidents and to develop corrective action plans to assist the DBM with preventing and detecting potential Fraud and Abuse activities. The DBM shall provide its Fraud, Waste, and Abuse policies to FHKC for approval during implementation of this Contract, by the date established in the approved implementation plan, and prior to any changes. Changes to the DBM's Fraud, Waste, and Abuse policies are subject to FHKC approval. The DBM shall provide FHKC with a quarterly Fraud, Waste, and Abuse report detailing prevention activities conducted by the DBM, potential offenses being investigated and any confirmed instances of Fraud or Abuse. The DBM may report information on violations of law by Subcontractors, Providers, Enrollees, or other relevant individuals to FHKC and/or to CMS, as appropriate. The DBM may only report such information regarding Enrollees when the information pertains to enrollment in the plan or Covered Services.				

Comments

Strength

AON

2024 Annual Quality Survey—Quality Process Standards: DBM						
Evaluation Elements		**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
					Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program						
	Suggestion					
3.	Accreditation DBMC 26.1, 105	1) The DBM shall inform FHKC of any accreditations received by a private independent accrediting entity. The DBM shall authorize the private independent accrediting entity to provide FHKC with a copy of its most recent accreditation review. 2) The DBM shall provide FHKC with a report listing the accrediting entity, accreditation program and accreditation level of all accreditations during implementation of the Contract, by the date established in the approved implementation plan, and annually thereafter by December 15th. The DBM shall inform FHKC of any change in accreditation status within thirty (30) Calendar Days of such change.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments					
	Strength					
	AON					
	Suggestion					
4.	Utilization and Special Health Care Needs 42 CFR § 438.330(b)(3)-(4)	The comprehensive quality assessment and performance improvement program includes at least the following elements: 1) Mechanisms to detect both underutilization and overutilization of services; and 2) Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by FHKC in the Quality Strategy.	☐ Mechanisms to detect under and overutilization ☐ Mechanisms to assess quality of care furnished to enrollees with special health care needs	**0.50** **0.50**	**1.00**	**0.00**
	Comments					
	Strength					
	AON					
	Suggestion					
			☐ Yes	**1.00**	**1.00**	**0.00**

2024 Annual Quality Survey—Quality Process Standards: DBM						
Evaluation Elements		**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
					Value	**Score**
Quality Assessment and Performance Improvement (QAPI) Program						
5.	Annual Evaluation 42 CFR § 438.330(c)(2) DBMC 26.2,106-107	The DBM shall submit its QIP to FHKC during implementation of the Contract, by the date established in the approved implementation plan, and annually thereafter by July 1st . On an annual basis, the DBM evaluates its performance by completing one or both of the following activities: 1) Measure and report to FHKC on its performance, using the standard measures required by FHKC; and/or 2) Submit data to FHKC that allow FHKC to calculate the DBM's performance using the standard measures.	☐ No	**0.00**		
	Comments **Strength** **AON** **Suggestion**					
6.	Performance Improvement Projects 42 CFR § 438.330(d)(2)	Each performance improvement project is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and must include the following elements: 1) Rationale for selection; 2) Specific population targeted; 3) Relevant clinical practice guidelines; 4) Date of remeasurement; 5) Measurement of performance using objective quality indicators; 6) Implementation of interventions to achieve improvement in the access to and quality of care; 7) Evaluation of the effectiveness of the interventions based on the performance measures in paragraph (d)(2)(i) of this section; and 8) Planning and initiation of activities for increasing or sustaining improvement.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments **Strength**					

2024 Annual Quality Survey—Quality Process Standards: DBM						
Evaluation Elements		Criteria	Criteria Met	Criteria Value	Element	
					Value	Score
Quality Assessment and Performance Improvement (QAPI) Program						
	AON					
	Suggestion					
7.	Reporting Results to FHKC 42 CFR § 438.330(d)(3)	The DBM reports the status and results of each project conducted to FHKC as requested, but not less than once per year.	☐ Yes ☐ No	**1.00** **0.00**	**1.00**	**0.00**
	Comments					
	Strength					
	AON					
	Suggestion					
			Quality Assessment and Performance Improvement Program (QAPI) Score	**0.0%**	**7.00**	**0.00**

ACA MCO and DBM File Review Tools

These guidelines were used to conduct PA file reviews for the 2024 ACA.

UM Denials

Tool Components

Record the name of the MCO/DBM and the date of the review in the spaces provided. Review the MCO/DBM's policy and procedure regarding UM denials and note the maximum hours/days allowable for a decision to be made and for the member and provider to be notified of the decision to deny/reduce the requested service. Then compare the MCO/DBM's standards to the CFR timeframes listed below. The time standard used for review is the shorter of the MCO/DBM or CFR timeframe.

CFR Timeframes:

- *Expedited authorization decisions* must be made and notice provided as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. The MCO/DBM may extend the 72 hour time period by up to 14 calendar days if the member requests an extension, or if the MCO/DBM justifies (to FHKC upon request) a need for additional information and how the extension is in the member's interest.

- *Standard authorization decisions* must be made and notice provided as expeditiously as the member's condition requires, not to exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days if the member or provider requests the extension or the MCO/DBM justifies (to FHKC upon request) a need for additional information and how the extension is in the member's interest.

Review the sampled UM denial files for members ages 20 years and younger, completing columns 2–12 on the *UM Denials File Review Tool.* If a file is not applicable (i.e., anything other than a denial), it may be necessary to review additional records from the oversample to reach a denominator of 10 UM denials. Mark each box with an "X" for columns for either a yes ("Y") or no ("N") answer.

Column 1 – File #: This column is prepopulated (1–10) to identify total number of files required to be reviewed.

Column 2 – Case ID: Record the case identification number assigned to the file.

Column 3 – Date Request Received: Enter the month, day, and year (M/D/YY) on which the request for the service or procedure was received by the MCO/DBM.

Column 4 – Appropriate Review Criteria Used?: Mark under "Y" for the file in each row if review criteria were used appropriately to make the decision to deny or reduce the amount, duration, or scope of the requested service; otherwise, mark the "N" column. If the MCO/DBM did not receive the required medical/dental records with the request and did not follow up with the provider's office to request such records, mark the "N" column for the file.

Column 5 – Requesting Provider Consulted: Mark the "Y" column for that record if the requesting provider was consulted prior to making the denial decision. Mark the "N" column for that record if she or he was not consulted, but there is evidence she or he should have been; otherwise, mark the "NA" column for that record.

Column 6 – Final Denial Decision by Qualified Professional: A licensed physician or Doctor of Dental Surgery must make all final denial and reduction of service decisions regarding inpatient hospital services. All other decisions to deny or reduce a service should "be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease." Mark the "Y" column for that record if an appropriate professional made the decision; otherwise, mark the "N" column for that record.

Column 7 – Decision Based on Medical Necessity of Member's Condition: MCO/DBMs may not deny or reduce the amount, duration, or scope of a requested service solely because of the type of illness, diagnosis, or condition of the member. The member's individual medical needs must be considered. Mark the "Y" column for that record if the decision was based on the member's individual needs; otherwise, mark the "N" column for that record. If the MCO/DBM did not receive the required medical/dental records necessary to make a determination based on the member's individual needs and did not follow up with the provider's office to request such records, mark the "N" column for that record.

Column 8 – E/S: Indicate the type of file under review by recording an "E" (expedited) or an "S" (standard).

Column 9 – Date Notified: Enter the month, day, and year (M/D/YY) on which the MCO/DBM notified the member and provider of the decision to deny.

Column 10 – Number of Days for Notification: The number of days will auto-populate based on the dates entered in column 3 and column 9.

Column 11 – Notification Time Standard: Enter the number of days the MCO/DBM used as its time standard to notify members and providers about a denial/reduction in service decision.

Column 12 – Notification Time Standard Met: If column 10 is ≤ column 11, mark the "Y" column for that record; otherwise, mark the "N" column for that record.

- **Scoring Directions**

Compliant Answers: Auto-calculates in columns 4-7 and 12 based on compliant answers (i.e., number of Xs designating "Y" for a given column).

Applicable Answers: Auto-calculates in columns 4-7 and 12 based on applicable answers (i.e., number of Xs in "Y" and "N" columns)

Total Compliant: Auto-calculates sum of the Compliant Answers.

Total Applicable: Auto-calculates sum of the Applicable Answers.

Percent Compliant: Auto-calculates a percentage by dividing Total Compliant over Total Applicable.

Grievances

Tool Components

Record the name of the MCO/DBM and the date of the review in the spaces provided at the top. Review the MCO/DBM's policy and procedure regarding grievance resolution and note the maximum hours/days allowable for the resolution and notice to the affected parties. Then compare the MCO/DBM's standards to the CFR resolution timeframe, which is 90 calendar days from the day the MCO/DBM receives the grievance. The time standard used for review is the shorter of the MCO/DBM or CFR timeframe.

Review the pre-selected grievance files, completing columns 2–10 on the *Grievance File Review Tool.* If a file is not applicable (i.e., anything other than a grievance), it may be necessary to review additional files from the oversample in order to reach a denominator of 10 grievances. Mark each cell with an "X" in the columns requiring either a yes ("Y") or no ("N") answer.

Column 1 – File #: This column is pre-populated (1–10) to identify which of the files is being reviewed.

Column 2 – Case ID: Record the case identification number assigned to the file.

Column 3 – Grievance Rcvd. Date: Enter the month, day, and year (M/D/YY) on which the grievance was received by the MCO/DBM.

Column 4 – Grievance Documented: Mark the "Y" column for that record if the grievance was documented by the MCO/DBM; otherwise, mark the "N" column for that record.

Column 5 – Investigation of Grievance: Mark the "Y" column for that record if the substance of the grievance was investigated and documented and if the resolution was not arbitrary; otherwise, mark the "N" column for that record.

Column 6 – Date Resolved: Enter the month, day, and year (M/D/YY) on which the grievance was resolved by the MCO/DBM.

Column 7 – Number of Days to Resolve: Auto-calculates the number of days it took the MCO/DBM to resolve the grievance. Calculated by subtracting column 3 from column 6.

Column 8 – Time Standard: Review the MCO/DBM's policy and procedure regarding grievance handling and note the maximum days allowable for grievance resolution. Enter the number of days the MCO/DBM uses as its time standard to resolve grievances.

Column 9 – Time Standard Met: If column 7 ≤ column 8, mark the "Y" column for that record; otherwise, mark the "N" column for that record.

Column 10 – Notification of Resolution: Mark the "Y" column for that record if the member was notified verbally, by mail or electronically and if notification was documented. If the member was not notified or if notification was not documented, mark the "N" column for that record.

Scoring Directions

Compliant Answers: Auto-calculates in columns 4, 5, 9 and 10 based on compliant answers (i.e., the number of "Xs" in "Y" column).

Applicable Answers: Auto-calculates in columns 4, 5, 9 and 10 based on applicable answers (i.e., the number of "Xs" in "Y" and "N" column).

Total Compliant: Auto-calculates sum of the Compliant Answers.

Total Applicable: Auto-calculates the sum of the Applicable Answers.

Percent Compliant: Auto-calculates a percentage by dividing Total Compliant over Total Applicable.

Appeals

Tool Components

Record the name of the MCO/DBM and the date of the review in the spaces provided. Review the MCO/DBM's policy and procedure regarding appeals and note the maximum hours/days allowable for a decision to be made and for the affected parties to be notified of the decision. Then compare the MCO/DBM's standards to the CFR timeframes listed below. The time standard used for review is the shorter of the MCO/DBM or CFR timeframe.

CFR Timeframes:

- *Expedited authorization decisions* must be made and notice to the affected parties provided no longer than 72 hours after the MCO/DBM receives the appeal, with a possible extension of up to 14 additional calendar days if the member requests the extension or the MCO/DBM justifies (to FHKC upon request) a need for additional information and how the delay is in the member's interest.
- *Standard resolution of appeals* must be made and notice to the affected parties provided no longer than 30 calendar days from the day the MCO/DBM receives the appeal, with a possible extension of up to 14 additional calendar days if the member requests the extension or the MCO/DBM justifies (to FHKC upon request) a need for additional information and how the delay is in the member's interest.

Review the pre-selected appeal files, completing columns 2–11 on the *Appeals File Review Tool*. If a file is not applicable (i.e., anything other than an appeal), it may be necessary to review additional files from the oversample in order to reach a denominator of 10 appeals. Mark each box with an "X" for columns requiring either a yes ("Y") or no ("N") answer.

Column 1 – File #: This column is pre-populated (1–10) to identify total number of files required to be reviewed.

Column 2 – Case ID: Record the case identification number assigned to the file.

Column 3 – Date Appeal Received: Enter the month, day, and year (M/D/YY) on which the appeal request was received by the MCO/DBM.

Column 4 – Reviewed by Qualified Staff: If this is true, mark the "Y" column for that record; otherwise, mark the "N" column for that record. If no practitioner/provider was involved in the case, mark the "NA" column for that record.

Column 5 – Appeal Investigation Documented: Mark the "Y" column for that record if the substance of the appeal was investigated and documented; otherwise, mark the "N" column for that record.

Column 6 – S/A/E: Indicate the type of file under review by recording an "S" (standard), "A" (accelerated), or "E" (expedited).

Column 7 – Date Member Notified of Decision: Enter the month, day, and year (M/D/YY) on which the MCO/DBM notified the member of the appeal decision.

Column 8 – Number of Days for Resolution: Auto-calculates the number of days it took the MCO/DBM to make the decision and contact the member.

Column 9 – Resolution Time Standard: Enter the number of hours/days allowable for the file type (i.e., standard, accelerated or expedited). The most stringent standard (based on MCO/DBM policy or the CFR) should be used.

Column 10 – Resolution Time Standard Met: If column 9 is ≤ column 10, mark the "Y" column for that record; otherwise, mark the "N" column for that record.

Column 11 – State-Mandated Letter Used: Mark the "Y" column for that record if the MCO/DBM used and completed the template from FHKC to notify member of the appeal decision; otherwise, mark the "N" column for that record.

- **Scoring Directions**

Compliant Answers: Auto-calculates in columns 4, 5, 10 and 11 based on compliant answers (i.e., number of Xs in "Y" column)

Applicable Answers: Auto-calculates in columns 4, 5, 10 and 11 based on applicable answers (i.e., number of Xs in "Y" and "N" columns)

Total Compliant: Auto-calculates sum of the Compliant Answers.

Total Applicable: Auto-calculates sum of the Applicable Answers.

Percent Compliant: Auto-calculates a percentage by dividing Total Compliant over Total Applicable.

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. 2024 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 2023 ACA.

Table C-1. QP Standard: Enrollee Information Requirements

Element #	ACA Tool Element Name	42 CFR Reference(s)	2023 NCQA Element(s)	NCQA Equivalency	Comments

Table C-1. QP Standard: Enrollee Information Requirements					
Element #	**ACA Tool Element Name**	**42 CFR Reference(s)**	**2023 NCQA Element(s)**	**NCQA Equivalency**	**Comments**

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**

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**

Table C-3. QP Standard: Credentialing/Recredentialing					
Element #	**ACA Tool Element Name**	**42 CFR Reference(s)**	**2019 NCQA Element(s)**	**NCQA Equivalency***	**Qsource Notes**

Table C-3. QP Standard: Credentialing/Recredentialing					
Element #	**ACA Tool Element Name**	**42 CFR Reference(s)**	**2019 NCQA Element(s)**	**NCQA Equivalency***	**Qsource Notes**